'Maine Kids: The Way Life Should Be'

Knowledge Dissemination Conference
Adolescent Mental Health & Substance Use Disorders

Monograph of Conference Proceedings
May 9 & 10, 2000

Dear Reader:

We, as planners of the conference "*Maine Kids: The Way Life Should Be - -* Treating Adolescents Who Experience Mental Health and Substance Use Disorders" and as members of the Adolescent Co-Occurring Mental Health and Substance Use Disorders Collaborative, hope that the information contained in this monograph of the conference proceedings is taken back to agencies, programs and/or homes in order to improve the services and support for adolescents with mental health and substance use problems and their families.

As members of a Collaborative in southern Maine, we have made a commitment to raise awareness within both southern Maine and the State of Maine on the issue of adolescents with co-occurring disorders and to build best practice models. Adolescents and their families throughout Maine are facing the challenges of mental health and substance abuse in disturbing and alarming numbers. Adolescents will succeed in addressing their problems only if we are willing to work across agencies, departments and professions in order to provide individualized, strength-based and integrated care and services.

We sincerely hope that you will join in this effort and join with adolescents and their families to make life what it can and should be here in Maine.

The members of the Adolescent Co-occurring Mental Health and Substance Use Disorders Collaborative as of the time of the conference were:

- Counseling Services, Inc.
- Co-Occurring Collaborative of Southern Maine (Formerly known as the Cumberland County Dual Diagnosis Collaborative)
- Community Counseling Center
- Day One
- Department of Human Services, Region I
- Department of Mental Health, Mental Retardation and Substance Abuse Services, Region I
- Department of Juvenile Community Corrections, Region I
- MSAD #51 (Cumberland and North Yarmouth)
- Ingraham
- ANCHOR Program, Maine Medical Center, Department of Psychiatry,

- Division of Child and Adolescent Psychiatry
- Maine Youth Center
- NAMI CHOICES
- Portland Police Department
- Portland Public Schools
- Preble Street Resource Center
- Southern Maine Advisory Council on Transition
- Spring Harbor Hospital and Spring Harbor Hospital Outpatient Services
- The Spurwink School
- Sweester
- VNA, Home Health Care
- Youth Alternatives, Inc.
- YWCA of Greater Portland

TABLE OF CONTENTS

A SIGH OF BELIEF: HELPING PARENTS TO RAISE THEIR CONFIDENCE
Presented by Robert J. Ackerman, Ph.D.

This presentation examined the conditions and behaviors that destroy and undermine confidence in parents, and discussed techniques to build or restore it. It stressed the importance of parental confidence in successfully supporting the education of their children as well as supporting the educators who work with their children.

It is difficult for many parents to know where they stand as parents. They might wonder how they can be good at their jobs, professional in their interactions with other adults, composed in crises that are outside of their families, but constantly feel tested and frustrated dealing with their children. Parents want the best for their children, but are not sure of the best way to teach their children. It is critical to raise and maintain parents' confidence in their roles as parents. It is not as important to focus on strategies for handling children, but rather on how to raise parents' confidence in order to more effectively be a parent who feels secure rather than one filled with doubt.

DIFFICULTIES OF BEING A PARENT TODAY

Today's parents fill many roles, and they can feel very good about themselves as they successfully fill certain roles that are outside the family. A parent might be very successful at work; he or she is liked and respected as a fully functioning adult; he or she has enough money, knows what he or she is doing, and feels pretty good. Their self-confidence is high.

Then their teenager doesn't respond to them, or complains about something in the house, slams the door, states they are going to stay overnight in another home, and claims his or her parents embarrass them in front of everyone and they don't trust them. Suddenly something has changed internally within the parent. The parent's self-confidence is gone. The teenager hasn't changed; it is the parent who has changed.

Bookstores have hundreds of parenting books, but do those books really have anything to do with parenting. Those books are all about kids, not about parents. They tell how to teach kids

something or how to overcome a supposed defect in a kid. But they do not deal with what is going on with the parents -- how the parent is feeling, what are their hopes, their aspirations, their dreams, their doubts. The books do not cover the feelings engendered when, on one hand, a parent is supposed to spend time with this child and, on the other hand, they are supposed to be able to maintain the health, the wealth, the education, and the housing of his or her child. A parent is supposed to love his child, but is left often exhausted.

PARENTS MUST LEARN TO TAKE CARE OF THEMSELVES

Parents who feel good about themselves are able to take care of themselves. Parents spend so much time trying to figure how to take care of their children that they never realize the prerequisite for that is to be physically, emotionally, and spiritually healthy. The exhausted parent can only do so much.

PARENTS MUST ACCEPT THEIR PARENTAL RESPONSIBILITIES

There are now a large number of programs in this country for children. There are more programs for children today then there were ten years ago, and five years from now there will be even more. Many people in communities have worked very hard to develop programs for kids and they have done so with great pride. But the reason there are many programs for children is that there are too many adults in this country who will not accept their parental responsibilities. If adults would accept their responsibilities, we would not need institutions to do what families should be doing.

Children and teenagers have not changed much over the years. If children are allowed to do what they want to do, they will do just that. It is not that children have changed; instead, both the family structure and the society have changed dramatically.

EXPECTATIONS OF CHILDREN MUST BE CLEAR

Years ago, if a parent told a child to do something, he or she usually did it. They did it because of many reasons; they did not know any better; they were punished if they did not do it; respect for their parents, and they perceived that compliance was expected. In general, they complied because there was a good outcome if they obeyed or a negative outcome if they didn't.

They perceived very clearly where they thought their parents stood. Even if the parents were faking it, there was no doubt about what the children perceived about the parent. Additionally, this provided structure for the children to know where they stood as well.

PARENTS MUST BE LEADERS

Families that have problems, especially those with teenagers, often experience the roles of parent and child becoming blurred. The family situation is a constant struggle of who really is in charge. In addition, parents who mean well often are not parenting by leadership. They are not parenting positively, by their beliefs or the direction they want to go. Instead, what is driving them is a negative force. They are parenting by default. Instead of positively leading the child toward what they think the child should do, they are so fearful of ruining their children by not doing something, that they act out of fear and doubt. This is parenting by default, not by positive leadership.

PARENTS NEED SELF-CONFIDENCE

As mentioned earlier, in a bookstore, you can find many books supposedly on parenting. Some of these books are titled *Your Hyper-Active Child; A Parents guide to ADD; Raising Self-Reliant Children, The Strong Willed Child, Raising a Thinking Child, Raising Your Spiritual Child, Helping Your Child Cope with Divorce, Why Johnny Can't Tell Right from Wrong, Tough Love, The Difficult Child, How to Talk so Kids Can Learn, Your Child's Self-Esteem, Touch Points For Your Child's Emotional and Behavioral Development, Teaching Your Kids to Care, Solve Your Child's Sleep Pattern Problems, Toilet Training in Less than a Day, and Normal Children Have Problems Too, How Parents Can Help and Understand.*

There are many strategies to help parents raise their children, but it is self-confidence, not strategy, that really allows parents to be successful. Even without many strategies, if parents believe what they are doing is right, and both parents agree about what is best for their family, then they will be successful as parents. No technique will work in the hands of a parent who lacks self-confidence. Eventually the child knows the absence and the child plays on it.

The opposite of confidence is insecurity and doubt. Parents today have a lot of doubt about their abilities. It is to be expected that there is always some doubt, insecurity and hopefulness about doing the right thing found in all parents. But the tougher the situation with a difficult child, the more parents need confidence. The older the children get, the more parents need confidence. The closer a child is to being an adolescent, the more parents need confidence.

CULTURAL CHANGES OVER THE PAST THIRTY YEARS

A positive change in parenting is that more parents today have more involvement with their children than at any time in history. Parents are more emotionally involved with their children, and they are aware that childhood can be painful. Unfortunately, some parents have tried to protect their kids from all childhood pain. Also, one of the reasons we have so many problems with kids is that we put them into activities such as sports or academic pursuits when they are too young. In many ways we are creating excessive stress for children.

All children have stress in their lives. For example, the number one stress felt by American elementary school students is being called on to read aloud. That hasn't changed since we were children. But, in addition, they have concerns about safety and violence. Forty-three percent of children in this country's public schools will not use the bathrooms for fear of violence. Circumstances for children have changed and parents, more than ever, must be involved in their children's lives. This does not mean that children should not have some responsibility and accountability for their behaviors.

In this country, the cultural expectation is that the main roles of adolescents are to show up and to be consumers. An example is parental involvement in high school proms. Parents are doing all the decorating, they are making all the arrangements, they are footing the bill, and they are doing everything. The only thing the teen has to do is show up. This does not do teenagers a favor. If their job is just to show up, when they do show up, they expect something for it. They are contributing nothing. They have no investment in it. There is an attitude that they are owed this. What is it that we are teaching our children when we do everything for them?

These are examples of changes that have been gradually taking place. Children have inherited these gradual changes. These have been thirty-year changes. Children have not changed so much; instead, adults in this country have not stood up. Teenagers need to see their parents and other adults standing up for the right thing. And the community needs to stand up with the parent. If it takes a village to raise a child, then it takes that same village to support a parent. What has been have lost in this country is a sense of community. If the healthiest family in the world is put into a broken down community, they are going to barely be able to hold on. But if a family with a lot of trouble and a lot of problems is put into a healthy community, there are many offsetting factors. Again it is the adults that make the difference.

Our communities have lost a collective sense of identity. A collective sense of identity is an understanding among most adults of what was expected from kids. This expectation was conveyed to kids in a community. Most people understood what it meant to respect somebody, what behavior was allowed, and what was not. Children knew what was approved and disapproved behaviors because of parameters set and maintained by adults and then conveyed to children. Children also expected that adults, even if they were not related, would say something if their behavior was not what was expected. Adults have lost their confidence. Once adults lost their confidence, they stopped saying anything about poor behavior, and the children do whatever they want.

One of the results is that, in the eyes of many adolescents, adults have now become irrelevant. When an adult is present, they do not alter their gestures, their sayings, their conversations, or their topics. Years ago, teens might have said the very same things, but they certainly didn't say them in front of everybody. In the past, a teen was very much aware of an adult's presence and also aware of an adult's expectations. In addition, that teen was aware of the adult's confidence to speak up as needed.

The point is that in order to help teenagers, we must help parents and other adults feel relevant. It is important to respond to poor behavior. Silence is perceived as condoning, or at least tolerating, that behavior.

Teenagers often do not know what it means to be a member of their family, what their family believes, and what their family expects from them. They don't know what their family won't stand for, or what they will or won't tolerate. The teen can not say what beliefs his family has, what is their religion or values or rituals. If a teen does know those things, they are getting it from their parent or parents; they have been shown what is acceptable in their family home. If teenagers can not say what their family stands for, they may believe their family does not care, and that can be a cause of a teenager's anger.

LOW CONFIDENT PARENTS

There are several indicators of parents with low confidence. Parents with low confidence let their children get by with rude or impolite behavior because they are upset and it is inconvenient to be courteous. They let their child do something wrong because they are afraid to speak up. Some parents allow their children to avoid or withdraw from activities because of complaints that they are too hard or not fun. Or they constantly give their children money or buy things for them because that is what they want. When children neglect their chores and responsibilities, low confident parents usually do the chores for them while loudly complaining about it. That might be because it's easier, it will only take a minute or two, or because the parents are exhausted, and not remembering to give themselves self-care. Children often talk low confident parents out of disciplinary measures they have assigned. And low confident parents might automatically replace property that a child damages or loses through personal negligence, because the child is upset. These parents often intercede on their child's behalf when he or she gets into trouble by misbehaving. Low confident parents sometimes cross over the line from supporting their child in a project, or meeting a responsibility, to doing it for him or her. And they are willing to stretch ethical boundaries to help keep their child happy.

PARENTAL SELF-CARE

Parents need to learn to provide some self-care. Many times parents do not engage in self-care by enforcing what their boundaries or expectations are because they are tired. Kids will really, really, really wear you down. An example of providing self-care is shown by this story from when our oldest son was about 15.

One day I made a very routine request of him. I said, "Take out the garbage, please." He didn't reply. He just went over and did the adolescent shuffle. That night as I was getting ready to go to bed, I went around the house checking the lights and turning things off. I opened the door to the garage to check to make sure the garage doors were down. And when I opened the door, I saw the trash sitting on the top step. Now, it is three steps to the floor of the garage. At the bottom of the third step on the right hand side is the trashcan. It would have taken me only a couple of seconds to pick up the trash and put it in the garbage can, but I thought, "This is one of those times that I can use self-care. I should invest a little in myself instead of letting him get away with it." Even though it was a little after midnight, I thought, "Let us not deprive this youth of this learning experience that is about to occur." So I went up stairs and went to his room where he was sleeping. It was dark and I flipped on the overhead light. Right away my self-esteem started to improve immensely. I went over to him and he said, "What?" I said, "What did you do with the garbage?" He said, "I took it out." And I said, "Get out of bed, go downstairs, go open up the garage door, be careful not to trip, pick up the trash, walk down three steps and on your right-hand side there are two big green things that have been part of the family for years, take the lid off one, put the garbage in, put the lid back on, turn around, walk up the steps, turn out the garage light, close the garage door." "You mean, now?" "Yes, I'll wait."

Now, it might sound facetious, but I never had to tell him again where the garbage went. And I did not have to worry the next day about talking to him about being irresponsible.

RESILIENCE IN CHILDREN

Children are relatively resilient and, to a certain extent, children are rejection-proof. For example, if a child asks for something and the parent says "No," the child asks again. If the child asks for something nineteen times, and nineteen times the parent says "No," and the 20th time the parent says "Well maybe," the child hears "Yes." The child doesn't need a support group to deal with self-esteem because they have been rejected nineteen times. That is irrelevant to them. They were only looking for the "Yes." They do not care about the nineteen rejections.

Parents can be so afraid of being rejected by their children that they are afraid of having their own boundaries. Rule Number One if you have a teenager is "Don't take it personally." That is very hard to do, especially if dealing with an angry teenager. Parents need to remember that the teenager does not know why he or she is angry. In fact, they do not think that they are angry; they think they are being themselves.

Parents who are still trying to do everything for their child because they are afraid of being rejected should realize that, in many cases, the teenager has already rejected the advice of the parent, the guidance of the parent, and everything what the parent expects. It is easy to reject people when they do not stand up, when they do not stand for something. It is almost effortless. It was Martin Luther King, Jr., who said, "If you don't stand for something, you will fall for anything." That is excellent parenting advice. When we produce low confidence parents, we are probably producing low confidence children without realizing it.

PARENTAL PARADOXICAL DILEMMAS

Parents put themselves into many paradoxical dilemmas. The following are some examples.

EXPECTING CHILDREN TO SAY NO WHEN THEY HAVE NEVER HEARD NO

It is not sensible to expect this generation of adolescents to say "No" to drugs when they have never heard "No." They don't hear "No" to many of their requests, like seeing a rated movie, buying a particular CD, or hanging around with a particular crowd. They have not heard, "No, you are going to stay home because you have to do work" or "No, because it is one of our rules."

Research has shown that the most common complaint from parents in this country is not about kids; it is about other parents who let their children do things that they should not be doing. This makes it even more difficult to say "No." If there is consistency within the family about family rules, the children are less likely to complain. The values of the family must be consistently followed. This would be much easier if we had more consistency among parents about appropriate behaviors, their own and their children's.

MICRO-MANAGED CHILDREN CANNOT MANAGE FOR THEMSELVES

Many children are micro-managed. These are the children whose parent has stepped in and done everything for them. They are so concerned that their child gets everything, they are overly managing everything about their child. Then they wonder why their child can't manage to

do anything for himself of herself. A few years ago, the first group of micro-managed adolescents entered college in the United States. Many professors and staff in the United States reported that it was the parents that drove everyone crazy. The parents called to make schedules, to know why something happened, or to explain why their child could not get up in time for an early class. The parents moved everything into the dormitories. Some parents even came to the college three days early to set up the whole room because the student wanted to go do something else.

We are not doing these micro-managed young people any favors. They can only learn by being allowed to do things for themselves, and by sometimes failing. If parents have never allowed a child the feeling of not getting what they want, if they have never allowed them to sometimes do their best and fail when it still wasn't enough, then when they are beyond family and out in the world trying to make it on their own, people are not going to care, and the grown child will get torn up. It is very difficult for us physically and emotionally to sit on our hands and let them struggle, but it is the way to avoid raising a dependent person.

Sometimes parents must let their children struggle even if it is painful. Parents' pain over their child's situation is often greater than the child's pain. The issue is often really the parents' pain. Teenagers often say, "If they don't want me to do it why don't they just tell me no." It doesn't work all the time but at least the teen knows where the parent stands. Many teens do not know where their parents stand. There is too much negotiation going on. Parents need to have a strong identity in order for their children to have an identity. By helping too much, parents can deprive the children of the opportunity to learn. Some parents want to teach their children everything, but a lesson. Some things they need to learn on their own.

KEEPING CHILDREN BUSY AND FILLING UP THEIR TIME IS NOT THE SAME AS FULFILLING PARENTING RESPONSIBILITIES

Just because a parent structures all of a child's free time, this does not mean that much parenting has occurred. It only means that you have a very busy child. In fact, it can lead to even less time spent together for a parent and child. For example, some parents plan every week of their child's summer, thinking they are fulfilling their parenting responsibilities. If there is

some boredom in the child's life, there is room for some creativity. Too much structured time stifles creativity and develops exhausted kids.

WHEN CHILDREN GO OUT OF BOUNDS, DON'T CHASE THEM

When children go out of bounds of acceptable behavior, do not chase them. Someone needs to be stable. This is particularly important for adolescents. When children become adolescents, they can start to go a direction different from their family. They want to go outside those bounds to test the waters, and they may do things that are not good choices. The best thing to do is to stay the course, to stay with your values, to know what you stand for and what you believe in. The teenager is experimenting and needs stability at home. Family is home base. It is a place of safety and security.

STRATEGIES FOR RAISING CONFIDENCE AS A PARENT

A. BE COMFORTABLE BEING IN CHARGE

Parents need to learn to feel comfortable being in charge. One of the results of the 1960's was that it became common in this country to challenge authority. So many people have torn authority down that now when parents are in a position of being in charge, they feel uncomfortable with it. They do not want to make those tough decisions.

B. IDENTIFY WHAT YOU WANT TO TEACH

Parents must identify what they want to teach. It is very important to realize that parents are their kids' teachers. They are their first teachers. They are their last teachers. Parents should figure out ten things they want to teach their children, and then figure out how they want to teach them. If they want their child to be honest, then they must consider how to teach honesty. Parents must ask themselves, "What would I want my children to learn from me? What did I learn from my parent?" In one of my books, *Son and Sons*, I listed ten things I hope that I will be able to teach my children. They are in no order of significance:

1. Be fair to yourself and others
2. Respect people
3. Listen to your coach, others can see things that you can't
4. Learn to play

5. Find a job but find what you like to do first

6. Believe in God and believe in yourself

7. Love your family, respect your spouse, and enjoy your children

8. Do what is right, not what is popular

9. Open presents on Christmas morning; it is more fun

10. I love you.

C. *LEARN ABOUT HUMAN DEVELOPMENT*

When a parent has decided he knows what he wants to teach, if he is fortunate enough to have a partner or another parent, the two of you must agree on what you are trying to do. It helps to learn about human development. Read those books that talk about kids, so you know what to expect and what not to expect. Learning about human development helps you to understand the various developmental stages of your children. You can learn what is age appropriate for your children, which will help you when making decisions about them.

D. *LEARN ABOUT YOUR CHILDREN'S PROBLEMS*

Parents must learn what problems their children face in the world. For example, if you are worried about your children and drugs, and you want to talk to your children, first you should go out and learn about the subject. If you are uncomfortable about talking to kids about sex, you need to know what is going on, in order to be able to tell them. If there are other problems in the community, parents must become knowledgeable about them. Learn about your children's problems because if you don't talk with them, someone else will. You may not like what they are hearing from others.

E. *KNOW WHEN AND HOW TO GET HELP*

Parents must know when and how to get help. This is critical for raising confidence. Parents need to know what help is available in their community. They need to talk with other parents about what is going on. They should plan ahead – if we do run into this situation, what would we do? Communicating with other parents is very important.

F. LEARN HOW TO PARENT TOGETHER

If there are two parents, they must learn how to work together to guide their children. Even if parents no longer live together, or they were never married, or they are divorced, even if they are spouses no more, they are parents forever. They must work out some way to parent without the spouse relationship contaminating it. That is called respect.

Parents need to be on the same sheet of music for their children. It is important to come across as a team to your children.

G. LEARN HOW TO SAY, "NO"

Learning to say "No" is a two way street. It doesn't mean just to the kids. It means to yourself as well. Saying no to too many demands can simultaneously mean you are saying yes to the things that you would really like to do.

H. LEARN WHEN AND HOW TO PROTECT YOURSELF

This is important, particularly with teenagers. Some teenagers have gone in directions that parents no longer can identify with or control. These teens are not ready to change, and they can be very painful to live to around. At that point, it is important to know how parents can protect themselves. In some cases this means how to be safe physically, as well as how not to get emotionally beat up all the time and how not to get drawn into conversations that are not helpful. Some teenagers seem born to argue. They want their parents to argue. The teen wants to be angry with a parent because that anger justifies their behavior to themselves. Some teens can become very intimidating and create fear in parents.

I. RELY ON COMMON SENSE

Parent need to rely on common sense. Make a valid judgement, and stick with it. It seems very simple, but many parents lose their confidence because they start to make things too complex. They overly process because they are afraid of making decisions. These parents are not just afraid of making decisions; they are afraid of their children. Being afraid to upset your child is being afraid of your child, and that means being afraid to be a parent. Parents need respect from counselors and educators. They need help identifying how they are going to support each

other to work out problems with their children. Parents need to be a team. Being a team builds confidence, and being part of a team raises parents' level of confidence to be able to ask for help.

CHARACTERISTICS OF A HEALTHY FAMILY

1)   Develops and maintains positive rituals

2)   Possesses a sense of order and direction

3)   Teaches a sense of right and wrong

4)   Has a sense of spirituality

5)   Teaches tolerance of others

6)   Teaches respect

7)   Affirms and supports its members

8)   Spends time together and has a healthy sense of humor

9)   Is flexible during trying times

10)   Knows when to ask for help

11)   Becomes part of the community

12)   Interacts positively as a group

TIPS FOR PARENTS OF TEENS

1) Let your child be a child. Don't push your young adolescent or let others influence him or her to grow up too quickly.

2) Make your home a place where your teen feels she or he belongs.

3) Respect your teen's need for privacy and separation, but expect some level of commitment and involvement in the family.

4) Make your home a place where your teen's friends feel welcome.

5) Get to know the parents of your teen's friends.

6) Make your teen's best friend your best friend.

7) Keep your focus on safe behaviors and moral values.

8) Know the warning signs of unsafe behaviors.

9) Negotiate mutually acceptable limits with your teen.

10) Do not abdicate your parental authority.

11) Be available.

12) Be a good listener. Keep the lines of communication open even when your teen doesn't want to talk or is disrespectful. Keep the door open on any subject.

13) Treat your teenager as you would your adult friends, but don't try to be his or her friend.

14) Don't take it personally.

About the Presenter.
Robert J. Ackerman, Ph.D., is Professor of Sociology and Director of the Mid-Atlantic Addiction Training Institute at Indiana University of Pennsylvania and a Fulbright Scholar. He is a co-founder of the National Association for Children of Alcoholics.

As an author he has published numerous articles and research finding and is best know for writing the first book in the United States on children of alcoholics in 1978. Eleven books later, many television appearances, and countless speaking engagements he has become internationally know for his work with families and children of all ages. His books have been translated into several languages including Spanish, German, Finnish and Chinese.

He has served on many advisory boards and has worked with the National Institute of Mental Health, National Institute on Alcoholism and Alcohol Abuse and the U.S. Department of Education. He served on the Governor's Task Forces in Colorado and Michigan.

He is the recipient of many awards including the Distinguished Alumni Award from Western Michigan University and the 1995 Gooderham Award from his work in alcohol and drug abuse. He is a veteran of numerous TV appearances and his work has been featured on CNN Headline News, the Today Show, USA Today newspaper and Newsweek Magazine.

Contact Information:
Robert Ackerman, Ph.D., Director
Mid-Atlantic Addiction Training Institute
1098 Oakland Ave.
Indiana University of Pennsylvania
Indiana, Pennsylvania 15705
Telephone (724) 357-4405

References

Ambert, Amme-Marie (1992). *The Effects of Children on Parents.* Haworth Press.

Galinsky, Ellen (1987). *The Six Stages of Parenthood.* Addison-Wesley.

Gordon, Thomas (1970). *Parent Effectiveness Training.* Peter H. Wayden.

Mercer, Ramona, T. (1990). *Parents at Risk.* Springer.

DEVELOPING HEALTHY FAMILIES
Presented by Robert J. Ackerman, Ph.D.

Our ability to strengthen families has been affected by the impact of the many changes, some subtle, that have occurred over the last forty years. The most effective intervention with families is intervention long before problems occur. However, most of our help for families takes place after problems occur. So, at best, therapists are faced with taking an unstable situation and trying to stabilize it. We look at those who are in trouble and then try to figure out what to do with them or how to control them.

Families are blamed for everything. Years ago, we might have said a kid got into trouble because of a "broken home." But the family has not broken down in America; we still have family, and we will always have some form of family. What is lost or broken down in the United States is a sense of community. All over this country, there has been a significant breakdown of community. If a family with a lot of problems is put into a very strong community, there will many offsetting factors and informal structures. But if a healthy family is put into a broken down community, they will barely be able to hold on. Over the years, there have been a tremendous number of structural changes in communities. There are more programs in America today for young people than there were ten years ago and five years from now there will probably be even more. But the issue is not the development of these programs; the issue has to do with why these programs are being developed. There is a very basic fundamental reason. These programs are developed because there are too many adults in this country who will not accept their responsibilities. The issue is not only about family, and it is not only about adolescents. Instead of only looking at causes and at intervention, we need to look at ourselves and the communities that we have created for families.

As adults, we need to stand up. Many times adults are afraid to say to the kids, "You are out of bounds." There was a time when adults felt good enough about themselves to say what they believed. For example, thirty or forty years ago, if a boy was hanging around the corner with other boys, a man who was not sure what they were doing did not hesitate to say, "You boys, what are you doing?" And he would come over, look at the boys, and say, "I know your

father." What did that mean? That meant that this is going to get home before the boys could get home. There was no hesitancy. At that time, children had a clear vision of what was expected from them because it was mutually supported, but now they do not have that clarity.

We have gone from a collective identity among adults to what might be called a theory of adult irrelevancy. For most teenagers in this country, adults are irrelevant. If an adult walks through a group of teenagers, they will not alter their behavior, their language or their discussions. It is as if the adults are not even there. Adults need to become relevant again in teenagers' lives. The family needs to become relevant in the lives of its members. Kids need to know what it means to belong to their family. They need to know what it means to be a member of their family, what the family stands for, what they do not stand for, what the boundaries are, and what the expectations are.

WORKING WITH PARENTS

The most important thing to do to help a family is to work with the parents. If a person has a 15-year-old who has some problems, she brings her 15-year-old to the experts and asks them to fix this child. And she says, "When you are done, leave a message on my answering machine. Fix the kid, return him to the environment he came from, and don't ask me to come in here and be part of this." The 15-year-old becomes the focus point. No one is thinking about what is inside Mom -- her sense of futility, her sense of self-indictment, her fear that nothing else can be done, and the relationship between her and her husband that is now tenuous and strained. None of those issues are being addressed.

Every adolescent program in this country really ought to have someone there who is a counselor for parents. Every adolescent program should have a marriage therapy or couple therapy counselor. And we ought to look at the levels of violence in families. But, instead, programs are very fragmented.

One thing that would help American families, instead of a particular clinical or therapeutic approach, would be to make sure that at least one adult in the family had a meaningful, viable, justifiable, paying job. If at least one adult in that family had a good job

there would be fewer problems. Counselors have to think outside the lines, and to be willing to do that in working with kids.

"DYSFUNCTIONAL" FAMILIES

In the mid-1980's, the phrase "dysfunctional families" became common. That helped people to understand some things about themselves, and the concept provided some validity. However, that concept which once provided legitimacy and validity has been used indiscriminately and it has lost its original validity. When the phrase was first used, it made a lot of sense to people, but unfortunately it has now become too glibly and commonly used. The first use of the phrase "dysfunctional family" that I remember in a book was authored by Nathan Ackerman, who was one of the founders of Family Systems Therapy in the United States. In 1958, he said that the number one indicator that a family was dysfunctional was the relationship between the spouses.

We have heard "experts" state that at least 96% of the American population is in or were raised in a dysfunctional family. What an unfortunate statement. If 96% of the people in a culture have a characteristic, and you have it too, I would argue that you are culturally normal. The other 4% better watch out because the will be accused on not being culturally normal! The more we have implied one thing, are we not implying the other simultaneously? We have almost eliminated what we mean in this country by "functional" family. We need to understand that healthy families are not healthy all the time, and dysfunctional families are not dysfunctional all the time. If a healthy family does a dysfunctional thing, that does not make it a dysfunctional family. The more we have assumed that 96% figure, the more people have stopped trying to solve some of the problems within their own families.

For example, the first time there is a problem, people want to run outside of the family to some agency for help. Families have lost the ability to solve their own problems. Ten years ago conflict-resolution skill training was suddenly found in all of our schools. Was it because we had was more conflict, or was because there were so many people who had not seen any conflict resolved in their own families. They believe it is somebody else's job to resolve it. What we are seeing is outcomes of very subtle changes.

BEAVERS SYSTEMS MODEL

W. R. Beavers talks about looking at families by looking at an assessment of family functioning. The Beavers Systems Model is based on how well a family functions as a group. Therefore, the structure of the family is not the key variable by which to assess a family. The family structure, whether it is one parent, two parents, partners or blended families, is not the characteristic that tells us how well the family is doing. It is how well the family functions as a group that is an indicator of family cohesion or health.

This is a particularly applicable model because today there are so many different forms and ideas of family. The emotional state of the family is often the main concern. When people seek help, it is their emotional state that is bothering them. Issues of intimacy, power and control should be addressed. If families are dysfunctional, they are dysfunctional by degree. Beavers postulated five levels of family dysfunction.

BEAVERS' FIVE LEVELS OF FAMILY DYSFUNCTION

Level Five – Severe Dysfunction

This level includes those families with severe dysfunction. In families in Level Five, there is a lot of pain, chaos and no clear authority figures. Members avoid a problem they do not want to deal with by focusing on a side issue. Therefore, nothing is resolved and they avoid any realistic improvement. Beavers postulated that about 8% of American families fit this level. That is a far cry from 96%.

Level Four - The Borderline Family

Beavers called this group Borderline Families. These families are more functional than the Level Five families. But they are usually run by a tyrant who not only insists on his or her way of doing things, but who will tells family members what to do, and if they let them, will tell them what to think, and will tell them what they are feeling. The tyrant is not necessarily a person.

For example, a drug could be the tyrant that is controlling a family; it could be somebody's addiction. The tyrant could also be the teenager who dictates absolutely everything. If a family lets this happen, this person will literally define what the family is thinking and feeling and after a while, family members might finally not know what they think. They can be bombarded so much that the family begins to believe that they cannot do anything right.

Level Three – Midrange Families

There are Midrange Families, those families whose members live by a series of internalized rules and in some cases, if they go too far, the rules actually rule them. There is too much emphasis on role performance behavior, and guilt, intimidation and manipulation is used to keep family members in line.

Level Two – Adequate Families

The next category is Adequate Families. Rules are consistent. There are clear authority figures, hopefully the parents, and those authority figures are flexible.

Level One – Optimal Families

The Optimal Level Family has all the adequate qualities along with a strong sense of belonging and acceptance.

<u>**BARNHILL'S DIMENSIONS OF HEALTHY FAMILY FUNCTIONING**</u>

In 1970, Barnhill noted certain dimensions of healthy family functioning. He said there are dimensions of identify (individuation versus enmeshment and mutuality versus isolation), dimensions of how change is handled (flexibility versus rigidity and stability versus disorganization), dimensions of information processing (clear versus unclear perception and communication), and dimensions concerning the structuring of roles (role reciprocity versus unclear roles or role conflict, and clear versus diffuse or breached generational boundaries). These dimensions can be used to help assess various levels of family functioning and problems. However, not all dysfunctional families are the same.

NOT ALL SURVIVORS OF DYSFUNCTIONAL FAMILIES ARE THE SAME

There are degrees of dysfunction and there are different types of dysfunctional parents. Children have differences in their reactions to stress. Children's personality and their perceptions affect the degree of dysfunction they experience. Girls and boys react differently as well. In addition, age and developmental factors play a role, and there are cultural considerations as well as other offsetting contributing factors. Not all survivors of dysfunctional families are the same.

UNSPOKEN RULES OF TROUBLED FAMILIES

Most troubled families are closed information systems. This is a system that demands loyalty. These families may be extremely dysfunctional, but they demand loyalty. These families avoid internal or external criticism. They are afraid to let anyone break into that system, and they only add new members who conform to their existing beliefs. In many cases, troubled families develop a set of unspoken rules. No one ever voted on them, but they maintain them. Often, these families bring these rules with them when they come for help. If a family in therapy is not improving it might be because they are adhering to certain unspoken rules.

One rule "Be in control at all times" is an interesting rule. In very troubled families, "being in control at all times" means you attempt to become a counter-controller in a situation that is out of control. In a situation where there is a lot a chaos, confusion, pain and anxiety, most people try to lower their anxiety over the chaos and confusion by making sense or order out of it. Family members can become counter-controllers in order to find balance in their lives.

For example, if someone comes into the house by kicking that front door down, a family member figures out how not to get beat, not to get punched out, and not to have things thrown at them. They figure out counter-controlling measures that seem to make sense. Three patterns of behavior can result from the need for control when faced with an out of control situation. Some people develop a disproportionate need to control situations; they do not feel comfortable unless they are in a situation where they feel that sense of control. Others develop an overly strong need to want to control relationships. And some absolutely believe that they must maintain total control over their emotions. These reactions occur because controlling their emotions is what has allowed them to survive.

An example of control needs might be found in the following situation. If a ten year old asks, "If I tell you something, will you promise not to tell anyone?" and you say, "No," the child is likely to say, "Thanks anyway," and walk away. The interaction problem here appears to be a lack of trust. But in many troubled families, the issue is not just trust. By asking that, he wanted a guarantee. He was trying to control the outcome. And when the answer was "No" the child decided to keep the pain, because he could not control the outcome. The other point is that trust and control go together. For example, if the child trusts you with information about himself, at a later point he will have to trust that you will not use that information against him. But once he shares it, he can no longer control it. If he doesn't share it, he thinks he can control it.

Here is a suggestion about handling this situation. Suppose a young person says, "If I tell you something, will you promise not to tell anyone?" Say "No" and they might say, "Well, I thought you were a good guy." Then say, "Well, I probably am, but what's going on? I promise you this, whatever you tell me, if we need to go somewhere with that, I'll go with you. So are you going to deal or not? Because I'm going to go get on a plane, and whatever you've told me would go back with me and you're stuck here. Who are we going to go see?" Most of the time they will say, "I'll go with you." It allows the child to have some control over what is going to happen since he or she will be a part of it.

A second rule is "Always be right, do the right thing." In troubled families, who decides what is the right thing? In the case of the family with a tyrant, it is the right thing to whoever or whatever is dominating that dysfunctional family. In other words, it might be the right thing to do in the situation in order to get along, but it is not the healthy thing to do outside of that situation.

A third rule in a troubled family is "If something doesn't happen as planned, blame someone, something, or yourself." The idea is to place blame somewhere.

The fourth rule is to deny feelings, especially negative or vulnerable ones. This is especially true for adolescents. The teen does not want to feel vulnerable; he does not want to

risk rejection. Why is this so strong? Because most adolescents will do just about anything they can possibly think of to save face. It is just part of being an adolescent.

The fifth rule is "Don't expect reliability or consistency in relationships." That includes the person who is trying to help, the probation officer, the juvenile justice system, the judge, the counselor, the therapist, or the educator. Family members begin to believe that no one is going to be there for them or that others simply do not care. The message needs to be loud and clear from a helper the even if everyone else gave up, and maybe even people gave up on themselves, this counselor will not give up. Consistency is critical.

Two other rules that dysfunctional families bring into therapy include "We don't bring transactions or disagreements to completion or resolution" and "We don't talk openly or directly about shameful, abusive, or compulsive behavior in the family." Therefore, counselors who want to help are up against such issues as family loyalty, secrets and people who are afraid to leave the roles that they have adjusted to because of their family's unspoken rules.

CHARACTERISTICS OF FAMILIES WITH PROBLEM ADOLESCENTS

There are certain typical characteristics in families with behavioral problem adolescents. The first is that there is often an incongruous hierarchy. The parents who should be in charge are not in charge. The child is dominating. The child is making the decisions. Parents do many things because they are afraid of upsetting their kid.

Second, there is usually an attempt to shift family focus. Almost exclusively, they turn to outside forces to solve the teenager's behavioral problem, but not to solve anybody else's problem. Often the teenager is actually trying to shift the family focus off of themselves toward other dynamics that are happening in their family.

CHARACTERISTICS OF A HEALTHY FAMILY

Healthy families develop and maintain positive rituals. They possess a sense of order and direction; they teach a sense of right and wrong. A healthy family has a sense of spirituality, it teaches tolerance of others and respect. This type of family affirms and supports its members.

This family spends time together and has a healthy sense of humor. They are flexible during trying times. They know when to ask for help. A healthy family becomes part of the community, and, most importantly, a healthy family interacts positively as a group.

STRATEGIES FOR RAISING YOUR CONFIDENCE AS A PARENT

A parent has to learn to be comfortable being in charge. Parents need to identify what they want to teach their children, and learn about human development to aid them in that teaching. A parent should learn about their children's problems and know when and how to get help if it is needed. It is helpful to talk with other parents, and it is important to learn how both parents can parent together. Parents need to learn to say, "No!" And they need to learn when and how to protect themselves if that is necessary. Finally, parents should rely on their commonsense.

References

Ackerman, Robert J. (1993). *Silent Sons.* Simon & Schuster.

Ackerman, Robert J. (1989). *Perfect Daughters.* Health Communications.

Beavers, W.R. (1982). Healthy, midrange and severely dysfunctional families. In F. Walsh (Ed.), *Normal Family Process*. New York: Guilford Press, pp.45-66.

Becvar, Dorothy S. & Becvar, Raphael J. (1996). *Family Therapy.* Allyn and Bacon.

Mattaini, Mark A. (1999). *Clinical Interventions with Families.* NASW Press.

About the Presenter.
Robert J. Ackerman, Ph.D., is Professor of Sociology and Director of the Mid-Atlantic Addiction Training Institute at Indiana University of Pennsylvania and a Fulbright Scholar. He is a co-founder of the National Association for Children of Alcoholics.

As an author he has published numerous articles and research finding and is best know for writing the first book in the United States on children of alcoholics in 1978. Eleven books later, many television appearances, and countless speaking engagements he has become internationally know for his work with families and children of all ages. His books have been translated into several languages including Spanish, German, Finnish and Chinese.

He has served on many advisory boards and has worked with the National Institute of Mental Health, National Institute on Alcoholism and Alcohol Abuse and the U.S. Department of Education. He served on the Governor's Task Forces in Colorado and Michigan.

WORKING WITH HIGH RISK ADOLESCENTS
Presented by Robert J. Ackerman, Ph.D.

Most adolescents, including those who are at high risk, are resistant to interventions about their behaviors. This presentation addressed adolescent resistance and provided some techniques to deal with that resistance. Additionally, it addressed the issue of adolescents' self-defeating behaviors, and provided a model for eliminating such behavior.

RESISTANCE IN ADOLESCENTS

Common traits of resistant adolescents include poor internal controls, a bad attitude, not being comfortable with emotional expression, and peer relationships based on shared rebellion. Resistant adolescents are self-protective and fearful of their own vulnerability; they see themselves negatively and use bravado to cover that up. They do not believe they control their own destinies. They are easily ignited and susceptible to boredom, and can be immune to consequences with a decreased capacity to express guilt. These children minimize difficulties, resist intervention, and distort information. They often have a sense of entitlement.

There are three kinds of resistance with teenagers. We see active resistance, unintentional resistance, and passive resistance.

ACTIVE RESISTANCE

Active resistance includes the deliberate refusal to talk. These teenagers are very determined not to deal with the issues, and to prevent others from helping them. This includes the adolescent who debates absolutely every statement in order to prevent getting to the real issue. This can include aggressive and intimidating behavior. Some teenagers refuse to see that anything is wrong. For them many of their behaviors no longer have any shock value. Though adults might be shocked by their behavior, teenagers often feel that "everyone is doing it" and the behavior is not novel.

UNINTENTIONAL RESISTANCE

A second kind of resistance is unintentional resistance, one of the most difficult to break through. This is found in adolescents who might be genuinely silent or shy. These young people do not know how to express themselves. They are very withdrawn and quiet; they do not know how to ask for or to accept help. Unfortunately, they can use this inability to talk as a way to deal with a problem. When they are quiet, someone else in the group or their counselor might speak up for them. People are uncomfortable with silence.

When working in groups with kids, I usually use "go arounds." No matter what the issue is, it goes to everyone in the group. Group members have the right to say "Pass" if they don't want to talk about the issue. To encourage the participation of someone who is very quiet, withdrawn, and afraid to say anything, I usually sit in front of that young person, look at him or her, and say, "We have time." If that does not encourage their participation, then say, "We'll come back to you." Now that person knows you will be coming back to her. She or he might not like it, but they might even think of something to say to become part of the group. If a quiet and withdrawn person does say something, simply treat that person exactly the same as someone else, and say "Thank you."

PASSIVE RESISTANCE

The third type of resistance is very different. This is the child who is engaging in passive resistance. The passive resistant kid has absolutely no intention of complying no matter what. They don't argue. They don't give excuses. They just do nothing. A caregiver can say what he or she wants and the teenager will just look at him or her. They have no intention whatsoever of complying. They invented the word "whatever." They express no indication of compliance or non-compliance, and they are non-argumentative. They just sit there and say "all right," "okay," "right," and then they do what they want to do. If they are confronted again, they give the same response. Usually they have an agenda that the caregiver does not know about.

SOCIAL SKILLS NEEDED BY RESISTANT ADOLESCENTS

Our culture is close to an all time low on civility and social skills. There are very few boundaries of respect, and communication skills are lacking. These patterns are not developed in adolescence; instead they have been in place for a long time. Parents have not taught civility and

social skills. Helping teens to develop such skills requires that you be extremely literal.

Asking for help, apologizing, and accepting defeat are helpful social skills. Accepting decisions of authority, negotiating, and making a complaint are all skills adolescents' need. They have to know when to say "enough," and when it would be best to walk away or to do something different. They need to know how to choose appropriate friends.

Other social skills adolescents need include knowing how to compromise with others and how to deal with boredom. They need to learn about appropriate risk taking, and avoiding temptation.

SELF-CARE

Because adolescents at risk, especially if they are very resistant, can easily burn out caregivers, those who work with teens need to learn to provide some self-care. An example of providing self-care is shown by this story from when our oldest son was about 15.

> One day I made a very routine request of him. I said, "Take out the garbage, please." He didn't reply. He just went over and did the adolescent shuffle. That night as I was getting ready to go to bed, I went around the house checking the lights and turning things off. I opened the door to the garage to check to make sure the garage doors were down. And when I opened the door, I saw the trash sitting on the top step. Now, it is three steps to the floor of the garage. At the bottom of the third step on the right hand side is the trashcan. It would have taken me only a couple of seconds to pick up the trash and put it in the garbage can, but I thought, "This is one of those times that I can use self-care. I should invest a little in myself instead of letting him get away with it." Even though it was a little after midnight, I thought, "Let us not deprive this youth of this learning experience that is about to occur." So I went up stairs and went to his room where he was sleeping. It was dark and I flipped on the overhead light. Right away my self-esteem started to improve immensely. I went over to him and he said, "What?" I said, "What did you do with the garbage?" He said, "I took it out." And I said, "Get out of bed, go downstairs, go open up the garage door, be careful not to trip, pick up the trash, walk down three steps and on your right-hand side there are two big green things that have been part of the family for years, take the lid off one, put the garbage in, put the lid back on, turn around, walk up the steps, turn out the garage light, close the garage door." "You mean, now?" "Yes, I'll wait."

Now, it might sound facetious, but I never had to tell him again where the garbage went.

TECHNIQUES THAT HELP

There are techniques that can help when working with adolescents. The first is to build a therapeutic alliance with kids. Try to build some type of rapport or some type of relationship. The success of almost all modalities of care and intervention with an adolescent depend on the same variable -- the relationship established with the adolescent. That is more critical than any other kind of intervention technique or skill.

Techniques for building a therapeutic alliance might be to say, "It must be hard for you to imagine your life being any different" instead of "Why are you doing this, and why are you in trouble?" The teenager may simply not see an alternative. They have many feelings inside themselves, and they will share many reasons why they don't think it can be different. The real trick is to be able to enter through the teenager's world and to bring them out through yours. But they will not enter your world on their own. You have to enter theirs to bring them out through yours.

It is important to understand the adolescent world. How many caregivers actually know what it is like to be an adolescent in the year 2000 in this country? For example, do we know what the top five CD's are? Do we know what the top video games are? Do we know if it's more acceptable to go with a date or without a date to the prom? Do we know what their opinions are about what is happening in high schools? Do we know which shoes are better to wear now? If we don't know those things, we don't know anything that is important to the adolescents, because those are the things important to them. And they sometimes say, "You don't really care about me. You never even took the time to find out anything about me." So, enter through their world and take them out through yours. If you say, "It must be difficult being you" to the kid who always acts like nothing bothers her, you get be surprised what you get back.

Meet with peers. If you are going to work with someone, learn who are their friends and who are their peers, and find out what they think about what is happening. When an adolescent does not want to be involved in the treatment process, tell them that important decisions are

going to be made about them in their absence. If they choose not to participate, let them know you will go ahead and make those decisions without them. Some will be angry enough to stick around.

Another approach might be to say, "You look ticked off. Who has been hassling you? How can I help you?" This is a way of asking what the teen really wants. "I want these people to get off my back. They're always on my case." Then say, "How can you get these people off your back? If that's where you're at, fine. Let's talk about it."

It is important to develop an interaction contract, especially if you work with groups. Using a board, write, "Contract" and say, "Look, we're going to interact with each other. How are we going to treat each other?" As they contribute ideas, write it all down. Then say, "All right, that's your interaction contract. Now we need another type of contract. What are you willing to give to get? The interaction contract tells what you want. What are you willing to give each other to get it?" They might say, "I'm willing to show up." In addition, always put two things on the contract -- amendments, and a risk clause. A risk clause means that everyone in the group has the right to say, "I don't want to risk that" and everyone will respect that. Everyone in the group signs the contract. Every week get the contract back out and, before starting group, say "Would anybody like to amend the contract?" And sometimes they will come up with something else they didn't like in group and put it up there. This interaction contract helps the leader to figure out how to govern what happens in the group.

Develop a balance between authority and tolerance. The leader is in a position of authority, but on the other hand, the leader must decide how much to tolerate. For example, it is a good idea to decide ahead of time how to handle it if an adolescent gets up and starts going through the desk. If they start using the phone and ask, "What's the outside line?" or "You got a long distance line here?" plan ahead to know what to do. Avoid jargon and sarcasm. And do not ask a lot of yes or no questions.

It is helpful to offer alternatives and options. The more opinionated a therapist is, the stronger the adolescent's resistance. Often they are not sure what to do, and need some way to

save face. It can be helpful to ask an adolescent, "Are you strong enough to face the truth about what's going on inside?" Do not dispute what they say, but be curious about it. They may say things just to see if they can shock. Ask them "What things have you gotten away with when you didn't get caught? How did you do that?" as a way to encourage them to talk.

Wait until you have developed a therapeutic alliance before trying a confrontation. A confrontation should be about the behavior, not about their thought process. For example, say "I'll bet you can't think of any other explanation for why the principal might be on your case." This is helpful in trying to get them to think a little differently.

SELF-DEFEATING BEHAVIOR

There is a helpful cognitive behavioral model for eliminating self-defeating behavior. It is particularly helpful because it may be shared with the adolescent and, instead of the adolescent wondering or guessing what is going to happen, he or she will know exactly what will happen during therapy. Self-defeating behavior, at the time it develops, seems to make a lot of sense. However, later, when the situation has passed, continued use of the same behavior may have negative outcomes.

In addition to self-defeating behaviors, there are self-defeating thought processes. How we think can be as important as what we think. The more self-defeating thought processes a person has, the higher the probability he will engage in self-defeating behaviors, and worse, the higher the probability he will justify his behavior because it fits with the way he thinks. Then it becomes a cycle. It would be a breakthrough for a person to think they could do something different, for example, if they could develop a life-enhancing behavior. But for them to be able to think they could do that, they have to think something they have never thought before -- they have to think they have a choice. Even after they believe that there is an alternative way, and that they do have a choice, they might still run into their fear. If they cannot get through their fears, they want to run from them. They will not run back to a choice; they run back to a conclusion. Most self-defeating behaviors start with a conclusion, but if it is a faulty conclusion, the same cycle is predictable.

Teenagers need to have both inner and outer techniques in order to put their self-defeating behaviors into action. Inner techniques are thought processes; outer techniques are observable behavior. For example, if a teen's self-defeating behavior is that he is always getting into fights, he knows that if he does get into a fight, then he will have to pay a price. It is going to cost him, and it usually costs physical consequences, emotional consequences, or worse, it costs lost opportunity. There is an equation, however, between the thought process and the behavior. When the teen starts to feel and think and believe that the prices that he is paying outweigh his fear, then he is willing to try an alternative. The counselor can help discover the prices. But if the teenager's fear is stronger than the prices, he will pay the prices.

Then, if the teen is going to stay with the self-defeating behavior, since he does not want to admit he paid a high price, he will figure out how to minimize the prices. Eventually, he will figure out how to disown the self-defeating behaviors. He blames them on social inequities or other things outside himself.

If this model is tried with teenagers, it is amazing what may be pointed out. A counselor must remember to use "how" questions. Reframe all questions with "how" because it makes that person accept responsibility for her or his behavior. "How" questions get past "why."

WORKING WITH CHILDREN AND ADOLESCENTS IN GROUPS

Research on kids in groups with a facilitator has found that teenagers say the least valuable thing they got from group was insight. In contrast, adults say the most valuable thing they got from group was insight. For a teenager, it is alternative approaches to their behaviors that help them the most. They will tell you the most valuable thing they got from group was the relationship with the facilitator. So it is the ideas, behaviors, approaches, alternatives, and relationships, not insight into their behavior, that brings quicker success.

The following table provides some strategies for problems experienced in groups.

Group Problems

Problem	Evidence	Examples of Strategies
Low cohesion	Drop in satisfaction, attendance/promptness rate; low ratio of critical statements to	Increase attraction of group: serve food at meeting, use audiovisual aids and role-playing,

	positive statements.	
One or two members dominate interaction	One or two members speak more than twice the average amount available to each member of the group	Prepare low-frequency members prior to meeting; prompt them in meetings; reinforce low participants
Member withdrawal from interaction	Usually goes together with above problem. Withdrawn members speak less than half of their allotted time.	Set limits on high participators. Play Five Minute Fame
Too much off-task behavior	Off-task behavior more than 10% of total observed interaction	Help group to define "off-task," then have group set limits on off-task behavior.
Too little self-disclosure	Participants talk about self, own problems less than 10%	Discuss similarities to cases. Gradually increase demand for self-disclosure.
Low rate of assignment completion	Percentage of homework assignment completion less than 75%	Examine skills of members in carrying out assignment. If deficient in training skills, discuss with group. If pressure too much, reduce demand. Develop contingency reinforcement systems for assignment completion. Involve members in decision making as to what homework
Excessive sub-grouping	Members of one sub-group tease, fight with, or argue with others. Drop in average satisfaction of ½ point or more	Brainstorm, then role-play alternative ways of increasing pro-social behaviors with others. Set up contingency contracts for pro-social behavior with others.

References

Ackerman, Robert J. and Graham, Dee (1990). *Too Old to Cry: Abused Teens in Today's America.* McGraw-Hill.

Brendtro, Larry K, et.al. (1990). *Reclaiming Youth at Risk*. National Education Service.

Brohl, Kathryn (1996). *Working with Traumatized Children.* CWLA Press.

Fraser, Mark W. (Ed.) (1997). *Risk and Resilience in Childhood*. NASW Press.

<u>About the Presenter</u>.

Robert J. Ackerman, Ph.D., is Professor of Sociology and Director of the Mid-Atlantic Addiction Training Institute at Indiana University of Pennsylvania and a Fulbright Scholar. He is a co-founder of the National Association for Children of Alcoholics.

As an author he has published numerous articles and research finding and is best know for writing the first book in the United States on children of alcoholics in 1978. Eleven books later, many television appearances, and countless speaking engagements he has become internationally know for his work with families and children of all ages. His books have been translated into several languages including Spanish, German, Finnish and Chinese.

He has served on many advisory boards and has worked with the National Institute of Mental Health, National Institute on Alcoholism and Alcohol Abuse and the U.S. Department of Education. He served on the Governor's Task Forces in Colorado and Michigan.

He is the recipient of many awards including the Distinguished Alumni Award from Western Michigan University and the 1995 Gooderham Award from his work in alcohol and drug abuse. He is a veteran of numerous TV appearances and his work has been featured on CNN Headline News, the Today Show, USA Today newspaper and Newsweek Magazine.

Contact Information:

Robert Ackerman, Ph.D., Director
Mid-Atlantic Addiction Training Institute
1098 Oakland Ave.
Indiana University of Pennsylvania
Indiana, Pennsylvania 15705
Telephone (724) 357-4405

ADOLESCENT IMMIGRANTS AND REFUGEES
TRENDS, ISSUES, AND CHALLENGES
Presented by Sarah Alexander, LICSW

DESCRIPTION OF THE REFUGEE POPULATION

Refugees are people who have had to leave their home country and are faced with life in a different country, usually without common family units. For the past 20 years there have been huge influxes of people from Southeast Asia that have come to the United States. Those numbers are now decreasing, but refugees still arrive from Vietnam, Cambodia and Burma. Similarly, the once large numbers of families from the former Soviet Union have decreased. Current, there are increasing numbers of people arriving from Africa and the Near East, including refugees from Iraq, Iran, and Afghanistan, all with different languages and cultures.

Service delivery that is responsive to this increased diversity is more complex. Knowledge about where the individual or family has come from is necessary and it makes sense to think regionally rather than geographically or nationally. As an example, there are many conflicts going on in Africa, and consequently there is an influx of refugees from the countries involved in the conflicts, such as Sierra Leone, Rwanda, and Somalia. The refugees come with different religions and cultural understandings. Many are Muslims. Islam as a predominate religion worldwide makes it imperative that programs are knowledgeable about this religion. Refugee flow, however, has changed over the years. Adding to the range of diversity is the fact that it has become more common for isolated individuals rather than entire families to immigrate, as countries are tending not to have such large masses of people exodus at one time. This increases the diversity in the population that is arriving and puts more pressure on this service system to respond to the diversity.

More refugees arrive now with little cultural orientation, unlike in prior years when they would have had as much as six months of orientation in refugee camps. People arrive with as little as 12 hours of cultural orientation. Many have ongoing mental health issues and have experienced tremendous trauma.

REFUGEE YOUTH AT HIGHEST RISK

A. YOUTH WHO COME TO THIS COUNTRY WITHOUT PARENTS AND WELL FUNCTIONING FAMILY MEMBERS. These youth are at the highest risk. Often they arrive with family members other than their parents, sometimes arriving with neighbors or friends. Some come with siblings, such as an older brother or sister who is caring for the younger one.

B. YOUTH WHOSE PARENTS FACE CONFLICT. The parents may be dealing with difficulty in their marriage or other significant family issues.

C. YOUTH WITH LEARNING DISABILITIES OR OTHER DISABILITIES. Some of the disabilities may be easy to manage, while others may be difficult to identify. The youth may not have had access to education or the education they have received was not appropriate to their learning capabilities.

D. YOUTH WHO HAVE LOST SIGNIFICANT EDUCATION BECAUSE OF WAR OR TIME SPENT IN A REFUGEE CAMP. Some youth arrive here far behind their American peers in their education. They need a lot of academic support while also addressing how to help them earn money and allow them to do things that teenagers want to do. They are not going to want to sit in school for years and not earn money.

E. YOUTH WHO HAVE A PARENT WHO HAS LIMITED FUNCTIONING BECAUSE OF DISABILITY, WHETHER WAR RELATED OR NOT, AND YOUTH WHO HAVE BEEN SEPARATED FOR A LONG TIME FROM OTHER FAMILY MEMBERS. For example, in the Vietnamese population, there are families that have been reunited years after some family members have escaped. Sometimes this has occurred ten or more years later. Many changes occur with those long separations. In other situations, family members deal with separation from family members who chose to stay in their country of origin or have fled to different countries. Refugee or immigrant youth also face separation related to inter-generational conflict. This conflict parallels what most teenagers experience developmentally. However, for the refugee youth it is complicated and it is enhanced. Youth acculturate faster than their parents, taking on many aspects of the American culture - the language, clothing styles, mannerisms, slang, ways of

doing things - that parents do not accept. School offers primary socialization experiences for youth that further separate parents and children and these factors can make the inter-generational conflict worse. Communication becomes increasingly difficult between the generations and the youth may end up in shelters or in the criminal justice system as family relationships disintegrate. Refugee and immigrant youth live in two worlds. They live with their families' cultural customs and in a very different community environment. They struggle with the contrast between those two worlds - confusion on how to talk, to act, to think, with a different language, different ways of responding to people, different ways of giving opinions. Family expectations contrast with expectations in American schools and in clubs and social systems in which they are involved. A Cambodian worker was heard to say "Kids aren't supposed to have opinions, they don't know anything." This is opposed to expectations in American schools, where teachers support young people expressing their thoughts and opinions.

FAILURES OF TYPICAL SUPPORT SYSTEMS FOR FAMILIES/ PARENTS

A. SCHOOLS ARE ONE OF THE CRUCIAL PLACES TO MONITOR AND IDENTIFY PROBLEMS - PROBLEMS AT HOME AND INTER-GENERATIONAL CONFLICT -BUT SCHOOLS OFTEN FAIL. Refugee parents have little experience in advocacy and have no idea of where to go, how to approach people, or how to get the appropriate services for their children. Refugee or immigrant parents may not know what a guidance counselor is and often do not understand the integration of extracurricular activities and organizations and the importance of those activities for teenagers. They may not trust systems given their trauma histories and they may particularly want their daughters at home, near the family. This can be very problematic for youth who want to participate in school activities with peers.

B. LACK OF ACCESS TO MANY OF THE SUPPORT SYSTEMS, PARTICULARLY LIMITED BY LANGUAGE AND VOCABULARY CONCERNING SPECIAL EDUCATION, AND TO COUNSELING AND MENTOR PROGRAMS. If the parents do not speak English at home and they do not have any understanding of what a "core evaluation" is, Pupil Evaluation Team meetings are lost on them as they are unable to advocate or even to ask questions that would lead to better services for their children. Long-range counseling focused on career goals should be done by a therapist who understands the culture of the family of origin and who is able

to define step-by-step what the young person will need to do to reach his or her goals.

***C.   LACK OF TIME FOR REFUGEE PARENTS TO SPEND WITH THEIR CHILDRE,
BECAUSE MANY OF THEM ARE WORKING MORE THAN ONE JOB AND LACK
TRANSPORTATION.*** Everything that needs to be accomplished within diminishing time
constraints becomes even more difficult. Appointments may be missed as a result of parents not
understanding how to schedule time, transportation, or how to communicate their needs or
barriers.

D.   FAMILY ISSUES MAY INVOLVE THE PARENTS' SENSE OF FAILURE. Parents may
have had to give up the things that they had been trained, educated or had planned to do and are
working in much lower level jobs than they had expected. It is hard for them to feel competent
and effective for their kids. The one thing that they can do well and with which they are familiar
is to be good parents. If, in addition, their ability to parent is not working well, they feel totally
defeated.

***E.   COMMUNITIES AND SUPPORT SYSTEMS DO NOT WORK WELL FOR REFUGEES
AND IMMIGRANTS.*** Hindered by difficulties in language, there is a lack of trust of the support
systems available in the community. The concept of seeking support is foreign to the refugee
population. They may not understand or accept the use of self-help books, marriage counseling,
legal aid or other supports. The lack of access to the traditional supports available in the
community and the increased potential for family stress and conflict places the children at risk.
The disintegration of the family and the complexity of issues surrounding divorce, such as
custody, alimony, and legal intervention, all compound the stress and difficulty of accessing
support systems.

***F.   AN UNDERSTANDING OF THEIR CHILDREN'S NEED FOR TREATMENT AND
THE COMPONENTS OF TREATMENT ARE DIFFICULT FOR REFUGEE AND
IMMIGRANT PARENTS.*** The youth and parents often are confused and have questions about
medication, levels or types of treatment, the concepts of treatment, and other systems or services
with which they may become involved. Parents may be antagonized by this society, which gives

shelter to a child that has run away from their family. Therapists need to be able to explain the systems and services and to help parents understand their value.

G. REFUGEE AND IMMIGRANT FAMILIES OFTEN LACK THE EXTENDED FAMILY AND COMMUNITY SUPPORT AVAILABLE IN THEIR OWN COUNTRIES. Loss of rituals as part of the cultural support system is particularly difficult, especially around death. Moreover, the increased social supports offered through social service agencies are not able to replace the supports lost or to deal with some of the trauma issues.

INDIVIDUAL AND PROGRAM ADVOCACY

Program interventions are crucial in working with refugee and immigrant youth. Financial support for refugee programs and collaboration among the programs are needed to achieve success. Examples of the kinds of simple but much needed programs are:

HOMEWORK HELP: This is one of the best ways to help the youth catch up and to establish trusting relationships.

TRANSPORTATION SUPPORT: There must be an emphasis on safety, particularly for parents to be reassured that their daughters will be able to get home from evening activities.

COLLEGE ACCESS AND GOAL ORIENTED ACTIVITIES: Support programs that teach youth how and when to fill out applications, how to set goals and how to find support, are essential.

CULTURALLY-APPROPRIATE ROLE MODELS: The refugee and immigrant youth need to have role models they can identify, relieving some of the stress induced by feeling the need to be "Americanized." Groups that help develop self-esteem and positive directions are helpful, especially if the group involves their own ethnicity. It is important to build the parents' acceptance of their children's activities rather than inducing gaps in family systems.

THERAPISTS THAT EMPOWER FAMILIES: Families and the youth often need strong case

managers or therapists who advocate, help with language barriers, navigate systems and provide role models, but who do not assume decision-making. Validation of the parental role is crucial in building trust and relationships between parents and children and between families and systems. Therapists need to be mindful of cultural norms in introducing American belief systems and practices and to be aware that while some changes may be needed, refugee families need not abandon their own ethnicity.

STRUCTURAL THERAPY: Strong support of the parental role is very important. Youth become acculturated more quickly than the parents and often are put in the position of translating for their parents and, in general, assuming parenting duties. It is important to help with integrating Western beliefs with the cultural values and practices of the family of origin, while strengthening and maintaining the parents' dominant role.

BICULTURAL CLINICAL INVOLVEMENT: It is recognized that there are not as many bicultural clinicians available to help with integration as would be desirable, particularly in view of the number of refugee and immigrant families arriving in America recently. However, the bicultural worker is the most effective at helping the refugee family as they have knowledge of both cultures and are going to be accepted more readily. A second model that works well is the native born clinician paired with an immigrant worker. In this way, the family gets a sense of both cultures through the two clinicians, although it may double the cost of the service.

About the Presenter

Sarah Alexander, LICSW, is the Coordinator of Social Services at the International Institute of Boston. She has work with refugees for the past 12 years, six of which have been with refugee youth. She has developed and managed programs to assist refugee youth and families in the Boston area.

Contact Information:
Sarah Alexander, LICSW, Coordinator of Social Services
International Institute of Boston
One Milk Street
Boston, Massachusetts 02109
Telephone (617) 695-9990

References

Department of Public Health in Massachusetts, *Refugee and Immigrant Overview*, is free, and may be requested by mail: 250 Washington Street, Boston, MA.

Ahearn, F. and Athey, J. (Eds.) (1991). *Refugee Children: Theory, Research and Services,* Baltimore, MD: Johns Hopkins University Press.

Amodeo, M. & Jones, K. (1977). Viewing alcohol and other drug use cross culturally: A cultural framework for clinical practice. *Families in Society, 78,* 240-254.

Apfel, R. & Simon, B. (Eds.) *Minefields in Their Hearts: The Mental Health of Children in War and Communal Violence.* New Haven: Yale University Press.

English, T. J. *Born to Kill: America's Most Notorious Vietnamese Gang.*

Reichelt, S. & Sveass, N. (1994). Therapy with refugee families: What is a "good" conversation? *Journal of Family Therapy, 33,* 24-263.

Scheinfeld, D., Wallach, L.B. & Langendorf, T. (1997). *Strengthening Refugee Families.*

Strier, D.R. (1996). Coping strategies of immigrant parents: Directions for family therapy. *Family Process, 35,* 363-376.

Tammy Bell, MSW, MAC

Tammy Bell, author and national lecturer, provides consultation and training to treatment centers, industry, correctional systems and schools throughout the United States and Canada. Her special commitment to the recovery of chemically dependent adolescents has led to her reputation as a leading authority of adolescent recovery and relapse prevention.

Ms. Bell is President of TAMMY BELL AND ASSOCIATES, a training, consultation, and counseling services located in Charlotte, North Carolina, where she resides with her family. She is also Director of THE RELAPSE PREVENTION CENTER in Charlotte, an outpatient program that specialized in the treatment of adult and adolescent relapsers.

As Director of Relapse Prevention for the CENAPS Corporation, Ms. Bell worked closely with Terence T. Gorski for many years. As EAP Administrator for Borg-Warner Chemicals, Inc., she designed, implemented and managed their corporation Employee Assistance Program.

Ms. Bell has been responsible for the development and supervision of both inpatient and intensive outpatient chemical dependency programs. She has written numerous articles for magazines such as, *Professional Counselor, Adolescent Counselor, Addiction and Recovery* and *EAP Digest*. Her book, *Preventing Adolescent Relapse: A Guide for Parents, Teachers, and Counselors,* has been widely acclaimed.

She is a Certified Clinical Social Worker with both a Bachelor's and Master's Degree in Social Work, a Nationally Certified Addiction Counselor II and a Certified Relapse Prevention Specialist. Ms. Bell is a member of the Adolescent Treatment Consortium, National Association of Relapse Prevention Specialists, Society of Americans for Recovery, National Associate of Alcohol and Drug Abuse Counselors and the National Association of Social Workers.

Contact Information:
Tammy Bell, MSW, MAC, President
TAMMY BELL and ASSOCIATES
5517 Tullamore Lane
Charlotte, North Carolina 28269
Telephone (704) 948-1330

NORMAL ADOLESCENT DEVELOPMENT
Presented by Tammy Bell, MSW, MAC

An understanding of normal adolescent development is necessary in order (1) to recognize when adolescents are not moving along the normal continuum because that is a treatment implication and (2) to understand that adolescents who develop slowly or too quickly bring with them different stressors that affect the way in which they respond to treatment and their ability to adhere to a treatment plan. A thorough understanding of the developmental tasks learned in adolescence will help providers and family members respond to the adolescent with mental illness and chemical dependency in a holistic, helpful and healthy way.

For the purposes of this presentation, the discussion focused on adolescents between the ages of 13 and 19. However, in some of the developmental research currently available, adolescence is being defined as between ages 11 and 22. The age span of adolescence is increasing and there is now both a pre-adolescent age and an older adolescent age that can span college age. The adolescent developmental process involves tasks that all adolescents are internally driven to complete. The three major developmental tasks are individuation, separation, and autonomy. Treatment planning for the adolescent involves an assessment of the degree of accomplishment of these tasks in the biological, psycho-social and cognitive realms. Completion of these tasks for normal adolescents and for adolescents with mental illnesses and chemical dependency must take place in order for the person to move developmentally into adulthood. Adulthood is defined as becoming an independent thinker and independent actor.

<u>ADOLESCENT TASKS</u>
INDIVIDUATION
Individuation is an internal struggle for identity. It is, "I am separate from…I am different from…I am not just a chip off the old block." Prior to the age of 12, children share their parent's identities, but around age 12 they begin to separate and want to be seen as unique and as their own persons. They begin to form their own opinions, which frequently are in opposition to their parents' views and values. This struggle and separation may be difficult for both adolescents and their parents.

SEPARATION

Separation is a physical process. Adolescents separate in order to figure out who they are, to make up their own minds and to be seen literally as separate from their parents. The adolescent is evaluating which of the imposed parental values he or she will accept. The parents the adolescent once idolized are now embarrassing to be seen with. The harder the parent holds on during this stage, the stronger the adolescent pulls back.

AUTONOMY

Adolescents begin to experiment with self-governance - they decide what they believe in and what they want to do. They become independent thinkers and begin to develop the tools to live independently. They have an internal drive to challenge authority and to involve adults in power struggles. Those struggles are necessary if the adolescent is going to develop the tools for adulthood.

BIOLOGICAL, PSYCHO-SOCIAL AND COGNITIVE DEVELOPMENT
BIOLOGICAL

- **Ages of 13 and 15**

This period of rapid physical development is the second fastest growth period after infancy. Growth, however, is quite variable, with early bloomers and late bloomer. Extremities of the body grow before the body itself, which makes the adolescent appear gangly. Boys and girls are of almost the same relative proportions for shoulders, hips and waists, yet their arms and legs hang down. Along with the limbs, the nose and feet grow. The nose develops 2-3 times its size during this period and may appear as an "adult" nose on a child's face. Their brain has trouble incorporating these changes and the adolescent can be quite clumsy during this period.

Adolescents also are developing sexually between the ages of 13 and 15 and they are preoccupied with sex and their sexual development. This can be a period of embarrassment. Boys and girls frequently dress in oversized clothes, covering themselves until they can psychologically adjust to their new bodies and feelings. This period might be little bit easier for girls than for boys at this age because girls generally will talk and share experiences more

comfortably than the boys will.

- **Ages 16-19**

    Physical maturity is nearing completion and adolescents are adjusting to their hormone surges and to their bodies. What they were hiding by wearing oversized clothes at ages 13 and 14 now becomes a source of exhibition. Their posture and clothing shift to show off their bodies. There are additional stresses, however, for the late bloomers and early bloomers. The early bloomers are perceived as an older child and may not be ready for dating, leadership or other expectations based on their physical prowess. The late bloomers are under a different kind of stress. The 13-year-old that still looks 11 may be ostracized based on size; this may be even harder on males than on females. A research study tracked late blooming boys over a 20 to 25 year period and examined the impact of being a late blooming male in their adult life. They found that these men viewed themselves as less mature, less responsible and less capable in many ways than other people.

PSYCHO-SOCIAL

- **Ages 13-15**

    This is a period of psychosocial stress. Peer pressure is at its highest intensity. This is where what the group thinks is more important than anything else is. Adolescents migrate to peers and adults who listen, understand and affirm them. For example, the athletic kids organize around sports and they talk about sports and sports figures. Sports figure posters are hung in their rooms. It is very apparent what an adolescent is involved with by the symptoms and language they are using at this time. It is not until age 15 or 16 that they are sophisticated enough to conceal what they are doing. This need for a peer group continues regardless of the psychopathology of the client. Unfortunately, when the adolescent can not fit in anywhere else, the druggie subgroup is always available because all the adolescent has to do is use. This need for a peer group is also an issue for adolescents in recovery. Adults in AA are difficult for adolescents to accept as peers and it can be difficult to find other recovering peers. Substance use also is a normal social experience for adolescents and for adolescents with addiction this can pose many problems for their recovery.

- **Ages 16-19**

    Intimacy becomes the focus of the 16 to 19 year old age group. Adolescents seek to bond and connect on a deep and meaningful level to another person. They begin to develop preliminary intimacy skills, which means that they can stay outside of themselves long enough to emotionally bond and connect to another person. Prior to this age, they change best friends according to convenience; friendships now become enduring. Typically, a first love experience happens between the ages of 15 and 19 with or without sex. Relationships that break up following first intimacy experiences can be devastating and a setup for suicide. Without any experience in handling intimacy, sometimes the adolescent trusts the wrong person or shares too much of themselves. It is a powerful experience. The intervention is to help the adolescent through their thoughts and feelings while focusing on their contributions to the lost relationships and what things they have learned and can take with them. The self-conscious adolescent at age 13 to 15 becomes preoccupied with self-concepts between ages 16 to 19.

COGNITIVE

- **Ages 13-15**

    Prior to the age of 12, cognitive processes are characterized by concrete thinking where learning occurs based on the senses and through repetition. Around the age of 12 or13 regions of the brain develop to support abstract thinking. They may not be able to think through complex issues but they can begin to think about things that are not there. Rote learning then becomes much less effective as a teaching tool than the application of abstract concepts. Moreover, the concept of time only develops around the age of 15. Adolescents may have developed rituals and habits around its measurement but there is no real meaning to the adolescent. Prior to that understanding of the concept of time, need gratification is more difficult to delay and adolescent's impulsive behavior is more problematic. The capacity to wait, however, can be learned with help and support.

- **Ages 16-19**

    Adolescents move to more formal operational thought with the ability for abstract thinking during this age period. Complex ideas, cause and effect and deductive thinking all derive from the ability to abstract. Adolescents also develop a sense of time around the age of 16

and are able to possess a sense of past, present and future events and relate it to themselves. The primary cognitive difference between adolescents and adults at this age is now life experiences.

SUMMARY

The mastery of the developmental tasks of adolescence leads to independence and the readiness to address the adult struggles and tasks. For adolescents with mental illness and addiction, the completion of those adolescent tasks are disrupted and delayed. Assessment and recognition of where the adolescent is in terms of his or her developmental tasks is vital to developing a treatment plan to habilitate and support the adolescent. The adolescent with mental illness and addiction is able to master these tasks with support and intervention by the treatment provider.

PARENTING STYLES FOR HIGH RISK ADOLESCENTS

Presented by Tammy Bell, MSW, MAC

PARENTS WITH DYSFUNCTIONAL PARENTING STYLES

Most of society is dysfunctional in some way and every parent, even the "best of parents," exhibits parenting that is dysfunctional. It important to recognize and identify dysfunctional parenting styles, in ourselves and in the parents we work with, in order to develop more successful ways of interacting. Moreover, it is imperative to recognize your own parenting styles as they can prejudice you against other styles as you work with people whose parenting styles do not match your own.

ENGAGEMENT

Engagement of the parents or parent in treatment is critical to the successful treatment outcomes of the adolescent. There are a variety of reasons why parents do not, and historically have not, been engaged in treatment with their child.

- Historically parents have been patronized and excluded by professionals.
- Parents fear and have a history of being blamed. Treatment providers must recognize that they are not better, smarter or know more about what is best for a child than do parents. In order to work with and engage parents treatment providers need to understand the dynamics for themselves, as well as for the parents with whom they work. The differences between the parents they work with and themselves are only the degree of dysfunction and the amount of recovery and growth and development that one or the other may possess.
- Denial and fear are major reasons for non-involvement. Denial about problems that their child is experiencing keeps parents away. They want to believe that their child is fine, that the family is fine.
- There can be a fear that family problems, large or small, will be exposed - more chemical dependence in the family or a bipolar illness in the family that is going untreated.

There are basically four different types of parenting styles that are dysfunctional and there can be a great degree of overlap among them. For each style there are specific vehicles to

engage and work with the parents.

PARENTING STYLES THAT ARE DYSFUNCTIONAL

THE CONTROLLER

Parents who are controlling tend to have a rigid personality; they are black and white thinkers - it's on or it's off, there is no gray. They tend to be angry, uptight, and seem to be unhappy, resentful people. These are the parents with the chip on their shoulder and have this anger going all the time. The controlling parent is just waiting to engage in a power struggle. They have a strong need to be right. Treatment providers are not going to win because the parent is not going to stop unless they are one of them.

The controlling parenting style is one of a strict disciplinarian with a lot of rules and regulations. They do not have a lot of respect for children. Children are seen as an extension of themselves and how their children behave is seen as a reflection on them. Individuation on the child's part or the child's position on things is not supported, and when the child enters adolescence some real problems can start. The controlling parent has the philosophy, "There's one opinion in this house and as long as you share mine, feel free to express it. When you don't share mine, you'd better shut up or I will verbally and emotionally annihilate you to prove you are wrong. I will make you afraid to take me on in the future. I will out-think you, out-smart you and out-talk you."

The goal of working with this type of parent is to win them over. Do not engage in the power struggle. The approach is to find some way to connect to them such as, "Frank, sounds to me like you've done everything you know how to do. Sounds to me like you've pretty much been raising this boy the same way you were raised and with some of the values you had growing up, and it sounds to me like this must be exhausting to be doing everything that your parents did right, and everything you know how to do, and this kid's still out of control. It must be driving you nuts." Find some positive things about their parenting and stroke it.

The parent who uses a controlling style is threatened by the fact that the therapist might have influence over their child. Honor that fear, do not engage it and do not try to prove

something as this is a person who will, in the best case, not undermine you at home. This parent is never going to go home and talk about how wonderful a therapist you are. The controller should not be pulled in very early in therapy. The focus should be on some of the other dynamics in the family first as a relationship is built with the parent. Tolerance, not trust is the goal. And then the therapist might slowly say, "You know, Frank, let's talk about that. Do you think it's also possible that maybe he is experiencing not ever being able to win? That maybe knowing how to be a winner might be something useful?" Also do not put this parent in the parents' support group until they have begun to discuss their own problems or needs or it will undermine the group.

THE PRETENDER

The pretending parenting style is one of being uninformed. The unaware parent walks around with blinders on, never quite sure what is happening. They seem to be helpless and powerless and they confuse and shock easily. Something the pretender might say to a behavior that their child has done is, "Oh, you're kidding." They do not feel very empowered and they are insecure. Their parenting style is permissive; they have no structure or limits and the children tend to be disrespectful. The phrase that is the tip-off is, "Honey, please…" There is a lot of begging the child to cooperate in the voice and a lot of pleading with the child. The children make the decisions and when they grow up they will not take direction or recognize authority. The children as a consequence tend to be selfish and self-centered.

Pretenders respond very well in a parent support group. They can come and share their stress of dealing with children who are out of control and get support and some ideas from other parents. They also work well one on one. They cooperate with educational sessions, take notes and ask questions but do not do any of it. It is usually best to wait until the adolescent is stabilized before working with the family together in family therapy.

EMOTIONAL MANIPULATOR

Parents who have an emotional manipulating style of parenting can be emotionally needy people who are very distrustful of other people. Control as with the controller is their issue but they do it differently. They do not use physical discipline but rather use guilt or over

involvement and over protection to control the child. They may say something like, "Oh, God, after everything I've done for you." What they are trying to do is keep the child bonded to them. They often produce children who do not leave home before they're 30 or 40 or ever. This style of parent tend to engage very well with children and often therapists who are emotional manipulators work well with children because they can do something with them other people are not able to do.

Therapists should avoid attacking the emotional manipulator's parenting style or they may flee or be easily wounded. They will do well in family support groups where people can begin to give them some feedback about their control strategies, "You know what, Harold, my mother used to do that to me and I felt strangled." Emotional manipulators are responsive to discussions of parental problems but it has to be done with great delicacy with a little feedback here and there.

THE BELIEVERS

Believers tend to have a very rigid belief system with a very superior attitude based on that belief system. They have an answer for everything. They believe that their belief is more important than the family and they are distrustful of people outside the belief system. This group includes members of fanatical, fundamentalist religious organizations and alcoholics, drug addicts and codependents who are very rigid in their recovery. Their parenting style is confrontational and unresponsive. They use guilt as a weapon and they are lecture oriented.

Parents with this style of parenting should not be put in a parent support group because they often disrupt the whole group and the other parents are going to hate them. A technique that is effective is called divide and conquer. Work is centered on the parent who is a little weaker or to call them in alone and engage them in some conversation about some things to start helping their child. It can be difficult to have the parents together in sessions reinforcing each other. The focus is to get past the belief. It is also helpful if you can find somebody who is as strongly entrenched in the belief as they are, but not as rigid, to help you and who might be able to sit with you through the sessions.

RESPECT ALWAYS

The bottom line is that what parents need is respect, understanding, support, education and some therapy. Often the parents feel like failures. They feel out of control and overwhelmed, and they need support. The therapist's work is to find a way to engage them that will work for them by enjoying, accepting and respecting their parenting style. It is very easy to parent the neighbor's kid. All of us are guilty of getting in the car after a family reunion and, as the car pulls out of the driveway, saying to our spouse, "You know what my brother needs to do with those kids?" The judgment in parenting needs to be taken out of it: "I'm working hard at being a good parent and I know that you are too."

ADOLESCENT RELAPSE PREVENTION TECHNIQUES
Presented by Tammy Bell, MSW, MAC

RELAPSE PREVENTION TECHNIQUES

Terrence Gorski mentored Tammy Bell during the 1980's and his influence is very evident in her approaches and materials. The following definitions of recovery and relapse, which will help frame the following discussion of relapse, are from Gorski.

RECOVERY

Recovery is a productive and comfortable lifestyle while remaining abstinent. It is not enough for the addict to simply not be using in order to consider them self as recovering. Addicts can stop using drugs and alcohol for lots of reasons - to get a driver's license back, to get the kids back, to get their spouse back or to get their job back. However, the addict fully expects to return to that alcohol and drug use and usually has the day picked out and is anticipating how good the drug will be. There is a lot of fantasizing about the use. That is not recovery that is abstinence. What is considered recovery is being both abstinent and finding a comfortable lifestyle without chemicals.

RELAPSE

Relapse is dysfunctional sobriety that often ends in chemical use. Dysfunctional sobriety often but not always ends in chemical use. The research is clear that a person who is truly in recovery does not have a bad day, goes home and drinks over it. Relapse and chemical use follows a period of dysfunctional sobriety. Relapse is not an impulse, though with adolescents the period of dysfunctional sobriety is shortened, as they are more impulsive than adults. This also means the window of opportunity to intervene on the relapse dynamic before it ends in alcohol and drug use is shorter with a child than an adult. Moreover, the younger the child the less time a clinician have as they are less able to manage their impulses. Adolescents and children have difficulty delaying their gratification. They are immature and have no life experiences. All they know often is now.

RELAPSE RATES

Relapse rates with children will always be higher than they are for adults. There are factors that contribute to this higher relapse rate. Immaturity is one factor and the lack of control over life's situations is a second. Adult addicts who get sober and want to stay sober make active choices to support a sobriety centered lifestyle. Adolescents frequently do not have that control over their lifestyle and their choices. They may remain in the neighborhood, go to the same school and be taunted by their drug using peers.

ADOLESCENT RECOVERY

Adolescent recovery is a process not an event. Adolescents for the most part are not going to get sober the first time around. The expectation for recovery is a longer-term goal and the therapist must see them self as part of that longer-term process. Usually there is going to be three or four treatment providers in a child's life before he or she finds sobriety.

RELAPSE PREVENTION

Relapse prevention starts once a child makes a commitment to sobriety and is motivated to change their life. When an adolescent is at that point, relapse prevention needs to be 50% of the treatment focus. Prior to that point the adolescent is in pre-treatment and relapse prevention is not an appropriate intervention.

Norm Hoffman's research on successful recovery found that there were three major reasons for the children who relapsed. One reason was failure to accept chemical dependency as an illness. Reasons two and three centered on the lack of professional support and the lack of parental involvement.

PRETREATMENT

Failure to accept chemical dependency is basically the issue for the adolescent who is still in pretreatment and is not a relapse issue at all. The adolescent does not believe that his or her life consequences have anything to do with their drug use and is unwilling to attempt to change anything about their life. The pretreatment phase has three tasks that must be met before the adolescent can progress into recovery and begin relapse prevention work. Those stages are (1)

connecting the use of chemicals to consequences in their life; (2) attempting to control their chemical use; and (3) attempting abstinence. The adolescent who is addicted will fail their tests for controlled use and controlled abstinence and will come to the understanding for themselves that abstinence without a major lifestyle change makes one miserable and ultimately leads right back to the drug. Prior to this point the adolescent is not in recovery and relapse prevention efforts will not be very effective. Adolescents in pretreatment need a transition program, motivational work, or something else but not relapse prevention work.

LACK OF PROFESSIONAL SUPPORT

The lack of professional support is the second reason for relapse and has to do with the duration of treatment. Adolescents who are successful at moving from an addicted centered lifestyle to a sober centered lifestyle have been found to be involved with professionals for about 18 months. Eighteen months, however, is not that long when the whole continuum of care is considered, starting with (if one is lucky) some inpatient stabilization moving to intensive outpatient meeting everyday and then on to outpatient where there is a group that meets once or twice a week. Adolescents who had at least 18 months of treatment did better and had a much higher recovery rate than those adolescents put in 6 or 8 week outpatient programs or 6 or 8 week inpatient programs. Adolescents need continuous professional interactions at least weekly for at least 18 months with smooth transitions between providers. Children bond and have attachments with their counselors. These attachments must be transitioned and not severed until the next counselor's bond is in place. A signal that the bond has taken place is when the child begins to talk about their new counselor. More work needs to be done to support transitions for children and adolescents in treatment.

LACK OF PARENTAL INVOLVEMENT

The adolescent who does well also has been found to have at least one significant person from their life involved in the treatment process. It is usually a mother or father. Adolescents that have absolutely no family support are not going to do well. That is a significant issue for children who have families where there is either an addiction or a psychiatric illness that is not being treated. Mentors, supports, an involved aunt or uncle can also provide support but they need to

have a firm commit to the child. Parents and the supportive others also need support and counseling along with the adolescent in the treatment process.

RELAPSE JUSTIFICATIONS

Most people in recovery have a relapse justification. They may be afraid to say it but most people have something that they would identify that they would feel would justify drinking or drugging over. The less sobriety a person has the more problematic their relapse justification is and the more sobriety a person has the more improbable their relapse justification is. The adolescent may say something like, "If my parents split up…if I have to go live with my Dad…if my girlfriend leaves me I couldn't take it, I would drink." To work with people around relapse justifications, have the person list situations that would make sense for them to use- relapse justifications. The list is important to reference and intervene quickly if any of those happen to the individual. A group assignment that is very effective is having the adolescent present the relapse justifications to their group one at a time in sentence form. What happens is that they start to be able to laugh about some of their absurdity and so begin to reduce the list. The list is shared with parents, sponsors and others making the relapse justification situations public and preparing everyone around the adolescent to make a move immediately if any of these things happen. Long term sober people also have relapse justifications. They too need to identify and share their relapse justifications. "It is not scary to say them out loud. It is scary to not say them." The justifications need to be examined and reviewed. How would that affect the rest of their lives? What would the spiritual part of them say? Everyone has a relapse justification; it is the counselor's job to find out what they are.

HIGH-RISK SITUATIONS

High-risk situations are different from relapse justifications. High-risk situations are people, places, things, or events that trigger serious thoughts about drugging or drinking. These are not situations where a person might actually use but situations in which there would be a mental or emotional struggle about using. High-risk situations generally are going to be daily things, while relapse justifications are of a more serious nature. A high-risk situation for an adolescent might be walking down the halls at school, going to a regular school dance, Dad's beer in the refrigerator or brother's pot in his bedroom. The high-risk situations are situations

that overwhelm the adolescent. Similar to the relapse justifications, the adolescent in treatment shares their list one by one to the group. The group members have a task. Their task is to help solve how to deal with these issues through eliminating, minimizing or better managing them. In the group, there is opportunity to practice, rehearse and role-play. The adolescent will fight against this, as they do not think they can make the changes in their life but the group holds them to the task. Refusal skills are learned and practiced so that they will be able to refuse with coolness. The practice among themselves can help them feel successful.

RELAPSE EXERCISE

Another exercise for relapse prevention is the M & M exercise. It works best with a mixture of adolescents in pre-treatment and early recovery. All the adolescents in pre-treatment are given M & Ms, while none of the adolescents in recovery receive them. All of the adolescents in pre-treatment get M & Ms and they are told, because they are still very much in their active addiction, they are faking somebody, a probation officer or parent or "Here is the deal . . ." The adolescents with the M & Ms can eat them or use them to get more M & Ms. If they can convince any of the adolescents in the recovery group to take one, they can get another pack. And then the next pack can be used to secure more packs. However, if the staff sees them with the M & Ms, wrappers or packages, they are busted and must give up their M & Ms, forfeiting every M & M at that moment to that staff person, and they will get no more.
The adolescents in early recovery get to talk about what the experience is like day in and day out, walking in and out of the facility with these kids using these M & Ms - what is working and what is not working, how are they feeling about it.

EARLY RELAPSE INTERVENTION PLAN

An early relapse intervention plan needs to be made for every adolescent as soon as they say they are going to try to get sober because the chances that they are going to relapse are very high. The plan has three levels.

Level One

Level one is what they plan to do if they use– "call my sponsor, go pick up a white chip, call my counselor, tell on myself at group, follow all recommendations the group tells me." Now

that is great but it happens only about 10% of the time. Most people once they use just want to get blasted before they come in. The abstinence violation effect in recovering people is just this; they go for it once they have picked up.

Level Two

The second level is when the first level is not done and someone has figured out that adolescent is using. This will be a parent or a sponsor or the counselor, or somebody in the group. That person then organizes the intervention team that the person has previously crafted and an intervention occurs. The team attempts to stop the person from using, based on a plan that the person previously developed with their team.

Level Three

The third level is when the person is out of control and needs stabilization. The plan is arrived at ahead of time and the group's job is to make sure it will work and has no holes in it. The relapse process occurs when a person slides out of recovery and drops into a relapse dynamic and then ends with chemical use.

For most people who relapse, they only are aware of things that immediately preceded their substance use, such as sitting in the liquor parking lot or stopping going to meetings. The work is having an individual examine their relapse step-by-step, starting at the relapse and backing up. Typically for individuals who have chronic relapses, they will have the same relapse pattern over and over again. Most people have a pattern and getting a thorough history of past attempts to get sober can help to uncover it. These patterns form a relapse dynamic. Most recovering people have a relapse dynamic and most of them do not go all the way to alcohol and drug use before they figure out how much trouble they are in and turn it back around. The people who relapse are not able to figure this out. For adolescents, the treatment is to identify (i) how they think when they are experiencing this dynamic, (ii) how they feel when they are experiencing this dynamic and (iii) how they behave when they are experiencing this dynamic. The work then is to tease out earlier warning signs and put the symptoms into a sequence and identify ways to eliminate or manage the high-risk situation.

Relapse prevention efforts also include connecting the adolescent to 12 step programs. That connection may in the long run be more important than the counselor's intervention. However, for adolescents the integration into AA or NA is difficult because the program is complex and adolescents still think primarily in concrete terms. There are a number of ways, however, that can help them integrate that include (1) using guides or temporary sponsors to introduce them into the recovering community, which includes driving them to meetings; (2) introducing the adolescent around the meeting so that they can be comfortable; if possible, try to search out age matched peers; and (3) avoiding meetings where there are people that do not like adolescents; recovering people are no different from non-recovering people and many do not like adolescents. Orientation to 12 step programs is important. Introduce adolescents to how the meeting starts, what goes on, how long it lasts, how it ends and what the words mean.

Adolescents do recover, but many may not recover when they are with any particular therapist. Recovery is a process and as part of that process they need to know and be able to work with their relapse dynamics. The earlier the adolescent is able to intervene in the process, the quicker they can get back into working in a recovery program.

DEVELOPMENTAL MODEL OF RECOVERY
Presented by Tammy Bell, MSW, MAC

OVERVIEW OF DEVELOPMENTAL MODEL OF RECOVERY

The Adolescent Developmental Model of Recovery has its foundations in two developmental models for adult recovery, the developmental model of recovery developed by Stephanie Brown from Stanford University and the model developed by Terry Gorski and noted in his book *Passages Through Recovery*. The Adolescent Developmental Model of Recovery ("ADMR") developed and described by Tammy Bell has resemblance to those models but is specifically adapted for adolescents.

The developmental model can be viewed as road map into recovery. It is a series of progressive stages that lead people from basic skill attainment to the development of sophisticated skill capabilities. In each stage there are specific implications for treatment. There are six stages in ADMR (1) pretreatment; (2) stabilization; (3) early recovery; (4) middle recovery; (5) late recovery; and (6) maintenance. The first stage, pretreatment, is the process of connecting life consequences to alcohol and drug use and giving up the need to control use. Stabilization, the second stage, is learning how to abstain. The third stage, early recovery, is learning how to become comfortably sober. Middle recovery is developing age appropriate lifestyle balance. Late recovery is establishing healthy inter-dependence and the last stage, maintenance, is continued growth and development.

RECOVERY

The definitions of recovery and relapse help frame the concepts of ADMR. The definition of recovery is a productive and comfortable lifestyle while remaining abstinent. Abstinence for the adolescent who is chemically dependent is a prerequisite for recovery but it is not the definition. The reason it is important to make this distinction is that there are a lot of addicts that can stop using to get things back in their lives - their driver's license, their husbands, their kids or their jobs - but that does not make them in recovery. That makes them abstainers. Recovery is the making of active choices that supports a productive comfortable lifestyle while remaining abstinent.

<u>**RELAPSE**</u>

Relapse, on the other hand, is a dysfunctional sobriety that often ends in chemical use but not always. Most recovering people have a relapse dynamic. They have figured out where to short circuit their dysfunctional process before it ends in alcohol and drug use. People who have not figured that out are at risk of relapsing.

<u>**STAGES OF DEVELOPMENTAL MODEL OF RECOVERY**</u>
PRETREATMENT

Within the context of the definitions for recovery and relapse, pretreatment is the first stage of recovery and the last stage for active chemical use. Pretreatment is the stage where chemical use initially is regarded as normal but proceeds to where the adolescent who is addicted begins (1) to acknowledge the consequences of their chemical use; (2) to struggle with issues of control; and (3) to accept the fact that abstinence without life-style changes is not a viable option. Prior to pretreatment, the adolescent who is addicted believes that they are a normal user and their life problems do not have anything to do with their alcohol and drug use. It is important to note that they are not lying because most of the time it is what they truly believe.

Recognize the Pattern of Addiction-Related Problems

The first phase of pretreatment helps the addict connect consequences to their alcohol and drug use and recognize the pattern of addiction-related problems. That connection between the alcohol and drug use to life problems, however, must be meaningful for the adolescent. The connection may not involve the issues the therapist sees as problems such as probation issues, the school issues or the parental issues but rather the things that are meaningful for the adolescent such as the loss of the driver's license or the loss of the girlfriend. When this connection is made, motivation for recovery begins. The discovery of this connection, however, must be made by the adolescent for themselves. An adolescent will not accept adult wisdom. A process of inquiry, the "Columbo" technique, can help the adolescent find the common denominator in their drug use. Exaggerating the adolescent's logic can be helpful to this process. If one can go beyond where the client is, there is a chance of walking back together across the line. Motivational counseling, connecting the dots, thorough assessment, and insight-oriented therapy are other ways to help the

adolescent make the connection. Other recovery activities, such as writing out your first step, going to an AA meeting or getting a sponsor, are too early for this stage. The adolescent is not yet ready. They have to get to the point that they understand that there is actually a reason to do those things.

Controlled Chemical Use

Once the adolescent addict can connect pain or consequences to their alcohol and drug use they will be motivated to make some changes. They move into the second of three phases of pretreatment, controlled chemical use. The adolescent will attempt to use substances only under certain circumstances, such as limiting the frequency and quantity of their use or changing the substances they use so as to avoid problems associated with their use. What they are saying is that, "I am going to maintain my relationship to chemicals and not pay the consequences." This is a type of test that the adolescent must fail before they will be able to move farther along in recovery. It is a test that the addict not the substance abuser fails.

Adolescents in this pretreatment phase need to be separated from the adolescents in the other stages of recovery; stabilization, early recovery, middle recovery, late recovery and maintenance. Mixing the pretreatment group with the other stages of treatment can cause others to relapse as the pretreatment adolescent will frequently engage in power struggles and will attempt to undermine the efforts of others.

Controlled Abstinence

Once the adolescent understands that they cannot control their chemical use, the third and final piece of pretreatment is reached, controlled abstinence. This is where the addict swears off alcohol and drugs for a specific period of time but without making any lifestyle changes in order to prove they can control their use of substances. This teaches them a very important lesson. Abstinence without a major lifestyle change for an addict makes the addict miserable and ultimately leads right back to the drug. Most adolescents in treatment are in the pretreatment phase, however, treatment providers are frequently ahead of them, forcing them into treatment before they are ready. Motivational issues need to be addressed to help the adolescent gain an internal drive to want to make some changes in their life before active treatment is introduced.

Adolescents who resolve the pretreatment tasks are motivated to recover, present fewer problems in treatment, move into recovery faster and have lower relapse rates. Pretreatment should be time limited to around 8 weeks, during which time there is a thorough assessment and a transition through the tasks of pretreatment. After that if the adolescent is still not moving, the adolescent is not engaged further in pretreatment or recovery work. At times a more coercive intervention is attempted at this time.

Variability in Recovery

Recovery is a process that is highly variable. The recovery prone person is able to make the connection between drug and alcohol use and problems in their lives and tends to get sober the first time out. They respond to treatment and follow treatment directions. Another group of people called transitionally relapse prone are people who come in and out of sobriety, in and out of recovery until the missing parts click for them. People who are chronically relapse prone are those who seem unable to maintain continued abstinence no matter how well they work the program. Adolescents are in all three categories but the bulk of them are in the middle category.

STABILIZATION

Accepting that they cannot control their use, the adolescent reaches the second stage of recovery, stabilization. The tasks for stabilization include (1) recovery from acute and post acute withdrawal; (2) stabilize from their motivational crises; (3) accept the need for help; (4) interrupt addictive preoccupation; (5) recognize the possibility of an alternative life style; (6) learn non-chemical stress management; and (7) develop hope and motivation.

Acute and Post Acute Withdrawal

Acute withdrawal is not that often seen in adolescents. Typically adolescents breeze through with mild symptomotology of headache, stomachache and irritability. Then post acute withdrawal or a protracted withdrawal emerges. Post acute withdrawal consists of physical, social and psychological symptoms that emerge after the acute withdrawal phase has passed. Psychological symptoms include issues around loss, grief and anxiety about the decision to give up drugs. There are social symptoms of fear, confusion and frustration. Physically symptoms of headaches and stomachache may continue, as well as difficulty in focusing and attention.

Moreover, rigid, repetitive thoughts emerge and there can be difficulty managing feelings and emotions. Cravings can be acute. The post acute withdrawal can last for weeks or months. Stabilization is a critical piece to support continued sobriety at this stage. The symptoms must be aggressively addressed, monitored and checked during this period.

If they are not sleeping or experience difficulty falling asleep and staying asleep, which are all post acute withdrawal symptoms, then plans must be made. An adolescent's nicotine, caffeine or sugar intake are evaluated and a reduction scheme for one at a time is planned out. The belief that giving up only one thing at a time is a myth and research is now showing that with cocaine, relapse is tied to nicotine use. Wellbutrin or a patch can be utilized for the nicotine addiction.

For adolescents for whom craving is an issue, a craving management plan is developed. It is written out on cards with specific instructions, contact numbers and activities spelled out. The craving management plan consists of the following activities. The first action is to change or interrupt whatever activity that is occurring when the craving begins. That might mean getting off the phone or walking but not staying focused on the craving thoughts or feelings. The second action is breathing. The adolescent should be taught how to breathe with their lower abdomen, a meditative type of breathing. The third activity is to call someone and share the urge. Next, is to engage in a natural mood elevator. Natural mood elevators are things that bring either peace or happiness and are a great distraction. The whole process can be repeated until the craving passes. The adolescent needs to be educated about the post acute withdrawal symptoms and taught how to manage the uncomfortable feelings and symptoms of early recovery.

During stabilization, the therapist instills a great deal of hope and motivation. The adolescent needs to see that recovery for them is possible despite past failures. The treatment staff can be built up and efforts should be made to do whatever necessary to sell the hope and belief that this time will be different. Education about symptoms with linkage of their life consequences to the alcohol and drug use is needed to keep the motivation going.

EARLY RECOVERY

Early recovery is the stage that most counselors know how to do. It is teaching the adolescent what the addiction is, how they got it and what they are going to have to do to stay sober. This is where the spiritual part of the program begins. Prior to this point, the adolescent is too connected to the drug or in so much pain and mentally confused to connect spiritually.

The early recovery tasks are (1) to establish an initial recovery program; (2) to recognize the nature and presence of their addictive disease; (3) to accept their addiction; (4) to learn impulse control; (5) to develop a sobriety-centered value system; and (6) to learn to cope with family dynamics.

Early recovery is learning how to get sober and actually working a program. Adolescents need a sponsor and a home group where people will treat them as an equal in terms of the addiction. The focus is moving the adolescent from an addicted centered lifestyle to a sober centered lifestyle. They need social activities, new friends and will need to complete the developmental tasks required for their age, tasks that have been delayed due to their chemical use.

The second part of early recovery is coping with the family dynamics. While adults are not encouraged to deal with family of origin issues until late recovery, adolescents are living in it so it has to be dealt with early on and confronted. Coping patterns and core psychological issues are usually established in childhood and are based on mistaken beliefs learned during childhood. Generally these beliefs are from families but not always. It is possible to affect these beliefs by explaining the family's patterns, the unwritten rules and roles that the family members play and how they helped the adolescent survive but also how those patterns are interfering in their recovery. The adolescent needs to identify the primary thinking, emotional and behavior patterns they learned as a young child and then examine their perceptions of themselves and the world that they developed as a result of being in their family. They will need to grieve. It is not appropriate, however, to do this work, especially trauma work, if the adolescent is not stable. An iatrogenic factor in medicine is when the physician induces an illness and causes more damage. Therapists need not cause more damage. However, there is a balance between therapy and

relapse, not moving on something that should be moved on and moving on something prematurely or moving on something that should not be moved on. Children have opportunities to address issues before they accompany them into adulthood. For children issues may not be as life threatening as they feel with adults and the therapist should not shy away from dealing with them, "kids will cry and adults will wail."

MIDDLE RECOVERY

Middle recovery is about balancing out the life. A time to catch up in school if they are behind academically. In an AA program it is called practicing these principles in all of our affairs. For the adolescent that is making amends with family for their end of the insanity in the household because of the addiction; it is about making amends to people that they have harmed and it is about dealing with all the consequences and cleaning up their side of the street. The tasks of middle recovery are (1) to develop healthy self-esteem; (2) to clarify personal values; (3) to learn to recognize healthy personal preferences; (4) to repair addiction-caused social damage; and (5) to establish a self-regulated recovery program.

In middle recovery the therapist should no longer be telling them what their program looks like. They should be telling the therapist, "This is how often I get together with my sponsor. This is how many meetings I go to because this what works for me. This is how much time I spend on my recovery in terms of either reading or meditating." Frequently it will not be as time intensive as an adult recovery plan might be and will include typical adolescent oppositional behaviors. Middle recovery is about fitting back into the world as a recovering person so that other people around them do not know that they are in the program or that they are recovering unless they decide to tell them. It is about the recovery program being the foundation but not the definition of who they are.

Relapse in Middle Recovery

Relapse in middle recovery is because the adolescent cannot face the consequences of their addiction and is unable to balance out their life, make amends and begin to transition out into the world as an adolescent who is a silent recovering person. Father Martin used to say that a

lot of people stay stuck in early recovery because they don't want to come out and face the bad marriage created in the act of addiction.

LATE RECOVERY

In late adolescent recovery, adolescents resume normal developmental tasks, particularly around the development of intimacy skills. People from dysfunctional families have problems with intimacy. People with addictions have problems with intimacy. A great amount of time needs to be spent on intimacy skills because it is so lacking in their lives and they need it so much.

Adolescents who are recovering from chemical dependency need to develop a cooperative attitude towards society. They need to know that "no man is an island" and that in order to get their needs met they have to cooperate with other people. They need help to begin thinking independently and acting independently for the completion of the final stage of adolescent development.

MAINTENANCE

The last stage is maintenance where adolescents continue their growth and development. A major reason for relapse in maintenance is complacency. There is, "No understanding that if they don't keep putting fuel in the car the tank will go empty." Adolescents need to stay grounded in their recovery program or their spirituality will erode and the relapse dynamic will begin and they will find a situation where they cannot turn it down.

Maintenance Tasks

The maintenance tasks are (1) maintaining an active recovery program; (2) learning to maintain effective day to day coping with problems; (3) maintaining continued growth and development- not letting things build up; (4) following productive life planning; and (5) learning to cope effectively with life transitions and complicating factors.

The decisions that adolescents make now are big decisions. Decisions made during this five, six, seven, eight-year period have a huge impact on the rest of their lives. These decisions

create stress and when that stress goes up the desire to relieve it begins. They need to stay focused on their recovery and on their spirituality. The adolescents should have a touchstone they can come back to. Therapists should be available for the adolescent to come back to whenever they need to.

TREATMENT PLANS

Treatment plans should reflect the stage of recovery that the adolescent is in. The plans should indicate whether they are in pretreatment, early recovery, middle recovery, late recovery or maintenance recovery stages and address the adolescent's specific needs. Relapse causes for each stage need to be identified and worked with. Once the adolescents have actually entered recovery they are either in the process of recovery or in the process of relapse.

Tammy Bell, MSW, MAC
References

Bell, T. (1990). *Preventing Adolescent Relapse: A Guide for Parents, Teachers and Counselors.* MO: Herald House/Independence Press.

Brown, S. (1985). *Treating the Alcoholic: Developmental Model of Recovery.* New York: John Wiley & Sons.

Gorski, T (1997). *Passages Through Recovery: An Action Plan for Preventing Relapse.*MN: Hazelden

Gorski, T. (1996). *Adolescent Relapse Prevention Workbook: A Brief Strategic Approach.* MO: Herald House/Independence Press.

PROGRAM DEVELOPMENT IN SCHOOL SYSTEMS

Program development begins with recognizing the need, creating a shared vision and a willingness to tackle the problem. This presentation on the implementation of school programming by NRI Mental Health Center in the Woonsocket School District highlighted the process of program development and the critical elements that made it successful.

BEGINNING THE RELATIONSHIP

About 15 or 16 years ago the NRI Mental Health Center recognized that the schools were in trouble with treating severely emotionally disturbed kids. No one spoke about behavioral health or dual diagnosis even though those issues were there as well. The kids that were sent for treatment were the disruptive kids. "This kid's got a mental health problem, can you take care of him? He's so disruptive in class." Intakes at the mental health center reflected this need, so the issue of how to meet the school's needs rose to the attention of the mental health center. One of the initial questions was how to infiltrate the school system, which was perceived as a very closed system. An overture to a school department, the largest of the communities served by the mental health center, was made. Woonsocket, Rhode Island is a poor, post-industrial city. There is a lot of poverty and it is a very closed community. The mental health center said, "Let us come in and help you. Your kids are our kids. Let's see if there's something that we can possibly do." The approach was soft, with an offer for some sort of consultation. Offering the free service caught the school's attention and can be a tactic when there is no other way to engage the school. The cost of the worker was a sunk cost for the venture and the worker went in to hang out with the teachers, listen to their problems, validate them and help decrease their fear. The mental health worker knew the kids and knew how to work with them and how to work with their families. The process began with individual teacher consultations. The workers would come into the classroom and sit there and observe, then meet with the teacher afterward and say, "Yes, this kid is difficult, and we've thought about this and we can refer this family in." The teachers were supported and the mental health center got a better sense of the school. This continued for about

a year and a half, until the people in the school started to see the center as not the enemy. In the second year, the school started saying, "Okay, maybe you're not so bad and maybe we can contract for you to come into our classroom and offer some support in the classroom a couple hours a week." The program grew from individual consultation to direct in-service in the classroom - usually the behavior disorder classroom.

ISSUES IN SCHOOL PARTNERSHIPS

Some of the issues faced when entering schools systems are unique to the school system. Union issues are significant. The mental health center is offering a service on someone else's territory where they have union protected job that allegedly a school social worker or psychologist could be providing. However, these were children that nobody wanted to work with. They had the families that nobody wanted to deal with. So the union backed off. Later, when the union issues were still an issue, one of the things that was said to them was, "This kid is really tough to deal with. We really need to be working this family." The social workers in that town did not want to do home visits and they did not want to work past their contracted hour time. The mental health center offered something nobody else was willing to provide, they said, "We can go in after 3 and we'll do the home visits to the families and we'll start to provide services to the families." That gave the school union the permission to have the mental health centers services in the school as the center was providing something a little bit different than they were.

CREATING A SHARED VISION

By this point the school and the mental health center had started to "buddy up" and to talk about whether they had a shared vision and what was is it. This process can occur faster if there already is a relationship with the school but it generally takes time to build. After a common vision is built problems can be addressed more directly. "This is how we see this problem and what is it that we can do for you that's going to make your lives better." The mental health center did that for 8 or 9 years and expanded their services to include more classrooms in more schools. At one point there was a decision to try something really different- a behavioral disordered classroom. It did not work but served to lead to another solution. The children were integrated into the mainstream and service providers became a mobile team. Ten children were

75

divided among 3 or 4 different schools and a mobile team with a therapist and a teacher's assistant who the mental health center hired were sent to support all of the 8 classrooms. That worked well for about 2 years until the school decided to offer the service themselves. However, the children were getting more complex and the school asked the mental health center back in. Then a new off site alternative was considered. A Day Treatment Center was opened, which is different than an adult day treatment. It was a 45-day assessment program where the school provided the money to purchase 10 or 12 slots for which they would pay $17,000 a year. For that $17,000 a year the school got to be the gatekeeper. It got to say who came in and out of the program. The children were taken out of the school because it appeared to be a very disruptive place for them to be. They came to the treatment center for 45 days, where they and their families received an assessment. During those 45 days the children were there, school personnel came to the center every 3 weeks for planning and partnering so that at the end of the 45 days there were no surprises. The school and the mental health center shared the vision that children belonged in their schools, in their communities. There was a 95% return rate to the school. However, part of the job was to recognize the children who needed more intensive help than the program could offer. Some children would go to the next level of alternative education or to residential programming although that was done very carefully. Decisions were made based on the therapeutic needs of the child.

This time-limited 45-day center has been running now for 5 years and it has been running fairly successfully. It was started with just high school aged children from 4 different communities. The classroom size was about 8 and it had a teacher, a teacher's assistant and a masters level clinician assigned to each classroom. Then a middle school program was created and, with the thought that intervention should be occurring sooner, an elementary program was the last to be created. The program now serves children from ages 5 to 18.

Last year the State Department of Education informed the center that a school license is required to continue to operate and gave the center a year to transition. Parents had complained about the academics and the behaviors in the program and the school passed those issues along to the program. The program therefore this year became a licensed educational facility and has hired a nurse, a gym teacher and other staff. The center has 3 years to fulfill the library

requirement. Costs have risen but the program is still significantly below the costs of other alternative schools in Rhode Island. The program now is looking for a new site as it has outgrown its space and is adapting to its new educational role. A physical education teacher was hired part-time who had not previously worked with children at risk. She has been able to adapt her curriculum, making it all hands on and it has become the core curriculum integrating the other subjects of science, math and language. Curriculum development is a huge focus. Substance abuse education is folded into the health curriculum. There are home visits. The environment is very rich. The program hires staff for their attitude and trains them for skill. The need for creative staff with vision and humor is very important. Likewise, stability in staffing is needed. Presently in the school there are clinicians assigned to the classroom and to the school. This is only sometimes effective. The effectiveness of staffing patterns and roles need to be continuously evaluated for their effectiveness. As the children change, their needs are different and the program must change.

SUMMARY

Relationships and collaborations with schools are formed in the same way relationships are formed with anybody. They are built on interactions, cooperation and trust. Initially providers may offer services that the school might not provide or might not want to provide and then once relations are built work creatively to help the school fund programs or utilize funding streams they might not have experience with. Recommendations from the service provider need to be aware of school limitations and partner with the school on treatment planning solutions. School relationships are continuing to develop and shared visions are created from those relationships and are the basis for developing a mutual plan. We all need to engage in the discussion of where we go from here.

CHILDREN'S INTENSIVE SERVICES

The creation of a hospital without walls, a hospital diversion program, to maintain high risk adolescents in their community was created in response to an initiative to reduce the number of psychiatric bed days for children by Rhode Island's Division of Children, Youth and Family Services. The initiative began approximately 6 years ago. As found elsewhere across the nation, Rhode Island found that too many financial resources were going to support too few children in the hospital at too high a price. They requested that the eight community mental health centers that cover the state work with the state to put together programming to address the problem. The program that was developed was Children's Intensive Services ("CIS"). The CIS program, however, is one of many programs that comprise the continuum of services for children's mental health services offered in Rhode Island. The other services, ranging from highest to lowest intensity of service, are: inpatient hospitalization, children's residential services, outpatient mental health services, project early start, comprehensive emergency services and head start. The new CIS program level of acuity was below hospitalization but above the other community programs.

ELIGIBILITY

The CIS program was funded by dividing up the aggregate costs of hospitalizations of a recent number of years among the 8 community health center as a capitated per person daily rate for each child enrolled in the program. Additional Medicaid services also can be used and billed as regulations allowed. The eligibility as defined by the state is based on the following priorities: first priority is the Medicaid and uninsured children at risk of hospitalization, the second priority is Medicaid or uninsured children at risk of placement and the third priority is insured children at risk of placement. The population for whom the state was attempting to contain costs was clearly the Medicaid children and their families who are at risk of hospitalization and out-of-home placement. Children can range from age 3 up to age 21.

COMPONENTS OF CIS

The six (6) month hospital diversion program offers the full range of clinical services, including psychiatric treatment, nursing services, clinical services including individual and family therapy, case management, in-home respite, therapeutic recreation, hospital and community agency liaison, crisis intervention, weekend outreach and case coordination. There is a minimum of three times a week contact and that contact can be in combination with the child, with the family and/or with collaterals. All staff are masters level clinicians who provide the clinical work and the case management. Caseloads are ideally around eight. Case management is seen as clinical services to these children. There are also individual rehabilitation workers who take the children out on a one to one basis to work on improving their social skills and teaching them how to get along in the community. These children frequently have been excluded from community programming because of behaviors; with the staff support they are able to access these activities. There also is a vocational specialist who helps the children look for jobs. During the summer, the program runs a therapeutic program for 6 weeks that offers different programs for children ages 3 to 13. At age 14 CSI begins working on job placements. All the services and work happen in the home, the school and the community. There are no office-based services. The services are available 24 hours a day, 7 days a week, with emergency services that offer 24-hour coverage. Weekend contacts are done with the children. It is a very intensive service and it works.

MAKES THE PROGRAM SUCCESSFUL

First, it is important to get people to believe that the children do not have to go into the hospital just because they are in crisis. Second, the program has to learn to partner with the hospitals and to use them effectively. The CIS program until recently had gate keeping responsibility for which children on Medicaid go into the hospital. The program determined admission, monitored the duration and linked between the hospital and the community to develop discharge plans. Under CIS, hospital bed days have gone down, length of stay has gone from 30 days to 14 days to 2 days. When gate keeping rests with physician, in contrast, notification about the hospitalization to the mental health center is not as smooth and consistent and children remain in the hospital longer. At present, Rhode Island's Medicaid managed care company has gate keeping responsibility, however, there is work going on to give that

responsibility back to the mental health centers. Hospitals also are in a position to sell the family on the community based services and their effectiveness. Third, the staff of the CIS program must be people who can work in the field and understand the nature of the work. They must have been able to make the switch from office-based treatment to community-based treatment. Staff training is vital and staff need to be able to function as a team. The team needs to include the psychiatric component.

SUMMER THERAPEUTIC PROGRAM

The children in the program need structure during the summer. For the young children, CIS runs a camp. The CIS staff provides transportation and there is 3 or 4 staff to 7 children. With the older children, there is some attaching of the older children to the younger children for some of the recreational activities. For the children ages 14 and up there is summer employment money that is used to hire 15 children and put them in a supported work environment. The children are mentors and offer job coaching. They get paid a small stipend. The program has been very successful. During the summer there has not been one psychiatric hospitalization of any of the children that have been in the program. CIS also has taken staff and placed them in community camps to support CIS children's attendance in those camps.

FAMILY THERAPY

Many of the families that are in the program are burned out with being in the system, burned out with the revolving door to the hospital. They initially balk at people coming into their homes because it is a fairly intrusive. The program works with the family to accept that level of intervention, however, if a family refuses therapy would be offered in the office and then work toward home based work. Such refusals are rare, however. Respite also is a service that is offered in the home and provides support and role modeling for the parent.

MULTI-AGENCY FUNDING

To be able to offer the intensity and the variety of services to fill the gaps and service need for an effective diversion program, funding from multiple sources is a requirement. No state is able to shoulder the entire amount of money that will be required. One way to access additional funds is to develop multi-agency initiatives. In Rhode Island, the CAST dollars were

used to create a multi-agency planning team to figure out how to fill the gaps in community based care. A grant of more than 15 million dollars over 5 years was obtained and divided among the community mental health center regions. Some of those monies pay for the camp, together with monies from the school department and the housing authority. Respite also is paid for with those monies. Public housing authorities are a funding resource and the state's Medicaid authority should be brought to the table to develop funding options. Creativity and pooled funding is needed for exemplary program development.

HISTORY OF NATURAL HELPERS OF MAINE PROGRAM

The *Natural Helpers of Maine Program* is a program of Day One of Portland, Cape Elizabeth and Hollis. For the past 12 years Day One has offered this program to schools across Maine. The program itself is about 20 years old. Two schoolteachers who noticed something going on in their school started it in Seattle, Washington. They noticed that there were certain people in the high school that other people were comfortable talking to about their problems. Here was a group of people who had naturally risen to the level of comfort around their peers. They were respected enough that people naturally wanted to go to them and talk to them. The teachers questioned how they might make effective use of this phenomenon to help the school and the school community. They developed the Natural Helpers program. About 3 or 4 years ago they sold the rights and Natural Helpers is now a national program.

MISSION

Natural Helpers of Maine, coordinated by Day One, is rooted in the knowledge that there exists within every school a natural network of teens helping teens that, when recognized and utilized, can play a primary role in the development of a school's overall prevention and helping system. *Natural Helpers of Maine* is committed to the identification, training and support of groups of *Natural Helpers* to the following end: that every student, regardless of status, feels that they have an appropriately trained peer from whom they can comfortably seek support and/or assistance with personal problems so that the link between adult professionals and the existing helping network is established and utilized for the referral of students with more severe problems, including physical abuse, sexual abuse, substance abuse, eating disorders and suicide. The *Natural Helpers*, individually and as a group, can initiate and assist pro-active prevention activities within the school and community.

PARTICIPATION IN MAINE

This year, 2000, in Maine there are 17 participating high schools, ranging from Fort Kent Community High School in Aroostook County to many schools in southern Maine. It is an

expense for each school that participates in the program, however, the rewards outweigh the expense. Today five schools, Gorham High School, Scarborough High School, Greely High School, Falmouth High School and Deering High School, were at the workshop to share their perspectives and to provide information about the program.

TRAINING

Training on how to be a *Natural Helper* is offered in the fall. Schools are grouped together in groups of 2 to 4 and schools that are in close proximity usually are separated. The training is 2- day residential training that prepares the *Natural Helper* to interact with peers who may be experiencing problems and teaches them a variety of skills. They are taught about red flag issues of physical abuse, sexual abuse, substance abuse, eating disorders, and suicide that need referral, as well as how to be better listeners. One of the activities that they do at the training is to sit for 5 to 10 minutes and listen to another person who is continually speaking while portraying an openness and willingness to listen. An unsaid part of the training is the bonding that happens among the participants and the learning about what issues are facing kids from school to school. The students get to hear about what other programs have done in their schools in past years and what has and has not been successful. The *Natural Helpers* return from this training and spread the word in their own school community. They may do a variety of things to make themselves and the *Natural Helpers'* mission known in the school. An example from one school is that each week the group sponsors events on different topics, such as drunk driving, in order to make the community and their school aware of these issues. Student coordinators from each school then meet together monthly throughout the school year. Additional training programs are offered through this group and the student coordinators also organize training programs for different schools. At the end of the year, there is a daylong conference for anyone. Last year there were 28 workshops covering topics from breathing to yoga to eating disorders and 200 to 250 youth and adults attended.

NATURAL HELPER STUDENT AND COMMUNITY ADVISORY COMMITTEE

The *Natural Helper* Student Advisory Committee and *Natural Helper* Community Advisory Committee gather input from the student body and from the community. How the program is going is reviewed and reflects on a variety of subjects including: How do you keep

the program going? How do you promote the program and keep its integrity at the same time? How are boundaries maintained? These are ongoing questions the *Natural Helpers* ask themselves and of which they must remain cognizant.

SELECTION

Natural Helpers are selected by their school community to participate. The school community is encouraged to choose students from every aspect of the peer community in order to match the diversity of the students at their school. The variety of people is important so that everybody can have someone with whom they can feel comfortable talking. Most schools circulate a survey asking students to identify 2 or 3 students with whom they feel comfortable talking and any particular issues that are pressing. Adult guides also are chosen based upon their approachability rather than any particular position they may hold at the school.

WHAT IT IS ALL ABOUT

The *Natural Helpers* program itself is, in essence, a peer advising program. Students can come at anytime to talk. Ninety-nine percent of what *Natural Helpers* do is just listening; they are cautioned not to see themselves as "fixing" things. A critical piece of the *Natural Helpers* Program is learning how to refer students who are having problems beyond the *Natural Helper's* capability to help. *Natural Helpers* are trained on how to handle and refer serious situations that are common among teens, such as suicidal situations, situations that need to be taken to someone such as a teacher or a clinician. Sometimes the *Natural Helper* will try to go to that first meeting with that adult or other person in order to make it more comfortable for the student. The *Natural Helpers* are encouraged to get together as a school group and put together a proactive prevention plan on some issue for their school for the year, e.g., substance abuse or eating disorders. Some schools do a weekly awareness event, participate in orientations or contribute to parent awareness nights.

REACHING OUT

Getting the Natu*ral Helpers* known is an important activity and one of the most difficult. The weekly awareness event helps and there is a bulletin board with pictures of all of the *Natural Helpers* posted. Students also know who the *Natural Helpers* are because they elected them.

New students are helped by the *Natural Helpers*, who show them around the first day. There is also a freshman orientation at one of the schools. The word also spreads, "You help your friend and they help their friends," and an extremely large network develops. *Natural Helpers* can be quite vocal, so people are naturally drawn to them.

LEARNING BOUNDARIES

Because the *Natural Helpers* are easily turned to for assistance and help, they are taught about boundaries. They are taught to refer certain issues, such as physical and sexual abuse, substance abuse, eating disorders, self mutilation or suicide, which are not that uncommon in high schools theses days. A system is set up with guidance people and adult facilitators whom the *Natural Helpers* know and to whom they can refer kids with these issues.

CONFIDENTIALITY

Confidentiality is maintained except when there are red flag issues. Support and debriefing is needed for the *Natural Helpers* and there is sharing with each other at the meetings without names and detailed information about things that have happened, things that they hear are building up and things that are affecting how they are doing. Confidentiality is an area that is covered in depth at the initial training.

About the Presenter
Norman D. Boucher, M.Ed., is Prevention Educator & Natural Helper Coordinator for Day One.

Contact Information:
Normal D. Boucher, M.Ed., Prevention Educator & Natural Helper Coordinator
Day One
P.O. Box 231
Cape Elizabeth, Maine 04107
Telephone (207) 767-0995

HOMELESS YOUTH

WHO ARE THEY AND HOW DO WE SUCCESSFULLY INTERVENE

Presented by Jon Bradley, DSW and Christine O'Leary

DESCRIPTION OF THE HOMELESS YOUTH POPULATION

A. CATEGORIES

Five categories of homeless youth have been identified, as defined by the National Network of Families and Youth Services.

Runaway Youth

Runaways are youth who have left a home environment and who, in theory, could go back home. Often they do return home fairly quickly. Many runaways are seen in shelters around the country. In Portland, a lot of the programs see young people who can go home with intervention, with family mediation, and often just with some real support.

Throwaway Youth

Second, there are the throwaway kids. These are the youth who have come from some stable living situations but have been thrown out for any number of reasons. There may be accompanied mental health issues and, commonly, substance abuse issues, or a combination that may result in parents just not knowing what to do other than to say "Get out."

Homeless Youth

Third, there are homeless youth who generally are defined as youth who do not have a place to which they can return. They may have come from very dysfunctional family situations, or the family has dissolved, or living situations have been primarily in various placements group homes. These young people really are on the streets and lack places to which they might return. There are many of those kids in this country, including some in Portland.

Systems Youth

Fourth, there are the "systems kids," young people who have been in the child welfare

system, who bounce out, who leave group homes, or leave placements. These are youth who end up on the streets because placements and foster care are not working. They often turn up in homeless youth and runaway programs.

Street Youth

Last, the category that is commanding attention in the Portland area is the street kids, or as they are now being called, homeless/street involved youth. They have been homeless for so long that they have become quite involved in the street culture. They may be episodically homeless, going home for a while or being in placement for a short time, but they become used to street life and street culture. This is a tough population because of the substance abuse and risk behaviors that accompany street culture. Their life situations tend to be complicated, and access and availability of multiple services have an impact on the scope and length of time they remain on the street.

B. *NATIONAL DATA AND BACKGROUND INFORMATION ON RUNAWAY AND HOMELESS YOUTH*

Whether researching national data, or looking at local anecdotal information, one finds that little is known that is very helpful or consistent in describing this population. The incidence of substance abuse among homeless youth ranges from 20% to 70%, depending on where the sample comes from, the kind of program, and the geographical location. Information on the incidence of sexual abuse indicates that 20% to 60% of this population are victims, based on where the data was gathered and how skilled the interviewer was, and at what point the questions were asked in terms of getting real information. Mental health issues are prevalent in this population, including depression. In a study in New York, more than 30% of the kids who came for services admitted to previous suicide attempts, a predictor of further suicide attempts. Obviously, this is a very high-risk population with many clinical issues.

It is important to note that homeless youth reflect the place that they come from, making it difficult to generalize about them. In New York City, most runaway homeless youth are kids of color or black kids and Hispanic kids. The issues that relate to running away relate to problems in families, to poverty, and to the kinds of problems that poor minorities have. In other

parts of the country the population may be quite different. In Los Angeles, there generally is more drug behavior and higher levels of drug behavior because of the culture of the community.

Runaway/homeless youth typically have been defined by an action, not by a clinical label. Studies of this population indicate that runaway/homeless youth basically look like outpatient or inpatient kids in treatment with a lot of problems. Kids in homeless shelters exhibit similar levels of depression or conduct problems, as do kids in the juvenile justice system. Each of these population groups has multiple problems.

C. CHARACTERISTICS OF HOMELESS/STREET YOUTH AT THE PREBLE STREET TEEN CENTER

The majority of the kids accessing the Preble Street Teen Center in Portland, Maine are white, most are from Maine, and most are from Portland. Over the past four years, 50% of youth coming to the drop-in center have been involved with the Department of Human Services, almost without exception they smoke, and 40% of them are involved or were involved in special education when attending school. Most have dropped out of school by the 8th grade. Reading levels average between 4th and 8th grade level. Many who have had HIV testing are HIV positive, or their HIV status has not been tested and is not known. They come from extreme poverty. The earning potential of their families has been around $15,000 per year, and many of the kids have not runaway; they have walked away and have no earning potential themselves. The issues that are associated with family poverty follow these kids to the streets. Family conflict is often part of the picture, and the kids lack self- esteem. Substance abuse is a huge issue, with heavy use of alcohol and marijuana. Recently there has been an increase in the amount of heroin and cocaine use, not just through intravenous drug use but also through smoking.

SERVICES FOR HOMELESS YOUTH
A. HISTORICAL PERSPECTIVE OF SERVICES FOR HOMELESS YOUTH

During the Great Depression, homelessness was not confined to any particular age group and families, including the young, were homeless in greater numbers than at the present time. However, since 1974 there has been a real focus on homeless youth. Homeless youth are really

at risk in our more modern society. The first federal legislation, the Runaway and Homeless Youth Act, was passed, creating funding and establishing runaway shelters. Some shelters had already been established to try to work with runaways, basically outside of more traditional systems that existed in the child welfare system. Since then, however, most communities have focused on a few basic services.

B. THE SERVICE CONTINUUM AND COLLABORATION

Outreach is a critical place to start with homeless youth because they often are disengaged. Outreach efforts need to include emergency shelter and low-barrier services. Although generally funded differently, transitional programs should be a part of the continuum as a vehicle in targeting kids who have become more stable and have started to work on independent living skills and treatment issues that may lead to their becoming independent adults.

In Portland, the MaineStay program is one component of a continuum of care that focuses on homeless youth having both mental health and substance abuse issues. However, even with a low barrier shelter and many transitional programs in the continuum, there are problems because of the various expectations and differing rules. The gap is huge between the low barrier shelter and the kids' willingness to stay in the shelter overnight and then go to other programs that have either treatment or skills building expectations. Many of the homeless/runaway youth are stuck at one stage or another for various reasons, some internal and some external.

C. THE EXISTENCE AND NEED FOR COLLABORATIVES

Nationally and in the Portland area, collaboratives between hospitals or mental health clinics and homeless shelters are important in responding to the needs of homeless youth. Homeless shelters often have been the place where the best caring has taken place, in spite of the low pay and lack of clinical training provided to the shelter caregivers. Resources for the shelters need to be increased, as the population utilizing these programs is at the highest risk, with issues of major depression, suicidal ideation, dual diagnoses, and limited skills or training.

In Portland, the Teen Center Collaborative is located at the Chestnut Street Church next

to Portland High School. There are six agencies represented. Preble Street Resource Center runs the drop-in center, which is low barrier. Outreach workers work on the streets to connect with kids, to get them connected to services. Day One has a substance abuse counselor who works in this building and directs efforts toward harm reduction. The Street Academy, run by the Portland Public Schools, provides an education for youth who want to earn their GED, helps with college prep and/or with vocational training, and engages them in the educational process. The YWCA runs clinical services at the Teen Center, with three counselors who do mental health counseling with individuals, couples and families. Portland Public Health provides health care at a clinic in the Center. Lunch and dinner are served daily, and kids are welcome to drop in during the evening.

The programs use a seamless system leading to intake, including a voluntary Release of Information form, which enables the intake process for the collaborative agencies involved in coordinating services. Youth accessing any or all of the services are made to feel that any issues can be addressed based on individual needs and not based on which program will provide a particular service.

As a low barrier day shelter, any young person under the age of 21 is eligible to access the many services available without having eligibility criteria predicated on diagnoses or poverty requirements. The shelter provides a safe and respectful environment for drop-in services, access to local and long distance phone calling, a clothing closet, a food pantry and dinner. Most important is the relationship building between the kids and the staff. By being accepting and caring, there are behavior changes that staffs are able to effect that are surprising and gratifying. The relationships established might be the only positive exchange some of the young people have ever experienced or witnessed.

Other services available for youth at the Portland Teen Center include substance abuse counseling and mental health counseling, based on the readiness of the individuals. Unfortunately, these are often looked at as separate issues. However, it is important to keep the kids engaged in low barrier services until they are ready to get involved in other levels of care and, while it may take years for some of them to get to that stage, that is the goal.

The staff at this low barrier shelter does not treat substance abuse or mental health issues as barriers for services, unless there are disruptive or harmful behavioral issues. The focus is on keeping these young people engaged, keeping them fed and clothed and safe. Harm reduction is critical and challenging for homeless youth, as predators in the adult homeless world jeopardize them, the street culture, and their heavy drug use. Therefore, initially strong emphasis on abstinence or any treatment goal is avoided. The low barrier shelter provides a safety net that is responsive to the many crises the kids face, and opportunities to move them along and help them learn new coping skills, which may result in eventual engagement in treatment.

D. ASSESSMENT

Assessment of homeless youth is a challenge, because of the stress level that is part of street survival. The mental health state and substance abuse issues are clearly affected by living on the street. What constitute a diagnostic criterion are the kinds of behaviors that kids do when they are on the street, often as a way of survival. If someone is stealing and someone is prostituting, using sex for survival, or using drugs, these are part of the culture, including running away, which is one of the criteria for things like conduct disorders. Making a clear assessment is very difficult unless there is a long enough time to establish some stability and a relationship; unfortunately, this does not happen frequently.

E. SYSTEMS - MENTAL HEALTH VS. SUBSTANCE ABUSE; ADULT VS. CHILDREN

In Maine, mental health system and substance abuse services are not well coordinated. The development of children and adolescents are not considered in transitioning into adult services. Children's Services seems to have one focus for children and families, while Adult Services are designed differently. As an example of what happens as a result of fragmentation of services that has nothing to do with mental health or labeling is that teens age 17 or under may stay at the Lighthouse, an emergency shelter for youth, for a full year. There are 16 beds, very caring staff, and lots of support. When the teen turns 18, the Lighthouse can no longer provide services. Teens then have to go to the Oxford Street shelter, which has 130 adults, many with major mental illness, chronic substance abuse, adults struggling with their own homelessness and a multitude of problems. Access to services for teens is not based on developmental issues or on

anything except the strict age criterion. For some teens that may be a motivator to get off the streets because options have been limited; for others, they are introduced to even more intense street culture and more opportunities to be victims of the dangers inherent in living on the street.

While this is a description of services in Portland, the same issues exist nationally. Funding criteria affect how services are delivered, and who the recipients are of those services.

RECOMMENDATIONS

A. COMPONENTS

1. **Case management** is a critical component that begins as soon as identification takes place, and continues to remain with that person until an appropriate point for transitioning out of the service. That is not necessarily at age 18. Adolescence stretches beyond age 18 and into the 20s. There is a critical need for continuity in the lives of homeless youth, and comprehensive continuing services to effect positive outcomes.

2. **Social supports** for adolescents are another important service component. For many homeless youth, support systems tend to be comprised of other homeless kids or support groups filled with drug users and substance abusers, whether family members, friends, or neighbors. There are few positive supports and role models among their peers. Staff in the low barrier agencies, and associated programs need to provide ongoing support around a variety of issues, and the service systems need to avoid establishing barriers that impede access to those social supports.

3. **Service plans** for homeless teens, which are developed specifically for individuals, need to be person related and holistic. A pilot project is being developed in Portland that will have collaborative service plans that incorporate substance abuse, mental health, education, social support, finance and health. Different agencies in the area are starting to work together with teens, and hope to get a core group of youth working on their goals with the service providers.

4. **Acceptance** of the youth with an understanding of behaviors that may simply mirror adolescence and the street environment is essential. Non-traditional engagement within an

atmosphere that is safe and respectful opens the possibilities for establishing productive relationships.

5. **Rapid response funds** to enable service plans quickly and flexibly is another service component. Resources are always scarce and needs are varied. Without DHS involvement, and with families that lack resources or the ability to help, it is important to be able to give the kinds of help that will tangibly lead to fulfilling a service plan. This may be paying for school, creating a stipended experience for vocational opportunities; paying a security deposit or the first month's rent on a place to live. Being creative and able to respond appropriately and quickly may help to keep a young person safe, off the street, and perhaps ready to engage in treatment.

B. *MEASUREMENT OF PROGRESS AND FUTURE PLANS*

1. As part of the pilot at the Preble Teen Resource Center, the Department of Human Services now has staff working at the Center one day a week. Integration of systems has been enhanced, and cross-referrals have been increased.

2. The Center will start to be open on weekends, in response to requests by the kids.

3. Training for the staff, with emphasis on evaluation, will be a focus. Evaluation of relationships and of progress, and really determining the status of the youth in terms of being at a pre-contemplative or contemplative stage, are goals for the program.

4. Strategies include increasing knowledge on how to work with dually diagnosed, homeless youth and how to ensure that they are being moved along, even while the emphasis is on safety and harm reduction.

C. *PILOT PARTNERSHIP PRINCIPLES*

A continuum of care for homeless youth will be framed around the following principles agreed upon by community providers participating in the Portland Pilot Partnership:

1. Every youth should have access to basic life needs/services.

2. A comprehensive "one-stop shopping" teen center shall be available/created.

3. Every youth should have access to an effective caseworker for as long as necessary. The caseworker is the point person for developmental planning for youth to get off the street.

4. All emergency shelters should be accessible 24 hours a day.

5. Every youth should have a meaningful plan with supportive, collaborative services.

6. The Teen Collaborative will include full meaningful participation with all local agencies, state agencies and state government.

References

Bradley, J. (1998). *Runaway Youth: Residential Instability, Social Supports, and Adjustments.* Garland Publishing, New York: N.Y.

\

About the Presenters

Jon Bradley, DSW

Jon Bradley, DSW has worked extensively with runaway homeless youth for more than two decades. He has worked as a program consultant, trainer, and researchers in issues to the causes of homelessness and in the development of strategies to improve the lives and safety of teens on the streets. Bradley is the author of the book *Runaway Youth: Stress, Social Support, and Adjustment*; editor of *Planning to Live: Evaluating Suicidal Teens in Community Settings*; and numerous articles on interventions with runaway and homeless youth. As Assistant Director of Preble Street Resource Center in Portland, Maine, he is currently active in planning efforts to improve services to homeless youth.

Christine O'Leary

Christine is the Coordinator of the Preble Street Resource Teen Center. Ms. O'Leary has worked extensively with homeless youth and is dedicated to advocating on behalf of youth

Contact Information:
Preble Street Resource Center
P.O. Box 1459
Portland, Maine 04104
Telephone (207) 874-6560

YOUTH SUPPORT PROJECT
FAMILY EMPOWERMENT INTERVENTION
Presented by Richard Dembo, Ph.D.

This presentation described the Family Empowerment Intervention project that was developed as a spin-off from the Hillsborough County Juvenile Assessment Center ("JAC") in Tampa, Florida. The NIDA funded project began in 1993. The JAC is a centralized intake facility where youngsters who are taken into custody are brought for processing. Similar centers are in operation throughout Florida, in Kansas and in a number of other states. The Tampa JAC was the first such center in the U.S.

The existence of the Tampa JAC allowed the development, implementation, and evaluation of this program. One of the purposes of these facilities is to reduce the flow of young people into the juvenile justice system. It is known that youngsters who become involved with the juvenile justice system face challenges in getting appropriate resources and services, and their recidivism rates are very high. It is important to develop programs both to divert kids out of the system and to provide effective services to reduce their recidivism.

In addition to its delinquency component, the Tampa JAC has a truancy program, which works with youngsters who have been picked up for being truant. There are a number of related agencies located on the complex, including the Department of Juvenile Justice, the County Department of Children and Families, the Hillsborough County School Board, local service providers, the Tampa Police Department, and the Hillsborough County Sheriff's Office. This environment creates many opportunities for collaboration.

The Family Empowerment Intervention relates to a number of key issues and experiences in the field. There has been an increase focus on family. Youth crime continues at very high rates throughout the country. There has been some reduction in youth crime but it is still at a high level in Florida. Florida's rates of drug use and drug arrests have tripled in the last five years. In addition, there are an increased number of youngsters coming into the justice system who have a co-occurrence of mental health and substance abuse problems.

In-home interventions can be very effective in making a positive difference in youngsters' problem behavior and they are cost efficient. For example, in Florida, it costs $95 per day to house a youngster in a juvenile detention center for an average of 14 days. The Family Empowerment Intervention is less expensive, costing less than $1,200 for a family to go through the service. A related issue is that family interventions using paraprofessionals can be very effective. It is already known that professional clinicians are very effective. But a number of experimental studies in the clinical realm have indicated that, for many types of interventions, appropriately trained and supervised paraprofessionals can produce outcomes that are equal to those produced by professional therapists.

In the Family Empowerment Intervention, paraprofessionals called Field Consultants works with the families. Field Consultants were clinically supervised non-therapists with a bachelor's degree and 1 to 2 years' human service experience. They carried caseloads of 5 to 6 families at a time, and were supervised by licensed clinicians. The ideal intervention consists of family meetings with the Field Consultant for ten weeks, with three family meetings per week. The meetings last one-hour, are videotaped with the family's permission, and the recorded information is confidential. The videotapes were brought to weekly clinical supervision meetings during which the clinical supervisor coached the Field Consultant to improve his or her skills. In addition, there were bi-weekly group supervision meetings, and weekly Field Consultant training sessions and project meetings.

In addition to the structured activities of the Field Consultant, there is another component to the intervention, the Activities Manual. Many of these families did not respond well to verbal interventions. The Activities Manual includes one hundred behavior activities that relate to the goals of the intervention. They help to symbolize for the family some of the issues they are experiencing, and become openings for the Field Consultant to do interventions. The Activities Manual has been a powerful and effective tool.

MAJOR GOALS OF
THE FAMILY EMPOWERMENT INTERVENTION PROJECT

More often than not, youngsters' behaviors are symbolic of issues their families are experiencing. Usually their troubled behavior reflects many family dynamic issues. In the intervention, the family was defined the people who lived under the same roof with the target youth who have a parenting role; the family does not refer only to the biological mom or dad.

There are nine major goals of the Family Empowerment Intervention. The first goal is to put the parents back on top. Restoring the family hierarchy is critical. Secondly, boundaries between parents and children must be restructured. Many of the families are too involved in the youngster's life, with no separation and no boundaries. Third, parents must be encouraged to take greater responsibility for family functioning. Fourth, family structure must be strengthened through implementing rules and consequences. Often Field Consultants help families to establish a set of rules that are posted at home to remind each member what is expected. The importance of rules and consequences is reinforced at the family meetings. The fifth goal is to enhance parenting skills. Number six is to have parents set limits, expectations, and rules that increase the likelihood that the target youth's behavior will improve.

The seventh goal is to improve communication skills among all family members and to increase their ability to have fun together. Many of these families never spend time with each other. Families are asked to do activities together. For example, one activity is to make a tower out of newspapers. These activities are simple and inexpensive and make use of such items as newspapers, magazines, and crayons. Once families start working on these activities, opportunities are opened for discussing issues and reviewing feelings about issues that otherwise might not be addressed within those families.

The eighth goal is to improve problem-solving skills particularly in the target youth. Moreover, the final goal, where it is needed, is to connect the families to other systems such as schools, community services, and churches. Most often, this involves working with schools. The Field Consultant will accompany the parents and the youth to the school to try to work out some

arrangement to permit the youngster to stay in school while working on overcoming some of the problems of his or her behavior in the classroom. More often than not, the dean or principal is willing to give the youngster an opportunity to show a change. This helps to empower the parents, since many parents feel intimidated going to a school to meets a school administrator. They may feel an inequality of power or unable to speak or share their feelings. Another situation where a "system fix" helps is in contact with law enforcement. For example, one Hispanic family was unable to communicate with an Anglo police officer; the Field Consultant arranged to have a Hispanic officer visit to the family to explain a case involving them and a neighbor, and to explain the probable outcome. This arrangement enabled them to feel more comfortable in their own cultural framework, and to speak with someone who could understand them.

THEORETICAL FOUNDATIONS OF
THE FAMILY EMPOWERMENT INTERVENTION PROJECT

The parent intervention project is formed by a number of theoretical threads, with four major theoretical themes underlying the service. One theoretical underpinning is the systemic view that family members are interconnected and interdependent units of a larger system, with each member influencing the others. This includes the understanding that the problem is not only with the juvenile but is symptomatic of the entire family's activities, interactions and experiences.

Secondly, there is a structural theme, with the family organization critical in understanding the family. Family dysfunction is understood as a reflection of difficulties in structure. One of the first goals is restructuring the hierarchy, so that the family is organized with parents on top and children below. This organization of the family is important. For example, who makes family decisions? Often in the family meetings, the parents are asked to sit together to reinforce the importance of who they are. It is also important to understand the family's sub-systems, those small units in a family such as parents or siblings, which are involved with one another. Clarifying these sub-systems helps to make decisions about boundaries. Boundaries are related to setting up rules and expectations, balancing rigidity and vagueness about people's roles, and understanding each member's behavior and what should be expected of them. Alignments, and how family members join or oppose other members, are important in

understanding relationships within the family. The intervention works on strengthening those alignments so that they are more conducive to pro-social family relationships. An alliance between one subsystem in the family (such as siblings) against another subsystem (such as a parent) can be detrimental to the entire family. Alternatively, one parent might be in an alliance with a child at the expense of his or her relationship with the other parent. Those issues are worked on within the context of the intervention. These are examples of the kinds of challenges that are brought to the clinical supervisor who meets with each Field Consultant every week to review their families' situations.

Another major point is that families are viewed from a transgenerational perspective, and many have experiences that echo an earlier family history. One of the first activities, after reviewing the intervention's expectations of the family, is to complete a genogram, which is a structured format for drawing a family tree involving at least three generations. This activity provides the family an opportunity to share with the Field Consultant who they are. Often the genogram brings up issues that become incorporated into subsequent interventions of the Field Consultants. It becomes an opportunity for the family, as the intervention proceeds, to reflect on their response to certain events reflects responses to similar circumstances in the past. The genogram reflects the alignment of the family at the beginning of the intervention. Often, at the end of the intervention, another one is done so that the family may make comparisons.

A genogram also helps engage with the family. One of the critical issues in the interventions is the continuing need for the Field Consultant to become effectively involved in working with the family. The genogram provides an opportunity at an early point to begin to build linkages, and it focuses attention on the whole family, not just the target youth. The families often say, "You fix this kid," when the problem is most often a family issue. Many times, families have to work through that denial to see how they can make an effective difference in the youth's life. In completing a genogram, the Field Consultant gains very valuable information about the family.

Fourth, there is a psychoeducational component, which emphasizes skill-building and behavioral change. The Field Consultant can help by working with the family to improve their life management and interpersonal skills. They can open opportunities in family meetings and

through games and activities to deal with communication issues, such as how to respond to someone, and how you might deal with a problem like working with the schools.

MAJOR PHASES OF
THE FAMILY EMPOWERMENT INTERVENTION PROJECT

First, families were asked, usually by telephone, whether they were interested in being part of the project. If they were interested in participating, a research staff member visited them at home to discuss the project, and answer any questions the family had. If they agreed to participate, all families were given baseline interviews, following which they were randomly assigned to either the Family Empowerment Intervention or the Extended Services Intervention (or referral service).

Adolescents were not screened out for clinical reasons such as mental retardation. One of the major reasons for excluding a family was simply geographical location; for logistical reasons, there was a fifteen-mile radius of service. Another reason for screening out a youth and his or her family was, if the youth was were arrested in Hillborough County but lived in another county. The family had to live in the county we were serving. If the Department of Juvenile Justice case manager of an arrested youth indicated the youth was going to be placed in a long-term residential facility that youngster was excluded. However, if he or she was taken into custody and sent to a detention center for 21 days, or to jail, he or she was not excluded from the project.

The Family Empowerment Intervention is discussed in detail in this paper; the Extended Services Intervention was basically a referral system. Extended Services, families could call the project office for information about resources available in the community, and project staff would help to connect them with services. At times, reasonable limits were stretched in order to be helpful to the family. In many cases, assistance involved connecting with legal assistance or getting more information for them from the juvenile justice agencies or the State Attorney's Office that was very helpful to them. All families had access to that.

The two types of interventions were explained to the families. Many of the families were jaded by their experience with the justice system and often, when they were told about the

project's service, they did not believe that they could have services at no cost, and they wondered what was the catch.

PHASE 1: INTRODUCTORY PHASE

There were four major phases in the Family Empowerment Intervention. Phase 1, the Introductory Phase, consisted of one or two sessions and included the introduction of the Field Consultant to all the family members. During the first and second session, the Field Consultant would discuss the Family Empowerment Intervention and the supervision design for the project. Intervention procedures were reviewed, signatures were gathered for permission for the videotaping, and timing was discussed. Some families would not allow videotapes but would allow audiotapes. Very few people refused to do either. When they understood the purpose of the video taping, and that the tapes would be destroyed at the end of the project, families were willing to be recorded. Any questions about the intervention were answered, and the completion of genogram was discussed.

PHASE 2: CONSULTATION PHASE

Phase 2 was the consultation phase. During Sessions Two/Three through Sessions Nine/Twelve, the Field Consultant took an active role in opening inquires, participating in the meetings, and helping to demonstrate methods to use in asking and sharing. This included touching on the issues and goals described above. The Field Consultants actively conducted the family sessions.

PHASE 3: FAMILY WORK PHASE

Sessions Ten/Thirteen to Session Twenty-Seven covered the portion of the intervention when the family took the lead role in organizing the meetings, re-organizing ways of communicating, relating to one another, and thinking about family functioning--with attention to the target youth's goals. The Field Consultant participated but was more of a coach. Families could set up their own meetings in addition to the meetings with the Field Consultants. They set up rules and consequences, which they posted, and they set up expectations to monitor change in the family.

PHASE 4: GRADUATION PHASE

The last phase, moving the family toward graduation, took place in the last three sessions. This phase included a review of the intervention experience. It often included showing a videotape of a recent meeting to allow comparison with how the family interacted at the beginning of the intervention. Families saw some very dramatic changes in their lives and they were strongly impacted by witnessing them. This phase also prepared the family for separation from The Family Empowerment Intervention. At the last meeting, there was some sort of celebration, the family received a graduation certificate, and the Field Consultant had a cake or pizza with the family.

Following this, families were called periodically, every month to six weeks, to monitor family functioning and stress levels, and to remind them that the project office was always available for them to contact.

STRUCTURAL INTERVENTION STRATEGIES

A number of structural intervention strategies were used to change behavior. The strategies could change as the Field Consultant engaged with the family in an empathetic manner and joined with a subsystem. These strategies could also change as the intervention proceeded. While specific games, artistic projects, and exercises were taking place, the Field Consultant used skills such as engaging, joining, tracking, being sensitive to significant symbolic expressions by individuals, and to gestures, words and behaviors that open opportunities for focusing on the goals of the intervention.

The family meetings were the critical component. Family members were asked to interact in a typical way and then a discussion was held about that interaction in the hopes of improving it. Circular questioning, a style of inquiry designed to reveal family patterns and connections, was used to invite family members to reflect on issues, explore individual perceptions, and to address concerns in a highly interactive manner. This approach is based on the view that behaviors are systemic, interactional, repetitive and predictable. The systems theme that underlies a large part of the intervention holds that families do not live in a linear world, and that much of what goes on is interaction, with different individuals interacting at different levels

simultaneously, each with cause and effect, and each influencing others at the same time. For example, family members may take turns talking about how they feel about different things and how they respond to what other family members say about certain issues. Another important intervention strategy is reframing. Reframing refers to relabeling a negative behavior by putting it in a positive light. A youngster who is seen as very difficult can be translated as a youngster who seems to be very focused on having some things done in specific ways.

FIELD CONSULTANTS

Critical to the success of this intervention are the Field Consultants who work with the family. The past several years have shown that Field Consultants need certain very important competencies. One is self-directness. Field Consultants, after being trained for a five-week period, are infused with the theoretical foundation and goals of the intervention, the clinical practices and policies of the intervention, and the activities that surround each phase of the intervention. They must have a sense of moving forward and understand what is expected of them. That is reinforced through weekly clinical supervision sessions and a bi-weekly group supervision meeting where each Field Consultant presents a videotape meeting with a family with whom they have a particular challenge. This challenge is presented to the rest of the clinical and Field Consultant staff and other Field Consultants provide coaching on how they responded to the problem, and how effective it was. This is a very empowering experience as well as a skill transfer experience. It also helps Field Consultants identify themselves as a member of a team.

Another important skill is the ability to tolerate ambiguity. There are many responsibilities placed on the Field Consultants to carry out within a 40-hour workweek. They cannot expect that their job will be a 9:00 – 5:00, Monday through Friday job. They may have to work evenings and weekends, since some families have work schedules that necessitate meeting at least some of the time on the weekends. In addition, many of the families served are disorganized and chaotic, resulting in unexpected and unpredictable situations at family meetings.

The Field Consultants must be non-judgmental and accepting, not only in terms of cultural sensitivity, but also by not using their own values to make statements about another

family's way of living or to make decisions about their lives. Also important is having good communication skills, and being able to help articulate and share their own feelings about certain issues. In addition, they must be able to translate the goals of the intervention in ways that the families can understand them. They must have empathy, self-awareness, and an orientation toward action. The Field Consultants took a highly active role in both the structure and the process of the Family Empowerment Intervention. Completing the genogram becomes a basis for sharing with the family. The Field Consultants must be sensitive to the kinds of issues that many of the families are experiencing. The Field Consultants know that their success will depend on making a difference in the lives of these families, and in being an active catalyst in helping to facilitate change. They must have a sense of self-awareness about themselves and their importance in this process. Authenticity is also very important. The Field Consultants must be genuine people and they must meet the families on human terms, since that opens so many possibilities of sharing and communicating and developing trust. Field Consultants are human beings trying to make a constructive difference by their behavior during family meetings, and by being flexible, and showing that they are working to help the families make a difference in their own lives. Training continues throughout the project to help give the Field Consultants empowerment to be effective with the families they serve. If they do not feel empowered, they cannot empower the families.

New Field Consultants participate in a five-week training period. There are two major components to the training manual: one component covers the theoretical foundation of the intervention in clinical practices and procedures, and the other is the activity book. They are trained by clinicians and by experienced Field Consultants. They become aware of community resources and helping agencies, such as Juvenile Court, Public Defenders, and various diversion programs. Before they begin working with a family, they shadow experienced Field Consultants. They help videotape family meetings with that experienced Field Consultant, and they participate in the weekly clinical supervision meetings with the Field Consultants whom they are shadowing.

As they felt comfortable and competent, and with the approval of their clinical supervisor, the Field Consultants began to assume a caseload of no more than six families. They

also continue training, with weekly in-service training and one-and-a-half-hour clinical supervision meetings each week. Part of their training included using the activity book. During their weekly training meetings, they received additional training on systems theory, family and human development, life management, cultural sensitivity issues, HIV and AIDS training, other at-risk issues like substance abuse, and information new drugs of abuse. They also attend off-site training at various conferences or workshops.

Every Field Consultant had a mobile phone and a beeper. These were important to them for a variety of reasons, and it gave them a sense of being empowered in the community to be in contact with the office. They did not feel that they would be out in the community without any back up or support. Extra precautions were taken to deal with safety issues. Field Consultants were expected to check in with the office daily and to keep in regular contact with the office. If they were out in the field for a longer period of time then could reasonably be expected, the office would try to locate them and to beep them to see what was happening. If there was any concern for safety in the family, the Field Consultant was expected to visit the family with another Field Consultant or to hold family meetings at neutral place in the community like a church or daycare center.

The role of the Field Consultant was that of an intervention worker who conducts activities to achieve the nine goals of the intervention. They were helping families learn new life skills, being a role model for communication and interpersonal skills, and acting as a liaison between the family and community agencies.

CATEGORIES OF FAMILIES SERVED

There were four categories of families served by the intervention. One was an "active family" currently being served by the Field Consultant. The second was called "graduation provisionally delayed or on hold." If a youngster were sent to a short-term secure facility (e.g., jail) and the expectation was that the youngster and family would graduate from the intervention, that family was put on hold. When the youngster was released, the intervention was completed. Families who did not complete the intervention, and for whom there was little expectation they would complete the intervention and graduate, were considered an "inactive" or "closed case."

This was a voluntary program, not required by the courts or other justice system agencies. Further, a number of families moved. For example, one parent might have lost their job and the family had to relocate.

CLINICIAN SUPPORT AND SUPERVISON

Clinical support during the individual, a weekly supervision meeting was essential since the Field Consultants were paraprofessionals. Clinicians provided concrete instruction, and sometimes referred the Field Consultant to additional training. It was important to continually reinforce the connection between the activities of the intervention and the theoretical foundation and goals of the intervention. How the activities made a difference in the families' lives was continually reinforced.

The clinical supervisor helped to determine the family's intervention phase. As they moved from one phase of the intervention to another, there was an evaluation of the family's achieving the various goals of the intervention. A checklist aided that evaluation, and any decision to move the family to the next phase was supported by a detailed assessment. The clinical supervisor helped the Field Consultant deal with any personal issues that came up in their own life. The clinical supervisor also provided professional and emotional support, served as a sounding board, helped the Field Consultant schedule activities, and continually reinforced the intervention's goals. One critical piece of this work was the importance of insuring treatment integrity. Consistent efforts took place during the entire intervention to ensure that the Field Consultants carried out their work by implementing a theoretically informed Family Empowerment Intervention.

POST GRADUATION

Occasionally families who graduated or who were closed cases would contact us and ask to resume the intervention. If that happened, the family would be contacted to learn more details about what they wanted; and during our weekly project meeting, clinical input would be obtained on how to proceed. At the very least, we assisted these families in contacting appropriate agencies for the services they needed. Occasionally these families were transitioned back into the intervention.

About the Presenter

Richard Dembo, Ph.D., is a Professor of Criminology at the University of South Florida in Tampa. He received his Ph.D. in sociology from New York University. He has conducted extensive research on the relationship between drug use and delinquency; has published a book and over 130 articles, book chapters and reports in the fields of criminology, substance use, mental health, and program evaluation; and has guest edited five special issues of journals addressing the problem of drug misuse. He is a member of the editorial boards of *The International Journal of the Addiction* (recently renamed *Substance Use and Misuse),* and the *Journal of Child and Adolescent Substance Abuse.* He has served as a consultant to the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the National Institute on Drug Abuse, the National Institute of Mental Health, the Center for Substance Abuse Treatment, the Office of Substance Abuse Prevention, and the National Science Foundation; and is a reviewer of manuscripts for numerous professional journals. He is Past-Chair of the American Sociological Association on Alcohol and Drugs. He has extensive experience working with trouble youths in a variety of settings. He has a long-term interest in applying research technology to social problems with a view to improving understanding of these problems, and in developing innovative programs and service delivery systems for high risk youth and their families. He is currently working on a NIDA funded experimental, longitudinal service delivery project designed to implement and test a Family Empowerment Intervention involving high risk youth and their families; and is responsible for the research component of the Hillsborough County Juvenile Assessment Center in Tampa (which he helped develop). He has been a major party in the flow of millions of dollars in federal, state and local funds into the University of South Florida and the Tampa Bay area for various research and service delivery projects addressing the needs of high risk youth, their families and their surrounding communities.

Contact Information:
Richard Dembo, Ph.D., Professor
University of South Florida
Department of Criminology
ACTS Building, 8620 North Dixon Ave.
Tampa, Florida 33604
Telephone (813) 931-3345
Fax (813) 933-1146

YOUTH SUPPORT PROJECT
FAMILY EMPOWERMENT INTERVENTION
OUTCOMES STUDIES
Presented by Richard Dembo, Ph.D.

The Family Empowerment Intervention ("FEI") was developed as an offshoot of an existing juvenile centralized intake facility in Tampa, Florida. The FEI was implemented as part of a NIDA funded, Youth Support Project, begun in 1993, which involved family interventions using supervised paraprofessionals as the main contact with the families. Three meetings a week were held with the families in their homes over a 10-week period (ideally). This project had nine goals and objectives:

1. Restore the family hierarchy (Parents > Children)
2. Restructure boundaries between parents and children.
3. Encourage parents to take greater responsibility for family functioning.
4. Increase family structure through implementation of rules and consequences
5. Enhance parenting skills
6. Have parents set limits, expectations, and rules that increase the likelihood the target youth's behavior will improve.
7. Improve communication skills among all family members and the ability to have fun.
8. Improve problem-solving skills, particularly in the target youth.
9. Where needed, connect the family to other systems (school, church, community activities) – "system fit"

This was a controlled clinical trial using random assignment. All characteristics, including demographics, were controlled. Short-term results (twelve months) and longer-term results are reported.

<u>OUTCOMES</u>

- Recidivism.

For recidivism data, up to 48 months of data was used. Arrests, not convictions, were used as a recidivism measure. These data included the number of new charges and the number of new arrests.

- Psychosocial Functioning

For psychosocial functioning data, follow-up continued for up to 36 months, with three interviews during that time, using the last available observation of the youngster's functioning. In the recidivism analysis, adjustments were made for time at-risk. Multiple information systems in the Sheriff's office, the Department of Juvenile Justice and the Department of Corrections, allowed gathering of the number of days during each twelve-month follow-up period the youngster was in detention, jail or in some other secure facility.

STRUCTURAL DESIGN OF THE PROGRAM

There were two interventions: the Family Empowerment Intervention ("FEI"), and the Extended Services Intervention ("ESI"). Families were asked if they were interested in the service, and were told that they would get one of two types of services. If they were interested, they participated in a baseline interview carried out by a research-trained person that lasted about two hours. After that baseline interview was completed, the family was randomly assigned to one of the two service conditions.

EXTENDED SERVICES INTERVENTION

The Extended Services Intervention is basically a referral system. ESI families could call for information about resources available in the community, and the project workers would help to connect them with these services. At times, reasonable limits were stretched in order to be helpful to the family. In many cases, it involved connecting with Legal Assistance or getting more information for them from the juvenile justice agencies or the State Attorney's Office that was very helpful to them. All families had access to that.

FAMILY EMPOWERMENT INTERVENTION

The Family Empowerment Intervention project consisted of a ten-week (ideally) structured series of family meetings with specially trained paraprofessionals called Field Consultants. It consisted of four major phases.

Phase 1: Introductory Phase

Phase I, the Introductory Phase consisted of one or two sessions and included the introduction of the Field Consultant to all the family members. During the first and second session, the Field Consultant would discuss the Family Empowerment Intervention and the supervision design for the project. Project procedures were reviewed, signatures were gathered for permission for video taping, and the project timing was discussed. Any questions about the intervention were answered.

Phase 2: Consultation Phase

Phase Two was the consultation phase. During Sessions Two/Three through Sessions Nine/Twelve, the Field Consultant actively conducted the family sessions, including taking an active role in opening inquires, participating in the family meetings, and helping to demonstrate methods to use in asking and sharing. This included touching on the issues and goals described above.

Phase 3: Family Work Phase

Sessions Ten/Thirteen to Session 27 covered the portion of the project when the family took the lead role in organizing the meetings, re-organizing ways of communicating, relating to one another, and thinking about family functioning with attention to the target youth's goals. The Field Consultant participated but was more of a coach. Families set up rules and consequences, which they posted, and they set up expectations to monitor change in the family.

Phase 4: Graduation Phase

The last phase, moving the family toward graduation, took place in the last three sessions. This phase included a review of the intervention experience. It often included showing a videotape of a recent meeting to allow comparison with how they interacted at the beginning of the intervention. Families saw some very dramatic changes in their lives and they were strongly impacted by witnessing those. Also included was preparing the family for separation from Family Empowerment Intervention portion of the project. At the last meeting, there was some

sort of celebration. They received a graduation certificate, and the Field Consultant had a cake or pizza with the family.

Following this, families were called periodically every month or six weeks to monitor family functioning and stress levels, and to remind them that the project office was always available for them to contact, seven days a week.

OUTCOME MEASUREMENT

These measures were used:

- Psychosocial functioning, using the SCL-90-R which is a 90-question, short answer test. Comparisons were made between the entry period from 9/1/94 when intervention first began to the last interview on 1/31/98. Those who entered the project from 2/1/97 to 1/31/98 experienced a 12-month follow-up on psychosocial functioning, those who came in between 2/1/9 and 1/31/97 experienced a 24-month follow-up, and those who came in between 9/1/94 and 1/31/96 experienced a 36 month follow-up.

- Self-reported delinquency, using the National Youth Survey developed by Delbert Elliot at the University of Colorado. This includes 23 self-report items from which four scales are developed: theft crimes, person crimes, index offenses, total delinquency. In addition, a measure of drug sales (including the frequency of selling marijuana, cocaine or crack or other hard drugs like LSD and heroin) was created.

- Self-reported use of alcohol, marijuana, cocaine, inhalants, hallucinogens, and the non-medical use of psychotherapeutic drugs (e.g., stimulants). The National Household Survey on Drug Abuse questions were used. In addition, hair testing and urine testing for drugs were employed.

- Recidivism data: the number of new arrest charges and the number of new arrests. Official records were used to learn the rate of recidivism; contact with the youngster or family was not needed.

RESULTS

There were significant differences in outcome among those who completed the FEI, those who didn't complete the FEI, and the comparison group of youths in the Extended Service group. Those who did not complete the FEI were very close to the Extended Service group in their results. Youths who completed the FEI had (significantly) better outcomes than youths who did not complete the FEI or ESI youths.

Youths did not complete the FEI for a variety of reasons. Many of their families moved out of the area. The intervention was totally voluntary, and there were some families who felt they could not keep up the intervention. There were some families who stayed in town but the target youngsters left and were "lost" to the study. There was a very low refusal rate in follow up interviews.

DEMOGRAPHICS OF TAMPA

Tampa is a City that has grown in size in the last fifteen years. The Florida legislature, as in most states, controls the flow of resources for social services. Florida is in the position of being one of the lowest States in the country for providing funds for education, mental health, and substance abuse, and this is a real challenge. The legislature seems more interested in expanding deep-ended programs in the juvenile justice system. The history is that the Department of Health and Rehabilitative Services, which once had children's services, juvenile justice services and health services together, was split apart, so there is now a separate juvenile justice agency created in 1994. This agency, in response to legislative mandate, has become increasingly community safety oriented. There are some early intervention programs but not as many as practitioners believe would benefit the agency, the community, and the youngsters in the long term. Tampa has a Hispanic population that historically came from Spain. In recent years, an increasing number of people have come from Mexico and Puerto Rico. There is not the Latin mix that is found in Miami with many people from Columbia, Venezuela, Equador and other Latin countries. In Tampa, the large industries are service industries, and the University itself is fairly large. There are no manufacturing entities like Toyota or GM or steel plants. There is an attempt to develop the corridor between Tampa and Orlando as an eastern version of the "Silicone Valley." Agriculture in Florida is a very significant industry. It has declined somewhat

in recent years, but the citrus industry remains very important. In those outlying areas where produce is grown, there is a fairly large transient migrant population, most of whom are from Mexico. About 15% of the population are African American, and about the same percentage are Hispanic. Normally, about 75% of the youngsters processed at the juvenile intake facility are males.

STRUCTURAL MODEL

The grant application design was for an intensive case management program. The design was that intensive case management would work with these families for about ten weeks, meeting with them frequently. The people were hired, trained, and they started working with the families. The first step was a dry run in May 1994, which was a field test to see how the program could be fine-tuned. Within the first two weeks, the case managers had identified a large number of service needs and could find few programs to link families with. The waiting list for mental health was nine months, and for substance abuse it was six months. The case managers could not imagine how they could service these people with no resources. So the design of the intervention was modified, and transitioned into family intervention.

There was a graduate student from the psychology department who knew about the work of Scott Henggeler involving MST and, for a while, this project worked in parallel with them. But eventually the Youth Support Project developed on its own. Much was learned by working with the families. The project activity book is an example of something that developed from the families. It evolved out of necessity, and from the interest of a clinical staff person who was aware of recreational therapy. It flowered and became a very rich component of the intervention. The intervention was developed by those in charge of the project, and the families helped fine-tune it. The goals and strategies never changed, but the vehicles used to realize them matured as we began to work with the families who were served. The needs of the families also changed during the intervention and it is important to be sensitive to that likelihood.

Clinical supervisors made choices of which activities were to be done in the family meetings. Field Consultants were given a certain number of choices at each phase. In Phase Two, when Field Consultants were meeting with the families, activities are chosen to facilitate specific

goals. The Field Consultants always knew what was planned for the next family meeting, but sometimes that could change. One of the things the Field Counselor always did in the meetings was to refresh the family about the work done last time and then transition into the next meeting. All of the activities used inexpensive materials, and they served to help family members visualize issues, and open up conversation.

Occasionally families felt that the activities could be somewhat silly and that they were not being treated as adults. The Field Consultants would be sensitized to that early when working with the family. When the Field Consultant agreed that the activity might be silly, but suggested it is interesting to see how the families work on it, this modeled ways of dealing with family disagreements. The Field Consultant would say it quietly without making a major point, and that would show a way of trying to figure out family issues, and the families could appreciate that. So what sometimes seemed immature became in itself an opportunity to get into some deeper issues.

SOCIOECONOMIC DIVERSITY

In this group, income was low to moderate on average, but there were a number of professional families in the project. They were among the most difficult to work with, and some would not even participate in the meetings, apparently because they believed that they were not part of the family problem. They thought they should just send the target youth to a program to get fixed. They did not believe in the family systems model that we were using successfully. There was no screening for eligibility by socio-demographic level. The two major screens were geographic residence for logistics purposes, and whether the youngster was going into a long-term facility

Some research claims that the single most significant predictor of successful intervention in this group of co-occurring disordered kids is the nature of the relationship, the working alliance, between the primary intervener and the family and youngster. This project's experience indicated that one of the important ingredients was authenticity. One of the reasons for the intervention's success was that the Field Consultants were young, so the target youngster could relate to them. And they were sincere. Many of the families were cynical when contacted by telephone to inform them about the project. They were in situations where, for example, their son

hadn't heard from his case manager for six months. The offer of a free service that was intended to make a difference was often met with disbelief. Having people who are authentic and caring and skilled, with specific training, really made a difference. It is not very expensive to do that. Some other interventions are highly effective but may cost five or six times the amount of the FEI to do this. Many jurisdictions cannot afford that.

The clinical supervisors were paid $40 per hour to supervise the Field Consultants. One supervisor had three and one had two Field Consultants; in addition, the clinical supervisors did training and participated in group supervision. One clinical supervisor worked nine hours per week, and the second worked six hours. They never did direct service with the family. If there was a serious problem, the family would be referred to someone to address any emotional psychiatric issues that were indicated.

FIELD CONSULTANTS' EXPERIENCE

The Field Consultants were people at the B.A. level with one-two years of experience. They were not people who had been in the field for ten or fifteen years; these were people who were young without much experience. They were paid about $21,000 per year to start, which wasn't a bad salary in Tampa. In addition, they were paid for mileage, has mobile phones, and other kinds of things that enhanced their importance, and they were excited to do this kind of project. They could call on the phone to get a mobile crisis team to come within fifteen minutes, so they had lots of support. They went to conferences, where they presented clinical experiences. It helped their education. Many of them went on to acquire master's degrees in counseling. They found this project an exciting stepping stone for them.

The important thing is to try to hire good people, train them well, provide appropriate support and supervision for them, be there when they need you, help empower them, and give them the things they think they need to feel they are valued. The excitement of doing this itself is an empowering experience. To work with a family and to have that family say "Tim, I can't tell you how much I'm thankful that you worked with us" is such a long lasting experience and memory. Later, the families would ask, "So, how is Tim doing?" They would remember their Field Consultant. Some Field Consultants stayed with the project for years and they felt that their

experience was a valuable one. Most other project staff had had field experience themselves, so that was helpful. Part of what Field Consultants saw was how committed the rest of the project staff was to make this work. Research staff worked on the weekends, as did the Field Consultants. That kind of commitment becomes infectious. In addition, there was group support, and there were reinforcing experiences with group supervision and weekly project meetings and the on going inservice training, and all that developed a sense of teamwork. A strong infrastructure is a very critical issue.

This intervention was an attempt to develop a service that was sensitive to cost issues but still effective. Documentation of outcomes is important to be able to convince budget committees at the state or county level to provide funding. We did not do any booster intervention after the families graduated. Some called for a referral, but this was relatively infrequent. Even without that, the long-term outcome of reduced recidivism and improved psychosocial functioning is impressive.

The Center for Violence Prevention at the University of Colorado in Boulder lists four criteria to meet model program status: rigorous evaluation design, demonstrated effects, multi-side replication, and sustained effects. Many programs show effects for a relatively short period after completion (up to a year) but the long-term effects decline over time. This intervention satisfies three of those four criteria. There has not yet been any multi-site implementation, but the other three criteria are met by our evaluation data.

About the Presenter

Richard Dembo, Ph.D., is a Professor of Criminology at the University of South Florida in Tampa. He received his Ph.D. in sociology from New York University. He has conducted extensive research on the relationship between drug use and delinquency; has published a book and over 130 articles, book chapters and reports in the fields of criminology, substance use, mental health, and program evaluation; and has guest edited five special issues of journals addressing the problem of drug misuse. He is a member of the editorial boards of *The International Journal of the Addiction* (recently renamed *Substance Use and Misuse),* and the *Journal of Child and Adolescent Substance Abuse.* He has served as a consultant to the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the National Institute on Drug Abuse, the National Institute of Mental Health, the Center for Substance Abuse Treatment, the Office of Substance Abuse Prevention, and the National Science Foundation; and is a reviewer of manuscripts for numerous professional journals. He is Past-Chair of the American Sociological Association on Alcohol and Drugs. He has extensive experience working with trouble youths in a variety of settings. He has a long-term interest in applying research technology to social problems with a view to improving understanding of these problems, and in developing innovative programs and service delivery systems for high risk youth and their families. He is currently working on a NIDA funded experimental, longitudinal service delivery

project designed to implement and test a Family Empowerment Intervention involving high risk youth and their families; and is responsible for the research component of the Hillsborough County Juvenile Assessment Center in Tampa (which he helped develop). He has been a major party in the flow of millions of dollars in federal, state and local funds into the University of South Florida and the Tampa Bay area for various research and service delivery projects addressing the needs of high risk youth, their families and their surrounding communities.

Contact Information:
Richard Dembo, Ph.D., Professor
University of South Florida
Department of Criminology
ACTS Building, 8620 North Dixon Ave.
Tampa, Florida 33604
Telephone (813) 931-3345
Fax (813) 933-1146

Richard Dembo, Ph.D.

Published Papers Relating to the Youth Support Project and Family Empowerment

Intervention

1996   Cervenka, K.A., Dembo, R. & Hendricks, C. (1996). A Family Empowerment Intervention for families of juvenile offenders. *Aggression and Violent Behavior: A Review Journal, 1,* 205-216.

1997   Dembo, R., Pacheco, K., Schmeidler, J., Fisher, L. & Cooper, S. (1997). Drug use and delinquent behavior among high risk youths. *Journal of Child and Adolescent Substance Abuse, 6,* 1-25.

1998   Dembo, R., Schmeidler, J., Pacheco, K., Cooper, S. & Williams, L.W. (1997). The relationships between youths' identified substance use, mental health or other problems at a juvenile assessment center and their referrals to needed services. *Journal of Child and Adolescent Substance Abuse, 6,* 23-54.

1998   Dembo, R., Pacheco, K., Schmeidler, J., Ramirez-Garnica, G., Guida, J. & Rahman, A. (1998). A further study of gender differences in service needs among youths entering a juvenile assessment center. *Journal of Child and Adolescent Substance Abuse, 7,* 49-77.

1998   Dembo, R. Shemwell, M., Guida, J., Schmeidler, J., Pacheco, K. & Seeberger, W. (1998). A longitudinal study of the impact of a family empowerment intervention on juvenile offender psychosocial functioning: A first assessment. *Journal of Child and Adolescent Substance Abuse, 8,* 15-54.

1999   Dembo, R., Cervenka, K.A., Hunter, B., Wang, W. & Schmeidler, J. (1999). Engaging high risk families in community based intervention services. *Aggression and Violence: A Review Journal, 4,* 41-58.

2000   Dembo, R., Shemwell, M., Guida, J., Schmeidler, J., Baumgartner, W., Ramirez-Garnica, G. & Seeberger, W. (1999). Comparison of self-report, urine sample, and hair testing for

drug use: A longitudinal study. In T. Mieczhowski (Ed.) *Drug Testing Methods: Assessment and Evaluation.* New York: CRC Press.

2000   Dembo, R., Ramirez-Garnica, G., Rollie, M., Schmeidler, J., Livingston, S. & Hartsfield, A. (2000). Youth recidivism 12 months after a family empowerment intervention: Final report. *Journal of Offender Rehabilitation, 31,* 29-65.

2000   Dembo, R., Seeberger, W., Shemwell, M., Schmeidler, J., Klein, L., Rollie, M., Pacheco, K., Hartsfield, A. & Wothke, W. (2000). Psychosocial functioning among juvenile offenders 12 months after Family Empowerment Intervention. *Journal of Offender Rehabilitation, 32,* 1-56.

2000   Dembo, R., Ramirez-Garnica, G., Rollie, M. & Schmeidler, J. (2000). Impact of a Family Empowerment Intervention on youth recidivism. *Journal of Offender Rehabilitation, 32*(3/4).

2000   Dembo, R., Wothke, W., Seeberger, W., Shemwell, M., Pacheco, K., Rollie, M., Schmeidler, J., Klein, L., Hartsfield, A. & Livingston. (2000). Testing a model of the influence of family problem factors on high risk youths' troubled behavior: A three-wave longitudinal study. *Journal of Psychoactive Drugs, 32,* 55-65.

2000   Dembo, R., Ramirez-Garnica, G., Schmeidler, J., Rollie, M., Livingston, S. & Hartsfield, A. (2000). Long-term impact of a Family Empowerment Intervention on juvenile offender recidivism. *Journal of Offender Rehabilitation, 33*(1).

2000   Dembo, R., Schmeidler, J., Seeberger, W., Shemwell, M., Klein, L., Rollie, M., Pacheco, K., Livingston, S. & Wothke, W. (2000). Long-term impact of a Family Empowerment Intervention on juvenile offender psychosocial functioning. *Journal of Offender Rehabilitation, 33*(1).

In press   Dembo, R. Shemwell, M., Pacheco, K., Seeberger, W., Rollie, M., Schmeidler, J. & Wothke, W. A longitudinal study of the impact of a Family Empowerment Intervention on juvenile offender psychosocial functioning: An expanded assessment. *Journal of Child and Adolescent Substance Abuse.*

In press   Dembo, R., Wothke, W., Shemwell, M., Pacheco, K., Seeberger, W., Rollie, M. & Scheidler, J. The relationship of high risk youth family problems and their problem behavior: A structural model. *Journal of Child and Adolescent Substance Abuse.*

In press   Dembo, R., Wothke, W., Shemwell, M., Pacheco, K., Seeberger, W., Rollie, M., Schmeidler, J., Klein, L., Hartsfield, A. & Livingston, S. Testing a longitudinal model of the influence of family problem factors on high risk youths' troubled behavior: A replication and update. *Journal of Child and Adolescent Substance Abuse.*

ETHNIC, CULTURAL AND GENDER ISSUES
Presented by Nancy Jainchill, Ph.D.

This presentation reviewed issues of cultural identification, ethnicity, gender and co-morbidity in relation to the treatment needs of adolescents with substance abuse problems.

WHAT IS CULTURE?

Culture is described by the values, beliefs and customs of a group of people and includes their thoughts, ideas, behavior patterns, customs, beliefs, values, arts and prejudices (at a given point in time). Only recently, have we acknowledged the reality of a culture of gender and a culture of race/ethnicity.

CULTURAL IDENTIFICATION

Among adolescents cultural identification is influenced by many factors including the attitudes of established social institutions (e.g., schools, government), peer attitudes toward a specific culture and parental feelings about their culture of origin as well as the host culture. The extent to which specific factors impact cultural identification will vary among individuals, even among those who share the same culture of origin. For example, a person's age is likely to affect the experience of acculturation.

ACCULTURATION

Acculturation involves the adaptation from the person's culture of origin to the host culture, in this case, the American culture. Acculturation is not a unidirectional process going from culture A to culture B; rather it is both a multi-directional and multi-dimensional process. Successful acculturation usually involves some adaptation and acceptance of elements from both the culture of origin and the new culture.

For most immigrant groups, acculturation involves adaptation from a traditional culture, which provides controls on behavior, to the more modern American culture, which places fewer constraints on nonconventional behavior (Rodriquez, Recio-Adrados & De La Rosa, 1993). The acculturation process is influenced by a complexity of contextual factors including

126

socioeconomic status, accessibility to educational and vocational opportunities, and the person's neighborhood ecology - the environment where the family lives, who lives nearby, the youngsters' peers and the neighborhood norms.

The acculturation experience involves an individual's ongoing adjustment (or not) to mainstream values, living a life that requires a continual shifting back and forth between different cultural orientations and alliances, and encountering and countering disrespect for one's traditions and values (i.e., discrimination). An individual's personal resources i.e., his/her self-image and emotional stability, will moderate the impact of the experience. Also, if the two cultures are compatible and if the acculturation is agreeable with significant others, then it is more likely to be a successful and less stressful process (De La Rosa, Vega & Radlich, 2000).

There is a relationship between acculturation, mental health and substance abuse. The loss of cultural identity is a risk factor for both substance abuse and psychopathology. Adolescence is the period of identity formation, and this is made even more challenging by additional issues of identity. Among adolescents who experience conflicts with their parents over cultural adaptation or identification, there is the increased likelihood for problems such as substance abuse and psychopathology.

THE ROLE OF CULTURAL COMPETENCE IN TREATMENT.

Treatment programs that admit individuals from a diversity of cultural backgrounds need to provide services that are culturally competent. Three essential components of cultural competence have been identified: (1) cultural knowledge – having familiarity with the cultural characteristics of another group; (2) cultural awareness – reflecting sensitivity and understanding of another group; and, (3) cultural sensitivity – seeing differences without judgment. Treatment must also be culturally responsive in terms of language and non-verbal cues. Programs that offer treatment to individuals from different cultures ideally should have staff who speaks the client's language, and has familiarity with the cultures and cultural issues of those in treatment. It is also helpful to have someone on staff who shares physical similarities with the people entering treatment (e.g., skin color).

Assessment of substance abuse and mental illness problems must go beyond the reliance upon a nosological system that is defined by the mainstream culture. For example, the social undesirability of symptoms or the mental health significance of experiences may be not equivalent across cultures. And cultural differences between the diagnostician and the "patient" influence the complexity of cognitive, affective and behavioral exchanges that are involved in the process of mental health assessment (Rogler, 1993).

The spectrum of life experiences of immigrants, as well as their current life situation may require attention to a range of health concerns, for example, primary medical care, prenatal care, treatment for mental health and/or substance abuse, as well as educational and vocational training. Access to a variety of health care options is therefore critical.

ACCESSING TREATMENT

Often, particularly with cultural minorities, there are difficulties in accessing needed services because of real and perceived barriers. One barrier to treatment among those who are not from the host culture is social-cultural stigmatization that is external. Individuals may perceive or experience disrespect from the host culture. A second barrier to treatment is social-cultural stigmatization that is internal and this may be reflected in several ways. Commonly, the self-perception of being different is experienced as "abnormal." And, among many non-American groups, there is greater stigma attached to receiving psychiatric care or getting treatment for substance abuse. An example of the latter is demonstrated by the reluctance among Latinos (including the variety of subcultures) to seek treatment for substance abuse. The close family-orientation of the culture, in addition to other culturally specific ways of relating (e.g., personalismo) and language barriers, discourages the sharing of problems outside of the family.

Socio-economic conditions also influence self-perceptions in terms of how individuals feel about themselves and how they feel others experience them. Often those who have less feel they are worth less and they do not view themselves as having options. A goal of treatment is to have people enhance their self-worth, to develop a sense that they have alternatives to their original lifestyle and to provide them with the tools to begin to pursue those options.

RACE/ETHNICITY AND CULTURE

Acculturating to European-American mainstream values will have an impact on the social-behavioral and psychological characteristics of individuals. In particular, substance abuse among other cultural groups has been associated with a stressful acculturation process.

According to Glazer (1998), African Americans comprise the most distinct cultural group in the United States. Because they are Americans, their different heritage has not been acknowledged or respected and this has been a continual source of disenfranchisement. Controlling for known risk factors for substance abuse (e.g., familial drug use), studies show less substance abuse among African Americans than other ethnic groups in this country including European Americans, and they also show less psychiatric disturbance.

Among Hispanics, both adolescents and adults, skin color, home location, educational and economic status of those who are foreign or U.S. born, influence the social and personal adjustments that they make to the American society. For adolescents, the level of dissonance experienced because of differences between the values of their (or their parents') culture of origin and the dominant American cultural values will impact the young person's acculturation process.

Poorly acculturated U.S. born Hispanic adolescents experience the highest rate of substance abuse initiation and of continued experimentation. A study of young adult men in New York showed that there were different factors that contributed to drinking problems in each of three different Latino groups. Similarly, among New York City Latinos, the acculturation of Puerto Ricans is less successful than that of other groups. One reason is that they came from a society and a culture that has not been respected by mainstream America and they have internalized that disrespect. This highlights the importance of distinguishing among subgroups within the more comprehensive race/ethnic classification.

Asian American adolescents have lower rates of substance abuse than European Americans; one explanation is that they have fewer role models for substance abuse. They tend to be more connected to their families and less influenced by peers (Au & Donaldson, 2000).

CULTURE AND GENDER

There have been a number of studies that have examined gender differences in relation to psychiatric disturbance and substance abuse. The results are equivocal: some of the studies have reported a different profile of comorbidity, while others have found similar levels of severity and types of psychopathology among males and females. Several studies suggest overall greater comorbidity among drug-using girls in comparison with drug-using boys, while others have indicated more internalizing problems among girls and more externalizing disorders among boys.

Community samples. As early as 1978, investigators reported a positive relationship between illicit multiple drug use, depression, and normlessness for girls (Paton & Kandel, 1978). Conduct disorder is predictive of later drug use for both genders, however there are gender differences in the pattern and progression of substance use. Females are more likely to have a diagnosis of nicotine dependence, and start drinking at a later age than males, however, the age at which they qualified for a diagnosis of alcohol abuse/dependence did not differ. Females also revealed a shorter interval between experimental marijuana use and abuse/dependence (Mezzich et al., 1994). Conduct disorder has also been found to be predictive of internal disorders such as depression, among girls.

Alcohol use has been associated with increased lifetime occurrence of depressive disorders, disruptive behavior disorders, and other drug use. Among females there is a trend for increased alcohol use to be associated with anxiety disorders (Rhode, Lewinsohn & Seeley, 1995).

Treatment samples. A higher incidence of psychopathology among substance abusing adolescents has been reported for those with histories of physical and/or sexual abuse (e.g., Blood & Cornwall, 1996; Dembo et al., 1989). Among a sample of adolescent psychiatric in-patients with a substance use disorder diagnosis, almost one-third had co-morbid major depression. Significantly more females had co-morbid affective disorder and, for both genders, secondary major depressive disorder was more common in its primary form (Bukstein, Glancy & Kaminer, 1992).

Among drug abusing adolescents, females showed higher scores than males on scales measuring physical symptoms, escape, and emotional consequences of drug use. The small number of scales that yielded differences, as well as the relatively small magnitude of the differences suggest that the gender are more similar than not (Opland, Winters & Stinchfield, 1995).

Other studies report that among males in residential treatment for comorbid conduct disorder and substance abuse, poorer outcomes were predicted by more severe symptomatology at admission (Crowley, Mikulich, MacDonald, Young & Zerbe, 1998); and, that girls use drugs and engage in externalizing behaviors as extensively as do their male counterparts, but they also have higher levels of internalizing symptoms and family dysfunction (Dakof, 2000).

PSYCHOPATHOLOGY AND SUBSTANCE ABUSE

The directionality of the relationship between psychopathology and substance abuse may vary. Psychopathology can serve as a risk factor for addictive disorders. In this regard, psychopathology can influence the process of the addictive disorder, its repetition, its symptom picture and its response to treatment. Thus, an individual may initiate drug use to "feel better" as suggested by the self-medication hypothesis. On the other hand, psychiatric symptoms may emerge during the course of an addiction or as a consequence of sustained substance abuse. The negative impact of substance use/abuse on an individual's life may produce symptoms of depression or other psychiatric disturbance.

Psychiatric disorders may be unrelated to substance dependence/abuse. In contrast, psychopathology and substance use disorders may originate from a common vulnerability, whether an organic vulnerability, a cultural vulnerability, or a contextual vulnerability (i.e., a troubled family environment).

THE THERAPEUTIC COMMUNITY TREATMENT APPROACH FOR ADOLESCENT SUBSTANCE ABUSERS

Residential therapeutic communities ("TCs") established in the 1960s focused on the

treatment of adults who were primarily involved with heroin, and treatment ranged anywhere from two to three years. The therapeutic community is distinguished from other treatment approaches by its adherence to "community as method" which refers to the purposive use of the peer community to facilitate social and psychological change in individuals (De Leon, 1994; 2000; Jainchill, 2000). This paradigm is reflected in the fact that all of the activities in a TC are designed to produce therapeutic and educational change in the participants, and all of the participants (residents) are themselves, mediators of this change (De Leon, 1997). The group process is the primary therapeutic tool, and one-on-one therapy sessions between a client (resident) and counselor are infrequent.

Over the past two decades TCs have been considerably modified. Most programs no longer see people who abuse opiates. The primary drug of abuse for adults is usually cocaine or crack cocaine, and for adolescents, it is marijuana and alcohol. The planned duration of treatment typically ranges between 6 and 12 months; this change, however, has been based more on funding exigencies and the influence of managed care, than on empirical data. Today, the reduction in treatment tenure challenges the possibility of effecting the kind of holistic change or habilitation that is required.

Historically, individuals with severe psychiatric disturbance were generally not admitted to TCs because of their treatment needs. However, currently, 90% of the people who come into therapeutic communities have a co-occurring disorder, although only a small minority will have a diagnosis of schizophrenia or other psychosis. Adolescents who enter TCs are often at the extreme end of the continuum in terms of antisocial or conduct disorder problems, as well as emotional and psychological distress. They usually have a history of school problems such as truancy, poor performance, learning disabilities, and problems with authority. They are also struggling with the general turbulence that characterizes the normal transition to adulthood (De Leon, 1988; Jainchill, 1997).

STUDY RESULTS

The remainder of this presentation summary describes a study that has been funded by the National Institute on Drug Abuse to describe the profile of adolescents who entered TCs for

adolescents and to evaluate their post-treatment outcomes programs (Jainchill et al., 1995, 1997, 2000). Data were obtained on more than 900 adolescents who entered six TCs (9 sites) in the United States and Canada during the years 1992-1994. A one-year post-treatment follow-up study was conducted on a subsample of those who completed an interview at admission to treatment and a 5-year post treatment follow-up study is nearing completion.

DESCRIPTION OF STUDY SAMPLE

The large majority of the 938 admissions to treatment were male (77%) and most were European American (49%). The majority (56%) were 16-17 years of age, while almost a third were under 16 years old. The distribution of primary drug of abuse at admissions was: marijuana (56%), alcohol (20%), crack/cocaine (9%) heroin/opiates (5%) and "other" (10%).

There were several other gender and race/ethnic differences: proportionately fewer Hispanic females enter treatment; more African Americans report marijuana as their primary drug of abuse, while among Hispanics (males) there is more use of heroin/opiates. The latter finding is of particular significance as Hispanics have the highest increase in the rate of HIV transmission of all race/ethnic groups in the United States.

The mean age for initiation of drug use is 12 years, and the age of first involvement with an illegal activity was thirteen. Females began their criminal activity earlier than did males, however twice as many males than females had been arrested and booked.

Sixty-eight percent of the admissions were mandated to treatment by the legal system. Males were more likely to be referred by the criminal justice system, while females were more likely to be sent to treatment by family court. Fifty-seven percent of the Caucasians were referred to treatment by the criminal justice system, compared with 85% of African Americans and 71% of Hispanics, a difference that likely reflects the bias of the legal system. A minority of adolescents was self-referred (less than 9%) reflecting their low internal motivation for treatment or recovery.

PSYCHIATRIC STATUS

A structured psychiatric interview, the revised Diagnostic Interview for Children and Adolescents (DICA-R-A; Reich, Shayka & Taibleson, 1991) was used to assess the presence/absence of DSM-III-R disorders among the adolescents. Initially, trained research assistants administered the interview. However, a computerized version became available and was employed for the majority of the data collection because this approach was preferred by the youth. (A research assistant remained nearby.) The DICA was not employed to diagnose substance abuse or dependence for several reasons. First, an extensive Baseline Interview developed by the research team elicited sufficient information concerning the adolescents' drug use to generate diagnoses according to both DSM-III-R and DSM-IV criteria. Second, the interview battery was lengthy and the amount of additional information that might have been obtained was considered unwarranted. Third, the validity of current diagnostic systems for the classification of adolescent substance use disorders has been questioned (e.g., Bukstein et al., 1989).

Approximately 90% of those who completed a psychiatric interview (n=829) yielded at least one psychiatric diagnosis. The majority (61%) had both a developmental/behavioral and affective/anxiety disorder. Nineteen percent had an affective/anxiety disorder only while 13% had a developmental/behavioral disorder only. The most frequently occurring diagnoses were, in order: conduct disorder, oppositional defiant disorder, simple phobia, separation anxiety, attention deficit-hyperactivity, overanxious disorder, and depression or dysthymia.

In the current sample, females yielded significant more positive non-substance diagnoses than did the males (mean=5, females; mean=3, males). Of note is that a higher percentage of females than males were diagnosed with all of the developmental/ behavioral disorders (i.e., conduct disorder, oppositional defiant disorder, attention deficit-hyperactivity). Significantly more females were diagnosed with affective disorders and twice as many had post traumatic stress, which may relate to incidents of abuse (discussed below).

Differences by race/ethnicity were generally consistent. African Americans obtained significantly fewer DSM-III-R diagnoses, as well as fewer psychotic symptoms and psychosocial stressors.

In summary, being female and being European American is associated with psychiatric disturbance on admission to treatment. More psychiatric disturbance is also associated with having lower motivation for treatment, and with a greater number of previous drug treatment episodes.

PHYSICAL AND SEXUAL ABUSE

Histories of physical and sexual abuse were assessed with a face-to-face interview conducted by a research assistant, and with a standardized paper and pencil questionnaire (PEI: Winters & Henly, 1989) completed by the adolescent her/himself. The questions on the face-to-face interview required clients to identify themselves as abuse victims and to report their abuse status to an interviewer. In contrast, the PEI was completed by the interviewee, and screened for the *potential* of sexual and/or physical abuse as well as for actual abuse experiences. Both methods were employed because there was a concern that the youth might be reluctant to disclose incidents of abuse in a face-to-face interview, which lacks the anonymity of a self-administered questionnaire.

The data presented include adolescents admitted to mixed gender programs only so that the sample is reduced to n=703 (females, n=193; males, n=500). Utilizing information obtained from both sources of data, 36% of the sample reported a history of sexual abuse and almost 47% reported physical abuse. There were significant gender differences: 65% of the females compared with 25% of the males reported some kind of sexual abuse, and 75% of the females and 46% of the males reported some kind of physical abuse. Even using the more conservative criteria of
the face-to-face interviews, 61% of the females and 32% of the males reported abuse. Fifty-two percent of Caucasians report some kind of sexual or physical abuse compared with 18% of African Americans and 14% of Hispanics.

POST TREATMENT OUTCOMES

Of the original 938 adolescents who were admitted to TC treatment during the interview period, a minority was excluded from the follow-up component of the study for any of several

reasons (for more information see Jainchill et al., 2000). A follow-up status was obtained for 64% of the sample and data are reported for 485 adolescents who completed one-year post-treatment follow-up interviews. Of this subsample, approximately 31% graduated or completed the residential phase of treatment; 52% dropped out of treatment; and, the remainder were terminated for a variety of other reasons (e.g., referred elsewhere, discharged for behavioral reasons).

Analyses of one-year post-treatment data revealed generally significant reductions in drug use and criminal activity. Those who completed treatment showed reductions in use of all categories of drugs (i.e., alcohol, marijuana, crack/cocaine, heroin/opiates) while the findings were not as consistent for those who did not complete treatment. Both those who completed treatment and those who did not complete treatment showed significant improvement on measures of criminal activity, i.e., sale and distribution of drugs, property crimes, violent crimes and arrests, however the changes were larger for those who had completed treatment.

Logistic regression analyses were run to identify factors that predicted post-treatment outcomes. Declines in drug use were predicted by: race/ethnicity (being Hispanic), lower levels of drug use pre-treatment, positive relations with counselors (reductions in marijuana use), and having completing treatment (reductions in alcohol use and use of illicit drugs). Two post-treatment variables were related to declines in drug use: the adolescent's living situation (away from the family of origin) and association with "positive" peers were associated with less alcohol and illicit drug use. Criminal activity was assessed as present or absent post-treatment. The absence of criminal activity was associated with being female, not associating with deviant peers pre- or post-treatment, being satisfied with one's social life and having completed treatment. The most consistent predictor for lowered criminal activity and/or drug use was having completed treatment. Those who complete treatment were much less likely to be involved with criminal activity and much more likely to have reductions in drug use post-treatment.

ISSUES FOR TREATMENT, POLICY AND RESEARCH

There are outreach and recruitment issues when dealing with adolescents since they have little self-motivation for treatment. Furthermore, gender and ethnic identity issues must be

addressed since, for example, females often feel pulled by family issues and those of Hispanic background are generally less comfortable with public acknowledgement of personal problems. Overall, the profile that emerges is that adolescents who use and abuse drugs, particularly those who enter residential programs, present with a spectrum of disturbance and dysfunction requiring a global approach to treatment and rehabilitation. Drug involvement, criminal activity, and family problems and psychopathology are often found together. Thus, there is a need for integrated services involving cross training and a diversity of staff.

CO-MORBIDITY: ISSUES OF DIAGNOSIS AND TREATMENT

Symptom assessment must take into consideration the occurrence or onset of the symptomatology, the severity of the manifestation and the nature of the symptom profile (i.e., which symptoms are involved). Cultural issues include the social undesirability (or not) of symptoms, whether the behaviors are healthy within the context of the individual's culture and acceptable treatment modalities. The interpersonal situation of the diagnostic interview will also impact the assessment of disturbance, e.g., gender and cultural differences between the client and the interviewer/diagnostician.

THERAPEUTIC APPROACHES

The use of medication is especially challenging when dealing with issues of co-morbidity, and the reduction of medication is an important therapeutic goal. In therapeutic communities, certain treatment processes may need to be moderated and/or integrated with other approaches. For example, the "encounter" group may be less confrontational and the use of one-on-one sessions may be an important tool to teach youth how to relate to and trust senior role models. While treatment tenures have been shortened because of funding exigencies, the planned durations of treatment may need to be changed to accommodate the complexity of adolescent treatment issues.

Two hypotheses have been offered to explain the profile of psychopathology and antisocial behaviors that describe adult substance abusers also have relevance for adolescents. . The self-stigma hypothesis suggests that because females are more socially conditioned to perceive their drug use as worse or sicker, they internalize that belief. One positive result of that

is that whey they stop the drug use, they get better faster and it remains a more stable improvement. The role-conditioning hypothesis suggests that among socially disadvantaged non-Caucasian groups, drug abuse and psychological symptoms are more often corollaries of chronic frustration and precede social impotency. However, for whites or those more socially advantaged, drug abuse represents a greater break from social role expectations and is more likely to be associated with increased psychopathology (De Leon & Jainchill, 1981-82; 1991).

RESEARCH

There are many research questions that remain to be answered. In particular, studies need to focus on understanding the interaction that takes place between the individual and the treatment process. What are the critical factors that treatment providers must address in dealing with issues of gender, race/ethnicity and other cultural parameters? Furthermore, we need to understand the temporal sequence of co-morbid disorders and substance abuse, the difference if the symptomologies precede or succeed one another and the interplay that they can have on each other in terms of a synergistic or ameliorating effect.

About the Presenter

Deputy Director for the Center for Therapeutic Community Research at the National Development and Research Institutes, Inc. in New York, Dr. Jainchill's present research focuses are adolescent therapeutic community programs and Hispanic-American/Venezuelan Youth-Drug Use Risk Factors.

Contact Information:
Nancy Jainchill, Ph.D., Deputy Director
National Development and Research Institutes, Inc
71 West 23rd Street
8th Floor
New York, NY 10010
Phone: 212.845.4400

References

Please note: Certain references are included that are not mentioned in the text because they are considered to be of potential interest and relevance to readers.

Au, J.G. & Donaldson, S.I. (2000). Social influences as explanations for substance use differences among Asian-American and European-American adolescents. *Journal of Psychoactive Drugs, 32,* 15-23.

Berry, J.W. (1997). Immigration, acculturation, and adaptation. *Applied Psychology: An International Review, 46,* 5-34.

Blood, L. and Cornwall, A. (1996). Childhood sexual victimization as a factor in the treatment of substance misusing adolescents. *Substance Use and Misuse, 31,* 1015-1039.

Boyd, C.J., Blow, F. & Orgain, L.S. (1993). Gender differences among African-American substance abusers. *Journal of Psychoactive Drugs, 25,* 301-305.

Bukstein, O.G., Brent, D.A. & Kaminer, Y. (1989). Comorbidity of substance abuse and other psychiatric disorders in adolescents. *Americal Journal Psychiatry*, *146*, 1131-1141.

Bukstein, O.G., Glancy, L.J. & Kaminer, Y. (1992). Patterns of affective comorbidity in a clinical population of dually-diagnosed adolescent substance abusers. *Journal of the American Academy of Child and Adolescent Psychiatry, 6,* 1041-1045.

Crowley, T.J., Mikulich, S.K., MacDonald, M., Young, S.E. & Zerbe, G.O. (1998). Substance-dependent, conduct-disordered adolescent males: Severity of diagnosis predicts 2-year outcome. *Drug and Alcohol Dependence, 49,* 225-237.

Dakof, G. (2000). Understanding gender differences in adolescent drug abuse: Issues of comorbidity and family functioning. *Journal of Psychoactive Drugs, 32,* 25-32.

De La Rosa, M., Vega, R. & Radlich, M.A. (2000). The role of acculturation in the substance abuse behavior of African-American and Latino adolescents: Advances, issues, and recommendations. *Journal of Psychoactive Drugs, 32,* 33-42.

De Leon, G. (1988). The therapeutic community perspective and approach to adolescent substance abusers. *Annuals of Adolescent Psychiatry 15.*

De Leon, G. (1994). The therapeutic community: Toward a general theory and model. In: F.M. Tims, G. De Leon & N. Jainchill (Eds.). *Therapeutic community: Advances in Research and Application.* NIDA Research Monograph 144 (pp. 16-53). Rockville, MD: National Institute on Drug Abuse.

De Leon, G. (1997). *Community as method: Therapeutic communities for special populations and settings*. Westport, CT: Greenwood Publishing Group.

De Leon, G. (2000). *The therapeutic community – Theory, Model, and Method.* New York: Springer Publishing Co.

De Leon, G. & Jainchill, N. (1981-1982). Male and female drug abusers: Social and psychological status 2 years after treatment in a therapeutic community. *American Journal of Drug and Alcohol Abuse, 8,* 465-497.

De Leon, G. & Jainchill, N. (1991). Residential therapeutic communities for female substance abusers. *Bulletin of the New York Academy of Medicine, 67,* 277-290.

Dembo, R., Williams, L., LaVoie, L. & Berry, E. (1989). Physical abuse, sexual victimization and illicit drug use. *Violence Victims, 4,* 1212-1238.

Gilligan, C.J., Ward, V. & Taylor, J.M. (1988). *Mapping the Moral Domain.* Boston: Harvard University Press, pp. 3-21.

Glazer, N. (1998). *We Are All Multiculturalists Now.* Cambridge, MA: Harvard University Press.

Hubbard, R.L., Cavanaugh, E.A., Craddock, S.F. & Rachal, J.V. (1985). Characteristics, behaviors and outcomes for youth in the TOPS. In A.S. Friedman & G.M. Beschner (Eds.) *Treatment Services for Adolescent Substance Abusers.* Rockville, MD: National Institute on Drug Abuse.

Jainchill, N. (1997). Therapeutic communities for adolescents: The same and not the same. In G. De Leon (Ed.) *Community As Method. Therapeutic Communities for Special Populations and Special Settings.* Westport, CT: Praeger, pp.161-177.

Jainchill, N., Bhattacharya, G. & Yagelka, J. (1995). Therapeutic communities for adolescents. In E. Rahdert, D. Czechowicz (Eds.) *Adolescent drug abuse: Clinical assessment and therapeutic interventions.* NIDA Research Monograph 156. Rockville, MD: National Institute on Drug Abuse, pp.190-217.

Jainchill, N., De Leon, G. & Yagelka, J. (1997). Ethnic differences in psychiatric disorders among substance abusers in treatment. *Journal of Psychopathology and Behavioral Assessment, 9,* 133-148.

Jainchill, N., Hawke, J., De Leon, G. & Yagelka, J. (2000). Adolescents in TCs: One-year post-treatment outcomes. *Journal of Psychoactive Drugs, 32,* 81-94.

Jainchill, N., Yagelka, J., Hawke, J. & De Leon, G. (1999). Adolescent admissions to residential drug treatment: HIV risk behaviors pre- and post-treatment. *Psychology of Addictive Behaviors, 13,* 163-173.

Kail, B., Zayas, L.H. & Malgady, R.G. (2000). Depression, acculturation, and motivations for alcohol use among young Colombian, Dominican, and Puerto Rican men. *Hispanic Journal of*

Behavioral Sciences, 22, 64-77.

Kirmayer, L.J. (1991). The place of culture in psychiatric nosology: Taijin Kyofush and DSM-III-R. *The Journal of Nervous and Mental Disease, 179,* 19-28.

Mezzich, A.C., Moss, H., Tarter, R.E., Wolfenstein, M., Hsieh, Y-C. & Mauss, R. (1994). Gender differences in the pattern and progression of substance use in conduct-disordered adolescents. *The American Journal on Addictions, 3,* 289-296.

Opland, E.A., Winters, K.C. & Stinchfield, R.D. (1995). Examining gender differences in drug-abusing adolescents. *Psychology of Addictive Behaviors, 9,* 167-175.

Paton, S.M. & Kandel, D.B. (1978). Psychological factors and adolescent illicit drug use: Ethnicity and gender differences. *Adolescence, 13,* 50, 187-200.

Portes, A. & Rumbaut, R.G. (1997). *Immigrant America: A portrait.* Berkeley, CA: University of California Press.

Reich, W., Shayka, J.J. & Taibleson, C. (1991). *Diagnostic Interview for Children and Adolescents (DICA-R-A).* St. Louis, MO: Washington University Press.

Robins, L.N. (1987). The consequences of conduct disorders in girls. In D. Olwens, J. Black & M. Radke-Yarrow (Eds.). *Development of antisocial and prosocial behavior.* New York: Academic Press.

Rodriguez, O., Recio-Adrados, J.L. & De La Rosa, M.R. (1993). Integrating mainstream and subcultural explanations of drug use among Puerto Rican youth. In M.R. De La Rosa & J-L Recio Adrados (Eds.). *Drug abuse among minority youth: Advances in research and methodology. NIDA Research Monograph 130,* Rockville, MD: National Institute on Drug Abuse, 8031.

Rogler, L.H. (1993). Culturally sensitizing psychiatric diagnosis. A framework for research. *The Journal of Nervous and Mental Disease, 181,* 401-408.

Rounds-Bryant, J.L., Kristiansen, P.L. & Hubbard, R.L. (1998). Drug Abuse Treatment Outcome Study of adolescents: A comparison of client characteristics and pretreatment behaviors in three treatment modalities. *American Journal of Drug & Alcohol Abuse, 25,* 573-591.

Reporting Program (DARP): A follow-up study. In G.M. Beschner & A.S. Friedman (Eds.), *Youth Drug Abuse.* Lexington, MA: Lexington, 571-628. Sells, S.B. & Simpson, D.D. (1979). Evaluation of treatment outcomes for youth in the Drug Abuse.

Vega, W.A., Gil, A. & Wagner, E. (1998). Cultural adjustment and Hispanic adolescents. In W.A. Vega & A. Gil (Eds.), *Drug Use and Ethnicity in Early Adolescents.* New York: Plenum Press.

Winters, K.C. & Henly, G.A. (1989). *Personal Experience InventoryTest and Manual.* Los Angeles, CA: Westeron Psychological Services.

Zoccolillo, M. (1993). Gender and the development of conduct disorder. *Development and Psychopathology, 5,* 65-78.

CHALLENGES IN SERVING RURALCHILDREN AND ADOLESCENTS UNDER MEDICAID MANAGED BEHAVIORAL HEALTH CARE
Presented by David Lambert, Ph.D.

The State of Maine began an initiative, the Maine Dual Diagnosis Demonstration Project, on co-occurring disorders 6 or 7 years ago. The Cumberland County Diagnosis Collaborative began during that period of time and has continued since then. Often these projects and grants come and go, so it is unusual that the Collaborative has continued to flourish and is sponsoring a conference like this today, 6 years after its conception. It is very heartening because it is often very hard to put in practice these wonderful ideas with all the other competing interests that happen in health services today.

BACKGROUND
GROWTH OF MEDICAID MANAGED BEHAVIORAL HEALTH ("MMBH") IN RURAL AREAS

One of two major areas of concentration at the Maine Rural Health Research Center at the Muskie School of Public Service is mental health. Over the last 3 or 4 years, the center has been looking closely at what has been happening nationally under Medicaid managed health care and specifically the mental health and behavioral health care that have been brought under it. A vast majority of the states have undertaken Medicaid managed care initiatives in contrast to Maine, which has not gone forward with managed care for behavioral health. These managed care initiatives almost always include and target children and adolescents. The experiences, however, are relevant to Maine because (1) Medicaid managed care will come to Maine, although there is a good chance that by the time it comes here, it will look different; and (2) the issues other states have wrestled with are similar to the issues that face Maine.

Thirty-five states have implemented Medicaid managed behavioral health and in 22 of those states there is a large rural area being served. That list includes states such as Maryland, Connecticut, Vermont, Washington and Wisconsin. Medicaid managed care typically includes different populations, a primary care population and special populations. The primary care population typically is the AFDC/TANF population. The benefit for mental health and

behavioral health care is usually modest, around 20 visits, and includes children for an initial intake or assessment. For the special populations under Medicaid managed care there usually is a triggering mechanism to determine Medicaid eligibility. The criteria vary from state to state but generally include children with serious emotional disturbances, adults with serious mental illness, and, increasingly, older persons who are dually eligible for Medicare and Medicaid. These varied populations are important because it means that under managed care the states are responsible for serving these various groups, which have a lot of competing demands. And everyone says "Yes, we can do it," but they start and then run into difficulties. They then have to re-bid the contracts, usually with less money available in the second bidding cycle.

CONCURRENT INITIATIVES/TRENDS AFFECTING SERVING CHILDREN UNDER MMBH

There are also a number of concurrent initiatives occurring across the states that affect the services for children and adolescents under Medicaid managed care. A number of states are moving to increased management of child welfare services through welfare reform. In addition, the Family Preservation Act passed in the mid-90's poured a lot of money into states at the same time as they were going to managed care. Moreover, the so-called CHIP Programs (child health insurance programs) also have enabled states to use more money for covering children who otherwise do not have insurance. Some states are only beginning to realize fully this source of revenue. These various revenue streams have caused access and utilization to actually increase. However, at the same time, in-patient facilities for children have closed, so the services have shifted from in-patient settings to the community with the managed care company or the state Medicaid program managing the financial risk. Consequently, the additional dollars and the political backing may look good in the short term but from a longer-term perspective many of these states now have run into difficulties.

<u>CHALLENGES</u>

EXCLUSION/LACK OF COORDINATION WITH SUBSTANCE ABUSE UNDER MMBH

The challenge to serving children as well as adults under Medicaid managed care is that often there is an exclusion of a lack of coordination with substance abuse services. The progress that had happened in many states has taken a step backwards under managed care. Because of all

the challenges involved with integration under managed care, substance abuse benefits typically were left under the physical health benefit while separate programs were created for mental health or behavioral health. This has made coordination even more challenging. This separation is particularly serious for rural care where there is already a limited infrastructure of all types of services: transportation, facilities, specialized services, etc. Managing care across systems of health, behavioral health, juvenile justice and education becomes more complex with additional system boundaries.

DIVERSE FUNDING STEAMS

Under diverse funding streams from separate systems, the substance abuse benefit often pays less than the mental health benefit. As a consequence, the incentive is to just keep billing on the mental health side and ignore the substance abuse issues. Sometimes you get the consult and sometimes you do not. If you do get the consult, how do you bill for the collateral contact? These double binds are not new but they have not been solved by managed care either. The actual practice of blending the funding streams has been limited in actual practice.

PROMISING PRACTICE AREAS
ENHANCING ACCESS

In rural areas there are few specialty mental health providers. The front line workers often are not credentialed or licensed. This is an issue for managed care programs because they typically create a list or panel of approved providers with specific qualifications. The managed care companies are under a lot of pressure with quality assurance to monitor and be responsible for the panels so they tend to be more, rather than less, restrictive. That is a problem in rural areas where there is a scarcity of licensed providers. A good example of this is in New Mexico, where new social workers cannot be reimbursed under the Medicaid managed care system until they have had two years of supervision. It becomes a "Catch-22" problem to get them licensed because you need the licensed provider for the supervision, but if you had enough licensed providers you would be able to provide the service in the first place. Some states have been successful in getting waivers around those rules.

Although treatment facilities are closing there is still is a need for some limited beds. The

question becomes how many. Practice standards about medicating children and the reimbursement mechanisms for community medication regimens often change and therefore it has been very difficult to determine the actual hospital need. Avenues that managed care companies are exploring in rural mental health to increase the access and manage utilization are the emerging fields of telemedicine and physician extenders for prescription practices.

MANAGING CARE ACROSS SYSTEMS
Flexible financing

Flexible financing is one mechanism to pay for what is needed rather than just for existing programs. This problem has been around for a long time and one would expect that it could be solved under managed care. Medicaid managed care has done away with fixed fee schedules and in most states, even though they do have approved lists of services, it has actually increased the number of services that can be reimbursed. Sometimes very important services that were not reimbursed under a typical Medicaid fee schedule, such as family counseling, anger management, and group therapies, are now reimbursable. There is more freedom to create flexible financing. But having said that, the problem is how do you really do that and how do you maintain it where there are different people and competing interests that want different priorities.

Important Venues & Inter-Organizational Issues

Very important venues or settings must be included in managed care if children and adolescents are really going to be served better across the continuum. Treatment and linkage must be established among the human services, the juvenile justice systems and the schools. Again, the question is how do you open up the venues while maintaining control and assurance of quality of care. Issues around the lines of authority, how to determine eligibility, coordinating multiple case managers, exchanging records and information all need to be clarified and put into place.

REDUCING STIGMA

Stigma to mental illness is a significant issue across the nation. For children and adolescents it can be seen when someone is first referred or even when there is a hint that there

might be a problem. Family issues and problems the person is facing compound the stigma. And then add, particularly in rural areas, the attitude to "mind one's own business" and the layers of nested problems become immense.

PROMISING PRACTICES

New Mexico

I want to give you a quick snapshot of two states, New Mexico and Oregon. Both have well established managed care programs, and have taken children and adolescents health care very seriously. In New Mexico, the general Medicaid Managed Care model is a carve-in model. They do not have separate mental health programs under Medicaid Managed Care. They have 3 large Managed Care Organizations ("MCO") that collectively serve the whole state and provide choice. They are very different programs, with each one responsible for partnering or sub-contracting out to a behavioral health organization that specializes in managing behavioral health care in the regions they serve. There is more integration between mental health and primary care in this model and yet you still have the specialists that come in and help you. The largest MCO is Presbyterian Medical Services. It is well established and is a very sophisticated health network. They are primarily located in the Santa Fe area and serve all the way up to northern New Mexico. Another MCO is in the middle of the state, and a third MCO in the southern border area, which is actually a collaborative of all the community mental health centers that existed before managed care. This southern border area is a very Hispanic area, and the local providers basically pooled together. As a local group it is able to meet the cultural needs of the area that might not have happened with an outside group coming into the area. New Mexico is very rural and poor. The southern part of the state has more people of Mexican origin; the northern part of the state has people of more Spanish descent, going back centuries. There are a lot of distinctions between these groups that is very much reflected in the service networks.

Serving children has been very challenging in New Mexico because of several things. There is a tremendous level of need with limited resources. Almost all the treatment facilities in the state were closed prior to managed care or concurrent with managed care, which has shifted care into the community. The infrastructure in the communities was not there and managed care reduced reimbursement for both in-patient and outpatient care. And then, with the limitations

imposed by the provider panels, providing care was difficult. New Mexico is slowly addressing some of these issues. There is some movement toward getting more reimbursement to the service level and they have been able to work with the state toward relaxing some of the requirements of who can be reimbursed.

Oregon

Oregon has a very ambitious approach to managed behavioral health, the Oregon Health Plan. They have been much more willing to allow for experimentation. In a nutshell, what Oregon has been trying to do is allow more local input into what happens in service delivery. They have allowed different models that range from fully capitated managed health plans to mental health organizations that are usually a collaboration of local providers. In Oregon, as in New Mexico, there is a lot of high need among the children and adolescents in terms of assessments, alcoholism and drug abuse. Again the experience in Oregon, as it has been elsewhere, has been that the substance abuse treatment has been very difficult to integrate. Substance abuse continues to be a separate service under managed care with different reimbursement rates. Two rural areas in the State have worked hard to make the system work. An area of 5 counties spanning from the coast to the central part of the state, called the Accountable Behavioral Health Alliance, report that they have been able to take advantage of the flexibility under managed care to offer services tailored to adolescents and children that were not previously offered. They also have been able to gain relief from the credential guidelines of the provider pool through an appeal process. Another area, Josephine County, which is in the southern part of the state, on the California border, is an area that has been bypassed by any economic boom. The young adults leave the area and the young and elderly are left. They have created a system for wrap-around services but have not been able to do much about coordinating across venues yet. The successes under Medicaid managed care are only just emerging on a state-by-state or region-by-region basis. The work still happens by person to person and by agency to agency.

MAINE CONTEXT

Maine does have an extensive telemedicine capacity, however, it is has been difficult to get mental health providers to fully utilize the resource. Maine, as elsewhere, has found that

there is a lot of resistance to utilizing telemedicine without first having established trust and relationships. Some of the proposals here in Maine and across the nation involve developing and training teams before taking it out into the field. And even with this, telemedicine does not work well for on-call schedules or emergencies. An example of its use for physical health is when someone has been hospitalized and they go home to a rural area where access is difficult, especially during winter months. They can take home a unit that can take all their vital signs through a health on-line and transmit back to the doctor's office to determine if they need to be seen.

As to Maine's use of physician extenders, we are probably under-utilizing our ability to do this. Oregon and a few other states have allowed non-physicians to prescribe medications pretty openly. It usually entails supervision and a consult back with the psychiatrist. Again, to make this work, it requires developing a prior relationship.

Also, another thing that can happen under Medicaid managed care with children and adolescents is cost shifting. The cases that are high utilizers under capitated-managed care are shifted back to child welfare with its fee for service. Some states have made explicit criteria to stop this.

In Maine and Washington, Regional Children's Cabinets have been established that have brought together the various state departments that serve children to assist with cross-system coordination. Their various initiatives are making changes in care, however, the questions are whether their activities are going to be officially endorsed by the government as a public document, whether they have the "hammer" to make them work, or whether they will need managed care. The Children's Cabinets provide a needed function for coordination, however, the question will be how will the Children's Cabinets be integrated into managed care when it comes and how can they can continue to keep the heat and incentives on integration.

Reference

Lambert, D., Gale, J., Bird, D. & Hortley, D. (2001). *Medicaid Managed Behavioral Health in Rural Areas. Working Paper #24.* Maine Rural Health Research Center. Muskie School.

University of Southern Maine. Portland, Maine

About the Presenter

David Lambert, Ph.D., is an Assistant Research Professor of Health Policy and Management at the Muskie School and Research Associate in the Maine Rural Health Research Center, funded by the Federal Office of Rural Health Policy, DHHS. Dr. Lambert was the Principal Investigator of Maine's Dual Diagnosis Demonstration Project (a random-assignment longitudinal study of person with co-occurring mental health and substance abuse issues). He has directed several studies tracking the implementation, effects and best practices in delivering Medicaid Managed Behavioral Health in rural areas. Dr. Lambert was co-chairperson (1991 – 1994) of the Bingham Mental Health Research Study group, which sought to foster collaboration among researchers, providers, consumers, and state policymakers. Dr. Lambert currently serves on the Board of the National Association for Rural Mental Health (NARMH) and was conference chairperson of the 1998 NARMH Annual Conference held in Portland, Maine.

Contact Information:
David Lambert, Ph.D., Assistant Research Professor
Muskie School
96 Falmouth St.
Portland, Maine 04103
Telephone (207) 780-4417

HISTORICAL PERSPECTIVE

The Denver Juvenile Justice Integrated Treatment Network ("DJJITN") was funded in 1995 by the Center for Substance Abuse Treatment ("CSAT"), which is under the Substance Abuse and Mental Health Services Administration, Department of Health and Human Services. In 1994, CSAT, based on its experiences with criminal justice and juvenile justice initiatives, wanted to fund networks that served both juveniles and adults with the hope of improving outcomes for the participants. CSAT goals for the treatment networks were to integrate the efforts of the courts in the criminal justice communities with that of the alcohol or other drug treatment communities and to implement a continuum and comprehensive system of care. CSAT saw a need to develop continuity for the individual as he moved among or through criminal justice or juvenile justice systems. Furthermore, CSAT wanted to demonstrate that networks would be able to expand access to services delivery and show cost efficiency. Ultimately, the outcomes that CSAT wanted to see were lower drug usage, lower rates of recidivism and an increase in levels of positive social functioning.

KEY COMPONENTS OF NETWORKS

The key components for these networks that CSAT felt were critical were the implementation of a centralized intake system for uniform screening and assessment and a system to track offenders and manage information across the criminal justice and juvenile justice agencies such as courts, jail and community corrections. CSAT also saw the need for consortiums to integrate not only alcohol and other drug treatment, but mental health, primary physical health and other services. The consortium partnerships would be formalized and developed through use of inter-agency agreements to share information, staff and resources.

NETWORKS

The Denver Juvenile Justice Integrated Treatment Network was formed to meet the purposes that CSAT sought. There are seven CSAT funded networks at this point in time. Four

of them are adult criminal justice networks and three are juvenile justice treatment networks. The juvenile networks are located in Denver, Colorado; Austin, Texas; and Lane County, Oregon.

DENVER JUVENILE JUSTICE INTEGRATED TREATMENT NETWORK

MISSION

The mission of DJJITN is to build on existing efforts to implement a culturally competent, comprehensive continuum of care across systems to meet the needs of the substance abusing juvenile offenders, at risk youth and their families. The DJJITN identifies the gaps and barriers to effective services and then collaboratively addresses those gaps through a systems change model. The membership is very inclusive - it includes every juvenile justice agency, state and city government agencies, families, family advocacy groups and public and private providers of education, employment, health, mental health, pro-social activities, substance abuse treatment and family services. Denver has been working on collaborative models for quite some time and actually built the DJJITN model on some early collaborative successes. Those successes included two other programs in Denver funded by CSAT. One program had a focus on the juvenile offenders who were abusing alcohol and other drugs ("AOD") and one was and still is our juvenile TASC program.

DENVER JUVENILE JUSTICE INTEGRATED TASC PROJECT

The TASC model began in the mid 1970's with a focus on the adult offender. It bridges the alcohol and other drug treatment community with the criminal justice community, utilizing case management to increase the likelihood of the offender's success in treatment. We adapted the TASC model for juveniles in Denver between 1990 and 1994. The TASC program focused on the community-based youth, which is under the Denver Juvenile Court Probation. Another program called the Pearl Project focused on youth in institutions that are within the Division of Youth Corrections.

JUVENILE TASC PRIMARY COMPONENTS

Multiple System Involvement

There were five critical components in these two projects that were the underpinning for the DJJITN. The first was multiple system involvement. Our juvenile TASC program, when we

implemented it, had a very simple goal - to increase the number of juvenile offenders who were abusing substances who were able to receive treatment. The second goal for that program was to implement continuity of care between the point of probation and the point of commitment. Three primary systems needed to be involved in that project to meet its goals. These included the Division of Youth Corrections, Denver Juvenile Court Probation and the state Alcohol and Drug Abuse Division.

Provider Network to Build Capacity and Capability

A second component was the establishment of a network of alcohol or other drug treatment providers. At that time the primary treatment model was hospital based, but the initial three to four community-based programs involved in the project were willing to examine their treatment practices in order to increase access for juvenile offenders and improve outcomes. Within 4 years the four treatment provider network grew to eighteen. Processes were created for training, for information sharing and for capacity and capability development.

Collaborative Oversight

The TASC activities had collaborative oversight. The juvenile TASC program was administered by all three of the previously mentioned agencies through contractual relationships and an oversight team from the three agencies met monthly.

Centralized Assessment, Referral to Treatment and Case Management

A system for centralized assessment, referral to treatment and case management was established. Prior to centralizing these functions, pilot programs had many of the initial participants managing all their own assessments and referrals individually. In a two-year period only twenty-five kids were referred to the project. Whichever agency to which they were referred was the only agency from which they received treatment. The move to centralization not only insured objective assessment and placement based upon standards for levels of care but also insured that the youth were linked to appropriate alcohol and drug treatment.

Family Engagement

The fifth component was family engagement. The Pearl program modeled this by including families in the assessment process; at that time it was unheard of for a correctional institution to do that. They also engaged the families by going out to their homes, instead of expecting them to drive many miles to the institution.

OUTCOMES

These programs had good outcomes. The TASC program showed a 19% reduction in the rate of recidivism in the year following termination and a 20% reduction in commitment. In addition, the TASC program showed an increase in the levels of positive social functioning by the youth. The number of youth in treatment jumped from twenty-five to over three hundred and fifteen per year over a two-year period. Until recently, however, there has not been a lot of research on what are the characteristics for success or what the programs should look like. However, we knew we needed a network.

WHY A NETWORK?

Many of the youth were not completing treatment. There was about a 37%-50% rate of completion. Granted, there is research that says that 50% of the youth are going to do okay if you just leave them alone, however, we did not know which youth would be included in that 50%. We did know that if we got the youth in treatment we would reduce recidivism and increase the level of positive social functioning. Also, we found that the TASC program was the first treatment experience for most of the youth who were now adjudicated and on probation or on parole. We wanted to be able to reach them at an earlier stage. The youth also have multiple needs and it was not only for alcohol and other drug treatment. Typically, these youth have been disenfranchised from school and from other pro-social institutions and 35% of them had co-occurring disorders of alcohol and other drug disorders and mental illness. Yet we did not have the linkages with the other providers and systems to offer comprehensive care. A statement by Elizabeth Shore in 1988 states this eloquently: "The Children's Defense Fund concluded that children's problems and need for services were often identified early and often repeatedly, but the services themselves seldom materialized."

DEVELOPMENT OF DJJI TREATMENT NETWORK

GOALS FOR THE DJJI TREATMENT NETWORK 1995

DJJINT goals are to ***expand the identification, assessment, case management and substance abuse treatment*** services to include youth at all points in the Denver Juvenile Justice System. Youth should not have to be on probation or on parole in order to access these services. We wanted to ***enhance the services*** to include mental health, primary health care, educational and vocational training and any other service that would make it comprehensive and meet the needs of the youth and their family. We had a long-term vision, which was to have people trained in their institution of higher learning who were ***trained in best practices.*** Therefore, we wanted to develop a Center for High Risk Youth Studies, which would provide cross training and develop a baccalaureate degree and certificate programs for current workers on best practices with high risk youth. Last but not least, we needed ***to develop a consistent management information system*** among the state and local agencies and community providers in order to ensure that we were able to have a continuity or continuum of care.

HOW?

The five components of a network, multiple system involvement, provider network capacity and capability, centralized assessment, referral to treatment and case management and collaborative oversight all required planning. A year-long planning process was undertaken to look at how business was done, what were the gaps and barriers in the status quo and what were the resources and/or under-utilized strengths that could be brought to implement the network. The outcome of the planning process was to develop a vision of how things could be and an implementation plan for the following four years of the project.

STRUCTURE FOR MULTIPLE SYSTEMS

A structure for the project was created. We had engaged about 350 people and involved them in the planning process. They represented 125 distinct agencies. The structure that was created is an "inside-out" hierarchy where the power is flipped. The structure was designed to engage all systems and agency expertise. The Denver Juvenile Court is the lead agency, however, it is located in the middle, not at the top.

STRUCTURE FOR MULTIPLE SYSTEMS AND THE PLANNING PHASE

A structure for the project was created. We engaged about 350 people and involved them in the planning process. They represented 125 distinct agencies including: education, AOD, juvenile justice, law enforcement, mental health, health, employment, pro-social and family services. The structure was designed to engage all systems and agency expertise. The Denver Juvenile Court is the lead agency. Subcommittees did the planning work in identifying gaps and barriers to a comprehensive system of care. The subcommittees were vocational, employment, education, AOD, allied social services, health, mental heath, pro-social adjustment, Center for High Risk Youth Studies and juvenile justice. Each person was asked, based upon personal or professional interest, to join one of these subcommittees. The work of the subcommittees was fed into what we call our Local Coordinating Committee, which was composed of chairs of all of the subcommittees plus administrative representatives of all public systems that were previously mentioned. The subcommittees were staffed with "loaned" managers from four public systems - the metropolitan State College of Denver, which is where our Center for High-Risk Youth Studies is located, the Division of Youth Corrections, the Alcohol and Drug Abuse Division and the Denver Public Schools. We paid for them to loan us, for one year, some of their best management people and we got their best. Their job was to staff the subcommittees and the local coordinating committee and they brought with them expertise from their own disciplines, and a feedback loop to their own systems, which helped to engage and maintain the engagement of those key systems.

The first step in our network development was to build a map so that we would know where we were going. We did this through a very simple visioning exercise. The question was, "It's the year 2001 and a system is in place that effectively services the AOD juvenile offender and family. What does it look like?" The only rules we had were to be creative, think globally and take risks. The task for the planning by the Local Coordinating Committee and subcommittees was answering these two questions: "Is treatment developmentally and culturally appropriate for the juvenile offender population?" And, "what policies, procedures and gaps in pro-social, education, mental health, employment and health systems are barriers to the delivery of effective integrative services?" Because people self-selected into these subcommittees to do this work, we had a very rich mixture of expertise and interest. Our education subcommittee, as

an example, had as members not only teachers and school managers and administrators and school social workers, but also alcohol or other drug treatment providers. Each of these committees had to look at that specific area or discipline and identify these gaps and barriers. All of the gaps and barriers identified by all of the subcommittees and the local coordinating committees fell into these areas: access, information, continuity of care, family, policies and procedures, culture, program quality, quantity and content, linkages, resources and training. They went through the process and came up with the implementation plan and the first thing the Local Coordinating Committee did to get the implementation plan kick started was to agree to eliminate all barriers to access to the centralized case management assessment referral to treatment for kids. The model they designed was that the public systems who are responsible for the AOD abusing juvenile offenders are responsible for screening and identifying which youth are more likely to be those needing treatment. They identified a screen that was developed to complement our assessment instrument, which is called the Substance Use Survey, developed by Dr. Ken Wanberg. Then they all agreed to the same protocol of screening and referring juveniles to our juvenile TASC program, which then performs a full blown assessment, gets them into treatment and comprehensive services, and provides case management.

Implementation Phase

We formalized the relationships with our network and entered into formal memoranda of understanding with our members. They all committed to working with the kids referred to them, to participate in training, to participate in MIS development, evaluation and other activities. Here are some examples of implementation strategies. Mental Health – the mental health subcommittee decided that we needed a mental health specialist assigned onsite with our juvenile TASC specialists. Our juvenile TASC specialists are trained alcohol and other drug treatment counselors. They did not necessarily have the comprehensive, holistic approach, so a mental health specialist position was created and placed on staff. That specialist has been involved in training the staff through consultation, as well as providing direct evaluations of kids and families as they are brought in, and then integrating the mental health plans into the AOD treatment plans. Putting a specific emphasis on co-occurring disorders included not only the mental health specialist. We also entered into a pilot of Multisystemic Therapy, with which many of you are probably familiar. The education subcommittee identified a need for the educational

liaison position to integrate education into the TASC assessment and services processes and to bridge the juvenile justice and education system processes.

We continued to do a lot of capacity and capability building. We trained 250 network members within our first year and a half on the same curriculum on best practices of working with the AOD abusing juvenile offenders and their families. Every discipline and system was represented in this. It really pushed the issue of family strength-based approaches to us as well. Every one of our cross trainings had a panel of family members on it. These were parents and some siblings of kids who were either co-occurring disordered or who were in need of AOD treatment. They told their stories on what it's like to be a family member and/or parent of a youth who is involved in the juvenile justice system. It opened the eyes of many of our people and was a very powerful way to educate us on how we respond to families, how families see us, and how we set up our own barriers to families. I give a lot of credit to our Colorado chapter of the Federation of Families for Children's Mental Health. I believe that there is a chapter in every state. I do not know if you have any connection with your local chapter but I highly recommend them. It is a fine advocacy organization. We also would train people on what was happening in the field. We had training programs on managed care assets in youth development. We did training on leadership for our local coordinating committees and subcommittees and on what is a management information system.

Information sharing: When we came into this, we were thinking that MIS was the least of our worries. Of all the networks, ours was probably the slowest in getting our automated management information systems started, but there are so many other critical areas around sharing of information that are beyond automation of the information that you share. We got very keyed in to the family strength based way of thinking on redundancy of data collection. Families answer the same questions over and over at every point of entry they have into the juvenile justice system and social services, child welfare system, the schools and any services to which they might be referred or with which they wish to engage. We wanted to have an impact on that and we also streamlined the intake processes. This led us to ask, "how are we going to share this information with everybody?" We developed, with the assistance of the State Department of Human Services, what we call a common informed consent form. A parent will sign and specify

the type of information that they are willing to have shared among network membership. They sign this once per year. The feedback from the families is very positive. They were tired of inappropriate information being shared, but more frequently they were tired of information not being shared among agencies. We had cases where families demanded that information be shared and the professionals refused to share it. We then had a multi-agency, multi-system common consent form and confidentiality issues came up. We developed an interdisciplinary, inter-system confidentiality manual for use by professionals. We then needed to train people on what can be shared and what cannot be shared, what can be shared without consent and what can be shared with consent.

Question: Was this all worth it?

Answer: Yes. We have seen benefits clearly at three levels, the systems level, the client level and the services level. At the systems level it was evident in the collaboration and operational pieces; at the client level in functioning and outcomes; and in services delivery at the service level. The preliminary findings on the systems benefits, based on our evaluation, were improvements in referral patterns of kids among systems, the flow of information, and case management practices within and among systems have improved. They see an improvement in the comprehensiveness of assessment and they see more visibility and improvements in family supports. By eliminating barriers to access and ensuring comprehensive services, a family or youth should be able to enter anywhere. The services have expanded in scope, duration and quality. They are more intense, the length of stay has increased and they are available. The family piece has also shown significant improvement. The family's involvement and parents' engagement in AOD treatment and the more comprehensive services, particularly mental health, have increased. There is a greater likelihood that the kids will abstain from AOD use and their ability to handle life problems has improved. They are better able to function in school, with their family, in a job and to stay out of trouble with the law.

Lessons Learned

If you embark upon doing a network kind of thing, one of the primary things I have learned is that you do not know what you do not know. You walk into a meeting and the outcome is so much better than the preconceived notion that you walked in with. It is amazing.

The network really does not look like what we thought it would. Our goal has remained the same and it created the framework for the activity. The network serves as an investigator of issues and of gaps and barriers, and it serves as an innovator. The network creates an environment within which things can be tried out across systems. It is an instigator. It is an incubator for those practices. Here is an example. One of the subcommittees, the Integrated Human Services subcommittee, had a strategy to create a single entry process for kids and their families coming into the system, expanding our scope beyond the AOD abusing juvenile offenders. They felt that there were inconsistent assessments and that if you could get to kids earlier, before they come into the system, it will keep them out of the system. We all have parents calling us, saying "my kid is out of control, can you help me?" If you are in juvenile justice, the first thing you say is, "has she been arrested yet?" If the answer is no, then you ask if they've tried social services. Chances are that they have tried them all. Nobody can provide that family with the assistance they need because they do not fit in a category or definition. The subcommittee was very passionate about that. We went through an RFP process with the Office of Juvenile Justice and Delinquency Prevention and got a planning grant for their community assessment center model, which matched what subcommittee strategy. We have implemented a family strength-based assessment, service coordination, and family advocacy process for at risk youth and juvenile offenders coming into our system. Our Juvenile Drug Treatment Court was relatively easy to put together because the cross system relationships already had been established.

Our network also has been involved in other related initiatives. We have a state mental health system of care initiative that utilized our network model of collaboration and the Denver Public Schools used our network model as a basis for a Safe Schools initiative.

Just a few thoughts on why it works: Recognition of the multiple needs of the AOD abusing juvenile offenders and their families, and engagement of all systems with a responsibility or expertise in need or strength areas. The engagement also means that you don't say no to anyone who wants to join. It is a totally inclusive, non-excluding model. You empower the expertise of each entity or person and focus on the integration of all of it. A network doesn't start as a group of experts. Everyone who comes in changes the network just by virtue of what they bring to the table.

CSAT CRITICAL ELEMENTS

CSAT, based on its experience with the juvenile justice treatment networks, came up with a list of critical components for juvenile justice networks. These critical elements include a planning process, a lead agency, public/private partnerships, identification of stakeholders, memoranda of understanding, a commitment from judges, management of the network, screening and assessment, case management, management information systems, training capacity, a self adjusting evaluation process and continuity of care.

> A quote from John Shaw, whom, I have been told, was a superintendent of the Minneapolis School District, describes the change process and the philosophical shift in approach that network development demands. His mission was to change the public education approach to children from a problem, or deficit based model, to an asset based model: "The future is not a result of choices among alternative paths offered by the present, but a place that is created. First in mind and will and created next in activity. The future is not some place we are going to but one we are creating. The paths are not to be found but made, and the activity of making them changes both the maker and the destination." Another wise quote from an anonymous person on change: "If you always do what you always did, you always get what you always got."

About the Presenter

Jennifer S. Mankey, MPA, is the Project Director of the Juvenile Justice Integrated Treatment Network, Denver Juvenile Court, Colorado. Ms. Mankey has worked to integrate and expand the comprehensiveness of treatment services for Denver's substance abusing juvenile offenders. She has twenty-seven years of experience in private and public sector juvenile and adult offender programs.

Contact Information:
Jennifer S. Mankey, MPA, Project Director
Denver Juvenile Justice Integrated Treatment Network
333 West Colfax, Suite 400
Denver, Colorado 80204
Telephone (303) 893-6898
Fax (303) 893-6848
Email jmankey@djjitn.state.co.us

JUVENILE JUSTICE INTEGRATED TREATMENT NETWORKS
CHALLENGES AND OPPORTUNITIES
Presented by Jennifer S. Mankey, MPA

NETWORK DEVELOPMENT

What makes a network run and be successful is a structure and process for collaboration, a common vision with guiding principles, information sharing, collaborative decision-making, collaborative implementation and capacity and capability building.

BARRIERS TO NETWORK DEVELOPMENT

The barriers to developing a network impede these essential elements for network development. Many of these barriers are political and are in the realm of power and control. One of the largest barriers for network development is the mistrust between systems and across sectors. This mistrust can arise from the different vocabularies in the different system such as the different languages between correction and mental health as well as from the contradictory statutory, legislative, federal, state and local initiatives in each system. Each system has evolved with its own goals and objectives and has different visions, different funding streams, different disciplines and different philosophies.

Unfortunately many collaborations are already happening with very little getting done and without true collaboration. These collaborative efforts undermine the efforts of creating possible more effective efforts. Why would you want to do a network or join another collaboration? Many times there is a lot of make work versus real work in collaboratives that are not working well.

Also, unfamiliarity with target population of the collaborative effort stalls network development. In our case we had many people who had never seen a drug abusing juvenile offender and therefore they questioned why they should be at the table. There might be unfamiliarity with other systems, no history of shared initiatives or just a sense of being overwhelmed and not having the time to sit down at the table with other agencies.

THE WORK OF THE NETWORK

Collaboration is not the goal; it is the means to the goal. The work needs to be strategic and be inclusive so entire collaborative wisdom can be incorporated. It needs to be innovative and centered on youth and family, not systems. If the collaboration process is happening, it will result in systems change, services integration, coordination and sector response, inter-department capability and improved outcomes.

STRUCTURE OF THE NETWORK

Kevin Kelly, editor of Wired Magazine, defines network as "structured relationships." The question then is what structures the relationship and what are the elements? There needs to be rules that structure the relationship, a recognition of roles and a definition of what or who you are.

We at the Denver Juvenile Justice Integrated Treatment Network see ourselves as more than the sum of what everybody is contributing and more as a brand new entity. However, this perspective varies across the membership with some seeing us as a point of confluence among systems and others seeing us more as a new organization and entity that has truly changed the way of doing business.

Dr. Robert Terry from the Terry Group in Minnesota identified the following required elements for the framework of an organization. These elements include a shared mission, meaning, existence, structure and power. The mission is your purpose, the meaning is what takes you to work every day, existence is the why and the resources to make it operate, structure is the organizational chart, processes, procedures, policies, rules and laws, and the power is the energy, motivation, morale, control, spirit and the decision-making.

PHASES OF NETWORK DEVELOPMENT

Networks phases of development can simply be described by two phrases, "Yes, But" and "Yes, and." A theater group that does management and organization training called Chicken Lips says that the worst word in a collaboration is "but" because it cuts off communication. When we get into a confluence where people are still holding on to who they are, there is a lot of

"yes, buts" and that negates a yes. It is only when that becomes "yes, and" through constant feedback loops where people are feeding who they are, what they are and their expertise and their weaknesses and strengths to create a new approaches does network development proceed.

LEADERSHIP

Leadership is critical to collaborative/network building. Leadership also is more important initially than later on. The emphasis is on leadership versus management. According to Dr. Robert Terry, the only leadership question you have to ask is "what is really going on?" A leader is able to ask that question and thereby begin the problem-solving process.

For the Denver Juvenile Justice Integrated Treatment Network, the local coordinating committee was the leadership entity and it was the positional leadership piece of Denver network and continues to be so. Some of the specific leadership tasks for this group of key public administrative representatives includes addressing policies and procedures in their own systems and then collaboratively problem-solving across systems, broadening their funding base, identifying the target population and keeping their eye on the environmental issues that might affect the network.

Leadership also emerged from all levels in the network, from administrative, service system and family levels in the Denver network. They represented many different models of leadership. Some leaders were position dependent and some people dependent. It was critical, however, that leadership was there to help lead changes in their own systems by stepping outside of the boundaries of their own systems. For example the probation officer might be asked to do things they have not done before such as contacting the parents when the child is not in school.

Leadership also is important in promoting the network vision and mission outside of the network as well as inside. The leaders have a function in motivating and guiding their own system on what is happening in the network. The 35 or 40 people at a local coordinating committee are representing thousands of people back in their own systems.

SYSTEM CHANGE

The change that the network is directed toward includes both changes in how business is done and how agencies relate to other system changes. Some of these changes include becoming client consumer focused, addressing the gaps and barriers in the continuum of care, contributing and changing language, accepting other service philosophies, maintaining a clear understanding of other systems and services, and accepting responsibility to change what is not working. This sounds so simple but it is very difficult in practice. Agencies become very interdependent on other systems and agencies and services. And if it is done right, agencies will also become interdependent with the family and the youth.

About the Presenter

Jennifer S. Mankey, MPA, is the Project Director of the Juvenile Justice Integrated Treatment Network, Denver Juvenile Court, Colorado. Ms. Mankey has worked to integrate and expand the comprehensiveness of treatment services for Denver's substance abusing juvenile offenders. She has twenty-seven years of experience in private and public sector juvenile and adult offender programs.

Contact Information:
Jennifer S. Mankey, MPA, Project Director
Denver Juvenile Justice Integrated Treatment Network
333 West Colfax, Suite 400
Denver, Colorado 80204
Telephone (303) 893-6898
Fax (303) 893-6848
Email jmankey@djjitn.state.co.us

**UNDERSTANDING THE ADOLESCENT WITH CO-OCCURRING DISORDERS &
DEVELOPING BEST PRACTICE MODELS**
Presented by Kenneth Minkoff, M.D.

OVERVIEW

This presentation focused on co-occurring disorders in adolescents, looking at an overview of the problem and the principles for successful treatment intervention in the context of an integrated model of service delivery that utilizes a common language and philosophy and makes sense from the perspective of both the mental health and the substance system. These concepts are seen as an emerging national best practice design for individualized clinical treatment intervention for individuals and families with co-occurring disorders, as well as a model for designing systems of integrated, comprehensive and continuous systems of care at the state, region wide or system wide level.

NATIONAL STANDARDS

Recently these concepts have been organized into a set of national standards for the treatment of people with co-occurring disorders. Although these standards were developed with more of an adult focus in mind they are applicable also for the treatment of adolescents and their families. The Federal government, through The Managed Care Initiative with the Center for Mental Health Services ("CMHS") in 1996, brought together experts and through a consensus process developed standards for the treatment of the various populations affected by managed care, being either the use of managed care organizations or through the use of internal managed care systems within agencies or public sector systems. The co-occurring disorder panel was chaired by myself, Kenneth Minkoff, M.D., and included people from both mental health and substance backgrounds, families and consumers from all over the country. The annotated bibliography (1997) and subsequent report, entitled *Individuals with Co-Occurring Psychiatric and Substance Disorders in Managed Care Systems: Standards of Care, Practice Guidelines, Work Force Competencies and Training Curricula (1998)*, can be obtained through the CMH Policy and Services Research web site, www.med.upenn.edu/cmhpsr or by phone order: 215-622-2886.

COMPONENTS OF THE CO-OCCURRING MANAGED CARE REPORT

The managed care report is divided into 5 parts. The first part is dedicated to the idea that if we are designing systems of care then they should be oriented to the needs of the consumers and families who are using them. It identifies the key principles of the system of care; welcoming, accessible, integrated, continuous and comprehensive.

The second part of the report is standards for designing systems to meet the needs of consumers and families. These include things like a mission statement, a philosophy, a set of principles and a structure for overseeing the system. It speaks of the need for an array of programs within the system that has standards or competencies for each program. In addition, it says that the system needs to develop other sets of materials for helping the system to establish that kind of welcoming accessible integrated continuous comprehensive model.

The third part of the report is practice guidelines for clinicians to follow that include assessment, treatment, rehabilitation, and psychopharmacology, for clinicians to follow to meet the standards of the system and to meet the needs of the consumers and families.

The fourth part of the report is provider competencies that include attitudes and values as well as knowledge and skills for clinicians to acquire to implement the practice guidelines, to meet the standards of the system, and to meet the needs of the consumers and families.

The fifth part is a training curricula that includes both models for designing competency-based curricula as well as about a half dozen sample curricula that were found around the country to train clinicians.

RELEVANCE OF THE MANAGED CARE REPORT

The report establishes real material for real systems to use even in the event that they had no additional resources for moving forward in the creation of more successful system level interventions. The intent was that this report could be used at any level of system organization. It can be used at a state level, a regional level, a network program level, an individual agency or a program within an agency.

Since the report was issued, a growing number of states and other systems are using this material to facilitate or catalyze system level change initiatives. States such as Pennsylvania, New Mexico, Massachusetts, Arizona, Louisiana, and Illinois to a certain extent are restructuring their services. Aspects of this system change also can be found in Washington, Oregon, New York, Florida, Texas, Michigan, and so on.

TRENDS IN CO-OCCURRING DISORDERS

These changes are being fueled by the emerging consciousness over the last several decades of the problems of co-occurring disorders in both the adult and the adolescent children's families service systems. First, to some extent this relates to pressures for deinstitutionalization. Even among younger children there is less likelihood that people will be maintained in sustained institutional environments.

Second, people are more likely to be retained in community based settings in which individuals have more access to and for people with emotional disturbances, a high likelihood of using, abusing and frequently becoming dependant on psycho-active substances. People have access increasingly to substance use at earlier ages and greater varieties and combinations and use of substances that is more psycho-pathologically dangerous in its ability to either initiate or exacerbate psychiatric symptoms and syndromes.

Third, another trend that is contributing to the awareness of dual diagnosis is a change in our understanding of the nature of psychiatric illness in general. During the past decade, the decade of the brain, there has been an explosion of research. A wide range of biologically based brain disorders, not just the most serious mental illnesses but an assortment of affective anxiety and trauma related cognitive impairment, have been identified. Behavioral disorders that we used to term personality disorders are all being recognized as having varying degrees of biologic impairment with them. Consequently there is also a wider array of psychopharmacologic agents to treat these disorders.

There is an increased awareness that these disorders are very common in the general population and 2 to 3 times more common in populations of adolescents with substance use disorders. People's symptoms and syndromes that once were attributed only to substance use disorders are now increasingly more likely to be recognized as representing distinct psychiatric disorders that require distinct treatment.

CHARACTERISTICS OF POPULATION

The population of people with co-occurring disorders, both adolescents and adults, present with many difficulties. One of the ways in which they are difficult is that they do worse. People with more than one problem do worse than people do with only one problem. We know that from the perspective of either system, people with co-occurring disorders are more likely to relapse and be rehospitalized, be treatment resistant, be treatment non-compliant and be medically involved. There is a higher risk for sexually transmitted disease among substance using and dually diagnosed populations. They also can be criminally involved. Among mentally ill offenders in the adult population, recent state studies indicate a prevalence of co-occurring substance use disorders in the 90% range. Most states will find a high prevalence of adolescent substance users among the adolescent offender population, usually 80% or more, of which at least half will be identified as having some kind of co-occurring psychiatric disorder.

In addition, there is a high prevalence of co-occurring psychiatric and substance disorders in the homeless population. This may not only include individuals who have co-occurring disorders but, when we are dealing with children and adolescents, it increasingly includes families who are dually diagnosed in which different members of the family have different disorders. All of this contributes to poor outcome including housing instability, vocational instability, educational performance problems, involvement with social service protective service systems around abuse and neglect issues and the like.

In addition, people with co-occurring disorders, adolescents and adults, are more likely to engage in violent and self-destructive behavior. Recurrent studies indicate that among emotionally disturbed individuals the presence of substance use disorders may be the most powerful predictor of either self destructive or violent behavior.

Moreover, individuals with co-occurring disorders tend to have poor outcomes from the perspective of a scarce resource service system. They are often over represented among the highest system utilizers, utilizing acute expensive resources in both mental health and substance settings. They may be experienced as system misfits. They are misfits at every level of the service system. These are individuals or families who are suffering from more than one disorder in systems of care that are designed for one disorder at a time. The programs within those systems tend to be similarly designed so that those of us working with real families and real systems are constantly experiencing a need to either contort our patients to fit our programs or contort our programs to fit our patients. These individuals also tend to be misfits at the level of our own skills as clinicians, since most of us are trained to be either mental health clinicians or substance clinicians but not both.

In addition, these individuals tend to be difficult in other ways as well because of how we encounter them in the service system. Some of the difficulties may come directly from the adolescents, while some of them are experienced more because the adolescents are embedded in families with multiple problems with often multiple locations, all of whom are difficult and in conflict with one another. These are individuals and families who present frequently in crisis and states of disarray. Adolescents are showing up often with impulses to harm themselves or others. They may be demanding instant relief. They are often using multiple categories of substances and multiple categories of psychotropic medication, all of which they are using in interesting and creative ways and about which they are also not terribly forthcoming.

As a result these people or families are difficult because they tend to stir up feelings in us. The feelings include feelings of helplessness, hopelessness, and despair as well as frustration, irritation, and rage. They often acquire the special labels we reserve for people who make us feel that way, "antisocial, manipulative, borderline, med-seeking, and sociopaths." It becomes very difficult to engage in these very difficult situations in a positive manner.

MODELS OF EVIDENCE-BASED TREATMENT

There are certain principles of care based on the variety of best practice models that have emerged. Most of the research is more adult specific but those models that do work specifically with families also incorporates certain common principles into their design. There are research models that arise from both mental health related research working with individuals with serious mental illness or emotional disturbances with high prevalence of substance disorders who are disengaged from treatment and from addiction research that identifies complex addiction populations of public health interest such as pregnant and parenting women, homeless families with co-occurring disorders, IV drug users, people with HIV infections and the like. These models incorporate certain common themes.

INTEGRATED INTENSIVE CASE MANAGEMENT

One of the most commonly looked at models is the concept of the integrated intensive care management team model. This has been most commonly studied in adults with serious mental illness in New Hampshire through the continuous treatment team approach. It involves creating a team of clinicians with multiple areas of expertise with access to psychopharmacology that offers direct clinical care and work with individuals and their families incrementally over an extended period of time.

MODIFIED THERAPEUTIC COMMUNITY

Other models incorporate what has been called the modified therapeutic community approach. This model starts with an addiction residential environment and integrates modifications to take into account people's psychiatric impairments. More flexibility is built in to accommodate people who have more symptomotology or functional impairment in terms of level of expectation. Continuity is built in to follow people as they move from residential settings into less intensive settings where they have more exposure to substance use. Continuity of relationship is maintained while allowing flexibility to allow for people to have the possibility of slips or lapses with treatment consequences without being fully excluded or extruded from the treatment relationship. Using evidence-based models as a starting point, the consensus panel attempted to identify generalizable principles of successful treatment interventions in wider populations.

PRINCIPLES OF CARE

Empathic Hopeful Continuous Treatment Relationship Over Multiple Treatment Episodes

All these models are similar to the work that has been done with complex addiction populations and they all have certain common treatment principles. For any kind of intervention the most significant predictor of treatment success initially is an empathic hopeful continuous treatment relationship in which integrated treatment and coordination of care are provided over the course of multiple treatment episodes. As adolescents and families bounce from acute episode to acute episode and from service system to service system they need someone to engage with them over time.

Outreach

Integration or the ability to provide mental health and substance treatment together in the same place at the same time alone is not enough. It is necessary but not sufficient. One of the key elements that research points to is the capacity to perform proactive outreach, both physical outreach and empathic outreach. The capacity to form a relationship with an individual adolescent or the system in which that person is embedded, regardless of the fact that neither the adolescent nor the members of the system may be aspiring to what would be called traditional treatment readiness or goals. It is the capacity to do empathic outreach and make a connection with people who are unmotivated or only intermittently motivated has been a significant predictor of the ability of these programs to work and be successful.

Continuity

The next aspect has to do with continuity, the ability to maintain or sustain a relationship over time unconditionally, even though people are not necessarily doing what is expected of them in the course of this ongoing connection. The relationship itself is the vehicle in which continuous treatment occurs and in which there is a process of continuous learning and growth. This may mean that different individuals or different members of the system may be engaged in interventions that are more mental health or more substance specific at any point in time. The key element is that there is a primary treatment connection in which all the diverse inputs are integrated into a person's centered coherent whole and that this relationship is maintained across

multiple treatment episodes. Both mental illness and substance disorders are chronic relapsing conditions and at any point in time the individual and/or family may or may not be involved and following treatment recommendations. Part of the recognition of how treatment works is that there is a continuous relationship in which from time to time people have an episode of care and the goal is to link these episodes together in a context of continuous learning.

Establishing the Relationship

The challenge is how to establish empathy, hope and continuity for people and families that we experience as system misfits. One of the ways of approaching this, at least from my point of view, is what I call my empathy mantra. My mantra goes like this. However much it may seem to the contrary, these individuals and families are not engaged in a complex conspiracy to drive me personally crazy. They are in fact doing their job. It is my job to understand their job so that I can join them in it and help them to do it better. This is particularly true for adolescents in whom the job of the individual at the time that we are encountering them is struggling with the very difficult task of identity formation. For an adolescent who has serious emotional disturbances and substance abuse and is a victim of trauma choosing an identity is very difficult. Neither the adolescent nor the families have an easy time signing on to the treatment recommendations that we so easily toss out, nor do they want to participate in the systems of care that we represent. The process of coming to terms with the reality of the changes that need to be made individually and collectively is a terribly arduous task that is normally made through a sequence of approach avoidance maneuvers. People do only a small part of what is recommended while trying to hold onto their sense of autonomy and control even in the face of poor outcomes. Our job is to recognize what a painful task that is so that we can join the adolescent and join the family in the terrible dilemma that confronts them of wanting to be normal and act normal but not being able to, of having to face choices of how to engage with a number of external systems, none of which are terribly pleasant. These are very tough choices.

To the extent that we can join people empathetically over time, present an integrated formulation or conceptual framework for them and help them to make these decisions more effectively over time we will be able to promote better outcomes. This task is the cornerstone of a welcoming approach in a system of care.

TREATMENT MATCHING

One of the next challenges is to recognize that as we are developing these kinds of continuing relationships that people with co-occurring disorders are a complex group. We need to recognize how to match systems and services according to the specific needs of these individuals.

Model for Subtyping Co-Occurring Disorders

One of the models that is emerging is a model for subdividing people with co-occurring disorders according to high and low severity of psychiatric and substance disorders. There are 4 general categories: high substance disorder severity and low serious emotional disturbance, high substance disorder severity and high serious emotional disturbance, low substance disorder severity and low serious emotional disturbance and low substance disorder severity and high serious emotional disturbance.

Individuals with High Serious Emotional Disturbances

The categories with high serious emotional disturbance ("SED") define a mental health priority population. These are people who are the priority targets of scarce mental health resources. In addition, within the larger category of individuals with SED, there is a significant sub category of the individuals who have the most significant impairments, that is individual adolescents who may have persistent psychoses, who are quite disorganized and dysfunctional who even at their best baseline when they were using no substances and taking all their medicine need fairly high degrees of structured care. For these individuals there are distinct clinical needs as well. They are less able to participate in generic substance services. More of their substance services as do all of their services have to be integrated into the mental health support system that manages their severe impairment. Children with SED who are higher functioning, when they are reasonably stable, may have a better ability and more likelihood to participate in generic substance treatment settings both in the community and various kinds of residential episodic treatment. Within the larger group of people with SED it is important to distinguish abuse and dependence, an issue that is also important with adolescents in general.

Individuals with High Severity of Substance Disorder Severity and Low Severity of Emotional Disturbance

Individuals that have substance dependence or severe substance abuse also can present with significant psychopathology in the context of their substance use. This pathology can relate to suicidal or violent behavior, psychotic symptoms which maybe substance induced, a variety of mood instability - anxiety, panic, depression, personality behavior traits, etceteras. Unlike children with SED who ordinarily meet criteria for serious emotional disturbance whether they are using substances or not, these children once they stop using substances for a period of time in a relatively short period of time, weeks or a month maybe at the most, they no longer appear to meet criteria for serious emotional disturbance. In some of these kids, once their substance use is discontinued, all their psychiatric symptoms appear to clear up. Increasingly we are finding, however, that there is a much larger population that still has psychiatric disorders but not necessarily serious emotional disturbances. They have an assortment of attentional problems, emotional problems, mood disorders and anxiety disorders with trauma histories and the like. These may not meet criteria for SED formally speaking but which nonetheless complicate the treatment of their substance use disorders.

In addition, in multi problem families with dual disorders members they may have a variety of combinations of substance symptoms and psychiatric symptoms without meeting the criteria for serious mental illness. What happens often is that these individuals may fall through the cracks of the treatment system the most because the children with SED become the responsibility of the mental health system. For the children without SED the responsibility for their on going care becomes much more murky. They may wind up in a social service, social welfare setting or criminal justice settings without clear accountability for integrating or coordinating their on going services in systems that are even less prepared to provide that integration than the behavioral health system. This group without SED and with co-occurring substance disorders becomes a population that requires distinct planning in the delivery of co-occurring disorder or dual diagnoses services.

Individuals Low Severity of Emotional Disturbance and Low Severity of Substance Disorders

Another group whose needs have not been met adequately are the low low people including the low low adolescent and the low low families. These folks don't realize that in our system it's very rude to present for behavioral health services without first knowing "which one" you are. People get screened into one or the other "box" based on how they present, often by a receptionist, and then both systems shuffle these individuals back and forth between the systems, with neither taking responsibility for their care.

CHALLENGES TO TREATMENT MATCHING

One of the things that this illustrates is some of the difficult challenges in developing an accessible system. In an accessible system we recognize that it is bizarre to think that people should be able to sort themselves into one box or another at the front door. This is an artifact that the system has established that we all sort of fall into. It is equally bizarre to think we should be able to sort them within a very short period of time. In an accessible system we take it that routinely people will show up with multiple problems. It may take time to sort them out and when they are sorted they will wind up in multiple boxes. The whole idea that the goal of our assessment is to figure out which box they belong in is something that we begin to eliminate. We reduce all of the barriers associated with that arbitrary distinction.

SUBSTANCE ABUSE AND DEPENDENCE

Substance abuse and dependence are in fact different disorders. They are of a greater significance when we are talking about adolescents compared to adults and they are even more significant when we are talking about adolescents who may have psychiatric impairments.

SUBSTANCE ABUSE

Substance abuse, according to DSM III R criteria, which allows for a more continuous diagnostic matrix for adolescents regarding abuse and dependence than DSM IV criteria, is a behavioral disorder characterized by people using substances unwisely and harmfully. Harm may occur in any area of an individual's life including exacerbation of a psychiatric difficulty and other problems. People who have substance abuse disorders have never met criteria for substance

dependence. They are presumed to be doing it more or less on purpose and in control although they are making risky choices. Sometimes when they use substances their behavior gets out of control but their use of substances is more or less in the line of what it is they are choosing to do. The outcome of substance abuse treatment involves one to one and group interventions to help people make better choices, and provide skills to implement those choices. The outcome may be abstinence, but does not need to be. The outcome of abuse treatment may be controlled non-harmful use.

SUBSTANCE DEPENDENCE

Substance dependence is a different thing. Substance dependence is a brain disorder in which, apparently, there are significant brain changes that may be irreversible. These changes certainly appear irreversible in most adults, so that the individual loses the ability to reliably control their substance use even when they want to; even when they try to and even when the harmful consequences of that use are so out of proportion to their own sense of what it is they are willing to tolerate. They are still unable to use in a controlled fashion.

The treatment of substance dependence is more intensive than for abuse. In fact substance dependency treatment tends to focus on the treatment of the disease of addiction, using more of an abstinence-oriented model. The treatment, compared to substance abuse per se, needs to be much more intensive to counteract what the brain is doing through a variety of chemical pathways to sort of talk people into using substances, even when they do not choose to or even when they know that it is harmful. The outcome of substance dependence treatment generally needs to be abstinence because even small amounts of use will trigger further lack of control.

One of the challenges of working with people who have demonstrated patterns of substance dependence is the recognition that, even though consciously they may want to not use substances, their brains are essentially on the other team. Their brains are triggered by an incredible array of internal and external conditioned cues to create chemical events internally in the brain that lead the brain to sort of direct the organism into addictive behavior. The target of that behavior is not the actual use of the substance but that the brain essentially has become addicted to itself in the sense of wanting to create internally its own internal states of euphoria or

euphoric relief that are chemically mediated. This becomes the primary focus of the organism progressively over time.

For people with healthy adult brains, by time they get into trouble enough with substances to wind up in the substance treatment systems they are often over the line into dependence or pretty close to it. The more that people have other than healthy adult brains, whether they are adolescents or they have neurological impairments, developmental disabilities, or psychiatric impairments, the lower the threshold of substance use that will be problematic and potentially harmful and the pattern of substance use that is abuse drops dramatically. With adolescents who have co-occurring psychiatric difficulties, their vulnerability to the harmful effects of the use of substances is lower than that of their peers.

PREVALENCE OF CO-MORBIDITY

There have been a variety of epidemiological studies over the past couple of decades looking at the prevalence of co-morbidity, primarily in adults. The indication is that whatever we know about adults, the prevalence of co-morbidity in adolescents is higher. In adults with serious mental illnesses the prevalence of co-morbid substance use disorders in household surveys, lifetime for adults in treatment for schizophrenia is 55% and for bipolar disorder 62%. For adults with alcohol dependence 39% have any kind of co-occurring psychiatric disorder; 56% of those with drug dependence have any co-occurring psychiatric disorder. These are higher with adolescents and they are higher the more that people are acute phases, in crisis, in trouble or entering into the service system. If we look at people who are actually admitted into psychiatric facilities for example, 60 to 80% may have a co-occurring psychiatric substance disorder that is active. For adolescents in treatment in addiction residential facilities the prevalence of co-occurring psychiatric disorder is similarly around 60%.

EXPECTATION NOT AN EXCEPTION

Dual diagnosis therefore is an expectation not an exception. The thing that is amazing about this principle is not so much that we don't know that it is true from our own clinical experience but that our entire system of care has been designed as if it is not true. In a system of care with scarce resources we have continued to organize all of our services in single disorder

service systems, guaranteeing that people with co-occurring disorders have the poorest outcomes at the highest cost. All the while, we keep wishing for new pots of money to develop specialized services for these "weirdoes" when, in fact, they are not "weird", but "expectable."

INTEGRATED SERVICE SYSTEMS

The problem is that there is never going to be enough money and that there needs to be another approach. If dual diagnosis is an expectation, then we need to plan the entire system according to that principle. We have to look at every aspect of the resources that we have across the systems and build the use of those resources based on the idea that dual diagnosis is an expectation. It takes an integrated system planning effort. It does not mean that we combine all the substance and mental health services funding together into one blended pot. In fact in many ways it is important that we maintain distinct substance specific treatment and mental health specific treatment. But it does mean we plan all of the ways in which that money is spent to deal with this issue wherever it goes in an integrated system planning effort with structures to oversee that planning.

In addition we recognize that integration of services has to occur at every level of the system organization. In other words, and research is increasingly starting to support this, if we look at best practice models of treatment they generally are individual demonstration projects funded to provide integrated services to individuals and families who otherwise would be disengaged from treatment. What the research is starting to discover is not only that integration has to be supported by proactive outreach and continuity but that isolated demonstration projects do not do the job as effectively unless they are supported within a total system context. Integration has to occur at the client level, program level, network level and system level.

PROGRAM LEVEL INTEGRATION

At the program level, what this implies is that all programs have to be dual diagnosis programs. It does not mean that they all have to be dramatically other than what they are so much that each program has to meet standards for competency in treating the people with co-occurring disorders that are already there. For example, there are in most states no regulations around standards for the treatment of co-occurring disorders for psychiatric inpatient units

despite the fact that in such units 50-80% of the people may have co-occurring substance use disorders in which the cost of services are the most expensive and most highly regulated. There are no standards for assessment, diagnosis, staff competency, treatment programming, treatment planning and discharge planning for the people who represent a substantial majority of the individual clients in that program. This is just one of many examples of where these basic standards and competencies need to be built into the expectation of all programs.

CLINICAN LEVEL INTEGRATION

The same thing applies at the clinician level. If dual diagnosis is an expectation then dual competency among clinicians needs to be an expectation as well. Even though substance use disorders are the single most common category of psychiatric illness, mental health professional programs routinely may not provide basic substance abuse training nor do substance abuse programs routinely provide basic mental health competency. There are specialized postgraduate programs but the question is why isn't it built into the pre-graduate programs. Basic competency needs to be built into routine expectations associated with licensure and certification and associated with people's basic job competencies in all behavioral settings.

OVERCOMING MYTHS

Genetic Predetermination

In order to achieve integrated care at the system, program and clinician competency level, we have to overcome some myths. One of the myths is what I call the myth of genetic predetermination. This states that people are genetically predetermined to be either mental health clinicians or substance clinicians and once they become one they can never ever become the other. This has been conclusively disproved; people who have acquired one set of skills to talk to people with one disorder can actually use similar skills to talk with people with different disorders.

Training

Another myth has to do with the myth of training. The training myth that is perpetrated by clinicians on their managers is as follows, "If you want me to work with those duals, I will do it but you have to train me first. Here is the thing about training, first of all, if I am not trained

first, I might make mistakes and that would be nasty. Secondly, I don't train easily. It takes lots of training before I feel trained." The truth is that none of us has ever been trained to do any of the things we do before we did them. The way to move people toward competencies is to create the expectation that this needs to be there. Give people some basics to get started and then provide supervision on the job so that people learn. Create a context in which it is okay to make mistakes and help people to become gradually better over time. This is part of a comprehensive approach to system change.

Irreconcilable Treatment Philosophies

Another thing that we have to do is move past the idea that there are inconsistent treatment philosophies between the two service systems that cannot be reconciled. These barriers have to do with the way in which treatment and treaters are validated within each field. The mental health system builds its relationships based on case management and care taking, with individualized nurturing wrap around support and flexibility. "We own our clients and we own them indefinitely, and we try to fix their problems proactively, whether they want them fixed or not."

The addiction system creates relationships based on empathic detachment. A connection is made with empathy but there is no assumption of responsibility for trying to fix everything that ails them. The philosophy is that people need to be confronted with the negative consequences of their own poor choices as a rationale for making different decisions baring some pain and in doing so work toward getting better. Also, the addiction treatment tends to occur in episodes. People receive an episodic intervention, return to their naturally occurring support system and are expected to use those skills to go forward. Of course, one of the dilemmas with adolescent treatment in particular, is that residential treatment puts them in an artificial environment and when they leave they may return to support systems that are not terribly supportive or sober.

Each system tends to look askance at what the other system does. The addiction people look at the mental health people and think they are just controlling and enabling because they are trying to do all this stuff for people and people are not doing anything at all. The mental health

people think the addiction people are cold and cruel because they are talking about people hitting bottom when the people may be on the streets engaging in self-destructive behavior, and they do not realize how "wonderful" it is that they have hit bottom. We have to figure out how to bring this together.

In addition, each system wants its own disease to be primary either for billing purposes or for clinical approach. The philosophy is that if the primary disease is taken care of first that will take care of everything else. This is a challenge because all of our schemes for figuring out which is primary, in adolescents in particular, never seem to work. In addition the adolescent does not want either disease, let alone both, so adolescents may try to throw us off the mark, whether through using "shifting denial", or by using our own denial of the comorbidity against us.

Shifting denial means whatever disease you want to talk about; I have the other one using the clinician's own denial to avoid addressing the issue. Shifting denial involves the assumption that the mental illness is causing the substance use or the substance use is causing the mental illness, and just forgetting the clinician's "more familiar" disorder will solve both problems.

PRINCIPLES OF SUCCESSFUL TREATMENT

How do we bring this together? We have to adopt the principle of mutual validation. Each system has something valid to contribute. If we are not familiar with how it works and why it works this is something that we need to learn. Mental health clinicians have to learn why addiction interventions are valid. Conversely, addiction clinicians need to learn that there really are such things as mental illnesses and people with substance disorders get them, too, and require similar treatments to stabilize their mental illness including medication as people without substance disorders do. We can bring this mutual validation together through adoption of the following principles.

Principles

- Co-morbidity is an expectation not an exception. At the clinical level this needs to be incorporated into a welcoming manner into all clinical contact.

- Treatment success derives from the implementation of an empathic, hopeful, continuous treatment relationships, in which integrated treatment and coordination of care takes place over multiple treatment episodes. Treatment needs to start with maintaining continuity. Data from integrated care management models for individuals who have high utilization patterns on out patient basis has shown that after a period of 6, 12, 18 months expensive utilization is reduced and harm reduction outcomes have improved. The reduction in expensive utilization precedes the attainment of absolute abstinence.

- In the context of the treatment relationship case management and care and empathic detachment are not mutually exclusive but absolutely complementary. That is for each individual, for each individual adolescent, for each individual family there is a right amount of what we need to do to support the things that they cannot do for themselves and at the same time each individual or system needs to be able to bear appropriately the degree of consequences that allows it to make better decisions and choices about the work that needs to be done to enter into treatment. The philosophical battles can be resolved into individual or family centered strategic discussions about the right place to draw the line for each system or individual at any point in time. The bad news is that there is no rulebook that absolutely tells you how to do this. The balance at each point in time is in accordance with the individual's motivation, capacity for treatment adherence, level of functioning, and extent of disability.

- When mental illness and substance disorders co-exist both disorders are considered primary. Two primary disorders, each of which requires specific and appropriately intensive primary treatment, integrated dual or multiple primary treatment. All disorders need treatment with as much treatment as it would need if it existed separately while also taking into account that the treatment may be more complicated because there is a co-morbid condition. In fact with co-occurring disorders people often need more addiction treatment not less to obtain a similar outcome. They will need more practice, more support, more rehearsal, and more repetition to achieve the same level of skill acquisition because their psychiatric illness will interfere with their skill acquirement.

- Finally to create an integrated model we need to move to a common treatment philosophy across both the mental health and substance system. Mental illnesses and substance dependence or addictions both are chronic biologic mental illnesses, which can be understood using a disease and recovery model. The parallels between addiction and major

mental illness are many. Both persistent disorders have both positive symptoms and deficit symptoms, stabilizing treatment regimes and are associated with denial, depression, despair, shame, guilt, failure, and stigma both on the part of the individual and their families. The process of working through these feelings is the process of recovery.

PHASES OF RECOVERY

Recovery is a hopeful term that comes through the mental health system from the substance system. It implies that even in the face chronic, incurable, unchangeable conditions that are associated with mental illness, dual disorders, trauma, homelessness, impoverishment and the like, there is a process of recovery by which people can emerge as well. People are able to recover or gain a sense of pride, self worth, hope, purpose and meaning.

The recovery process itself occurs in distinct phases. They include phases of acute stabilization, phases of engagement or motivational enhancement, prolonged stabilization, and recovery. What the research has taught us is not only the value of identifying these stages but that the treatment not only has to be divided into phases but it has to be phase specific. If we try to put pre-contemplators, adolescents or otherwise, in action oriented treatment it tends to backfire. The challenge of the work is providing phase specific interventions so that pre-contemplators become contemplators, contemplators become preparers, preparers move to action, and those in action move into maintenance. This model, in fact, not only defines specific interventions, it also defines measurable outcomes.

CONCLUSION

Within this integrated model we not only have a common language for talking about mental illness and substance disorders using the disease and recovery philosophy that can make sense for both mental health treatment and substance treatment, we actually recognize that there is no single set of interventions that is correct. For each individual adolescent and/or family the particular interventions have to be individualized according to subtype, diagnosis, phase of treatment, stage of change, and level of functioning or disability, which will determine the nature of the phase specific intervention that is required. It will determine the amount that we need to do for them versus where they have to take responsibility for themselves and how that relationship

will proceed over time. Within a managed care system, we have the further challenge of assessing level of care within which these interventions may take place. Models for vertical continuity need to be developed so that people can move through different levels of care, from residential to less intensive environments, with a continuous treatment relationship matching phase specific interventions as people's service intensity needs change.

This overall model allows us to do two things. One, it allows us to develop practice guidelines for individualized clinical service matching. The other thing it allows us to do is to design a comprehensive system of care in which each element of total systems supports these phase specific interventions in various ways. Within the context of this we have a design model for a comprehensive continuous system of care that matches the needs of adolescents and their families at each point of contact within the service system using a common language and treatment philosophy.

About the Presenter

Director of Integrated Psychiatric and Addiction Services for Arbour Health System, Kenneth Minkoff, MD, is a board certified psychiatrist with a certificate of additional qualifications in Addiction Psychiatry. He is nationally known for his expertise on co-occurring disorders and integration of mental health and substance disorder services. Dr. Minkoff has authored and edited numerous works on co-occurring disorders and is an experienced psychiatric administrator with considerable expertise in developing public and private managed care systems.

Contact Information:
Kenneth Minkoff, MD
12 Jefferson Drive
Acton, Massachusetts 01720
Telephone (781) 932-8792 x311
Email Kminkov@aol.com

ENGAGING THE ADOLESCENT AND FAMILY

Presented by Kenneth Minkoff, M.D.

OVERVIEW

This workshop emphasized the clinical application of treatment principles to the process of engagement. It focused specifically on engagement that occurs during the development of an initial treatment relationship and during assessment. It also included strategies for motivational enhancement with individual adolescents with their families, adolescents within their families and the adolescent and their family within the larger systems in which all of those are embedded.

INITIAL ENGAGEMENT

Engagement begins with the initial assessment. One of the challenges with adolescents can be the actual system that brings them in for treatment. As such it is important to establish a relationship in which you as the clinician can position yourself comfortably to move forward in the process of dealing with the myriad of issues. A set of mutual goals must be created that can be both supported by the individual and endorsed by the system. This process begins the very first time that you meet people, even before you have gathered information about the nature of what is going on. The process of establishing how to position yourself and engage people around their own individualized goals is an intimate part of the assessment process.

KEY ELEMENTS OF ENGAGEMENT DURING ASSESSMENT

WELCOMING/DETECTION

The first order of business is to hold a high index of welcoming for all persons for all their issues. You want to create a sense that whatever you hear is something that you expect and welcome. This proactive welcoming stance is critical to information sharing and gathering.

DIRECT INTERVIEW

Information should be gathered in a direct interview. When we are working with systems, figuring out whom we directly interview first is an important part strategically about how we approach the engagement process. The general rule is to identify who is the decision-making authority who established the treatment connection. The initial contact should be with that

person. If the parents are initiating the treatment contact, I am interesting in hearing from the parents about what their agenda for the treatment is so I have an understanding of their goals. The parent's goals may in fact be quite different from the goals of the adolescent who is being referred. This applies as well to adolescents who are engaged, not only with their family system, but also with other multiple systems of care. It can be that there is a system that is making the referral that has a set of agendas for how the goals of the treatment are and how they are established. I want to understand how those goals are articulated. Based on how those goals are articulated, I will try to follow a process for figuring how who to talk to, in what order, based on what people are asking. Directly interviewing the adolescent is an essential part of that process.

COLLATERAL SOURCES

It is routine as part of the evaluation and positioning process to have contact with all additional collateral sources. Information on their potential goals, viewpoints, and leverage is gathered using the same model for gathering information from each of them. The interview approach is non-judgmental, empathic, and detached.

INTERVIEW APPROACH

Empathy

Establishing the empathetic connection in this engagement process involves the recognition that all of the players in this drama which is presenting to you, the adolescent, the family, the divorced parents with their respective remarried spouses and children, the correctional officers and the school people, everyone in this drama including the adolescent is probably somewhere other than where you would like them to be. Part of your empathic process is to recognize that they all are in fact doing the best job that they can do within the context of who they are. All of them are experiencing challenges and dilemmas that in one way or another are painful. Some of the challenges and dilemmas involve the idea that there is a better way for them to be and yet there are resistances and difficulties getting there. It is fully empathizing with this position, recognizing the painfulness of this dilemma that is an important first step in creating a treatment connection.

Non-Judgmental Detachment

The second aspect of engagement is maintaining non-judgmental detachment. Detachment is a challenge for clinicians on either side of the system, mental health and addictions. We all are pulled in these treatment situations in different directions that undermine our detachment. One of the ways in which our detachment gets undermined at the individual level is that we experience a sense of wishing to be in control of things that we cannot be in control of. We wish to have the power to make this adolescent stop using because he/she is going to die or get into terrible trouble and we feel the need to rescue this person. Sometimes our detachment gets pulled in the other way. We are trying so hard and these people are just not listening to us and we want to blast through their denial. That also mitigates our detachment. Sometimes our detachment gets pulled with one aspect of the system or another. We totally accept and empower the choices the adolescent makes or we totally sympathize with the parents. Either way we get drawn into feeling that the solution is that there is something out there that we have to be in control of in order to have a successful outcome. Detachment implies that we become able to acknowledge both to ourselves and to the people we are dealing with the true limits of our own power. Not to do this, leads the people you are trying to engage to react against you.

Detachment does not come easily, so for myself, I use a detachment mantra. For substance abuse issues, it goes something like this. It is perfectly okay with me that you use substances as much as you want. Does this mean that I am recommending that you use substances, absolutely not? My recommendation to you, if you were to ask me, is probably that you don't use substances at all for a whole variety of reasons that you probably already know. What is most important is that I recognize that I can't make you do anything that you don't want to do and I am respectful of your choices, I will care about you the same whether you make the choices I think you ought to make or you make choices that are different from what I think you should make. Ultimately you are the one that needs to live with the consequences of your choices. My job is to help you to understand those consequences as clearly as possible and help you to articulate your choice making process as best as I can.

It is not sufficient to get yourself just in this detached position. In order to engage people, you have to find a way of communicating your detachment to them. Simple being neutral is not enough to let them know that we actually experience this non-judgmental, empathic, detachment. I find ways of trying to communicate this to people proactively and I try to do it early on. I want people to know that I am interested in how they think and what their choices are right at the beginning. Some of the things that I may say to a kid are, "many people in your situation find that using substances is helpful, is that true for you? If you are drinking and drugging, and you like it, why don't you do it even more than you do? I genuinely want to know." I am assuming that at any point in time, people are making a variety of decisions about what they do and what they are not doing and I want to get a clear idea of their decision-making process. The same kind of decision-making processes apply to any member of this particular drama and knowledge of this is important as we try to determine how to position ourselves in relationship to a complex system.

Hope

Another aspect I try to establish at the beginning during the assessment process is the communication of hope. One of the things that we frequently encounter, particularly with adolescents who are in very complex and difficult situations is a sense of pervasive despair for both the adolescent and their families. The reality also as we approach stopping the substance use, is that they will continue to experience pain or perhaps more pain. The dilemma is that we may feel that they are right, there is no hope, and so we wind up contributing to the charade. However without being able to talk meaningfully to people about hope, a lot of the rest of what we do gets lost. So how do we deal with the provision of hope? It is the provision of empathy and hope simultaneously with detachment that forms a powerful engagement hood for each of the members in this drama.

Acknowledge the Reality

From my point of view, providing hope is a three-part process. The first part of hope involves having the courage to acknowledge the reality of the individuals despair. One of the things that I try to do is to put the unspoken horribleness of the situation right out on the table. I put it into words, based on my feeling about what that person is sitting with. When we

communicate that we understand the reality of someone's despair, we are communicating a couple of things. The first is that we are saying I understand how you really feel and I am not afraid to say it. Two, you feel the way your situation is, is unbearable, but I'm letting you know it isn't, because I'm willing to bear it with you here and now. Three, you feel that there is no way out, but I'm saying that there is, we may not know what it is at the moment but I'm willing to join you in your despair and sit in it with you until we find a way out.

Entitled to Help

The second aspect of hope is help. One of the reasons people often feel helpless is that the things they have already tried have not worked and that they feel like the act of getting help is more help than they should have asked for in the first place. We need to both acknowledge how terrible the problem is and at the same time acknowledge that because it is such a terrible problem, people are entitled to receive as much help as they possibly can for as long as they possibly can to sort it out and have a solution.

Vision

The third aspect of hope is being able to create for people a vision of what a hopeful outcome can be in the face of the horribleness of their existence. You support the possibility that one day they will feel really proud to be a person, not only in spite of but also because of their adversities, and they can over come each and everyone of these adversities on a daily basis. Their vision of who they can be is open-ended, any possibility remains possible. You support that possibility, however impossible it may be that they can achieve that goal or the feeling equivalent of that goal.

HISTORY
LONGITUDINAL STRENGTH BASED HISTORY

The next aspect is how to move forward to develop a strategy to engage people in treatment around their own perceptions of what is going on and how treatment can be beneficial. However, the initial part of that process is organizing the assessment data into an integrated longitudinal strength based history. Longitudinal implies the data is chronological. Adolescents

and families tend to be poor historians, especially in relating cause and effect, so by using a longitudinal sequence time line some of the connections can be discerned.

The history is also integrated. Integrated implies in this context that the mental health and substance abuse information is combined at each significant time point in the longitudinal sequence. This is important because we are interested in gathering information about how mental health symptoms and substance symptoms interact. Often we feel like we do not have sufficient diagnostic data because people usually come to us when both sets of symptoms are more or less out of control and we do not have much information going forward. We do have information going backwards and gathering that data interactively in the past can be very helpful diagnostically in the future. The other reason that it is important is because routinely our history taking instruments do not encourage us to integrate this data. Integrating the information in the time sequence will give you more data about how the actual process moves forward and how these symptoms move together and the person's perception of how these things moved together.

STRENGTH AND FUNCTIONAL BASED HISTORY

Strength based and functional based history is also part of the foundation for determining treatment needs. The more impaired a person may be the more important it is to develop interventions that build upon their existing strengths rather than focus on correcting all their "deficits." In approaching people in a situation that is inherently judgmental, being able, to talk to people about what they have done well becomes incredibly important. In addition, looking at symptoms in isolation without looking at people's functional capacity gives a misleading impression. A person's functional capacity in relationship to their symptoms as they are negotiating the normal life tasks and sequence gives a clearer assessment with which to build a treatment plan with interventions that are built upon behaviors that have been successful.

During this assessment process, engagement with the individual occurs getting details about their situation. One of the things that people tend to do that creates distance and disengagement is to ask fewer questions about the things you know least about or the things that make you the most anxious. This is the time to push yourself to ask more questions, more details about people's substance using experiences or the efforts of different family members to deal

with or develop different interventions. The less I feel like I know exactly what is going on, the more detailed information I want, not that I will necessarily know at the end of getting all this detail what to do about it. In fact, part of the detachment is feeling comfortable gathering a lot of information and having the people look at you and say, "and?" You have to say that this is a big, serious, messy problem and I don't know what to do about it right now, but we're going to try to figure it out. Getting details allows me to have a clearer idea about the contingencies that operate in people's environments and begin to help formulate a picture of interventions that are specific to the details of their real life circumstances.

DETERMINATION OF TREATMENT NEEDS

MOTIVATIONAL ASSESSMENT GUIDE FOR INTERVENTION WITH CLIENTS ("MAGIC")

Determination of treatment needs occurs not just on your own formulation of what you think the recommendations but most importantly from what the people you are working with think is going on. There is a tremendous risk of presuming you know what is going on without having any idea of whether that is connected at all to the adolescent or the family's decisions about treatment within the context and contingencies that are presenting themselves to them. In addition, in adolescent systems it is typical for people to have many different ideas and different perceptions about what is going on. Those different perceptions between different members of the system and the persons own presentation is viewed as an "informational inconsistency," versus lies. "You said that you haven't used for three months, your mother said you've been using every night. Why is she saying these terrible things about you behind your back?" Always try to deal with the dilemma as it is presented. In the MAGIC model the focus is on continually asking questions and engaging the adolescent and the family around the possibility that there may be something that they can learn to do differently without challenging the idea that they have done anything wrong and without implying that there is something wrong with what the are doing. The focus is simply trying to help them to try to decide whether or not if there is something they can do that might help and it might be in their interest to learn what it is.

The challenge of developing motivational interviewing is that we are looking for opportunities within this structure where things can actually go wrong, so the challenge of a detached stance is that when you present people with motivational possibilities, the choices they

may feel free enough to choose may or may not work. The key of a motivational enhancement strategy is that you position yourself empathetically with people and then you leave it to them to make those decisions and choices and bear the consequences of those choices in the context of some kind of ongoing relationship.

An example of this technique for the adolescent who is returning home to parents who are actively using is the following. You approach all of the people in that dilemma with the set of choices that they are going to make regarding their substance use or not and figure out whether that is a reasonable strategy and work with the kid to say, what are the things that you can do to deal with the fact that your parents are using. Would you choose to live elsewhere, do you think you would be better off in a more sober environment? If you want to try to do this, what are the supports that you need in order to be successful and then you are developing an intervention that says you can try to do it this way but if it doesn't work then you will probably need more help or more structure to proceed.

In groups, motivational enhancement strategies operate by enlisting the group processes and involving members of the group in listening to each other's decisions and choices. Members of group begin to recommend and apply choices to others that they may not initially choice for themselves. In the process of doing so may begin to internalize those choices. The group becomes a very powerful strategy for facilitating motivation in people who are resistant.

About the Presenter

Director of Integrated Psychiatric and Addiction Services for Arbour Health System, Kenneth Minkoff, MD, is a board certified psychiatrist with a certificate of additional qualifications in Addiction Psychiatry. He is nationally known for his expertise on co-occurring disorders and integration of mental health and substance disorder services. Dr. Minkoff has authored and edited numerous works on co-occurring disorders and is an experienced psychiatric administrator with considerable expertise in developing public and private managed care systems.

Contact Information:
Kenneth Minkoff, MD
12 Jefferson Drive
Acton, Massachusetts 01720
Telephone (781) 932-8792 x311
Email Kminkov@aol.com

<p style="text-align:center">STANDARDS OF CARE</p>
<p style="text-align:center">Presented by Kenneth Minkoff, MD</p>

THE NEED FOR SYSTEM CHANGE

Dual diagnosis is an expectation not an exception so in order to develop appropriate interventions within our scarce resource system for people with co-occurring disorders, we need to look at change throughout and at every level of the system. We need to move beyond the idea that dual diagnosis interventions are only specialized interventions that require specialized funding. Collaboratively we need to figure out how to use our joint resources to achieve the goal of dual diagnosis services in all programs.

HOW SYSTEM CHANGE OCCURRS

Integrated service system planning happens more and more frequently across the country as awareness increases about the issue of dual diagnosis. One of the ways in which these initiatives have been supported at the Federal level is through Community Action Grants. The Federal government has discovered in recent years that although they have funded many demonstration projects that have established best practice models, people do not use them. There are many more established best practice models than there are models in use around the country. The purpose of the Community Action Grant, therefore, is an attempt to take existing models of successful treatment and figure out how to implement them in real systems. Typically this process of system change occurs through a process of building consensus within a system around a particular best practice and then building on the consensus to develop an implementation plan that identifies barriers to using the models and strategies for overcoming the barriers.

MASSACHUSETT'S EXPERIENCE

One of the first Community Action Grants to address dual diagnosis issues on a systems level started in Massachusetts in late fall 1997 (fiscal 1998). Massachusetts identified a comprehensive, continuous, integrated system of care ("CCISC") model and built consensus for the model and on how to implement the model throughout the state. Similar Community Action Grant processes are currently funded in Arizona and Louisiana. Other states, like Pennsylvania, are doing this without the benefit of a Community Action Grant. For system change, the

emphasis is on the process of consensus building. It is an active process in which people at various levels of the system actually sign on in a formal way that they agree with the model that is being presented and support its implementation. This is actually quite a challenging process for people to wrestle with, especially where there are controversial philosophies like with co-occurring disorders. One of the things that was done in Massachusetts to build consensus was to use the technology of continuous quality improvement ("CQI") to create a formal structure for building consensus. This can be done by creating a centralized leadership group that is empowered to develop goals with measurable objectives which then involves the participation of front line people in a bottom up structured process. In Massachusetts this was done by creating a leadership council with representatives from the Department of Mental health, the Bureau of Substance Abuse Services (which is in the Department of Public Health), the Division of Medical Assistance, the statewide managed medical MCO (Massachusetts Behavioral Health Partnership), consumers and family constituencies from both mental health and substance areas, provider constituencies from mental health and substance areas, and key legislators. A CQI facilitator was hired to facilitate the process and create regional work groups in each state region with input from front line clinicians, consumers and families. It took about a year for the community consensus building collaborative to arrive at a consensus that the entire state then signed off on.

MASSACHUSETT'S CONSENSUS DOCUMENT

Key elements of the developed consensus document for the care and treatment of individuals with co-occurring psychiatric and substance disorders in Massachusetts include the following. There is a preamble that says people with co-occurring disorders experience many difficulties and that they are too often not well served in the current service system. Therefore, all of these groups collectively are willing to address the needs. This willingness for shared responsibility is in writing and key people signed the document. The consensus document states that the named constituents will address co-occurring disorders according to the principles in the document to which they agree, to plan collaboratively how to use all existing resources to support this goal, to identify which components cannot be meet with current resources and to recommend collaborative strategies for funding to fill the gaps over time.

KEYS TO CONSENSUS BUILDING

One of the keys to this process was that from the beginning money was taken off the table. Thereby there was an opportunity for people to talk about the model that they wanted to adopt without being immediately concerned about how it was going to be paid for. The emphasis was on what are we going to do differently with the money we have, rather than what new monies are we going to find. A process like this, if properly facilitated, builds trust and a solution that everyone supports.

Complex bureaucracies are fragile systems that require special attention to support change. They respond poorly to criticism. They also tend when under stress to use primitive defense mechanisms of splitting and projective identification much like children and families under stress. Bureaucracies respond much better when you approach them in an empathic, hopeful, strength based way, building upon their strengths to give them courage to move forward. It is helpful to create opportunities for safe play. Consensus building is such a safe play opportunity; you bring the agencies together and give them a project that is designed to succeed. As they engage in safe play, they find that there are areas of communality, which they may not have experienced. They begin to build a certain amount of trust. They begin to take more risks. This consensus building model can take place, not just at the state level but at any level. It can be done in our agencies, in our programs, to create a network among agencies, or in any number of ways.

PRINCIPLES OF CARE

In Massachusetts, co-occurring disorders was the first real consensus building issue that was addressed within the State. Initially they limited their agreement to serious and persistent mental illness but now after a year and a half later they are discussing the possibility of expanding the principles to a broader population. The principles also have been adopted and extended by other projects such as a federally funded initiative to address the needs of women who were victims of violence and trauma with co-occurring disorders. The principles defined involve issues of integration, continuity, comprehensiveness, quality and implementation. They include agreement on disease and recovery models, common language, phases of treatment, peer support, phase-specific individualized treatment interventions, etceteras. The principles around

implementation were modified, extended and ultimately adopted by the American Association of Community Psychiatrist (AACP) to create a national set of principles. The final draft is in the AACP web site, www.comm.psych.pitt.edu. It defines that successful implementation involves the creation of an infrastructure with the power to oversee and direct the implementation processes. Quality monitors including structure monitors, process monitors and outcome define and support successful implementation. Structure monitors may include things like the number of programs that have adopted consensus principles or the number of programs that meet certain standards that are established. Outcomes include things like consumer and family satisfaction with the welcoming or accessibility of the system. Outcome might be the number of people with co-occurring disorders that exhibit reduction in utilization over time; high utilizes who become lower utilizes as a result of interventions. Outcome measures also involve documentation of people moving through stages of change over what time period. Process measures involve looking at things like treatment planning. A simple process measure is the diagnosis documented in the record and whether the assessment process identifies the phase of treatment with phased matched interventions. In the treatment plan, it might mean are both substance use and psychiatric problems identified and there specific interventions for the substance problem as well as for the psychiatric problem documented. In addition to system level change strategies, implementation involves change at the program, clinical practice and clinician competency level.

On the program level and clinical practice level there are a number of standards that can be put into place to support standards of care (see below for a discussion of program standards). Comprehensive strategies for flexible funding streams need to be identified. In addition on the clinician competency level, required clinical competencies and a comprehensive training evaluation plan to support achievement of these competencies can be implemented. One of the strategies that can be developed at any level of system organization is building consensus on what basic competencies all clinicians should be expected to have within the program.

An example of developing clinical competency is a project that we did in the Arbour Health System, that I was working in, which has three private mental health institutions, 16 outpatient clinics and a senior care nursing home consultation division. We created a dual diagnosis task force that adopted a mission statement and a set of principles. One of the projects

that we took on was the establishment of basic competencies. We took the national standards and distributed them to the members of our group and said everybody pick out at least two attitudes, two values, two areas of knowledge and two skills that you think everybody in our system should have regardless of who they are and where they work. We then condensed it into a list that was adopted by the board and incorporated into a human resource policy. We developed a competency exam for the adult clinicians and now are in the process of working on a children/adolescent exam. The exam has about 40 questions and has a self-learning workbook so that people can actually do the exam using a set of articles that answer the questions in the exam. Thereby, we were able to establish within this complex organization a set of mandatory basic competencies on substance use and dual diagnosis that was set up in such a way that we could easily require every clinician to have these competencies built into their basic orientation. We found that people who had taken the exam found it useful and stimulating. The next challenge is to create a continuous training plan so people continue to build upon their competencies as they go along. We are thinking about developing a state wide training strategy that is similar in design to the way in which we do competency around non-violent de-escalation and restraint. As such there would be an established set of skills with certified trainers that could recertify staff on a regular basis. An established curriculum would be created, reviewed and updated by a centralized curriculum development committee that would include senior people in the field. The whole process would fit into the regular and routine bureaucratic structure.

AMERICAN SOCIETY OF ADDICTION MEDICINE PATIENT PLACEMENT CRITERIA

All programs, in order to meet the expectation that people in their programs have co-occurring disorders, need to offer dual diagnosis programming. This implies that we need to start to create dual diagnosis program standards and competencies for all clinicians. In addition, incentives with special licensures or certifications such as a career ladder for more advanced clinicians need to be created. One way in which we are moving toward this has been through the American Society of Addiction Medicine ("ASAM") patient placement criteria. The ASAM criteria are a multi-dimensional assessment set of tools, in which there are fixed dimensions for assessment for level of care determination. The assessment dimensions are the following: intoxication withdrawal risk or potential; biomedical complications; emotional behavioral complications; treatment acceptance and resistance; relapse/continued use potential; and

recovery environment. The ASAM criteria were originally developed in 1991 and in the next version, PPC2, which came out in 1995, were made more user friendly and describes a larger array of services such as early intervention, opioid maintenance, sober housing, half way housing, therapeutic medically monitored detoxification, not explicitly described in the first edition. Currently, it is again being revised and PPC2R is due out April 2001. The PPC2R incorporates more intensively dual diagnosis issues overall and has much more variation and severity on dimension three, emotional/behavioral. David Mee-Lee, M.D., is the chair of the national committee working on the ASAM criteria.

ASAM PPC2R

The PPC2R has developed a way of categorizing addiction programs according to their dual diagnoisis capability: Addiction-Only Services ("AOS"); Dual Diagnosis Capable ("DDC"); and Dual Diagnosis Enhanced ("DDE"). AOS accepts people with dual disorders irregularly and does not routinely address dual diagnosis in their treatment. DDC, in contrast, routinely accepts people with co-occurring disorders, provided that the symptoms and functional impairment associated with those disorders while they are in the program do not substantially interfere with the person's ability to participate in treatment. This means that the programs have to have policies and procedures regarding the assessment, treatment planning and discharge planning for dual disorders. It has to have programming that talks about medication and presence of co-occurring disorders and integrates that discussion into discussing addiction recovery. There are policies and procedures about providing medication that is routine and comfortable. There is a mechanism for accessing mental health and psychiatric consultation on a routine basis that ideally is integrated into the treatment planning process. Staff has to be cross-trained in basic competencies relating to their implementation of those program policies.

DUAL DIAGNOSIS CAPABLE

Funding for DDC programs typically would occur the same way as regular addiction programs are funded with the addition of a mechanism for obtaining the mental health input. In some states the addiction programs are becoming a priority for psychiatric consultation with the recognition that all addiction programs should have access to this consultation routinely. Sometimes this can be done through blended or braided funding in which you create the

possibility or the facility to actually have the mental health clinicians bill for mental health intervention under mental health dollars even though they are doing within the context of an addiction program. It can be an outreach project under a mental health license or it could be one program operating with two licenses with two billing streams. In some states, like Massachusetts, the state wide managed Medicaid MCO gives a lot more flexibility about creating new billing structures while in other states Medicaid can be very restrictive.

Another way of getting funding in place is through advocacy. However advocacy has to be targeted for this issue. One of the problems is that routine advocacy usually focuses on the amount of money in the budget while more change can actually be gained by focusing on the regulatory side. For example, a reasonable legislative advocacy target might be for the legislature to pass a law saying dual diagnosis is an expectation not an exception and we mandate that the licensure requirements facilitate integrated treatment as a more cost-effective treatment. The advocacy also might facilitate the ability to bill for two primary disorders under Medicaid within the state regulations. In these examples the legislature would then have the authority to direct the administrative departments to figure out how to carry out its mandate. A novel approach that is working in Massachusetts is the idea of performance based quality oriented incentive funding. Funding is based on the quality, not just the utilization. The managed Medicaid entity makes more money by meeting the quality parameters than by restructuring utilization. These quality parameters include dual diagnosis outcome variables and training variables.

The ASAM criteria therefore are very relevant because managed care companies can build their criteria from what is in ASAM. In addition, managed care organizations ("MCO") can use established national principles of treatment to initiate more successful treatment models. For example, Massachusetts is just beginning to invest in continuous treatment team models with some shared initiatives between the Department of Mental Health and the MCO. They also created community support workers who can be attached to outpatient treatment teams to support more intensive engagement efforts that can support continuity in care.

DUAL DIAGNOSIS ENHANCED

The next category is DDE, which are dual diagnosis enhanced services that meet criteria for DDC services plus they can work with people who are more psychiatrically unstable or functionally impaired. DDE programs have more integrated and flexible programming with more involvement by mental health clinicians and psychiatry, staff are cross-trained with availability of senior mental health supervision, the staff to patient ratios are higher, they are more able to maintain continuity if a patients slips and are more costly. One of the models in Massachusetts, the Dual Diagnosis Acute Residential Treatment, is a 14 to 28 day program that costs about $250-$300 per day. That is about twice the cost of other residential programs and about half an inpatient cost, so it fills a gap within the system of care. What we are asking the ASAM task force to recommend as a benchmark is that all addiction only services become DDC and that in any system of care at each level of care there is at least one program that is DDE. Similarly, this benchmark can be applied to mental health programs and all programs would be capable and there would be a planned array of programs that were DDE. However, for mental health programs adding substance treatment is less costly. It can be built into the competencies of staff with training and supervision without changing the fundamental costs of services.

Program standards for DDC and DDE would be established. Program philosophy, policies and procedures would be require for co-occurring disorders including assessment, assessment instruments, treatment planning with phase specific treatment and motivational interventions, discharge planning and mandated staff competencies.

Practice guidelines also can be established as a way of structuring or creating standards for clinical practice. An example of a practice guideline includes phase specific assessment and treatment that is individualized accordingly. Harm reduction and abstinence orientations, for example, are both valid interventions provided that they are appropriately matched to individual's phase of treatment and diagnosis. For most adolescents, a lot of time is spent doing harm reduction, motivational enhancement interventions and dealing with people who have problematic substance use. Through these interventions the adolescent may come to realize that no matter how little they use they still get into trouble and choose abstinence or come to recognize that they have substance dependence and abstinence is the only thing they can do

because no matter how little they use, they lose control. Part of what the practice guidelines tell us is how to match treatment accordingly.

Another example of practice guidelines involves psychopharmacology. Psycho-pharmacology practice guidelines are one of the ways that I recommend that physicians get involved in the system change. Creating guidelines and a peer review process to enforce the guidelines can support better dual diagnosis practices. Those guidelines should include the following principles: initial psychopharmacologic evaluation of mental health should not require consumers to be abstinent, initial psychopharmacologic evaluations and substance evaluation should occur as early in treatment as possible and psychopharmacological interventions should incorporate the capacity to maintain existing nonaddictive psychotropic medication during detoxification and early recovery. If someone has a serious psychiatric disorder, medication for that disorder should be initiated and maintained even in the face of continuing substance use. If someone has as serious mental illness where without medication they would decompensate, you maintain medication regardless treating it aggressively while continuing to assess while you are continuing to work with the individual around maintaining sobriety. Standards become a way of influencing practice so people are welcomed into treatment, continued and engaged appropriately.

About the Presenter

Director of Integrated Psychiatric and Addiction Services for Arbour Health System, Kenneth Minkoff, MD, is a board certified psychiatrist with a certificate of additional qualifications in Addiction Psychiatry. He is nationally known for his expertise on co-occurring disorders and integration of mental health and substance disorder services. Dr. Minkoff has authored and edited numerous works on co-occurring disorders and is an experienced psychiatric administrator with considerable expertise in developing public and private managed care systems.

Contact Information:
Kenneth Minkoff, MD
12 Jefferson Drive
Acton, Massachusetts 01720
Telephone (781) 932-8792 x311
Email Kminkov@aol.com

Bibliography

Brady, K.T. (1998). Comorbidity of Substance Use and Axis I *Psychiatric Disorders Medscape Mental Health, 3*(4).
http://www.medscape.com/Medscape/psychiatry/journal/1998/V03.N04/mh3149.brad/mh3149.brad_01

Carey, K.B.(1995). Treatment of substance use disorders and schizophrenia. In A.F. Lehman and L.B. Dixon (Eds.) *Double Jeopardy: Chronic Mental Illness and Substance Use Disorders.* The Netherlands: Harwood Academic Publications, pp. 85-108.

Center for Substance Abuse Treatment (CSAT) (1994). *Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse: Treatment Improvement Protocol (TIP) Series #9.* DHHS Publication No (SMA) 94-2078. Rockville, MD: U.S. Department of Health & Human Services.

Deegan, P.E. (1988). Recovery: The lived experience of rehabilitation. *Psychiatric Rehabilitation Journal, 11*(4), 11-19.

Drake, R.E., Bartels, S.J., et. al. (1993). Treatment of substance abuse in severely mentally ill patients. *Journal of Nervous & Mental Disorders, 181,* 606-611.

Drake, R.E., McHugo, G.J. & Noordsy, D.L. (1993). Treatment of alcoholism among schizophrenic outpatients: Four year outcomes. *American Journal of Psychiatry, 150*(2), 328-330.

Drake, R.E. & Mercer-McFadden, C., et. al. (Eds.) (1998). *Readings in Dual Diagnosis.* Columbia, MN: IAPSRS.

Drake, R.E. & Mueser, K.T. (Eds.) (1996). *Dual Diagnosis of Major Mental Illness and Substance Abuse: Volume 2: Recent Research and Clinical Implications. New Directions for Mental Health Services, No. 70.* San Francisco: Jossey-Bass.

Evans, K. & Sullivan, J.M. (1990). *Dual Diagnosis: Counseling the Mentally Ill Substance Abuse.* New York, NY: Guilford Press.

Evans, K. & Sullivan, J.M. (Eds.) (1995). *Treating Addicted Survivors of Trauma.* New York: Guilford Press.

Hamilton, T. & Samples, P. (1995). *The Twelve Steps and Dual Diagnosis.* Center City, MN: Hazelden.

Hazelden Foundation (1993). *The Dual Disorders Recovery Book.* Center City, MN: Hazelden.

Hellerstein, D.J., Rosenthal, R.N. & Miner, C.R. (1995). A prospective study of integrated outpatient treatment for substance-abusing schizophrenic patients. *American Journal on Addictions, 4,* 33-42.

Lehman, A.F. & Dixon L.B. (Eds.) (1995). *Double Jeopardy: Chronic Mental Illness and Substance Use Disorders.* The Netherlands: Harwood Academic Publishers.

Leshner, A.I. (1997). Addiction is a brain disease and it matters. *Science, 278,* 45-47.

McHugo, G.J., Drake, R.E., Burton, H.L. & Ackerson, T.H. (1995). A scale for assessing the stage of substance abuse treatment in persons with severe mental illness. *Journal of Nervous and Mental Disorders, 183*(12), 762-767.

Minkoff, K. (1991). Program components of a comprehensive integrated care system for serious mentally ill patients with substance disorders. In K. Minkoff & R.E. Drake (Eds.) *Dual Diagnosis of Major Mental Illness and Substance Disorder: New Directions for Mental Health Services, No 50,* San Francisco, CA: Jossey-Press, pp. 13-27.

Minkoff, K. (1994). Models for addiction treatment in psychiatric populations. *Psychiatric Annuals, 24*(8), 412-417.

Minkoff, K. (1994). Treating the dually diagnosed in psychiatric settings. In N.S. Miller (Ed) *Treating Coexisting Psychiatric and Addictive Disorders: A Practical Guide.* Center City, MN: Hazelden, pp. 53-68.

Minkoff, K. (1996). Dual diagnosis in seriously and persistently mentally ill individuals: An integrated approach. In J. Vaccaro & G. Clark (Eds.), *Practicing Psychiatry in the Community.* Washington, D.C.: American Psychiatric Press, Inc., pp. 221-253.

Minkoff, K. (1996). Integration of addiction and psychiatric treatment. In N.S. Miller (Ed.), *The Principles and Practice of Addictions in Psychiatry.* Philadelphia, PA: W.B. Saunders Co., pp. 191-199.

Minkoff, K. (1997). Integration of addiction and psychiatric services. In K. Minkoff & D. Pollack (Eds.), *Managed Mental Health Care in the Public Sector: A survival Manual.* The Netherlands: Harwood Academic Publishers, pp. 233-245.

Minkoff, K. (1998). *Co-Occurring Psychiatric and Substance Disorders in Managed Care Systems: Standards of Care, Practice Guidelines, Workforce Competencies, and Training Curricula, Report of The Center for Mental Health Services Managed Care Initiative: Clinical Standards and Workforce Competencies Project: Co-Occurring Mental and Substance Disorders Panel.* Rockville, MN: U.S. Department of Health and Human Services.

Minkoff, K. (1998). Development of an integrated model for the treatment of patients with dual diagnosis of psychosis and addiction. *Hospital Community Psychiatry, 40*(10), 1031-1036.

Minkoff, K. & Drake, R.E. (Eds.) (1993). Intervention strategies for people with dual diagnosis. *Innovations and Research, 2*(4), 11-17.

Minkoff, K. & Drake, R.E. (1994). Homelessness and dual diagnosis. In H.R. Lamb and S. Goldfinder, *Treating the Homeless Mentally Ill.* Washington, D.C.: American Psychiatric Press, pp. 221-247.

Minkoff, K. & Regner, J. *Innovations in Integrated Dual Diagnosis Treatment in Public Managed Care: The Choate Dual Diagnosis Case Rate Program.*

Montrose, K. & Daley, D. (1995). *Celebrating Small Victories.* Center City, MN: Hazelden.

Mueser, K.T., Bennett, M. & Kushner, M.G. (1995). Epidemiology of substance use disorders among persons with chronic mental illness. In A.F. Lehman & L.B. Dixon (Eds.), *Double Jeopardy: Chronic Mental Illness and Substance Use Disorders.* The Netherlands: Harwood Academic Publishers, pp. 9-25.

Mueser, K.T., Drake, R.E., & Wallach, M.A. (1998). Dual diagnosis: A review of etiological theories. *Addiction Behaviors, 23*(6), 717-734.

Osher, F.C. (1996). A vision for the future: Toward a service system responsive to those with co-occurring addictive and mental disorders. *American Journal of Orthopsychiatry, 66*(1), 71-77.

Osher, F.C. & Kofoed, L. (1989). *Treatment of patients with psychiatric and substance use disorders. Hospital and Community Psychiatry, 40,* 1025-30.

Pristach, C.A. & Smith C.M. (1990). Medication compliance and substance abuse among schizophrenic patients. *Hospital and Community Psychiatry, 41,* 1345-1348.

Regier, D.A., Farmer, M.E., et. al. (1990). Comorbidity of mental disorders with alcohol and other drug abuse: Results from the epidemiologic catchment area (ECA)study. *Journal of the American Medical Association, 264*(19), 2511-2518.

Ries, R.K. & Miller, N.S. (1993). Dual Diagnosis: Concept, diagnosis, and treatment. In D.L. Dunner (Ed.), *Current Psychiatric Therapy.* Philadelphia: W.B. Saunders, pp. 131-138.

Sciacca, K. (1997). Removing barriers: Dual diagnosis treatment and motivational interviewing. *Professional Counselor, February,* 41-46.

Sciacca, K. & Thompson, C.M. (1996). Program development and integrated treatment across systems for dual diagnosis: Mental illness, drug addiction, and alcoholism (MIDAA). *Journal of the Mental Health Administration, 23*(3), 288-297.

Hazelden Foundation (1995). *Today I Will Do One Thing (Dual Diagnosis Meditations).* Center City, MN: Hazelden.

Miller, N.S. (Ed.) (1994). *Treating Co-Existing Psychiatric and Addictive Disorder.* Center City, MN: Hazelden.

Wilens, T.E., Biederman, J. & Spencer, J. (1996). Attention deficit hyperactivity disorder and the psychoactive substance use disorders. *Child and Adolescent Psychiatric Clinics of North America, 5*(1), 73-89.

Wilens, T.E., O'Keefe, J., et. al. (1992). A public dual diagnosis detox unit: Part I. *American Journal of Addictions, 2*(1), 181-193.

Ziedonis, D. & Fisher, W. (1996). Motivation-based assessment and treatment of substance abuse in patients with schizophrenia. *Directions in Psychiatry, 16*(11), 1-8.

MULTISYSTEMIC THERAPY
ESSENTIAL ELEMENTS OF AN EFFECTIVE THERAPY
Presented by Jeff Randall, Ph.D.

MISSION

Our mission at the Family Service Research Center in the Department of Psychiatry and Behavioral Sciences at the Medical University of South Carolina is to develop and validate clinically and cost effective mental health and substance abuse services for youth presenting serious clinical problems and their families. This includes youth that have substance abuse and co-existing mental health problems.

OUTCOMES

Multisystemic Therapy ("MST") has been around for approximately 20 years and over the last 20 years we have published 8 randomized clinical trials. Over 850 families have participated in these trials. The problems that the projects have focused on have been quite diverse and range from substance abuse, violent youth offenders, sexual offenders, and psychiatric emergencies to maltreatment.

We have many projects currently underway. MST is in about 25 states and 3 countries, Canada, Norway and the U. S. The problems that the projects are dealing with again are quite diverse and the age range has been extended to include middle school youth.

Over the past 20 years the outcomes have been quite consistent. MST, relative to usual service or the comparison treatment, has resulted in improved family relations and functioning, increased school attendance, decreased substance use, decreased parent psychopathology, decreased child psychopathology and decreased rates of out of home placements and re-arrests. Retention rates have been well above 95% and services have produced on average a decrease in out of home placement of about 50%. The services also have been found to be cost effective. A study done by the Washington State Institute on Public Policy compared programs that had both research and evaluation components and who were treating juvenile offenders and found that MST, relative to 20 other programs, ranked number one in cost savings. On average, MST had

cost savings of around $21,000. That number was computed by taking the cost of being a victim of a violent crime, which is roughly $13,000, adding the cost to taxpayers because we pay for associated medical costs, and then subtracting the cost of MST, which is roughly $4,500, to come up with that figure of $21,000.

BASIS OF MST SUCCESS

MST addresses the multiple determinants of serious clinical problems in children. The problems that adolescents and their families experience have multiple causes, whether on the individual level, the family level, or the community level. Traditional mental health treatment has only focused on pieces and MST focuses on the whole broad array. MST services are high in ecological validity. Ecological validity is the notion that in order to evaluate and treat a problem effectively, we need to observe the problem and treat the problem in the environment in which it occurs. Our services have high treatment fidelity and there are extensive quality assurances. We use interventions that have an empirical basis, because the trajectory of our kids often is prison or even death, so we feel a very limited opportunity to actually make a difference and we want to make sure what we use works. We view caregivers as the key to long-term outcome. About 70% of our efforts are devoted to developing caregiver capacity. Our therapists and program directors are accountable not only for the engagement of families but for the outcomes as well.

MULTIDETERMINED NATURE OF SERIOUS CLINICAL PROBLEMS

Decades of rigorous research done by eminent researchers, such as Dale Elliott and his group at the University of Colorado, have indicated some things that we already know - that when we have an adolescent come into our office with substance abuse problems, often times there are other associated problems. The problem itself is actually caused by multiple determinants.

Let us take, for example, a typical adolescent substance abuser. When we look at what is happening on an individual level, we might find some adolescents actually have a favorable attitude toward using drugs, they have co-morbid conditions such as anxiety and depression or they have poor school performance. When we look at the family functioning level, we might find problems such as domestic violence, poor monitoring strategies, or poor discipline strategies.

And when we look at the caregiver, we often find problems such as substance abuse, depression and anxiety that have actually compromised their ability to parent. The biggest predictor of deviant behaviors we find is association with deviant peers.

Many of these problems are interrelated. A lot of the youth we deal with do not perform well academically or have behavioral problems in school, which leads to suspensions, which gives them an opportunity to hang out with deviant peers. Often times the parents do not have a strong response to that and they do not monitor their kids well.

Many families do not have strong social support. Single mothers who do not have many resources can be a predictor of problem behaviors. Finally, a lot of the youth might come from neighborhoods where there is a high availability of drugs and a high rate of crime.

Now, if this is the landscape, then it makes sense from a clinical perspective that in order to be effective as treatment providers, we need to be able to address all of these issues. MST addresses these issues in a very comprehensive way and builds in protective factors. This is accomplished on an individualized basis because we need a treatment model that is not a "one-size fits all" but one that actually can be flexible to address what is actually there so that the work is clinically relevant.

HIGH ECOLOGICAL VALIDITY

Services Provided Where Problems Occur

We need services that are high in ecological validity. The services are provided where the problems occur, within the home, school and community environments. For the most part, our therapists do not have offices. They have an office where they come and do their paperwork, but the clinical work is in the community settings. In the community they can evaluate what is going on and actually set up interventions where the problems are occurring.

Overcome Most Barriers to Service Access

Now, when you come to the home environment, you overcome a number of barriers. First of all, it is pretty hard for families to get rid of us when we are sitting there on their doorsteps

communicating to them that we really care. This sends a strong message to the family that you are really concerned about them and 95% treatment completion rates demonstrate this.

Increased Validity of Assessment Data

Our assessment data tends to be more valid. You actually go to the home and observe the interactions and arguments – you look at what they argue about and at the sequence of events.

Increased Validity of Outcome Data

Your outcomes are more valid, because whatever interventions you are able to put in place, you are actually teaching parents how to handle the child's problem in the home environment. And being there, you can identify the barriers that may prevent parents from being able to carry out the things you want them to do. For example, a mother does not have any social support. We have to hook her up with some social support to help her deal with her teenaged son who tends to be aggressive.

Helps Engage Family in Treatment

Being in the home environment helps to engage families in treatment. It sends a very powerful message that you care when you are willing to go to the home environment. It shows that you want to try to understand their world.

Enhances Treatment Generalization

Being in the home helps generalization. We are better able to teach families what to do in their environment with problems that happen there. We have a sense of understanding that when we leave the scene, families may be able to do what it is that we have taught them because we have done it within the home environment.

INTENSIVE SERVICES

Our services are very intense. In order to provide our therapists with the resources to do this type of work they carry a very low caseload. Our therapists, on average, carry between 4 and 6 families. Therapists are available 24 hours a day, 7 days a week. The logic behind this is that problems do not necessarily occur in the 9 to 5 window when most offices are open and it makes

sense that when a problem is actually occurring, we should have a clinical response to that problem. The therapists work as a team and a team usually consists of 4 therapists and a supervisor. It is the team that offers the 24 hours availability and all teammates have knowledge of all cases through team supervision.

EXTENSIVE QUALITY ASSURANCE PROTOCOLS

One of the reasons for our success is treatment fidelity. We have done a study and looked at our therapists' adherence to our treatment model and principles – of being parent focused, empowering parents to actually address the problems the kids are having, giving them the resources and the talents to do that, linking them up with pro-social supports to actually help them do that. Therapists who follow these principles get better outcomes. In order to insure treatment fidelity we have a number of procedures in place.

We have manuals that lay out MST protocols. For clinicians, we have a treatment manual. For our supervisors, we have a supervisor manual. For our consultants, we have a consultant manual. There is a rigorous 5-day on site training program that teaches you our motto, the principles on which it's based, how to carry out interventions within the various sub systems, within the peer sub system, the family sub system, breaking association with deviant peers, and some limited individual therapy for kids and adults. Quarterly booster sessions follow to fine tune areas that the team feels needs to be strengthened. Weekly phone conversation with an expert also provides on-going consultation. The consultant will give advice on case by case in terms of how this would be done from a MST perspective. Our goal with consultants is to be able to empower an organization within a one to two year time frame to be able to do the treatment independent of the consultant. We also are able to identify organization challenges and problem-solve the issues to support MST. Adherence to MST therapy is evaluated in research sites through expert coding of audiotaped sessions.

INTERVENTION STRATEGIES

We use empirically based interventions. The reason why we use the empirically based interventions is that we have a small window of opportunity to work with children who are very near the deep end.

There are proven treatments in the literature that we tend to use when we are dealing with specific problems – behavior therapy, cognitive behavior therapy, family therapy, Menuchin's work, and Haley's work. For some conditions, such as attention deficit disorder, schizophrenia, bipolar disorders, we will augment it with medication. We also use community reinforcement approaches developed by Budney and Higgins and their colleagues at the University of Vermont. This model is getting results with youth and adults who are using substances. The model is based on frequent random urinalysis where contingencies are applied, rewards and sanctions, based upon the results of the urinalysis. When the urinalysis is positive for substances, the triggers for use are identified and interventions developed to address those triggers. A project in Charleston has adapted this model to be able to work with adolescents who are substance abusing. The goal is to teach the parent to be able to use this model to help their children.

So what makes MST different from other treatment approaches that are out there? The difference is in the context of the application of the technologies. We apply them in a social ecological context - that is, we go into the home environment with an emphasis on building the caregiver capacity. We are available more intensively, 24 hours a day, 7 days a week. The social ecological approach enables us to eliminate a lot of the barriers that are related to access to care. And importantly, the provider assumes responsibility for engagement and responsibility for outcome.

CAREGIVERS ARE VIEWED AS THE KEY TO LONG-TERM OUTCOMES

Seventy percent of our resources are devoted to empowering the caregiver to be able to deal with what the child is presenting and generalizing those results by identifying and addressing the barriers that may prevent parents from parenting effectively.

We look at it from an analogy of a football team. The parent is really the quarterback and the play is run through the parent, so if you have a quarterback that is injured, you want to do whatever you have to do to bring that quarterback back up to speed. Because in the long run, unless we are planning on adopting kids, we do not want to be the magic in terms of dealing with problem behaviors. The focus is clearly on the family and parenting versus the youth.

Now, in some cases you may find that the biological parent, for whatever reason, does not want to parent. These cases are rare, because we find for the most part that parents want to keep their kids. They want to parent but they just do not have the resources or the skills. But in those cases where the parent is not going to assume the parenting, we try to find someone else within that social ecology, a relative or a friend who is willing to do the parenting piece, and then we pour our resources into that person. So from our perspective, parenting is not necessarily related to biology. Parenting is related to someone who wants to love and raise the kid.

MST PROGRAMS ARE ACCOUTABLE FOR ENGAGEMENT AND OUTCOMES

Therapists assume accountability for engaging families and for outcomes. This high accountability requires access to the resources to accomplish it. Therefore, caseloads are low. Salaries are high. In the Charleston area salaries are roughly 15% above whatever the current salary range is. Clinical support is strong. You have teammates, supervisors and a consultant, all trained in MST. The organizational supports are strong. Flexibility in scheduling allows for time with the clients and time off.

And this last one our therapists really like - if you are able to reduce the number of out of home placements, and in the State of South Carolina, it's roughly $32,000 to $35,000 to house a kid in prison or in detention - we believe that the therapists should be able to share in the program's success. Oftentimes, we offer bonuses. Also, resources are built in to enhance competencies. Not everyone who comes to us comes with all the skills they need, so training opportunities are provided to develop those skills.

POLICY IMPLICATIONS

Our mission is to shift funding from ineffective institution-based services to effective community-based services. What we would like to see happen is that the 70% of our mental health dollars that is currently being spent on costly out of home placements be redirected to effective community based programs. We believe that ultimately the solution to a lot of the problems that youth are facing lies in the community itself and not in out of home placement. We realize in some cases, you are going to have to place a child in out of home placement, but we

believe that that system is overused.

FUTURE DIRECTIONS

Currently we are moving to evaluate the model with different populations. We have a study in Charleston using the Higgins' model to treat adolescents who are abusing substances and who are involved with drug court. We have a study that was just funded where Dr. Cindy Swenson is going to be looking at children who are physically abused and using MST as a treatment model that will address some of the family conflicts that may have led to their abuse. Dr. Merlisa Rowland is working with diabetic and obese children, so we are extending over into the health psychiatric area.

Follow-up studies are tracking our outcomes and costs. We have follow-ups that go out to five years that indicate that MST relative to other services has cut the number of re-arrests and out of home placements in half. A test of any model is not just what you do at post-test but, perhaps even more importantly, what the long-range trajectory is of the intervention outcomes. We are submitting a grant to study children we saw over 12 years ago. We are interested not just in how technology is working here and now but how it is going to work in the future as well.

We are developing MST based continuums of care. In Hawaii and Philadelphia we are developing a continuum of care from inpatient, foster care, respite, to outpatient care based on the MST philosophy. For example, in inpatient care the orientation would shift to the family. You might have mom actually setting up the criteria for the child coming back home and the youth would not be attending group therapy because we know one of the biggest triggers of some of the problem behaviors are associating with deviant peers. There is also a study integrating MST with school-wide prevention programs in inner-city middle schools and one that evaluates neighborhood solutions for neighborhood problems.

And the final question that we're looking at is - what will it take in order to transport effective MST? If we can get these results in Charleston, what are the variables we need to have in order to come to Maine and get similar outcomes? Dr. Sonya Schoenwald has a grant from NIMH to examine our transportability and generalization.

About the Presenter

Jeff Randall, Ph.D., is an Assistance Professor in the Family Services Research Center, Medical University of South Carolina. His primary research interests are Multisystemic Therapy ("MST") and adolescent substance abuse and anxiety. MST, a model of delivering home-based services, has produced some of the best outcomes of any children's treatment model.

Contact Information:
MST Services
268 West Coleman Blvd., Suite 2E
Mount Pleasant, South Carolina 29464
Telephone (843) 856-8226
or
Jeff Randall, Ph.D.
Medical University of South Carolina
Department of Psychiatry & Behavioral Sciences
Family Services Research Center
67 President Street, Suite CPP
Charlestown, South Carolina 29425
Telephone (843) 876-1816

MULTISYSTEMIC THERAPY
POLICY AND IMPLEMENTATION ISSUES
Presented by Jeff Randall, Ph.D.

<u>WEAKNESSES IN OUR PRESENT SERVICE SYSTEM</u>

Presently, we all agree that the need for mental health treatment outweighs the availability. There are youth out there who really need service who are not getting it. We also probably would agree that there is a grossly disproportionate number of dollars being spent on costly out-of-home services, services that are not necessarily effective and, in some cases, actually do more harm than good.

When we look at our communities, we find few community-based programs that are available to help our kids. So we use whatever is available. This creates an interesting situation because we end up justifying the very existence of these programs simply because they are used, not due to their effectiveness.

Another weakness in our service system is that we duplicate ourselves. We have so many agencies; we end up doing the same things. We have these fragmented services and we do not necessarily talk to each other. We end up spending a lot of time duplicating our efforts in actually trying to figure out where to go to get what.

And another problem is how programs are funded. If you are a drug and alcohol program, you are not necessarily funded to take care of the mental health needs of the children. Similarly, if you are a mental health program, you are not necessarily funded to take care of the substance abuse needs of the children. Our programs therefore are set up based on the structure of the organization or system and not necessarily the clinical needs of our kids. And, sometimes we end up blaming families for some of the problems that they walk into our office with.

There have been some initiatives to help us coordinate our services better. One is the Fort Bragg Project in Fort Bragg, North Carolina. It is a multimillion-dollar project, an effort to create a seamless system of service delivery. All agencies were brought to the table and one service for

children and families was created and it seemed great. We got rid of the duplication and red tape and families had better access to services. The treatment outcomes, however, were not better. People starting looking at why? The problem was that there were a lot of programs in North Carolina that actually were using approaches that were not effective in the first place. What happens when you put programs together and none of them are really effective? You have one program that is not really effective. A twenty million-dollar lesson was learned with that particular project.

REASONS FOR INEFFECTIVE SERVICES

So the question is - why aren't these services effective? There are two reasons we need to examine. First of all, they are low in ecological validity. Ecological validity is the notion that to best understand a problem we need to observe it within the environment in which it is actually occurring. And to best treat a problem, we need to treat it in the environment in which it is occurring.

The other reason is that when we are looking at adolescents using substances, there are many other problems associated with that and a lot of problems have multiple determinates. It could be there are family conflicts going on in the home environment, it could be a huge peer association, etcetera. Now, if we know that there are multiple determinates to the problems that we face, it makes sense that in order to be effective clinically, we need a treatment approach that is going to give us a structure and the resources to actually address these problems in a very comprehensive way. Multisystemic Therapy ("MST") is based on these premises.

MULTISYSTEMIC THERAPY

Three MST Organizations

There are three organizations that are associated with MST. The first is the Family Service Research Center, which is the research and development center. The Director is Scott Henggeler, Ph.D., who is also the creator of MST. MST has been around for over 20 years. To date, there have been over 50 million dollars spent in the development and refinement of this treatment. The Family Service Research Center is located at the Medical University of South Carolina.

Another organization is MST Services. It is responsible for disseminating the treatment model. It works with out-of-state agencies, such as Sweetser here in Maine, to disseminate the treatment model.

The other organization, MST Institute, is responsible for working with policy-level people and ensuring that there is quality control with everything that we do. The goal of the organization is to reduce criminal activities, to reduce other anti-social behaviors such as drug abuse, and to do this at cost-savings. We do that by saving money. On average it costs us roughly $4,000 per child to treat and by doing so we save the money that it would have cost to have a child in an out of home placement. By reducing the number of children that are going into out of home placements, we can pay for our program. What we have found overall is that we are able to cut the number of children going into out of home placement roughly in half.

Effectiveness

Our supporters include the families that we treat, the Office of Juvenile Justice and Delinquency Programs, the Washington State Institute of Public Policy, which has done a cost analysis, and the Blueprints for Violence Prevention, which has studied effective juvenile offender programs.

The reason why families are proponents of MST is because it is a family focused model. We spend 70% of our time and energy empowering families to deal with the problems that their youth present. We focus on what the family would like to see changed and creating strategies to help them meet their ends. For that reason, because they're full collaborators. Over 95% of families who enter our programs actually complete the MST treatment, which lasts anywhere from 4 to 6 months.

The Washington State Institute of Public Policy did a cost analysis of 16 programs that treated juvenile delinquents and that had research and evaluation components. They found that MST, relative to the other programs, was the most cost effective. The saving for each child was on average $21,000. That figure was computed by taking the cost to a victim of a violent crime,

$13,000, plus the cost to the taxpayers for the medical related costs for people who are uninsured and others associated costs, and subtract the cost of MST, $4,000, and end up with a net cost saving of $21,000.

The Blueprint for Violence Prevention Program examined those programs treating juvenile offenders to determine which programs are clinically effective. To date, they have examined over 500 programs and picked out 10 that were gold standards. MST is one of the programs that was selected as a gold standard.

MST Theory

The MST model is based on the theoretical work of people like Haley and Manuchin - family therapists. The notion behind their theoretical work is that children are actually embedded in multiple systems and these systems have bi-directional and reciprocal impacts on each other. It is like tossing a pebble in a pond and watching the ripples. The pebble actually has an impact on the entire pond. From our treatment perspective, your client is not the individual child, it is not the family, it is actually the entire ecological model.

Basis of Success

From research we have found that most problems have multiple determinants. For example, take a child who is using substances. When we look on an individual level, some of the factors that may relate to substance use as indicated by research include adolescents who have a favorable attitude toward using drugs and adolescents who are using drugs to self medicate for anxiety and depression. From a family perspective, we often run into situations with adolescents who are using drugs where there is domestic violence, where the parents have poor skills in terms of monitoring their child and poor discipline or ineffective strategies such as yelling. There might be low affect between the child and the parent. When you look at caregivers themselves, often times they are using drugs or have anxiety, depression or other psychiatric conditions.

Then we look at the school environment. A lot of the children are not doing well academically. Some are being kicked out for behavioral problems that set them up to hang out with the number one predictor of problems - deviant peers. You can see the circular nature of

these problems. You have an adolescent who has been kicked out of school, hangs out with deviant peers and mom knows it. They are getting into trouble but there are few consequences at home. And oftentimes there is a neighborhood environment where there is higher crime and ready availability of drugs.

In order to be effective, we need to be able to address these problems in a very comprehensive way. We need to have services that are individualized because treatment is not a "one size fits all." We want a model that is flexible enough to clinically deal with what is on our table. We need a model that has families as full partners. Parents are the driving forces in terms of interventions as you intervene with the natural ecology where the problems are occurring.

CRITICAL ELEMENTS OF MST

What are some critical elements to implement a MST program? First of all, MST focuses on outcomes. Second is treatment fidelity and the third is families having accessibility to treatment.

OUTCOMES

The Missouri Delinquency Project studied over 200 offenders and their families who were treated. On the average each child had over 4 arrests, about a third of the clients were females and about a third were African Americans. The families within the MST who had undergone individual therapy had increased family cohesion, decreased parental psychopathology and decreased child psychopathology. But what about the ultimate outcomes? MST resulted in fewer youth committing violent crimes, lower levels of drug use, and of the crimes that actually were committed, they were significantly less serious than the crimes committed by youth in the comparison individual treatment. These post-test successes continued at follow-up. Data show that 5 years after MST completers still have a lower number of re-arrests than youths who completed individual therapy. What also is interesting is that even the youth who dropped out of MST are doing better than the youth who underwent individual therapy.

What we have found in general after 8 randomized clinical trials and working with 850

families is that the outcomes have been very consistent in families who finish MST. They have better family relations, the children attend school more often, parents have decreased psychopathology, children have decreased psychopathology and the number of days in out of home placements has been cut in half.

TREATMENT FIDELITY

We did a study where we looked at treatment fidelity and essentially found that it was not treatment fidelity but rather a failure to implement the model that resulted in poor outcomes. Consequently, we believe that the only way to actually get treatment fidelity is to plan for it and to institutionalize treatment fidelity as part of your training protocol. To that end, we have manuals that lay out our treatments based on nine principles and within the manual we teach our therapists how to deal with the different sub-systems - whether it be peer interventions, parent-child interventions, individual interventions for parents alone, or interventions for our youths alone. We also have manuals for our supervisors. We want to make sure that they have guidance in terms of how to supervise our therapists. We have manuals for our consultants who are working with out-of-state sites, such as the one here in Maine, to give them guidance in terms of how to insure that everyone from top to bottom is actually adhering to the treatment model.

To become a MST site an agency has to undergo 5 days of training, where we come in and train you in the various models. Basically, our therapy techniques are those that are in the literature, that have been shown to be effective, such as behavior therapy, cognitive behavior therapy, family therapy, pragmatic family therapy and some of the therapies are working with addicts. One treatment in particular with which you are familiar that has been very effective with cocaine addicts is the community reinforcement approach developed by Higgins and his colleagues at the University of Vermont. This is a treatment approach that entails random urinalysis testing for cocaine use, on average about 2 to 3 times a week, coupled with providing sanctions and rewards for clean or dirty results. The treatment in particular goes after those triggers that are related to use. We have adapted the model to work with adolescents in Charleston.

In addition to the 5 day on site training, our consultants each week calls the team and

goes over the cases to make sure that the therapists are actually using a MST approach. Every three months, one and a half day booster sessions are delivered. The support is a constant relationship that enables MST to sustain or obtain some of the outcomes that we are looking for.

ACCESSIBILITY TO TREATMENT

It is important that families are able to have access to our services. To achieve that, our model is set up so that the treatment site actually occurs within the home environment. Our therapists carry very low caseloads of 4 to 6 families and they are available 24 hours a day, seven days week through a team treatment response. Clinical problems do not happen during a neat time frame of 9 a.m. to 5 p.m. They happen 24 hours a day, so we want to be able to go there. Our therapists work on a team; there's usually about 4 or 5 therapists and a particular therapist might not have to go, but someone from that team would go and address the clinical emergency. Treatment usually lasts from 3 to 5 months.

We take good care of our therapists and pay them 15% higher than comparable organizations. The therapists are viewed as being responsible for the family engagement and the clinical outcomes. That is, when we hire a therapist, we say, " If the treatment fails, we don't blame the family, we blame ourselves. If the family is not engaged in treatment, we don't blame the family, we blame ourselves." We look for the barriers that are keeping the families from being engaged and those factors become our treatment goal.

We treat the entire family. If we see a parent whose parenting ability is compromised because of psychiatric problems, that person becomes our client as well. A younger sibling with his/her own problems- that person becomes our client as well. The entire ecology is actually our client.

THERAPISTS CHARACTERISTICS

To be successful at doing MST, being a bright and motivated therapist helps. Therapists that are successful are willing to learn and are not particularly wedded to one way of thinking or to using interventions that do not have empirical support. Some weaknesses to be aware of when choosing therapists are if they have worked without the MST's level of accountability or if they

are used to doing things that may not be empirically based. These therapist may not be open to peer supervision.

FUTURE DIRECTIONS

We want to take the 70% of mental health dollars that are currently being spent on out of home placements and have them directed toward effective community based programs. That is why we do what we do.

About the Presenter

Jeff Randall, Ph.D., is an Assistance Professor in the Family Services Research Center, Medical University of South Carolina. His primary research interests are Multisystemic Therapy ("MST") and adolescent substance abuse and anxiety. MST, a model of delivering home-based services, has produced some of the best outcomes of any children's treatment model.

Contact Information:
MST Services
268 West Coleman Blvd., Suite 2E
Mount Pleasant, South Carolina 29464
Telephone (843) 856-8226
or
Jeff Randall, Ph.D.
Medical University of South Carolina
Department of Psychiatry & Behavioral Sciences
Family Services Research Center
67 President Street, Suite CPP
Charlestown, South Carolina 29425
Telephone (843) 876-1816

ASSESSMENT OF CO-OCCURRING DISORDERS AND RISK ASSESSMENT

IN ADOLESCENT OFFENDERS

Presented by Scott Reiner, MS

About the Presenter

For the past 13 years, Scott Reiner has focused his work on addressing the substance abuse and mental health concerns of juvenile offenders as a clinician, program manager and administrator. He is presently the Court Services Specialist for the Virginia Department of Juvenile Justice ("DJJ") and is responsible for planning and implementing major initiatives in the juvenile probation and parole services. Prior to assuming this position in November of 1999 he spent nine years as DJJ's Substance Abuse Program Manager, providing management and oversight to the agency's substance abuse activities. He has been with DJJ since 1987.

Mr. Reiner has a master's degree in clinical psychology fro Syracuse University and received his bachelor's degree from Brandeis University in Waltham, MA. He holds adjunct faculty appointments in the Departments of Criminal Justice and Addiction Medicine at Virginia Commonwealth University.

Contact Information:
Scott Reiner, Court Services Specialist
Virginia Department of Juvenile Justice
P.O. Box 1110
Richmond, Virginia 23218-1110
Telephone (804) 371-0720
Email reinersm@djj.state.va.us

CHANGING CLIMATE

The interface of the juvenile justice system with the mental health and substance abuse systems complicates an already complex situation. Unfortunately, with each system often approaching assessment and intervention separately instead of together, many youngsters struggle a long time and get deep into difficulty before anybody pays attention or identifies the full picture of what is going on. Some of the issues that stand out in this interplay of services and systems are:

- **It has become increasingly difficult for adolescents to access behavioral health care because of changes in the reimbursement funding streams.** There are discrepancies between substance abuse and mental health insurance rate reimbursement, there now are more and more types of insurance that have varying coverage, and in some States the resources for youth are shrinking in favor of the much larger adult population.

- **Over the last 10 years there has been a shift in the way the juvenile justice system is operated, from a philosophy with a focus on rehabilitation to a system that has become increasingly oriented toward public safety and punishment.** This shift is in part in response to both the media portrayal of and the real changes in juvenile violence. Facilities that used to be open now are behind barbed wire. Youngsters who, at the age of 14, never before would have been eligible to serve adult sentences now are being transferred to adult correctional facilities with greater frequency. Even for those who are retained within the juvenile justice system, the prevalent philosophy is that these are criminals, not children needing or deserving rehabilitation. These shifts have complicated the climate for providing treatment services.

- **And, finally, is the prevalence and severity of substance use and mental health disorders among court-involved and incarcerated youth, which have increased over the last several years.**

PREVALENCE

Comparing national studies of prevalence for mental health disorders in youth to those of youth involved in the juvenile justice system, those involved in the juvenile justice system have 3 to 4 times the rates of mental health disorders. Comparing substance use disorders in these populations, 25% to 80% of the young people in the juvenile justice system have either substance abuse or dependence disorders, as compared to 2% to 30% in the general youth population. And, disturbingly, only a small percentage of the youth in the juvenile justice system (13%) have any record of receiving any treatment services for those substance use disorders. There is a lag of 2 to 4 years between when a youngster initiates substance use and when they experience enough trouble with substances to receive treatment.

The higher prevalence of substance abuse and mental illness in the juvenile justice population often is a result of communities not responding effectively prior to the youth's becoming involved in the justice system. Parents who are struggling with their youngsters, even when there is not an offense against the community, property or a violent crime, are often

advised to go to the court for help. The courts are seen either as being able to bring the resources to bear in terms of funding of services by ordering those into place or as an avenue of last resort.

Sixty-six percent to 95% of youth in the juvenile justice system who have a substance use disorder also have at least one other mental health disorder. One study compared frequency of reported delinquent and depressive behavior to frequency of past year marijuana use. The results showed that rates of a whole variety of problem behaviors - being on probation, running away from home, having physically attacked others, or thought about suicide - were found to be directly proportional to the frequency of marijuana use.

PROGNOSIS

Youth who have co-occurring disorders more quickly progress from initial substance use, through abuse, and into dependence. They also have increased levels of poor compliance with psychotropic medication, are more likely to drop out of treatment and have higher rates of suicide.

INTERRELATIONSHIPS AMONG SUBSTANCE USE, MENTAL ILLNESS AND DELINQUENCY

HOW SUBSTANCE USE AND MENTAL ILLNESS INTERRELATE

There are a variety of ways in which substance abuse, mental health disorders and delinquency interrelate. Substance use can precipitate mental health symptoms that may have not been previously present. Where mental health concerns and symptoms exist, substance use can either exacerbate or mask them. Symptoms of substance misuse also can mimic mental health symptoms. Frequent amphetamine or cocaine use in both youngsters and adults can, after a short while, look like a paranoid psychosis. Also, substances frequently may be used to self-medicate underlying psychiatric conditions and, when the substance use stops, those mental health symptoms emerge.

HOW SUBSTANCE USE AND JUVENILE OFFENDING INTERRELATE

Impaired Judgement

The other part of the equation is - where's the relationship with offending? In young

people, as well as in adults, much criminal behavior is a result of bad judgment. The ability for good decision-making about what is appropriate behavior often becomes impaired. Many of us have thought about doing inappropriate things but never do them. Values, morals and good judgement prevent us from acting. Substance use often impairs those higher processes that inhibit us. You often will see a number of youngsters who are significantly involved in both delinquency and substance abuse who say, "Well, I never do that stuff unless I'm high because I'd be too frightened." The use of substance disinhibits behavior by impairing judgment.

Motivates Crimes

Drug use, abuse, and dependence also can play a motivating role in crime, particularly around financial issues. Many youngsters get involved in a full range of criminal behaviors in order to get money to supply their drug habits.

Global Pattern

Finally, in many youngsters, substance abuse is really part of a more global pattern of difficulty in getting along in the community and in the world. They break the rules and substance abuse is just one of the rules that they break. They have a nonconforming orientation. Treatment needs to address both the thinking and the pattern of behavior of which substance abuse is just one component. A number of good longitudinal studies now indicate that for most substance involved juvenile offenders, that pattern began early- not with substance abuse, but with a variety of minor nonconforming behaviors. Running away, staying out late, cutting school are behaviors that may progress with the addition of substances to more serious offenses and more involvement with significant negative involvement with drugs and alcohol.

Substance Abuse Is Illegal

The fact that substance use alone is illegal from a juvenile justice perspective complicates treatment goals. Many youth in recovery will continue to use to some extent, but the justice system says, "No, that's against the rules and we don't have any tolerance for that."

SCREENING AND ASSESSMENT

THE NEED FOR COLLABORATION

All professional disciplines - substance abuse, mental health and juvenile justice, need to have at least a basic understanding, if not a more detailed background, in recognizing signs of substance abuse, mental illness and delinquency. Without this basic competency, there are missed opportunities to intervene early. And, by doing this collaboratively, it allows the professionals in each system to focus on those things they know best and to bring that expertise to the table and share it with others. Collaboration also overcomes the discontinuity between systems that result in poorer outcomes for the client. This means evaluations do not have to be duplicated and information can be shared across systems. Continuity of care can be supported. In addition, collaboration can result in a treatment and supervision plan that is supported by all parties.

PURPOSES OF SCREENING AND ASSESSMENT

Screening is a preliminary procedure used to identify the likely presence of a problem and to identify the need for further evaluation. Assessment is a more comprehensive, detailed approach that results in a diagnostic impression and the beginning of the treatment process.

KEY CONSIDERATONS IN SCREENING

Screening should be done at the initial contact by the police, the detention center, whoever is that initial contact, and should be available at different points in time to identify changes. The method of screening and assessment can vary - by juvenile justice staff or through collaborative relationships with behavioral health staff, but it must be available throughout the continuum. Standardized instruments that are reliable and valid with the populations with which they are being used build confidence. Information gained from the screenings and assessments should be communicated across the systems. In evaluating for the presence of a mental illness, the guideline is 4 to 6 weeks of abstinence from alcohol or other drugs to see whether the mental illness still exhibits itself, whether it has gotten worse or whether it has improved. Collateral information and drug testing is an important component of the screening process. Typically, chemical testing in the form of urine drug testing is an important adjunct to the screening

process. Self-report by the juvenile has been found to produce a significant underreporting of drug use in comparison to the results of urine drug testing.

SCREENING FOR MENTAL HEALTH

Key areas that need to be screened for in mental health include acute symptoms, suicidal thoughts and behaviors, prior mental health treatment (including past and present psychotropic medications), cognitive impairment (either through injury or illness), and family history of mental health problems.

MENTAL HEALTH SCREEING INSTRUMENTS

The following are a few screening instruments that are particularly useful:

- **Brief Symptom Inventory (BSI)**

- **Massachusetts Youth Screening Instrument (MAYSI)**
  This instrument has been used extensively in juvenile detention facilities. It has excellent validity when compared to clinician judgement based upon more extended interview. It is brief and a variety of staff can be trained to use it.

- **Symptom Checklist 90 (SCL-90-R)**

- **Problem Oriented Screening Inventory for Teenagers (POSIT)**
  The POSIT is an instrument that is in the public domain from NIDA (National Institute on Drug Abuse). It generated "red flags" in ten different domains of functioning, substance use being one of them. It also picks up flags in a variety of other functional areas that can be used to trigger further assessment.

SCREENING FOR SUBSTANCE ABUSE

Key areas that are included on a substance abuse screening include:

- **Acute signs of intoxication**

- **Withdrawal or tolerance effects**

- **Self-reported substance abuse**

- **Negative consequences associated with substance abuse, including delinquent behavior**

- **Prior involvement in substance abuse treatment**

- **Family history of substance abuse**

SUBSTANCE ABUSE SCREENING INSTRUMENTS

The following are substance abuse screening instruments. This list is not inclusive and there are many good instruments available:

- **Substance Abuse Subtle Screening Inventory (SASSI)**

- **Personal Experience Screening Questionnaire (PESQ)**

- **Problem Oriented Screening Inventory for Teenagers (POSIT)**

TYPES OF CHEMICAL TESTING

Urine testing is really the "gold standard" in determining the use of illicit substances. It is cost-effective and very accurate. For alcohol, breath testing is very helpful. Newer technologies, such as hair and sweat patches, have a longer window of detection, but these methodologies are costly and their accuracy is still being studied. Similar to any other tool, the strengths and limitations of the particular test must be evaluated. For example, a negative urine drug test does not mean that someone is not a drug user. It means that they probably have not used in the last week or so, or for even a shorter period, depending on the drug. And, a positive test does not mean someone is substance dependent.

COMPREHENSIVE ASSESSMENT INSTRUMENTS

Broader, more comprehensive assessment instruments look at an adolescent's functioning across a variety of life domains:

- **Child and Adolescent Functional Assessment Scale (CAFAS)**

  This instrument uses a rating system and is particularly useful as it may readministered every three months. It may be used to track progress within a treatment program.

- **Comprehensive Addiction Severity Index for Adolescents (CASI-A)**

- **Personal Experience Inventory (PEI)**

- **Psychopathy Checklist (PCL)**

  This instrument is of particular relevance to the criminal justice population. It is from the work of a psychologist by the name of Robert Hare, who has worked primarily with adults in terms of psychopathy or anti-social personality but recently has been working on validating a psychopathy scale for adolescents.

RISK ASSESSMENT IN JUVENILE JUSTICE

The justice system has its own technology of screening and assessment that often falls under the general category of risk assessment. Risk assessment tools assist juvenile justice practitioners to make various decisions. The tools and the information that they provide are different based upon the points that are used and the outcomes desired. One of the decisions that judges and juvenile justice workers have to make when youngsters come before them is whether they need, at that moment, to be in a secure environment while they are waiting for their case to be heard. The concern is whether they are likely to continue to get in trouble or if they are going to take off before they get to court. Risk assessment instruments can be used to help us to determine which youngsters are likely to do that by looking at their characteristics. What is their likelihood, relevant to other juveniles who are before the court, of continuing to offend? A very small portion of juvenile offenders commit the majority of juvenile crime. About 65% of all juvenile criminal acts are committed by only 8% - 9% of all juveniles involved with the criminal

justice system. The risk assessment tools help to determine which juveniles are most likely to continue to re-offend, so that appropriate responses may be implemented to help deter them from those behaviors. For example, if they are in a community setting on probation, the risk assessment will help to determine how much supervision they need. Supervision can range from check-in once every other month to what is called intensive supervision, where someone may be checking up on the juvenile five and six times a week through methods such as electronic monitoring. Risk assessment helps to determine where to place resources in order to maintain safety. If a juvenile is already in a secure environment, risk assessment can help to determine which of those individuals need the closest custody. The risk assessment is completed at each different decision point, at court appearance/detention hearing, level of community supervision or institutional assignment/placement.

Juvenile justice systems, just like substance abuse and the mental health providers, assess different issues. The juvenile justice assessment will examine the current offense, prior detentions, disciplinary incidents in detentions, drug-related offenses and prior probation or parole violations. More serious offenses are going to be matched to higher sanctions, regardless of the severity of behavioral health disorders. Collaboration between the systems is needed in order to create a mutually supportive plan. The justice system needs to know what it looks like from the treatment side so that it can respond to behavior and support treatment. The justice system can put structure around the treatment through sanctions and consequences.

ASSESSMENT FOR CO-OCCURRING DISORDERS

Assessment for co-occurring disorders means taking careful histories in all three areas: substance use, mental health and criminal activity. Good treatment requires an understanding of the relationship among the three sets of problem behaviors. The diagnosis and current status alone are not sufficient for assessment, as one or more disorders may be in remission at the time of assessment. Assessment also identifies specific strengths that may be used in the treatment plan. This process of assessment begins the treatment engagement process.

WHY THE PERIOD OF ABSTINENCE?

A period of abstinence is needed in order to get a reasonably conclusive assessment of the presence of a dual disorder or co-occurring disorder. The biochemical effects of drug use need to clear out before one may make a determination of what one sees as the underlying psychological or psychiatric disorder. Without this period of abstinence it is difficult to clarify what behaviors, symptoms or disorders are driving the others.

IMPORTANCE OF HISTORY

Below are some of the key areas that should be addressed in gathering historical data:

- **Age of symptoms began**

- **Pattern of how symptoms are expressed**

- **Age and pattern of first substance use**

- **Patterns of use including 'drug of choice' and motivations for using**

- **Family history of mental illness/substance abuse**

- **The effects of one disorder on the other**

- **Motivations for treatment**

The chronological and longitudinal emergence and relationship across all realms, mental health, substance abuse and criminal behavior, must be analyzed in order to develop an effective treatment plan. However, the issue of which diagnosis is primary does not matter. The primary versus secondary diagnosis has been used historically to deny services and to shift individuals from one system to another. Currently, most experts feel that the distinction is not very useful in making treatment decisions, particularly for persons who are substance dependent. All systems have to work in an integrated manner in order to identify what is going on, and then need to work

collaboratively in order to coordinate their activities to address the needs of the juvenile offender with co-occurring disorders. No matter which system one is working in- whether it be mental health, addictions, or juvenile justice - the knowledge and the skills to identify those youngsters who have involvement in one or more of those problems areas is a prerequisite.

References

Center for Substance Abuse Treatment (1999). *Screening and assessing adolescents for substance use disorders.* Treatment Improvement Protocol (TIP) No. 32. DHHS Publication No. (SMA) 99-3282. Rockville, MD: Center for Substance Abuse Treatment.

Cohen, R., Parmalee, D.X., Irwin, L., Weisz, J.R., Howard, P., Purcell, P. & Best, A.M. (1990). Characteristics of children and adolescents in a psychiatric hospital and a corrections facility. *Journal of the American Academy of Child and Adolescent Psychiatry, 39,* 909-913.

Derogatis, L.R. (1979). *Brief Symptom Inventory.* Minneapolis, MN: National Computer Systems, Inc.

Derogatis, LR. & Melisaratos, N. (1983). Brief symptom inventory: An introductory report. *Psychological Medicine, 13,* 595-605.

Greenblatt, J.C. (1998). Adolescent Self-reported behaviors and their association with marijuana use. Rockville, MD: SAMHSA, Office of Applied Studies. Cited in *CESAR* Fax, November 9, 1998.

Grisso, T.J. & Barnum, R. (1998). *Massachusetts Youth Screening Instrument (MAYSI).* Worcester, MA: University of Massachusetts Medical Center.

Hare, R. (1998). The Hare PCL-R: Some issues concerning its use and misuse. Legal and Criminological Psychology, 3, 99-119.

Hodges, K. (1995). *Manual for Child and Adolescent Functional Scale (CAFAS).* Ann Arbor, MI: Functional Assessment Systems.

McManus, M., Alessi, N.E., Grapentine, W.L. & Brickman, A. (1984). Psychiatric disturbance in serious delinquents. *Journal of the American Academy of Child Psychiatry, 23,* 602-615.

Milin, R., Halikas, J.A., Meller, J.E. & Morse, C. (1991). Pscyhopathology among substance abusing juvenile offenders. *Journal of the American Academy of Child and Adolescent Psychiatry, 30,* 569-574.

Miller (1985). *The Substance Abuse Subtle Screening Inventory (SASSI) Manual.* Bloomington, In: The SASSI Institute.

Meyers, K., McLellan, T., Jaeger, J.L. & Pettinati, H.M. (1995). The development of the Comprehensive Addiction Severity Index for Adolescents (CASI-A): An interview for assessing multiple problems of adolescents. *Journal of Substance Abuse Treatment, 12,* 181-193.

Howell, J.C. (Ed.). (1995). *Guide for Implementing the Comprehensive Strategy for Serious, Violent, and Chronic Juvenile Offenders.* Washington, DC: Office of Juvenile Justice and Delinquency Prevention.

Otto, R.K., Greenstein, J.J., Johnson, M.K. & Friedman, R.M. (1992). Prevalence of mental disorders among youth in the juvenile justice system. In J.J. Cocozza (Ed.), *Responding To The Mental Needs of Youth in the Juvenile Justice System.* Seattle, WA: National Coalition for the Mentally Ill in the Criminal Justice System.

Peters, R.H. & Bartoi, M.G. (1997). *Screening And Assessment Of Co-Occurring Disorders In The Justice Systems*. Delmar, NY: The National GAINS Center.

Radhert, E.R. (Ed.) (1991). *The Adolescent Assessment and Referral System Manual.* DHHS Publication No. (ADM) 91-1735. Rockville, MD: National Institute on Drug Abuse.

Timmons-Mitchell, J., Brown, C., Schultz, S.C., Webster, S.E., Underwood, L.A. & Semple, W.E. (1997). *Final Report: Results of a Three-Year Collaborative Effort to Assess the Mental Health Needs of Youth in the Juvenile Justice System in Ohio*. Unpublished report. Columbus, OH: Ohio Department of Youth Services.

Winters, K.C. & Henly, G.A. (1989). *Personal Experience Inventory Test and Manual.* Los Angeles, CA: Western Psychological Services.

DEVELOPING EFFECTIVE PROGRAMS IN THE

JUVENILE JUSTICE SYSTEM

Presented by Scott Reiner, MS, CSAC, CAC, CCS, SASSI

HISTORY OF SEPARATE SYSTEMS: WHAT PRICE?

Historically, in both adult and adolescent services, there have been two separate systems of funding and authority for mental health and substance abuse services. This fragmentation has had detrimental consequences for the provision of services for clients with co-occurring disorders. These consequences include:

- **Clients with co-occurring disorders have been excluded from receiving treatment in both mental health and substance abuse programs.** If a client had a mental illness, a substance abuse program said, "we can't help you until you're stable." And to a client who had a substance abuse problem, the mental health program said, "you can't come here until you stop using." There was no place in the service delivery system to call home for the client with co-occurring disorders. Many clients who were not accepted in either the mental health or the substance abuse systems or who had histories of violence or sexual offenses were and continue to be directed into the juvenile justice system. These separate systems developed exclusionary criteria that have restricted and limited care.

- **Providers lack knowledge about both substance abuse and mental illness.** Educational preparation has not prepared providers to treat both types of disorders. Mental health training programs historically have focused on the mental health disorders with the belief that the substance abuse problems will go away if the mental health issues are treated. Similarly, traditional addiction training programs have stayed away from teaching psychopathology and focused solely on substance disorders with an underlying believe that mental health disorders will go away if the substance abuse issues are treated. And juvenile justice providers often did not get either mental health or substance abuse training and behavior was viewed in a third way - "folks just need to learn to follow the rules."

- **Treatment models that are fragmented place the burden of integration on the client.** The young person and their family have to go to one place for substance abuse treatment and

another place for mental health services. The adolescent and their family then have to put all that together and make those linkages themselves.

CHARACTERISTICS THAT COMPLICATE TREATMENT FOR YOUTH

Not only does the historical fragmentation of the systems create confusion, youngsters with co-occurring disorders often have a number of characteristics that also complicate treatment.

- **Multiple psychiatric diagnoses.** Many records for adolescents list 5 or 6 diagnoses, everything from bipolar disorders to conduct disorders. Some of these diagnoses make sense and some do not. The picture can be muddy and many of the behaviors that receive the focus of attention, such as self-mutilation, self-destructive or acting out behaviors, do not fit neatly into any diagnostic category.

- **Multiple drugs of abuse.** Early on, youth may use alcohol and marijuana, but later on as the adolescent progresses, they tend not to be selective and they will use whatever is available.

- **Removal of current coping strategy.**

- **Episodic nature of the disorders.**

- **Cognitive limitations.**

- **Recurrent suicidal and/or self-mutilating behaviors.**

- **Repeated incarcerations.** Effective treatment is based on a strong relationship with some consistency. For youth that have multiple episodes of juvenile detention, continuity is very difficult to maintain.

- **Potential for violent behavior.**

- **Family members with mental illness/substance abuse.**

- **Lack of stable housing.**

- **Lack of school/vocational involvement.**

- **Schools that do not allow youth to return following incarceration.**

- **Lack of supportive adults.**

- **Deviant peers.** It is very difficult for recovering youth to find a healthy peer group to support abstinence.

KEY PRINCIPLES

- **Treatment of mental health, substance abuse and delinquency must be integrated and be considered primary.** It does not make sense to have a young person who stops getting high and gets his depression under control who is still out breaking into cars. The treatment must address all the issues that the youth is experiencing.

- **Programming must be individualized and tailed to what the youth and family needs.** Programs cannot be of a "cookie cutter" variety. The programming should address the symptom severity, skill deficits and levels of motivation of the youth. For example, a youth that has low level of psychiatric and substance abuse symptoms but high levels delinquency might be in a juvenile detention facility, even though his clinical treatment might have pointed to a community treatment setting. The potential for delinquency places the youth in more restrictive settings. Moreover, youth on probation who have severe substance abuse problems with minimal offending might have their supervision monitoring matched to both the justice and clinical needs.

- **"Phased" treatment intervention should be of a graduated intensity.** Interventions should be titrated to engage with the young person. Interventions should be matched to both to the clinical status of the young person as well as to the need to slowly build a level of engagement. A strong engagement in treatment is needed to support the youth in doing the hard work - confronting the lifelong nature of some of these disorders and the fact that they have to look at making some serious changes. The issue of motivation and treatment matching is critical. Often treatment providers attempt to provide "treatment" to youth who are not ready for it. The beginning work needs to focus on motivational enhancement and engaging the youth in their treatment.

- **Treatment comprehensiveness, flexibility and continuity.** There need to be an array of treatment options across the continuum that can be individualized to the needs of the youth and their families including youth that have justice system involvement. Access is needed, either through individual agencies or through collaboration, to the full continuum of care that includes everything from brief residential or in-patient stabilization all the way through relapse prevention, briefer intervention and support services. Youth need to be able to move fluidly across services as their condition improves or deteriorates.

- **Engagement of the youth and their family.** The family work is critical as the family's influence will always be more important than anything the treatment providers are going to do. There are a lot of concrete ways the youth and their family can be engaged, e.g., providing food at the program site or providing childcare for the siblings.

- **Psychopharmacological interventions are used to stabilize co-occurring disorders when appropriate.** There is an emerging body of knowledge about the use of medication treatments for substance abuse. A psychiatric perspective is a necessary part of the team for treating co-occurring disorders.

- **Peer and self help groups.**

THREE TREATMENT MODELS
SEQUENTIAL

The sequential model provides treatment services first in one system (either mental health or substance abuse) and then the other. Unfortunately, the drug or alcohol use does not stop while the treatment providers are trying to figure out what to do about being depressed and suicidal and vice versa.

PARALLEL

The parallel model uses mental health and substance abuse treatment services to treat co-occurring disorders concurrently. This model is better than sequential but not ideal. A parallel model requires the client to make a lot of the linkages themselves.

INTEGRATED

In the integrated model, disorders are addressed within the same setting, with combined program elements delivered by cross-trained staff. It does not mean that everybody has to be an expert in all areas, but the program elements need to be comprehensive so that the relationships among the issues can be addressed. An example of an integrated program element is a group session on managing symptoms of depression that also addresses drug use factors in the management of the depressive symptoms. The same multidisciplinary clinician (or team) provides all services and has continuous responsibility for the treatment. Treatment is integrated in the program by selectively modifying, combining, and tailoring interventions for the specific client.

TREATMENT MODELS
THERAPEUTIC COMMUNITY

Therapeutic communities ("TC") operate in increasing numbers within correctional centers. They are a highly structured, long-term residential program of 6 - 18 months duration. Research suggests that the best length of treatment in a TC setting for adults is 9 to 15 months. There is little empirical research on the appropriate length of stay for adolescents. The program focus is on habilitation and changing negative behavior patterns and cognitive processes that lead to drug abuse and offending. Typical in therapeutic communities, there are strict community

norms that regulate participant behavior with positive and negative sanctions for behaviors and there is a wide range of client involvement in the community management itself.

History

The original therapeutic communities grew out of a model in Great Britain for psychiatric facilities. They originally were very supportive, peer-governed models with heavy professional emphasis. The model was brought to America and became what is called a traditional American model therapeutic community, often associated in its foundations with the Synanon Program. The programs targeted individuals addicted to heroin, most of which had criminal justice involvement. Treatment was not simply for an addictive disorder but also the lifestyle disorder associated with drug use. The problem was not just substance use; it was lack of skills for jobs, lack of educational accomplishments, poor social relationships and the handling of problems through aggression and power.

Characteristics

The focus in therapeutic communities is on habilitation or learning the skills for the first time rather than on rehabilitation. This is very germane to work with adolescents. The youth involved with treatment providers and the juvenile justice system typically have not mastered many of the age appropriate skills because of their impairment by psychiatric disorders or by their addictions. The therapeutic community helps to create a bridge for adolescents into adulthood by teaching them the developmentally appropriate skills and by changing a whole variety of negative behaviors and thinking processes. The problem in therapeutic community is seen not as the drug abuse but rather the client's behavior. Therapeutic communities are a socialization experience. They are highly structured with a very clear and constantly reiterated set of rules and expectations often termed "right living." The healing agent in the therapeutic community is not the professional staff, but the community itself. The peer community is the healing agent as a core strategy of "community-as-method." It occurs 24 hours a day, 7 days a week. It allows for a self-governance where participants are members and is called a family because it is a socialization experience. Community members are given roles that simulate what it is like out in the world with personal responsibility. Members have jobs - cleaning up the

dining hall, posting information for the community, working at the reception desk or answering the phone and taking messages.

Key Changes to the Therapeutic Community Model

The therapeutic community model, however, has been found to need adaptation for adults with co-occurring disorders. These key changes now need to be evaluated for changes in adolescent co-occurring treatment in therapeutic communities. These adaptations include:

- **More flexible**

- **Less intense**

- **More individualized**

These changes mean that sometimes the programs need to be longer in duration and sometimes shorter. The emphasis is on education and supportive approaches rather than confrontation and compliance. Movement through the program and specific tasks are more individualized. Rewards focus more on positive reinforcement (e.g., verbal praise, and privileges) rather than negative sanctions. Correctional research indicates, in terms of behavior change, four reinforcers are needed for every punisher. Conflict resolution or "community" groups replace encounter groups with more emphasis on affirmation of progress and individual change efforts. Youth in general and especially youth with co-occurring disorders have shorter attention spans and their cognitive skills are different. The pace, therefore, is slower with more overlap. Information is provided gradually with significant repetition. There is more individual counseling with higher staffing ratios, with staff that are cross-trained. And as opposed to an adult TC, any adolescent TC has to be more staff-driven and staff directed. Staff provides more monitoring and coordination of treatment activities.

Effective Linkages to Aftercare

Linkage and referral is critical if recovery is to be maintained when a person leaves a correctional facility. Special attention must be provided to ensure the continuation of psychotropic medication. Pre-release planning must involve the following: continuation of

psychotropic medication, preparation for stressors and high risk situations, strong client involvement, involvement of family and friends, support services and case management and criminal justice supervision, if required.

COGNITIVE BEHAVIORAL APPROACHES

Cognitive behavioral approaches work at changing the way people feel and behave by examining and changing how they think. Research suggests that for both for addiction and for mental disorders outside of those that respond to medication, as well as for offending, cognitive behavioral interventions are highly effective. The goals of cognitive behavioral approaches include changing the way the individual thinks about things, helping individuals identify obstacles to thinking and acting in a new and more helpful way and improving coping skills to improve functioning and access to social support. Self-control strategies can be taught to look at impulses, anxiety, mood elevation and handling and expressing emotions and managing anger. Skill-building strategies focus on planning daily activities, improving relationships through assertiveness, negotiation, asking for help, active listening, and use of positive self-statement and techniques that include didactic presentation, modeling, role-playing and feedback and homework to promote skill acquisition and self-monitoring. There are structured curriculums available to address all of these areas. A particular application to juvenile offenders and to offenders in general is the issue of cognitive restructuring and identifying patterns of thinking, called "thinking errors" that characterize offenders. Interventions help an individual to identify those thinking patterns and to confront and change them. Thinking errors that support continued offending behavior are targeted. An example of those offending thought processes include the victim stance: "It's never my fault. Poor me. The system is stepping on me." Self-centeredness is another thinking error: "If I want it, so what if it belonged to you. You can go buy another one." Interventions in the cognitive behavioral domain help to identify those thinking patterns and to confront and change them.

FAMILY-BASED INTERVENTIONS

Family intervention is a critical part of adolescent treatment. The adolescent must be viewed within the context of the family and the broader social system. The principles of the family interventions are the following:

- **Helping parents to develop skills to more effectively manage their children's behaviors;**

- **Services are provided in the family's natural environment;**

- **Services should promote responsible behavior among all family members;** and

- **Adolescent behaviors are targeted in multiple settings and systems.**

1About the Presenter

For the past 13 years, Scott Reiner has focused his work on addressing the substance abuse and mental health concerns of juvenile offenders as a clinician, program manager and administrator. He is presently the Court Services Specialist for the Virginia Department of Juvenile Justice ("DJJ") and is responsible for planning and implementing major initiatives in the juvenile probation and parole services. Prior to assuming this position in November of 1999 he spent nine years as DJJ's Substance Abuse Program Manager, providing management and oversight to the agency's substance abuse activities. He has been with DJJ since 1987.

Mr. Reiner has a master's degree in clinical psychology fro Syracuse University and received his bachelor's degree from Brandeis University in Waltham, MA. He holds adjunct faculty appointments in the Departments of Criminal Justice and Addiction Medicine at Virginia Commonwealth University.

Contact Information:
Scott Reiner, Court Services Specialist
Virginia Department of Juvenile Justice
P.O. Box 1110
Richmond, Virginia 23218-1110
Telephone (804) 371-0720
Email reinersm@djj.state.va.us

CURRENT TRENDS IN ADOLESCENT SUBSTANCE USE TODAY

Presented by David Rosenker

About the Presenter

David Rosenker is the Vice President of Adolescent Services for The Caron Foundation, a non-profit organization that provides addiction treatment for adults and adolescents. Mr. Rosenker has worked in the field of chemical dependency since 1976. He is a certified addictions counselor from the University of Minnesota and is a consultant for prevention program development for school districts on a local and national level.

Contact Information:
David Rosenker, Vice President Adolescent Services
Galen Hall Road, Box A
Wernersville, Pennsylvania 19565-0501
Telephone (800) 678-2332

GENERATION'S ATTITUDES AND BELIEFS

Trends in adolescent substance use relate directly to generational attitudes and beliefs. Each generation is influenced by the cultural norms of their group. During this session, the participants were divided up according to their generation and surveyed as to their use of alcohol and other drugs in high school and the frequency that they experienced divorce in their nuclear families of origin. The survey data is included in the discussion of each generation named below.

THE WORLD WAR II GENERATION

The World War II generation, commonly referred to as the GI generation, graduated high school between 1929 and 1944. This is the Hoover/Roosevelt years and individuals in this group are now between the ages of 72 and 89. Divorce in their families of origin was uncommon for this generation and this generation holds the prevailing attitude of - you made your bed and you lie in it. Although this group no longer is parenting adolescent children of their own they may be raising their grandchildren for various reasons. Either because their parents are fed up with them, the parents are deceased or the parents are otherwise not available. Typically, this group does not relate to the issues of substance abuse and divorce and frequently blames the current generation's problems on not having control over their kids.

THE SILENT/COLD WAR GENERATION

The next group is the silent/cold war generation. They are high school graduates from between 1945 and 1963. This is the Truman/Kennedy years and they are now between the ages

of 55 and 73. While seniors in high school this group reported that those who drank alcohol were around 10 – 15% and 0-5% smoked marijuana. Less than 1% had parents who were divorced. When you talk about substance abuse and different types of drugs, date rape drugs, heroin use among adolescents, this group tends to shake their heads and say, "I don't understand it. It doesn't make any sense to me." Marijuana was called dope and it was something that was mostly used by musicians and a few other offbeat characters.

THE VIETNAM EARLY BOOMER GENERATION

The next group is the Vietnam/early boomer group. Individuals in this group graduated high school between 1964 to 1974. This is also the Nixon/Johnson years, the proudest years of our country. Individuals in this group are now between the ages of 44 and 54. Approximately 20-85% of seniors in high school drank alcohol, 0-90% smoked marijuana and 0-25% had divorced parents. This group has somewhat of a split. Those graduating from 1964 to 1968 tend to have similar attitudes and beliefs to the Truman/Kennedy years, while those graduating around 1968, 1969 and into 1974 identify more with the later age of this generation.

THE HIGH TIDE "JUST SAY YES" ME GENERATION

The next generation - the high tide - is the "just say yes" generation. This is the Ford/Reagan years with high school graduates between 1975 to 1984 who are now between the ages of 34 and 43. Eighty-five to 95% of seniors drank alcohol, 15-60% smoked marijuana and 10-40% had divorced parents (this rate reported by the participants is lower than the average divorce rate nationally of 52%). Many couples in this group co-inhabited prior to marriage and the rate of divorce for those individuals increased another 8 to 10% rather than lowering the chance for divorce. Per capita this group's use of drug and alcohol is the largest percentage we have ever seen in the United States' history both prior to and since this time frame. These are parents now with kids in the middle and high schools. The attitudes from these parents are typically that they are tired of hearing about drugs and alcohol. They tend to have the attitude that if you just stopped talking drugs and alcohol and glamorizing it, there would be no problems. Many of them used/use drugs and feel that they have gotten to where they are without problems and hold the attitude that drug and alcohol use is to be expected in their children. In fact, the question "How many of you have used with your parents?" is now a standard question

in treatment programs. Not only are some parents using with their children, some parents are supplying for their children. Also, as this group ages we will be seeing grandparents who are addicted and/or recovering. The medical costs associated with this group will be significant over time.

THE JUST SAY NO GENERATION X BABY BUSTERS

The "just say no" generation, often called Generation X, are those representing the second Reagan and Bush years with high school graduates from between 1985 and 1992. They are now between 26 and 33 and while in high school 75-90% drank alcohol, 10-50% smoked marijuana and 10-30% had divorced parents. This group has heard more drug and alcohol prevention information, more just say no, more frying pan commercials, more McGruff crime dog commercials, than any group has ever heard in the history of the United States. However, it's impact on their drug and alcohol use and in their kids' use is minimal to none.

THE ECHO BOOM GENERATION

And then there is the most recent generation – the echo boom group. This is the Clinton [and now Bush] and who knows who generation whose high school graduate dates are between 1993 to 2012. They are now between the ages of 6 and 25. This group's drug use has not decreased, even with the entire "here's looking at you" 2000 curriculum, the entire project Charlie curriculum and the lifestyle curriculum. The substance abuse actually is on an increase as is the divorce rate.

OTHER INFLUENCES

Ethnic cultural influences on this generation's schema have become less and less in subsequent generations because of acculturation. As an example, what we used to see was that the Jewish religion tended to have less alcohol use than any other population. However, they also had a high rate of sedative and tranquilizer use, especially among the female population. But now what we are seeing over the past 3 to 5 years is that the Orthodox Jewish adolescent population's substance abuse is out of control. There also are genetic influences to substance use. However, there is as much data about it being genetic as there is data about it saying that it is not genetic.

WHY ATTITUDES ARE IMPORTANT

Whether you are affected by drug and alcohol abuse in your community or your own family or kids that you work with, understanding where the various attitudes come from gives you a different perception about not only the kids but also the people that you are dealing with. A lot of times we call up parents and we say, "Look, we're concerned," and we get so many different variables from resistant parents to parents that just seem ignorant to the whole issue and we hang up the phone and we get frustrated. A lot of it relates to whatever generation they grew up in. It does not make them right or wrong. It is what they understand and what makes sense to them.

These generation attitudes are also present in staff. The high tide generation often is complacent and becomes over saturated with information about clients. Their attitude tends to be blasé. We have to counteract this attitude and start getting outraged about what is happening.

WHY KIDS USE?

So, why do kids use in the first place? It is not a very complicated question. Kids use for some very particular reasons.

- **For one, it feels good and it works every time.**
- **It is very difficult to compete against.** For many years we tried to do these alternative high treatment programs and groups. The thought was if we could just get kids interested in rock climbing and canoeing and all those things, then they are going to want to stop using drugs. And what we found out was, we took these kids out, we did those things. They came back and said "Oh, God, that was fun. Could you imagine how much more fun it would be if we were on acid?" It had little impact. You cannot compete against it at least on the short-term basis.
- **Drugs and alcohol are readily available.** The other common myth about adolescent substance abuse is that if we could just get rid of the dealers, we would be in great shape. And those of you who work with kids certainly know that, especially looking at this information, the largest percentage of kids that get their substance abuse is from parents. Almost always first time use is with parental or brothers and sisters and then they may use

with peers or other family, like cousins, aunts and uncles.

- **They believe that they are going to live forever** so they are not concerned about their drug use. They do not think about consequences of things.

FIRST TIME USE

In the mid 70's the average age of first time use was between the ages of 12 and 13 with kids coming into drug and alcohol rehabilitation at about 15 to16 years of age. Now the average age of reported first time use for kids that we are seeing in the facilities is between the ages of 8 and 10. So when kids come into treatment at the age of 15 or16 years, they have had anywhere between 5 to 8 years of drug and alcohol use behind them. That is a totally different kid than it was 10 or 15 years ago. It makes a huge difference in their progression, symptomology and in the various other issues that they are bringing in with them.

RATE OF PROGRESSION

The rate of progression has accelerated over the years. The progression happens faster because they are using at a lower developmental age. So we're seeing the progression happen faster and faster as age of first use becomes younger and younger.

TYPES OF DRUGS USED

Substances around today are different than they were years ago. The marijuana's toxicity level is significantly higher. Different drugs are being used and different groups are using drugs.

There is a significant increase in heroin use among females. Heroin use among adolescent, white, suburban females has increased 5 to 8% more than any other population. Its use is attributed to its ease of use by snorting, its availability and the desirable sheik, thin, emaciated look. Inhalants also are on an increase depending upon age group. It is more popular in middle school than high school. Also some of the club drugs are being used. Ecstasy is on a real increase as well as GHB and there is a new one replacing GHB, called GBL. GHB often is called Georgia Home Boy and there are also other names for it. Within 15 minutes it causes a person to completely blank out for anywhere between 8 to 10 hours and it has been attributed to sexual assaults.

SENSE OF COMMUNITY

My belief is that the answer does not lie just within 1 person, or 2 people or 3 people. I don't believe it's the parents, although I do believe they have a significant part in it. I don't believe they are the ones that are at fault. I don't believe it's the school. I don't believe its probation. I don't believe it's the court system. I don't believe it's the managed care companies. But I certainly think it's every one of us. And as long as we continue to remain splintered, separated and not come together, that has created more and more of the problem. The difference between now and when drug use was not as out of control is the sense of community. When you look at treatment alternatives and treatment approaches, all treatment approaches are based on kids getting a sense of community back, by getting involved in the community and by getting a sense of spirituality.

GENDER SPECIFIC ADOLESCENT TREATMENT

Presented by David Rosenker

CONCEPT OF GENDER SPECIFIC TREATMENT

Gender specific treatment at The R.J. Caron Foundation provides specific and separate therapy for males and females. Primary and extended care treatment is gender specific with most of the staff gender specific, females working with females and males working with males.

OUTCOME DATA

CURRENT DATA ABOUT GENDER SPECIFIC TREATMENT

There is limited information about outcomes from gender specific treatment for adolescents in the literature. Conclusions presented in this paper are based on the Caron Foundation's initial experience with separate treatment. The Caron's experience has found that gender based treatment utilizing traditional treatment models improves abstinence and relapse rates, decreases illegal behaviors in post-treatment and improves self-esteem and coping skills.

CHANGES SINCE LATE 1980'S AFFECTING OUTCOMES OF TREATMENT

There have been changes in treatment over time that limit knowledge on whether gender specific treatment has had a positive outcome. Most studies are from the late 1980's and early 1990's, when societal influences as well as length and type of treatment were different from today.

In 1998, marijuana was the most common substance abused by adolescents in treatment (40%), followed by heroin and alcohol (21%), cocaine (10%), inhalants (1%), and others (5%). Adolescent heroin use grew substantially for both boys and girls from 1991 to 1998.

Age of Onset

Age of onset has decreased over the years and has dramatically affected the outcome of substance abuse treatment for adolescents. The age of onset for substance use is now between the ages of 8 and 10.

Length of Stay for Adolescents in Treatment

Current average length of stay for adolescents in treatment nationally is 21 days and at the Caron Foundation is 22 days. The average stay for a highly managed care population of adolescents is about 5 days nationally. At the Caron Foundation the average short-term stay is 7 to 10 days, which is reduced from 5 years ago when the average short-term stay was about 14 days. Limited treatment time has affected outcomes.

Heroin Use

Heroin use among adolescent females is 5 to 8 percent higher than for the male population, a significant increase in the past 3 to 5 years. This increase in one particular drug also skews the gender specific outcome data.

Increased Risk Behaviors

Risk behaviors of adolescents have increased in both genders. High-risk adolescent male behavior now has stretched across both genders, with adolescent females increasing their risky behaviors, taking more risks and doing so at a younger age.

DEVELOPMENTAL NEEDS OF ADOLESCENTS

An adolescent needs to _be somebody_ or to be important – there is a need to identify "what is your gift?" An adolescent needs to _be oneself_ – to build integrity, separation and autonomy. There is a need to _belong_, to have support and validation. And there is a need to _escape_, to build spirituality.

GENDER DIFFERENCES IN ADOLESCENT TREATMENT

Gender differences need to be honored, acknowledged and respected in the treatment process. The social developmental differences that influence gender communication and interaction patterns should be reflected in treatment.

GENDER DIFFERENCES IN GROUP BEHAVIORS

Girls do better than boys in smaller exclusive groups. They learn to read subtle cues for

liking and disliking and developing cooperative behaviors and they maintain a connection much better than do males. Boys tend to work better in larger groups; they are much more task oriented; tend to be more competitive to achieve rank order and dominance; and work to establish potency and confidence through teamwork in group settings.

GENDER DIFFERENCES IN COMMUNICATION PATTERNS

Thinking patterns in males tend to be a little bit more logical, procedural, sequential and solution oriented. Females tend to gather more information. They tend to be more process oriented, feeling focus and more intuitive in nature.

GENDER DIFFERENCES IN EMOTIONAL EXPRESSION

There also are differences in emotional expression. Males are more likely to defend against emotional responses. They try to alleviate rather than empathize with emotional responses. They are more likely to express anger and stubbornness as emotions. When males express emotions others attribute positive attributes to the individuals, such as honesty or vulnerability, and these feelings then are admired and respected. Females, on the other hand, tend to express emotions such as happiness, sadness and fear. Females may be considered over-reactive or hysterical and their feelings tend to be devalued as worthless.

GENDER DIFFERENCES IN VERBAL COMMUNICATION

Males tend to ask more questions to get information. They tend to talk, control the topic more and interrupt more. Females tend to ask questions to initiate and encourage conversation. They initiate more when males introduce topics and work more at maintaining conversation. They have a greater sense of self-disclosure; they have more head nods and more eye contact than males and they tend to have more empathetic responses.

GENDER DIFFERENCES IN SUBSTANCE ABUSE
GENDER DIFFERENCES IN MOOD AND BEHAVIOR DISORDERS

Eighty percent of the adolescents who abuse alcohol have some other type of co-morbid

psychopathology, often mood disorders and behavior disorders. As alcohol use increases, so does other drug/alcohol use. About 42% of youth in treatment for substance abuse have conduct disorders, about 35% have major depression and about 14% have attention deficit disorder.

Male substance abusers tend to have a co-occurring conduct disorder along with their substance abuse, often exhibiting conduct disorder symptoms three years prior to their substance abuse becoming a problem. Bipolar or attention deficit disorders were significantly associated with boys in treatment. They may have suffered from physical abuse or have been victims of violence. There may be a father-son addiction connection. They may receive pressure to risk-take – drugs, sex or illegal behavior.

Adolescent females with co-morbid substance abuse tend to have a high prevalence of mood disorders. These differences maybe related to differences in communication patterns previously discussed.

GENDER DIFFERENCES IN DRUG AND ALCOHOL USE

Severity of pre-treatment symptomology is definitely a prognostic sign for poor post-treatment success. Males tend to have a higher level of pre-treatment symptomology and a higher range of post-treatment failures in drug and alcohol treatment. Males' symptomology needs specific treatment intervention that has yet to be developed.

Although girls tend to use as often as males, their severity of use tend to be less, in part due to lower metabolic rates. Girls also use different chemicals than boys. Heroin use by female patients was greater than heroin use by male patients in 1997, 1998 and 1999. In fact, in 1999 heroin use decreased somewhat for males while it continued to increase for females. Females tend to use for the psychological reasons of emotional relief and emotional distress. Treatment and intervention strategies need to encourage adolescent females to find alternative ways for emotional empowerment and relief.

ADDICTION TREATMENT – PRIMARY CONCEPTS

A continuum of care is critical to support better treatment outcomes. Adolescents who

attend therapy and outpatient sessions two to three times per week have recovery rates of about 68% after the first year. Adolescents who attend only outpatient family care one to two times per week the recovery rate drops to 33%.

A significant difference in success rates of adolescents returning from residential and in-patient stays is affected by their participation in continuing care once they return to the community. In addition, the amount of family involvement is related to the rate of relapse. The lower amount of family involvement, the higher the rate of relapse.

The focus must be kept on recovery issues, including that of parental denial. Therapy must identify and begin to address recovery issues, and then refer the adolescent for continuing treatment to a specialist who understands addiction.

Both the content of treatment and the structure of treatment are important. Use of written materials, meetings, an emphasis on spirituality, and provision of a relapse track, especially for extended care programs, may reinforce the 12 Steps. The first step, Reality/ Responsibility/ Action, requires the adolescent to admit it, own it, and do something about it. Therapy groups should be kept active and task-oriented. Individual therapy should be gender-separate if possible. Individual therapy allows for establishment of rapport, diagnosis, and treatment planning. Family therapy should be diagnostic in nature and allow for identification and assessment of abuse or neglect. Family therapy provides an opportunity for confronting and getting a commitment.

When psychiatric co-morbidity is present psychiatric/psychological services are needed. Medications may be needed and the availability of on-going insurance coverage is important.

Support networks should be added and may include family, mentors, church members or other community members.

PREVENTION EFFORTS

The "4 Cs" of a healthy family are care/concern, communication, consistency and collaboration. Families can help by increasing awareness of the dangers of children's exposure to

drugs and by becoming knowledgeable about the dangers of drugs and alcohol. They should talk to children and teenagers about the dangers of drugs and alcohol. Those conversations should begin when the child is young.

Schools can help by increasing educators' awareness of students' exposure to drugs. Educators must become knowledgeable about the dangers of drugs and alcohol and school-based programs must be designed to meet developmental needs. Programs should continue throughout the school year.

Communities can help by creating and maintaining recreational and educational activities for young people, developing programs and activities that meet developmental needs and by including parents, schools, and media in drug prevention efforts.

SOME OF THE FACTORS INFLUENCING ADDICTION IN FEMALES

There are genetic differences between females and males in their response to alcohol. Females are less responsive to alcohol and are less able to judge the level of intoxication than males. Female alcoholic patients have a higher level of depression. They have lower self-esteem, a higher level of anxiety, and a higher level of shame or guilt compared to males, who tend to have more anti-social and pathological gambling behavior.

College females tend to drink more to relieve shyness, to want to get high and to get along better on dates. They tend to have the highest level of drinking later on in life.

Sixty-seven percent of females who are alcoholic report being sexually abused versus 28% of non-alcoholic women. History of sexual assault is three times greater for adolescents that have an alcohol problem and four times greater for adolescents that use alcohol and drugs. Girls with alcoholism are more likely to suffer from emotional problems before and after the onset of their use than adolescent males.

TREATMENT OF ADDICTION IN MALES AND FEMALES

According to research with adolescent males and females in addiction facilities, the type

of use (with the recent exception of the use of heroin), the style of use and length of use is not significantly different. Overall recovery rates are not significantly different between adolescent males and females. The largest difference when treatment is gender separated is with the initial outcomes of short-term treatment.

ADVANTAGES OF SEPARATE GENDER BASED TREATMENT

More Time Spent on Recovery

In gender separate treatment there is more time and treatment spent on recovery. Adolescent groups that are not separated by gender spend the majority of time on social issues. More time is spent by staff and clients on boy/girl relationship issues instead of on treatment. Gender-based treatment gives adolescent girls time to focus on issues with their own gender.

Less Competitive Atmosphere

The competitive atmosphere is almost non-existent in the female population when the sexes are separated.

Deeper Sharing for Females

Females tend to share at a deeper level with just females than they do with males. They also will tend to share their trauma more in a segregated population than with a mixed population. Females tend to bond tighter and are less competitive.

Deeper Sharing for Males

Adolescent males also spend more time sharing at a deeper level when they are separate from the other gender. Most males learn relationship skills outside of a female environment with other males. Males are more likely to talk at a deeper emotional level when they're in a separate population. Therapy success for teenage males depends more on the therapist and the clinical staff than it does for females.

Rights of Passage

Both genders are better able to focus on rights of passage easier in a gender separate facility.

DISADVANTAGES OF SEPARATE GENDER BASED TREATMENT

There is not a lot of data to substantiate either the advantages or the disadvantages of gender separated treatment. However, experiences at the Caron Foundation indicate the disadvantages include a tendency to have more same sex acting out and more male violence in separate gender based treatment.

Another disadvantage is the effect on staff. Staff who may be struggling with their own gender identity or gender issues from their own family of origin are going to experience more difficulties with gender separate treatment. It is important therefore before implementing gender separate treatment to spend time with staff on what it means to them, how it affect them and what issues do may have with gender separate treatment.

BOYS IN TREATMENT

Boys' Emotional Life

Boys need permission to have an inner life, to have a full range of human emotions and need help in developing an emotional base. They need help in establishing an emotional vocabulary so that they can describe their experiences and feelings and their emotional reactions. Their inner emotional life needs to be constantly acknowledged, respected, talked about and shared. The male staff can support this process by making reference to their own emotional inner life but only to the extent it benefits the males.

Boys will be open about their feelings in an environment that is safe. Boys' sense of safety is more critical perhaps than for girls. Providing rituals can help provide a sense of safety. Adolescent males do not have as many rituals as adolescent females.

Boys who are 16 or 17 years old may be reticent to talk about their feelings, but that lack of talking does not necessarily mean resistance. It may mean a lack of skill and/ or a lack of a sense of safety. The stereotypical boy tends to trivialize other boy's experiences and emotional life.

Boys' Active Life

Boys have a need for a high level of activity and they have to have a safe place to express that. Boys need activity more than females; they need to burn off some of their energy and they need to be respected for the energy level that they have. Adolescent males may not be like their female counterparts who will sit in a room and talk for an hour or two. They may sit around and talk for 30 to 45 minutes, but then they have to move and interact. Their high level of energy is not the same as that of girls and the same schedule and same format will not work for both. Boys are tremendously sensitive to adults who have a low tolerance for "boy energy" and boys see that as a challenge.

Boys' Need for Pride and Masculinity

It is important to talk to boys in a language that honors their pride and their masculinity. It is important to be direct with them and consult with them as part of the problem solvers. Boys like to problem-solve. Ask them how to solve the problem and what they think needs to happen. An adolescent male will not become an empathetic listener who will elicit and be more intuitive and will try to carry on a conversation and engage everybody in conversations. But they will come up with effective problem solutions quickly. Their solution will often include working together as a team and as a group.

Boys tend to have certain ideas about what is masculine and what is feminine. It is important that they discuss those preconceptions and understand that there are some things they can do that are part of their masculinity and that are not necessarily feminine.

Boys and Talking

Boys like to give brief answers. There will not be long conversations about the meaning of relationships and relational theory and adolescent development. Extended conversations should not be the goal of therapy.

Boys and Courage

It is important to teach boys that there are all types of courage, including emotional courage. There are ways to be brave emotionally, not just standing up face to face in a fight with

somebody.

Boys rarely are celebrated for having some kind of emotional or moralistic stance. Most boys feel that when they become emotional, they are going to lose themselves and lose their power. They need to understand there are other ways of being brave and courageous and other ways to be emotional without losing themselves in the process.

Boys and Empathy

Teaching boys empathy is difficult to do but is necessary. Girls tend to have more empathy, but most boys do not understand empathy and do not have it as a life skill. It does not come as part of their emotional growth.

If another person is talking about something that is very difficult and very emotional, it is important to teach boys how to respond. The facilitator/therapist must say, "I want you to go over, I want you to sit by them, I want you to stand by them, I want you to hold out your hand to them, I want you to embrace them. Here's how you do that and here's how to be empathetic."

Boys and a Sense of Attachment

Boys need to understand that males can attach just like females can attach. This sense of attachment can be modeled and taught.

GIRLS IN TREATMENT

Girls and Physical Changes

An atmosphere must be created for adolescent females so that their feminine traits and changes that occur with them are celebrated and honored, not ignored.

Girls and Roots of Addiction

It is also important to address the multi-dimensional roots of addiction with adolescent females. Girls often come into facilities with co-existing emotional disorders. More adolescent females than males are depressed in conjunction with their substance abuse.

Girls and Relational Treatment

Treatment for women and adolescent females is more relational in nature rather than conceptual. For example, it is not as important that they understand the concepts of the 12 steps of AA as much as they understand the relationships that they have and that they build with people in AA and how that helps and supports their recovery. Girls need to improve their relational skills.

Girls and Process

It is important to value process over product with adolescent females. Girls need to understand the steps needed for recovery versus just getting there. Males want to just get it done and solve the problems, while adolescent females need to spend a little bit more time on the process and the steps that must happen for that to take place.

Girls and Nurturing

There is also a need for nurturing with adolescent females, and the environment must be safe for them.

Girls and Safety

Girls' usually have a sense of safety when they come together as a group. However, some girls do not feel safe unless there are males in the room. Intimacy can be an issue for some girls and for some intimacy may mean just sex. Generally, adolescent females tend to feel safe quicker and faster than adolescent males as their relationship skills typically are more developed.

<u>**CHANGES IN ADOLESCENCE**</u>

The onset of puberty radically alters a person's physique. An adolescent experiences growth spurts, development of sex characteristics, and redistribution of body weight. They may feel "different" from others and from themselves. And they may feel a lack of control of their own body.

The major psychological issue of adolescence is identity. It's a period of greater narcissism, and adolescents often have a major focus on comparison with others.

Relationships change during adolescence. The focus shifts from family to peers. Girls need to express their emotions to friends, while boys focus more on "comradery." A major relationship issue is sexuality. The body becomes sexual, and there is increased awareness of sexual attraction for others. Adolescents experience mixed expectations, ranging from "Act like an adult" to "You're too young."

These are conditions for maladaptive behavior. Adolescents' confusion can be resolved through exploration in an environment of relative safety. Difficulties arise if there is an unsafe environment -- the family, or peers, or neighborhood, or if they experience themselves as different in physical appearance, or if they have learning problems, or have family or cultural differences.

Adolescents have vulnerability for psychological problems. They may seek control of their body through maladaptive behaviors. They may find affiliation through a "rejected" group or become a "loner", or they may escape through drugs and/or alcohol.

RESULTS OF GENDER-SEPARATE TREATMENT FOR ADOLESCENTS

It is important to acknowledge the differences between male and female development and to address the difficulties and needs in treatment. However, there is very little data yet to help direct the treatment. The information presented is from The Caron Foundation's initial experiences with separate treatment. For example, at the end of therapy, we often hear females and males walking out and saying, "I'm really glad it was separate because I know more about myself as a female or as a male than I ever knew before, and I know more about relationships by being separate than by being together."

About the Presenter

David Rosenker is the Vice President of Adolescent Services for The Caron Foundation, a non-profit organization that provides addiction treatment for adults and adolescents. Mr. Rosenker has worked in the field of chemical dependency since 1976. He is a certified addictions counselor from the University of Minnesota and is a consultant

for prevention program development for school districts on a local and national level.

Contact Information:
David Rosenker, Vice President Adolescent Services
Galen Hall Road, Box A
Wernersville, Pennsylvania 19565-0501
Telephone (800) 678-2332

ATTENTION DEFICIT HYPERACTIVITY DISORDER ("ADHD") AND SUBSTANCE ABUSE IN ADOLESCENTS

Presented by Timothy E. Wilens, M.D.

Increased recognition of attention deficit hyperactivity disorder ("ADHD") in children, adolescents, and young adults has focused interest in its co-occurrence with addictive disorders. Data suggests that an increased risk for substance abuse occurs in older adolescents and young adults with ADHD. Moreover, an over-representation of ADHD has been reported in youth with addictions. This presentation discussed these co-occurring disorders and the relationship of ADHD and substance abuse.

First, it is important to define what is meant by substance abuse. Substance abuse occurs when there is a pattern of use that develops along with impairment and/or consequences. With more severe use dependence occurs. Dependence is the physiological addiction to a compound, usually with severe impairment. Examples include a child continuing to use the substance even while missing school, drinking before school, failing school, truancy, and driving while intoxicated. The phrase psychoactive substance use disorders ("SUD") refers to drug use or dependence or alcohol abuse or dependence.

The mean age of onset of ADHD is three. Substance abuse in adolescents with a mean age of fifteen indicates a likely chronic condition of ADHD for an average of twelve years. Adolescents with ADHD are often seen with self-esteem problems. Poor self-esteem can be a result of having chronic ADHD. Just the self-esteem problems that go along with ADHD can lead to substance abuse. Adolescents with ADHD commonly have poor self-esteem, a poor self-image or both. Poor self-esteem is characterized by an adolescent who thinks, "I don't feel good about things; I don't feel good about the world; I'm not sure where I fit into the world." Adolescents with a poor self-image do not feel themselves to be good physically. They have a poor picture of themselves. Having a child draw a picture of who he or she is provides remarkable information. The child looks normal, but draws a picture of an enormous person, or shows somebody with sharp teeth, with no brain, or somebody with zits. With ADHD, where

perceptual problems in thinking processing may be awry, a child's self-image is very different from what others think of the child.

Poor self-esteem is often found with poor academics. Poor academic achievement is one of the major risk factors for people abusing substances as they get older. Authors of the *National Co-Morbidity Study*, found that one of the biggest predictors of adolescents having serious problems with drugs and alcohol is academic under-achievement and ADHD is highly linked to that.

Poor ego development is found in those with poor self-esteem. Their personalities do not develop well. With substance abuse, poor ego development becomes an even greater problem. Substance abuse exacerbates self-esteem issues. In fact, active substance abuse not only worsens self-esteem but can worsen many child psychiatric disorders as well. It can also make the child look sicker than they actually are. So it is critical to have people stop their substance abuse in order to reassess what other issues must be addressed.

Peer groups are important in addressing both general substance abuse issues and also ADHD issues. Adolescents with ADHD tend to move toward peer groups that are not the groups desired by parents. Often the only peer groups that accept kids with ADHD into them are the alternative peer groups. Typically, these are teens who do not have good social relationships with one another, and they are often found in peer groups that are not a good fit. They are accepted into those groups because they are often followers, and they can become victimized. Often they may be found with peer groups that are involved with drugs and alcohol. Delinquent peer groups are highly influential on drug or alcohol abuse or dependence.

Another issue that is very important when working with these teens is to realize the importance of their friends. Often their friends are using drugs. Teens must be asked, "How many of your friends are using drugs?" Peer pressure has a large influence. Drug availability is another indicator. Working with adolescents in certain areas that are drug infested is particularly difficult. The word "drug infested" is appropriate because it indicates the level of infection and contagion in a community. It is a big problem. Reducing the flow of drugs into this country is a

good and reasonable policy. If the availability of drugs is reduced, drug use is reduced. If it is difficult to find the drug, prices go up, and that cuts down use of the drug.

Disregard for values is prominent in drug users. A teen with ADHD in a peer group, which has a disregard for values, must be extracted from that peer group. The treatment counselor must talk to the teen about that, because the teen will not listen to his or her parents. The counselor has much greater impact than the parents on this issue. Change in these psychosocial issues is a critical aspect in treatment of substance abuse. Peer groups are influential in the development of substance abuse, and if they are removed, there is improvement in substance abuse, independent of ADHD or any other issue.

In adolescents with substance abuse, there is a significantly high degree of ADHD. Psychiatric disorders such as oppositionality are more common in those with ADHD. Often psychiatric disorders are found along with substance abuse. Fifty percent of adolescents with ADHD are oppositional and about 10% of kids with ADHD have a conduct disorder. Conduct disorder refers to delinquency. Mood disorders as well as bipolar disorders are also found with ADHD. It is important to assess for those disorders because they may be driving some of the substance use.

Most of those with bipolar disorder have ADHD, but, in addition, many have substance abuse. If a person has ADHD and a psychiatric disorder, ADHD always starts first. We know that because ADHD starts at a mean age of three. Other co-occurring disorders with ADHD include depression, bipolar disorders, and anxiety disorders. Major depressive disorder ("MDD"), or depression, occurs in 20% to 30% of children with ADHD. Seventy-five percent of the time, depression in children starts before substance abuse. So, for a depressed child with ADHD who is getting involved in substance abuse, it is not likely that the marijuana is causing all the depression. It is more likely that the child may really have ADHD and depression and is also smoking marijuana. The same is true for bipolar disorders. Often, psychiatric disorders that co-occur with ADHD start before the substance abuse. Aggressive treatment of the disorder will reduce the risk of eventually having a substance problem.

At least half of children with ADHD have an additional disorder. In children who are ADHD and have an additional disorder, the percentage of kids with ADHD who are going to develop a substance problem begins to increase at age ten, and there is a major rise by thirteen. At age sixteen, it is far too late for parents to discuss substance abuse. Substance abuse is a pediatric disorder that starts at an early age.

About 80% of children with bipolar disorders also have ADHD. There is a great overlap, and these are some of the most difficult patients. In adults, alcohol and substance abuse are associated with bipolar disorder. Those adults who have the earliest onset of bipolar problems also have the highest rates of substance abuse.

CIGARETTE SMOKING, ADHD AND OTHER DISORDERS

Cigarette smoking is a gateway drug. If a person starts smoking at an early age, there is a very good likelihood that he or she will become a drug abuser and alcoholic. There is a physical reason to account for this. Free-basing nicotine changes the brain's receptors. It may even change the development of the brain, and probably even changes some of the genes turning on and off. Exposure to nicotine in an animal brain will make the animal more or less likely to go for other compounds. Nicotine stimulates the same parts of the brain that are associated with substance abuse. Cigarettes are a gateway to further abuse because bathing the brain with nicotine probably causes neuro-developmental changes that predispose a person to substance abuse.

By seventeen years of age, about 12% to 13% of adolescents are smoking. But in a group of seventeen-year-olds with bipolar disorder, 55% of the group is smoking. Onset of bipolar disorder in adolescence is a major risk for smoking. Most adolescents who developed bipolarity as a child or teen went on to smoke. These teens are out of control, they feel miserable, and nicotine clearly settles them down, helps them focus, and helps them get control of their thoughts.

With ADHD and smoking, smoking is both the signal and may actually be attenuating the brain's response as well. Smoking may change the nerve chemistry to a predisposition toward

later substance abuse. This is being studied now in longitudinal samples. Those with ADHD have a much greater likelihood of having a smoking problem than those in the general population. In addition, the likelihood of quitting smoking is reduced in those with ADHD.

It appears that aggressive treatment of children with bipolar disorders that includes a combination of counseling plus medications, may result in the reduction of the ultimate risk for cigarette smoking. This result was found in a sample of children with bipolar disorder with either an adolescent onset or a child onset.

SUBSTANCE ABUSE, ADHD AND OTHER DISORDERS

Most of those with bipolar disorder have ADHD, but, in addition, many have substance abuse. Children who have adolescent onset bipolar disorder are at the biggest risk for additional substance abuse problems. Those with childhood onset (younger than age twelve) show less likelihood for such problems. This result appears to be independent of treatment. However, since most of the child-onset subjects had been treated, the study will be replicated in the future with a family design.

If there is increased substance use during manic episodes, the substance may actually cool off the mania somewhat. In a study of bipolar substance abusers, some received lithium and some received a placebo. The patients and the treatment person did not know which was which. The placebo group did not improve and had a high degree of problems with substance abuse. The lithium treated group did get a lot better and had a major reduction in substance abuse.

The result is that it is important to assess youth with severe or binge substance abuse problems for bipolar disorder and to assess all adolescents with bipolar disorder for substance abuse.

Substance abuse problems are found in 15% of the general population and in 15% of children with ADHD. However, both our smaller study and the *National Co-Morbidity Study* showed that more than half (55%) of adults with ADHD have a significant drug or alcohol problem sometime in their life, compared to only 27% of the general population. These

percentages, which are equal in fifteen-year-olds, greatly increase by adulthood. One reason is that 95% of these adults with ADHD never received treatment for their ADHD. It was not identified in their childhood.

Fifty-five percent of adults with ADHD and 27% of the general population with substance abuse problems like alcohol. The adults with ADHD are much more likely to prefer drugs, and also much more likely to abuse both drugs and alcohol. There appears to be some degree of self-medication in these results that show that adults with ADHD prefer the whole class of drugs and alcohol. But when drug abusers were asked what was their drug of choice, there were no differences between the ADHD group and the control group -- with marijuana, cocaine, stimulants, hallucinogens, or opiates.

There is no real evidence for the idea that adults with ADHD, as they get older through adolescence and young adulthood, tend to abuse stimulants. However, there is interesting evidence for differences between those with ADHD and the general population in how they describe the effects of using marijuana. Both groups say they started because they wanted to get high. But when asked why they continued, adolescents with ADHD overwhelmingly said it altered their mood. This shows some evidence for self-medication. A number of people say that they smoke marijuana and they get paranoid. When asked why they continue to do it if they get paranoid, they will say they continue because it helps them settle down. It is the only thing that breaks that internal restlessness. Hyperactivity in kids with ADHD changes to an internal restless feeling in adults. It is treatable.

PHARMACOLOGICAL TREATMENT OF ADHD

ADHD is a disorder that is improved by pharmacological therapy. Treatment of adolescents who have a substance problem and ADHD requires both addiction therapy and medications. When using medications for this disorder, it is important to think about the abuse potential. It is suggested to start with anti-depressants and then anti-hypertensives, and then use caution when going to a stimulant medication. It is important to have frequent follow-up. Intensive monitoring is important. Questionnaires can be very helpful. Adolescents are very honest when they fill out a questionnaire. In addition, there is excellent urine toxicology now,

including urine tests that parents can buy. One is "On-Track" from Roche Laboratories. Hair tests and saliva tests may be ordered. Hepatitis and HIV tests may be taken from saliva. Parents will be able to get good information to counteract the denial that is part of addiction. The client may not abuse the stimulant medication, but they are likely to be hanging out with others who will be very happy to abuse those substances. There is pressure on these kids, who are often ostracized from their own social support networks, to go toward their "friends" who will take them under their wings.

When treating substance abuse, the goal is to see the substance use decrease. Abstinence may be somewhat unlikely, but we certainly want to see (1) the substance use reduced over time, (2) people shifting from their inappropriate peer groups, and (3) families engaged in treatment, rather than kicking the user out. It is important to be very clear with the teen about the difference between prescribed medication and abused drugs. You are telling them, "Don't do illicit substances, but it's okay if I put you on this controlled substance called amphetamine." They must understand the difference.

Determining when to start medication with a teen with ADHD depends on how well the therapist knows the teen. The addiction can be done by connecting them to an addiction counselor or start engaging in some of the psychosocial issues by using family therapy treatment. Then they may restart their medicine. If this is a new client who is being seen for the first time, he or she must first get their addiction under good control and then be treated for the ADHD.

There are studies showing that if a person with bipolar disorder and substance abuse is treated for the bipolar problem through the substance abuse, it helps the addiction and it helps the bipolar issues. However, if there is an active abuse problem and an active ADHD, treating the ADHD does not help the addiction as much as it helps with bipolar disorder. Apparently ADHD is not a big enough engine to drive serious substance abuse. But it is a problem and it is a common co-occurring issue.

PHARMACOLOGICAL TREATMENT

In prescribing anti-depressants, we recommend starting with Wellbutrin or tricyclics.

Wellbutrin is an anti-craving medicine, it helps reduce cigarette smoking and it is easy to monitor. There is no concern about blood levels. It is a very safe anti-craving medication and nobody is going to hand it out as candy on the schoolyard.

With a stimulant medication, there is a certain level of abuse liability. Ritalin, which is methylphenidate, is in the lower spectrum of abuse. If a stimulant seems appropriate for a client who has ADHD and is an active substance abuser, the substance abuse should be cleaned up if possible. When the stimulant is introduced, consider the longest acting formula compound, highly supervised by parents, either Ritalin or one of the amphetamines. Pemoline is a reasonable choice, but there are some liver problems with its use.

In one study of adults with ADHD and cocaine abuse, use of methylphenidate led to some reduced cocaine craving and use and it did help the ADHD. However, the same result was not found under double blind controlled conditions. The medication did not make things worse. Even though those are compelling results, they are not strong enough in terms of treatment of the addiction. The addiction must be treated first and the ADHD treated next.

There is a big concern about the possibility of treating children with stimulant medications in early childhood possibly predisposing them to become substance abusers. Does giving children stimulants sensitize their brain the same way as nicotine, and will that create substance abusers? Does pharmacological therapy or treatment of ADHD actually reduce substance abuse? These are current unanswered questions.

A LONGITUDINAL STUDY

In a longitudinal study of treatment of youth with ADHD, children between the ages of ten and eleven were studied, and then followed four years later in mid-adolescence around fifteen and a half years of age. Some of the group had no medication, and some were on medications. A third group was the control group. Urine samples were not taken. Structured interviews and self-reported information were used. There were no differences between the two groups (stimulant treated versus not stimulant treated) in terms of baseline delinquency, family

history of substance abuse and other risk factors for substance abuse independent of the medication status. The two groups were very similar.

Thirty-five percent of the children who were not receiving any treatment for their ADHD had a substance problem. There was a much lower risk for substance abuse in the stimulant-treated group. The children who were not treated were the ones who were developing abuse and dependence, not the children who were treated.

The same trend was shown with alcohol abuse and dependence, as well as with marijuana abuse. The unmedicated children showed the most abuse and dependence, while the medicated group showed lower rates of use similar to the control group. Medication seems to protect against substance abuse.

Recently, an article stated that stimulant treatment led to cocaine abuse in young adulthood. However, in this longitudinal study, there was more cocaine use in the unmedicated group than in the medicated or the control group. In addition, stimulant abuse was greater in the unmedicated group than in the medicated group. Also, hallucinogen abuse was highest in the unmedicated group than in the medicated and control groups. It is possible that other things may have accounted for the differences in substance abuse rates in the untreated verses the treated groups. And there may be different results in the future as these fifteen and a half year olds age. Studies are continuing at this time.

One issue with this sample is that it is predominately boys. Funding is continuing in order to study these boys from nineteen to twenty-two years of age. Though studying the smaller sample of girls was not funded, we are continuing to do so. Another issue is the problem of substance abuse in the sample. Even though adolescents are fairly forthcoming about substance use issues, it is important to have objective measures, especially for research study. This study uses self-reporting, as well as urine and hair sampling.

Unmedicated youth with ADHD in mid-adolescence we found to be at highest relative risk for substance abuse, while the medicated youth at mid adolescence were at lower risk for

substance abuse. Medication status was found to be protective. A 65% reduction in risk for substance abuse was found to be associated with treatment.

In summary, ADHD is a risk factor for substance abuse but not as strong a factor as it is for other issues found with ADHD, such as conduct and bipolar disorder. For those who are newly diagnosed with this combination, first treat the addiction and then sequence in with pharmacological therapy to treat the ADHD. When using pharmacological therapy, first use the anti-depressants and then use the stimulants.

And, importantly, we can say with relatively good confidence that stimulant treatment of younger children with ADHD either does not affect later substance abuse or it is protective against later substance abuse. Prevailing data are strongly in favor of treating ADHD to reduce later substance abuse. Though there are no data to show that a medicated child with ADHD has reduced potential for relapse to the addiction, experience indicates that relapse prevention is related to other issues, such as mood disorder or anxiety disorder, rather than to the ADHD.

The pharmacological sequencing of antidepressants and hypertensives and stimulants is also applicable for kids under the age of twelve. There is good evidence of pharmacological response across the life span, with the same medicines that work in very young children working in adults with ADHD

CIGARETTE SMOKING AND TEENS

Though cigarette smoking clearly is bad for adolescents, it is not appropriate to start battling that issue when a client is first seen. Once a client is in the program, it is important to start talking about it. Cigarette smoking is not hopeless; something can be done about it. Cigarette cessation programs for adolescents are effective. Behavioral relaxation techniques help, as does therapy and education around cigarette smoking. For pharmacological treatment, nicotine patches are recommended. Teens prefer nicotine gum rather than nicotine patches. Children can overdose with nicotine toxicity from inhaled nicotine. Wellbutrin is strongly recommended.

One survey of adolescent in-patients showed that one-third of them want to stop smoking but they can't, two-thirds like cigarettes and do not want to stop and one-third can be treated successfully.

About the Presenter

Timothy E. Wilens, MD, completed undergraduate and medical school at the University of Michigan, and his psychiatric training at Massachusetts General Hospital. He is board certified in child, adolescent, adult, and addiction psychiatry. He is currently Director of Substance Abuse Services in the Pediatric and Adult Psychopharmacology Clinics at Massachusetts General Hospital, and is Associate Professor of Psychiatry in the Harvard Medical School. Dr. Wilens has extensive clinical and research experience in both pediatric and adult psychopharmacology and the Addictions having published over 250 articles, chapters, and abstracts. He has also recently written a popular book, *Straight Talk About Psychiatric Medications for Kids* (Guilford Press, 1999/2001). Dr. Wilens has federal funding from the National Institutes of Health as well as pharmaceutical support and is currently involved in pediatric and adult-related research projects including the characterization and treatment of attention deficit hyperactivity disorder ("ADHD") across the lifespan; overlap of ADHD, bipolar disorder and the addictions, the pharmacologic treatment of juvenile psychiatric disorders and studies of the children of substance abusing parents.

Contact Information:
Timothy E. Wilens, MD,
Director of Substance Abuse Services
        Pediatric and Adult
Psychopharmacology Units
15 Parkman St., ACC 725
Boston, Massachusetts 02114-3117
Telephone (617) 724-5600

JUVENILE PSYCHIATRIC DISORDERS
AND PSYCHOPHARMACOLOGY
Presented by Timothy E. Wilens, M.D.

There is an emerging recognition of the presence of psychiatric disorders in children and adolescents. These disorders are impairing, highly familial and often chronic. Some of these disorders, such as attention deficit hyperactivity disorder ("ADHD") and obsessive compulsive disorder ("OCD"), have presentations similar to their adult counterparts, but others, such as the mood disorders, have a varied presentation from that observed in adults.

Medications can be very helpful in the management of these disorders. This paper will consider juvenile psychiatric disorders and some of the major pharmacological treatments being used. These findings come from working with a group of researchers in pediatric psychopharmacology who have been together for over a decade. The team studies children and families and consists of M.D.'s, Ph.D.'s, people with master's degrees and people on their way to graduate school. The focus is mainly on the biology, neurobiology and pharmacology.

There are many prejudices and mythologies associated with the idea of using medications in young people. Because of this mythology, many children and adolescents are not being diagnosed and many are not being treated properly for conditions that are responsive pharmacologically. Just the mention of medications in children brings up many negative thoughts in parents and it takes a lot to overcome that. Many of these problems come from misinformation. The medicines that may be used are very safe. But most of what is heard is negative and most of the negative information is mythology. This is an impediment to treatment of these young people.

A current managed care way of dealing with psychotherapy is to provide a single session of therapy and then expect the patient to snap out of it. Therapy is much more engaging and important in these kids lives. Most of the children seen in our clinics are in therapy at one point or another. Medications and therapy are not exclusive; it is helpful to employ whatever is necessary. Some situations benefit from multisystemic family therapy, while others need

individual behavioral modification. Other possibilities include individual psychotherapy or more traditional types of therapy. Therapists should be specific when prescribing therapy for a child or adolescent. It is important to know the literature and to prescribe what they need. Do they need family therapy? Do they need individual therapy? Do they need behavior modification? If what is needed is family therapy, do they need systemic family therapy, or structural family therapy? A young child of seven who is telling everyone what to do and running his parents around needs a very different type of therapy than that needed by an identified depressed child within a family. In order to provide appropriate help, treatment providers must gather data and be specific. It is critical to know what are the best types of therapy and to prescribe appropriate specific types of therapy.

People should be aware that information on the Internet can be helpful, but it can also be entirely wrong. The Internet is not always correct and there is much misinformation out there. It is critical to know good sites. A book I wrote on medications and children includes a list of resources, including good web sites. Those sites are run by child-based organizations that are connected to the Manic Depressive Society, Children in Adolescence with ADHD and other legitimate groups from which parents can get good information that is not biased and is backed by good research.

Child psychiatric disorders requiring medication are typically not disorders such as adjustment problems. For example, a girl came into the office crying and sad. She was really quite despondent because her guinea pig had died. That is a reasonable reaction to a guinea pig dying. Certainly she should not have been started on Prozac because of that reaction. However, the problem was that she tried to commit suicide when her guinea pig died and she had a long history of depression that started five years earlier when she was fourteen. So the episode itself is something that patients can manage, but the reaction that the child had and the history and the context in which it occurred would indicate that there is something more pathological there. The context is important.

Sometimes child psychiatric disorders run in families and sometimes they do not. We tend to over-emphasize the psychosocial stressors that children have, blaming them on the

disorder. The first thing to be done with a child who has a psychiatric problem is to get a good assessment. Do not treat until there is a good assessment. With a surgical decision, for example, a good surgeon spends a lot of time trying to figure out what is wrong and to think about alternative solutions, only one of which is surgery.

Assessment is important in child psychology as well. For example, it is simplistic to assume that if parents are getting divorced and the child is acting up, the divorce must be the problem. It is important to learn not only that the child is acting up, but also to know what the child is doing. It is possible that the child has been acting up for a long time and nobody has noticed because there is so much strife at home. When there is a divorce, there is usually a year or two of separation issues and talk of divorce, and the child may have been acting up and everything was missed, or the child may have ADHD and now has developed anxiety because of losing a parent. Fifty percent of children in this country now are subjected to separation or divorce. But fifty percent of children are not in need of treatment because some children have resiliency factors that others do not have. This divorce may (or may not) be connected to the child's problem. We cannot untangle that until we note that the child has behavioral, emotional and cognitive problems and then question what else is going on that may be accounting for those. The cause may be the family disruption. Or there may be some type of genetic cause.

Some disorders are genetic. The younger the child presents with any type of psychiatric disorder, the more likely it is familial. "Familial" means it runs in families; it does not necessarily mean it is genetic. The earlier the onset, the more difficult course, the more problematic, and the more familial are the disorders. These are vulnerable children, either by genetics or family environment, who manifest quite serious pathology that requires treatment.

People are disturbed not by things or events or ideas, but by the views which they take of things or events or ideas. When it is time to talk to a family about considering treatment and medications for a particular disorder, one has to remember that.

It takes a lot of time to figure out what is wrong with these children. The process is to first determine what is wrong and then determine what are the available treatments and where do

medications fit in. Parents and families have to go through the same process. It is not easy having your child on a medication and the media is very anti-medicines for children. Though it is now pretty much agreed that adolescents have problems that can be helped with medication, that understanding does not exist for children of six, seven, eight or nine. These often are lifetime disorders and my sense is the earlier they are treated, the better outcome there will be. That is true for substance abuse and ADHD. Studies found that aggressive treatment of ADHD reduces the risk for substance abuse by 65%. We need to treat these other childhood disorders early.

There is a debate about the use of alternative agents. Certain alternative agents are appropriate for kids with different types of symptoms, but we must be concerned about a couple of things. For a medication to be used in this field, two things must be satisfied. First, is the medicine safe? And second, is the medicine effective? Does it work? Safety and efficacy are two critical aspects that must be understood when considering the use of medications in kids. Those are very reasonable questions for a parent or caregiver to ask. Ask, "Do we know that this medicine really works? What does the literature say and what is your experience, doctor?" And number two, "Is it safe? And in what combinations is it safe and what do we know about the safety?" The problem with alternative agents is that they have failed to look at those two issues of safety and efficacy.

ALTERNATIVE MEDICATIONS

An example of the issue of alternative medications is the use of St. John's Wort. It is effective for adult depression and because it works, it is a reasonable option for people who have to pay out-of-pocket for medications. The problem is that it has many drug interactions. It has the same level of drug interactions that Prozac has in terms of inhibiting the liver to break down other compounds. If a patient is on Prozac, the doctors and the pharmacists know that and they will not prescribe or authorize certain medications. But if the patient is on St. John's Wort or a number of other similar natural compounds, they may be having the same effect but nobody knows it. There is not much information or research in this area. There are no studies about alternative medications in children or adolescents. It is important to use compounds where there is data available. Data must drive the decision making process.

ATTENTION DEFICIT HYPERACTIVITY DISORDER

Attention deficit hyperactivity disorder ("ADHD") is the most controversial disorder. ADHD is a heterogeneous disorder with many different causes. It affects 3% to 5% of school age children, not only in the United States, but also in all countries. In an excerpt from an 1856 textbook, the British comment on the notion of concentrativeness. There has been awareness of this disorder for 150 years.

Children with ADHD are at risk for developmental sociopathy, alcohol and drug abuse problems, depression and anxiety. Before writing a prescription for the problem, it is critical to know what disorder is being treated. ADHD is a pervasive persistent impairment. It is considered a neuro-behavioral disorder. It is neurologically based with behavioral symptomatology and highly cognitive. These symptoms of inattention persist in children as they grow up to be adolescents and into adulthood. The behavioral symptoms tend to diminish a bit as children grow up. The attentive symptoms include careless mistakes, difficulty sustaining attention, problems reading, problems focusing, failing to finish tasks, starting one thing and moving onto something else and difficulty not listening. This not listening is not oppositional; it is a form of spacing out. An example is the person who is not really listening to you and appears to be looking through you because their mind is elsewhere. These children have difficulty organizing, they lose things, they misplace things – book bags, pencils, homework – and they are distractible and forgetful. In the hyperactive realm, they show much impulsivity, hyperactivity and fidgeting. Childhood onset is typically before the age of seven and it is present for more than six months. Sudden onset of these symptoms may not be ADHD. Typically, these symptoms are present in more than one setting, though there could be a high functioning child with a high I.Q. with only the attentional problems showing up only in school.

SUB-TYPES OF ADHD

There are several sub-types of ADHD. The combined sub-type is the most common. These children have all the attentional difficulties and are somewhat impulsive, are hyperactive, are fidgety, jump into things without understanding the consequences, intrude, interrupt, are impatient and have low frustration tolerance. Fifty to seventy-five percent of children with

ADHD are in this category. About 20% of children with ADHD have only the inattention difficulties and a very small percentage have just the hyperactivity and impulsivity.

ADHD commonly occurs with other disorders. This is known as co-morbidity or co-occurring problems. About half of children with ADHD have it alone. The other half of children with ADHD have ADHD plus conduct issues, plus opposition disorder, plus depression, plus anxiety, plus learning disabilities. Many kids have ADHD, anxiety and depression. It is not uncommon to see kids who have all three overlapping: anxiety, depression and conduct disorder. It is important to determine whether there are other disorders in addition to ADHD so that the right treatment may be chosen. If the child has ADHD alone, it is best to start with stimulants and move down. But if the assessment shows ADHD plus anxiety disorder, it is important not to start stimulants so quickly because, if stimulants are started, they may develop anxiety. If a child has ADHD along with tics and spasms, stimulants could exacerbate the tics. An example is a patient who has obsessive compulsive disorder and ADHD. This child was doing beautifully on treatment for the OCD, and then started ADHD treatment because she had a lot of problems with attention and focusing. That helped, but she then developed tics. Tics and OCD run together in families. One family member may have OCD, while another family member has tics. Parents whose children are on these medicines should look for such symptoms. If they are seen, it is necessary to move to a different agent for ADHD.

Children who are on medicine for ADHD and then develop other symptoms that indicate bipolar disorder must be re-diagnosed. To make sure the medicines are not leading to the disorder, the medicine must be withdrawn. If the diagnosis confirms the development of bipolar disorder, the data are very clear that the bipolar disorder must be treated first. Then treat the ADHD. ADHD treatments that may have stopped working with that co-morbidity of bipolar disorder may now work. Data indicate that the likelihood of responding with ADHD is much lower if the mania is out of control than if the mania is controlled.

If a child has ADHD and substance abuse, the addiction should be treated first, then the ADHD. There is not much evidence that treating the ADHD will help the addiction in the short term. If a child has depression, attempt to get him or her off the substance to see if the depression

will start to clear on its own. If not, then go ahead and treat the depression. When treating a child with anxiety, stay away from benzodiazepines such as Valium because of the addiction potential.

TREATMENT OF ADHD

The treatment of ADHD is non-specific. Even if other things may have caused the ADHD-like symptoms, the medicines work for those children. The medicines work for the symptoms. The effects of stimulants are not paradoxical. So if non-ADHD kids are given medication for ADHD such as amphetamine, they focus better, they are more attentive, they are less hyperactive and they are more vigilant. College students use amphetamines to help them study. What helps them is the anti-ADHD properties of these medicines -- the focus, the attention and the side effect of insomnia. They do not just make a hyperactive person calm. They work on everybody. But when there are many more problems to start with, we see the greatest change.

The response to stimulants is not diagnostic. About three-fourths (3/4) of people respond to stimulants, but about one-fourth (1/4) do not. If the underlying disorders are too severe, the medicines do not work. Sometimes that occurs with ADHD. It is not necessarily a function of severity; it could be simply that the ADHD does not respond to the medications. That is true for all psychiatric disorders across the life span; it is not only an issue with children. Because the medications work on different disorders, not just ADHD, and because they don't work in all cases, and because the effects are not paradoxical, it is not appropriate to say, "I don't know if this child has ADHD, so let's put him on medicines, and if he responds, then we know that he had ADHD." It is critical to make a diagnosis first and then try out the diagnostic hypothesis. Many children who have been diagnosed properly do not respond to stimulants. If that occurs, move on to other agents.

There have been two studies to determine if there is a difference in results when using medicines alone or in combination for ADHD. In one study, fifty children were put on methylphenidate (Ritalin) alone, and fifty children were given methylphenidate plus very good multisystemic therapy, behavioral modification, teachers' aides, etc. At the end of twenty-four months, there were no differences between the ADHD groups who were treated with medication

alone and those who were treated with medication plus psychotherapies. This study was replicated in a major study with more than 500 children. There were four treatment groups: (1) medicine alone, (2) medicine plus therapies, (3) therapy (behavioral modification) alone, and (4) community care. The best responders were those who were on medication, followed by those receiving behavioral management techniques. Nobody was on placebo because that was unethical. This does not mean that we should not use psychotherapy because the problem with these studies is that they took all comers, and all children are not typically put into therapy. Only those children who need therapy go into therapy. These studies really show that, first, medicine is essential for ADHD treatment. It is a foundation. And second, not everyone needs therapy along with the medication. Children who need therapy are those who are behaviorally disinhibited, argumentative and non-flexible, have outbursts, are anxious and have severe self-esteem issues. Those are the children who will benefit from therapy.

There is another point to make about these studies that have looked at medicine with ADHD. The children who were given medication received very good medicine management. There was very aggressive therapy, which included not only high doses but also a lot of interaction with the families, the schools and other aspects like that as well as very close observation.

The medications used for ADHD are the stimulant class agents and the stimulant medications. Typically, we use Ritalin (methylphenidate), which is a shorter acting compound, or Dexedrine (dextroamphetamine), which is also shorter acting, Adderall (amphetamine sulfate), which is a little bit longer acting, and Cylert (magnesium pemoline), which is used less frequently. Ritalin is very safe, and it has been around since the 1950's. Until recently, the only problem with it is that people prefer the shorter acting form and it must be given two or three times a day and that can be a real problem with a school nurse. The other problem is what occurs later on after school, when there may be social problems and other issues that are not being properly managed.

Dexedrine is an amphetamine and is the oldest compound that has been used for ADHD since the 1930's. It is more potent and only half as much is used. It tends to be longer acting, so

its behavioral consequences last longer. The child is more attentive, more focused and less impulsive. But, because it lasts longer in the blood, it may cause more insomnia. It has somewhat harsher some side effects. More moodiness may be noted, but typically that occurs when it is wearing off in the late afternoon.

Adderall is an amphetamine compound. It has salts, some of which release quicker and some slower. It also has mirror image compounds that provide longer action. It is the longest acting currently available preparation of medication in the amphetamine/methylphenidate class. Typically it can be dosed twice a day and therefore it allows the child to get through the school day without school time administration. Then he or she takes a repeat of half the original dose. It is very similar to Dexedrine, which has been around for years. Adderall has also been around but has been re-marketed in the last few years.

Cylert is the longest acting compound, but it is not as effective as the other compounds. Studies have shown that Cylert works in about 55% of the cases. It is typically given once or twice a day, and it can take up to six weeks to see if it will work. A nice quality is it provides around the clock coverage. The problem is that the FDA has put out a pretty significant warning that this medicine can cause chemical hepatitis. The FDA is recommending frequent liver function tests.

SELECTION OF MEDICINE FOR CHILDHOOD ADHD
Ritalin is usually the first choice of medicine for ADHD. But if the child or parents really do not want school administration, use Adderall. Dexedrine is somewhat longer acting. Dexedrine takes about two hours to work and it works for six or seven hours. Adderall works in about a half an hour and works for the same amount of time or a little bit longer. It starts working after about twenty or thirty minutes and it wears off nicely.

There is a new medicine, once-a-day methylphenidate, which is a once-a-day Ritalin-like compound. Once-a-day amphetamine should also be available soon. Once-a-day stimulants are the wave of the future. These pills are the size of a Tic-Tac. The pill itself does not dissolve. As it goes through the system, it absorbs water, and a polypropylene plunger expands, pushing the

chemical gradient out at a specific pharmacokinetic profile in order to provide efficacy for up to fourteen hours. It may be given early in the morning and it works all day. Studies show it works very well. In fact, it is not given at a flat rate all day because tolerance develops. It is given at a specific ascending curve of plasma concentration. Children love it because they do not have to go to school with pills. However, it does leave after-dinner time not covered.

Short-acting methylphenidate, the short-acting amphetamine, kicks in within an hour but within a few hours the therapeutic effects are gone. Adderall works quickly and it lasts for a long time. It is the longest acting current duration medication we have. A form of methylphenidate, which will be called Concerta, lasts ten to fourteen hours will soon be on the market. Most of the new compounds in the future will be in that range.

In addition to stimulants used for ADHD, anti-depressants and, in particular, tricylic antidepressants are also used. Stimulants are the first choice, but tricylics such as desipramine or nortiptyline are next. They are very effective for ADHD and are next to the stimulants in terms of how well they work. The anti-hypertensives, clonidine and guanfacine, are often used for the impulsive hyperactive child and for the younger child. Often they are used in combination with other medication. In addition, there are other miscellaneous medicines that may be used.

There is no evidence that an antihistamine like Benadryl would do anything for ADHD. Sometimes it may be used for sleep, since ADHD brings sleep problems.

DEPRESSION IN ADOLESCENTS

Depression is as common in adolescents as ADHD is in younger children. People are more familiar with childhood ADHD than with adolescent depression. At least 5% of adolescents have depression. Children and adolescents sometimes kill themselves or kill other children. Symptoms of adolescent depression are somewhat similar to symptoms of adult depression, but there are some differences. Adolescents with depression can be very irritable and have a very negative attitude. They look sad when they are younger. As they get older, they tend to tell you they are sad. They can act out, they can isolate and they can withdraw. Young children will have temper tantrums, while older children may cry. There is a great sense of

worthlessness and there can be self-injurious behavior. Some young people do not know how to kill themselves, so they will head-bang or hurt themselves in other ways.

Half of young people with depression show mood reactivity. They over-react to situations. They are very easily agitated, irritable and angry. If they have limits imposed, they quickly have serious problems. They may become seriously depressed, saying, "You don't love me, you hate me" while they cry and continue to act depressed. Or they may have a major relapse. The major medicine used for mood reactivity is a serotonin reuptake inhibitors for depression. The first and second choices are the Prozac-like drugs. Prozac is the first drug to be shown effective in children with depression. Paxil and Zoloft have also been shown to be effective. All of the new generation of anti-depressants are helpful with children and adolescents. That includes Prozac, Paxil, Luvox and Zoloft. Young people tolerate them well. Blood monitoring is not needed. It can take six to eight weeks before improvement is shown. It is typical to start with very low doses and bring them up slowly, so that the child will not become agitated. About a quarter become agitated.

For youngsters about the age of ten, full adult doses are used. A pharmacokinetic study of drug metabolism showed that children metabolize the drugs twice as effectively as adults do. For the same reason, ten, eleven and twelve year old children are starting to eat as much food as adults do. So they can handle the same dosage of these medicines as adults. It was found that appropriate dosage is about twice the weight-corrected dose, because they metabolize about twice as fast. But it should be started with a low dosage in order for it to be well tolerated. Children do not like to go onto medications, so it is important to be careful about how well it is tolerated.

Other medicines, such as Wellbutrin and Serzone, can help. These are medicines that are used in adult depression. However, there is not much data for children's use of these medicines. We believe they are effective, and we use them more for refractory cases. The first choice is to start with a serotonin reuptake inhibitor. Pharmacological treatment for juvenile depression is good, but it is not excellent. It is not as robust as pharmacological treatment for ADHD.

BIPOLAR DISORDER

About 25% to 33% of children who are depressed actually have bipolar disorder. We see the depression and the mania is hidden. Medicine is one of the things that can bring out the mania sooner. Data from two studies show that the medicine really does not cause the mania, and it probably would have occurred anyway. But it can speed up that process by unmasking what is already there. So, when using an anti-depressant in a child the results must be monitored carefully in case the child is really bipolar and mania is triggered. In such a case, pull that medicine away and treat their mania, and then work on their depression.

It is difficult to diagnose bipolar disorder because most adolescents experience both the depression and the euphoric mania at the same time, so they are miserable. They are agitated, irritable, angry, substance abusing, in your face and have temper tantrums. It is really difficult to diagnose. Many have delinquency at the same time. There can be much impairment associated with bipolar disorder; it often comes with other problems. Often they also have ADHD and conduct disorder. It is critical that people who understand bipolar disorder diagnose these children. Once a diagnosis shows bipolar disorder and the child shows more mania -- the agitation, the giddiness, the goofiness, the aggressiveness – that is typically what should be treated.

Treatments for bipolar disorder include the new generation of atypical anti-psychotic medications including Zyprexa, Risperidone and Seroquel. Either Zyprexa or Risperidone are appropriate as first line agents for young people who are bipolar with prominent symptoms mixed, that is showing both mania and depression at the same time. Data from a 1998 study on Risperidone showed it worked to help improve the mania, psychosis and aggression. Risperidone should not be used for ADHD alone. The same result was found when Zyprexa was used. It worked for manic symptoms. It took about two weeks to start working, and by six weeks the children were much better. The more severe cases of bipolar disorder should be started with an atypical anti-psychotic.

For mild cases that may not require an atypical anti-psychotic, or for youngsters already taking an anti-psychotic, usually another medicine should be started because an anti-psychotic is

a strong medicine. One approach is to use mood stabilizers such as Lithium to help the cycling underneath. Though it must be monitored carefully, it works well. Other possibilities include Tegretol and Depakote. Neurontin is a good choice because it is metabolized by the kidney. Blood levels need not be checked, and it works. It has a very good reputation, although it is probably not as effective as Lithium, Tegretol, or Depakote, but it is reasonable and with an atypical anti-psychotic, it works well.

If a child has bipolar disorder or is psychotic and also has substance abuse, there are no good guidelines on medication. In the face of substance abuse, treat the bipolar disorder and, if necessary, hospitalize the child and put him or her in day treatment in order to have control. If the bipolarity or psychosis is under control, there will be a much better chance of getting a better response with the addiction. Addictive substances should not be used and the prescriptions must be supervised.

OBSESSIVE COMPULSIVE DISORDER

Obsessive compulsive disorder is found in approximately one percent of young children and in up to four percent of adolescents. There is an overlap with substance abuse. OCD is one of the few things that can mimic a very serious psychiatric disorder. A child might appear to be schizophrenic and actually have OCD. If the OCD is treated, they do much better. OCD is a chronic illness, with marked distress of more than one hour a day, with compulsions or obsessions. With young people there is less hand washing and more concern about contamination. They will not do certain things, they line things up in their heads and they have superstitions such as having to count license plates or doing number reversals. This can become overwhelming and they become totally distressed. OCD in young people is also highly co-morbid with other disorders. The first medicine to try is a serotonin reuptake inhibitor, particularly Zoloft. A big study on Zoloft has been published in the *Journal of the American Medical Association* showing it to be effective for juvenile OCD. It is also FDA approved in that age group. Another study showed it has long-term cardiovascular safety. It is a very safe medication. Prozac has also been shown to be helpful for childhood OCD, as has Luvox, which is FDA approved for childhood OCD. Many compounds in the serotonin reuptake inhibitor family are highly effective for OCD and are well tolerated. Typically, higher doses are needed.

These medicines are started at usual doses but can go up to 40 to 60 milligrams of Prozac, or 300 milligrams of Zoloft, or 300 to 400 milligrams of Luvox, or 60 to 80 milligrams of Paxil. Anafranil is also FDA approved for children. Anafranil is more like a trycyclic. It has more side effects and requires cardiovascular monitoring and blood monitoring, but it can be a very effective agent. Typically, first try one or two of the serotonin reuptake inhibitors such as the new generation of medicines, Prozac, Paxil, Zoloft, or Luvox. If they do not work, then move to a different agent like Anafranil. If that is not working, add some Klonopin or Valium. The anxiety breaking medicines are good because children with OCD also have anxiety and anxiety can trigger the OCD. Reducing the anxiety helps to reduce some of their obsessive-compulsive problems.

Only in extremely refractory cases of OCD are anti-psychotics appropriate. Before using anti-psychotics for OCD, serotonergic-based compounds should be tried as well as two or three of the serotonin reuptake inhibitors. Start with Prozac, Zoloft or Luvox. If the child is on other medicines, a larger dose may be needed.

PRESCRIBING THROUGH SUBSTANCE ABUSE

There is no right or wrong to prescribing through substance abuse; there are no good guidelines. My sense is that if child has bipolar disorder or is psychotic treat the psychotic disorder and, if necessary, hospitalize the child or put him or her in day treatment in order to have better control. If the bipolar disorder or psychosis is under control, there will be a much better change of getting a better response with the addiction. Addictive substances should not be used and the prescriptions must be supervised. For adolescents with ADHD, the addictions typically is treated first and sequence back to the ADHD because there is not a lot of evidence that treating the ADHD will do much for the addiction in the short term. For depression, the aim is to get the child off of the substances and evaluate whether or not the depression will start to clear on its own. Anxiety is treated with a similar approach. Benzodiazepines should not be used for anxiety because of the addictive potential. Again, each is case is examined individually and there is no cookbook methods. If after 2-3 months into treatment and the child is getting worse, stop the medicines and re-evaluate. Hospitalizing the child at this point may be appropriate.

KEEPING CURRENT WITH THE FIELD OF PSYCHOPHARMACOLOGY

Textbooks are not very good in this field. Every year there is a Massachusetts General Hospital course in pediatric psychopharmacology. *The Child Psychiatry Journal* and its web site are helpful. *The Journal of Child and Adolescent Psychopharmacology* is also good.

About the Presenter

Timothy E. Wilens, MD, completed undergraduate and medical school at the University of Michigan, and his psychiatric training at Massachusetts General Hospital. He is board certified in child, adolescent, adult, and addiction psychiatry. He is currently Director of Substance Abuse Services in the Pediatric and Adult Psychopharmacology Clinics at Massachusetts General Hospital, and is Associate Professor of Psychiatry in the Harvard Medical School. Dr. Wilens has extensive clinical and research experience in both pediatric and adult psychopharmacology and the Addictions having published over 250 articles, chapters, and abstracts. He has also recently written a popular book, *Straight Talk About Psychiatric Medications for Kids* (Guilford Press, 1999/2001). Dr. Wilens has federal funding from the National Institutes of Health as well as pharmaceutical support and is currently involved in pediatric and adult-related research projects including the characterization and treatment of attention deficit hyperactivity disorder ("ADHD") across the lifespan; overlap of ADHD, bipolar disorder and the addictions, the pharmacologic treatment of juvenile psychiatric disorders and studies of the children of substance abusing parents.

Contact Information:
Timothy E. Wilens, MD,
Director of Substance Abuse Services
        Pediatric and Adult
Psychopharmacology Units
15 Parkman St., ACC 725
Boston, Massachusetts 02114-3117
Telephone (617) 724-5600

Suggested Readings

Ambrosini, P.J., Bianchi, M.D., Rabinovich, H. & Elia, J. (1993). Antidepressant treatments in children and adolescents: I. Affective disorders. *Journal of the American Academy of Child and Adolescent Psychiatry, 32,* 1-6.

Biederman, J. & Jellinek, M. (1984). Psychopharmacology in children. *New England Journal of Medicine, 310,* 968-972.

Biederman, J., Baldessarini, R.J., Wright, V., Knee, D. & Harmatz, J.S. (1989). A double-blind placebo controlled study of desipramine in the treatment of ADD: I. Efficacy. *Journal of the American Academy of Child and Adolescent Psychiatry, 28,* 777-784.

> This is the largest controlled trial of a tricyclic antidepressant for children and adolescents with ADHD. The response to up to 5 mg/kg/day of desipramine was 68% and was irrespective of comorbidity with other psychiatric disorders.

1994. *Diagnostic and Statistical Manual of Mental Disorders (DSM IV), 4th ed.,* Washington,

D.C., American Psychiatric Press.

Delong, G.R. & Aldersh, A.L. (1987). Long-term experience with lithium treatment in childhood: Correlation with clinical diagnosis. *Journal of the American Academy of Child and Adolescent Psychiatry, 26,* 389-394.

Gittelman, R. (Ed.). (1986). *Anxiety Disorders of Childhood.* New York: The Guilford Press.

Kafantris, V. (1995). Treatment of bipolar children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 34,* 732-741.

> A recent update on the pharmacological treatment of juvenile mania. The review points out the relative lack of positive data derived from systematic trials in the antimanic agents commonly used in Child Psychiatry.

Leonard, H.L & Rapoport, J.L. (1989). Pharmacotherapy of childhood obsessive-compulsive disorder. *Psychiatric Clinics of North America, 12,* 963-970.

> This is an excellent review of the basic neurobiology and characteristics of juvenile obsessive compulsive disorder. A thorough review of the data and pharmacological management of OCD in children and adolescents is presented.

Popper, C. (Ed). (1987). *Psychiatric Pharmacosciences of Children and Adolescents.* Washington, D.C.: American Psychiatric Press.

> This issue of the Progress in Psychiatry Series provides a comprehensive review of the basic biochemical and neurobiological mechanisms in developmental psychiatry attentive to issues of development. The differences in metabolism of major classes of mediation are provided in children and adolescents compared to adults.

Riddle, M.A. (Ed). (1995). Pediatric psychopharmacology, Vol. 1 & 2. *Child and Adolescent Psychiatric Clinics of North America.*

> A two issue very timely and extensive update on the research and clinical usefulness of the various diagnosis and agents employed within ADHD. These volumes are a compilation of various clinician researchers in Child Psychiatry and Neurology. Given that there are no "classic" texts in this area, these editions will serve very adequately as a text in the area.

Spencer, T., Biederman, J., Wilens, T., Harding, M., O'Donnell, D. & Griffin, S. (1996). Pharmacotherapy of ADHD across the lifecycle. *Journal of the American Academy of Child and Adolescent Psychiatry, 35,* 409-432.

> A comprehensive review of the stimulant and nonstimulant medication trials for ADHD. This review offers an analysis of the existing data on the efficacy of the various agents employed in ADHD in children, adolescents and adults.

Spencer, T., Biederman, J., Kerman, K., Steingard, R. & Wilens, T. Desipramine treatment of children with attention deficit hyperactivity disorder and tic disorders or Tourette's syndrome. *Journal of the American Academy of Child and Adolescent Psychiatry, 21,* 354-360.

Talbot, J., Hales, R. & Yudofsky, S. (1988). *Textbook of Psychiatry.* Washington, D.C.: American Psychiatric Press.

Wiener, J.M. (1984). Psychopharmacology in childhood disorder. *Psychiatric Clinics of North America, 7,* 831-843.

Wilens, T.E. & Biederman, J. (1992). The stimulants. *Psychiatric Clinics of North America, 15,* 191-222.

> This is a comprehensive review of the literature on stimulants with detail to the areas of controversy. The effects of stimulants across the lifespan, use with seizures, use in mental retardation and autism, and in adults are discussed. Strategies for nonresponse or adverse effects are presented.

Wilens, T., Biederman, J., Baldessarini, R., Geller, B., Schleifer, D., Birmaher, B. & Spencer, T. (1996). The cardiovascular effects of tricyclic antidepressants in children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 35,* 1491-1501.

> This review of the literature covers the data on the cardiovascular effects of the TCAs with comparisons between specific TCAs and the effect of development. Data on dynamic cardiovascular testing including 24 hour and graded exercise testing are listed. The tertiary and secondary amines are compared systematically. Guidelines on vital signs and ECG parameters are given when using the TCAs.

Wilens, T. (1999). *Straight Talk About Psychiatric Medications for Kids.* New York.: Guilford Press

BIPOLAR DISORDERS AND COMORBIDITY:
ASSESSMENT ISSUES
Presented by Linda S. Zamvil, M.D.

Bipolar disorder begins early, though child psychiatrists have differing opinions about just how early it starts. Moreover, 60% of individuals who have bipolar disorder sometime in their lifetime will have a substance abuse problem. Substance abuse is the most common comorbid diagnosis for individuals with bipolar disorders.

In my work I have been able to follow three generations of some families for over a decade. Typically adolescents that are referred to me have had many diagnoses such as conduct disorders and attention deficit hyperactivity disorder ("ADHD") but for many it is their mood disorders that have not been treated.

Bipolar disorder can be acquired but most often it is inherited. The phenomenon called genetic anticipation can be applied to bipolar disorders. A model for this phenomenon can be seen with Huntington's Chorea. It is an illness that is handed down from generation to generation and appears earlier in each subsequent generation. Originally it was thought that Huntington's was a mid-life illness; then it was seen in the 30's and 20's and now it is occurring in the teens. The same thing appears to be occurring with bipolar disorder with it being seen in younger and younger individuals. A parent with Huntington's has a 50% chance of passing the disease to their offspring. Two parents who are bipolar, have a 75% chance that their child will have the illness.

ASSESSMENT OF YOUNG CHILDREN

In families where both parents have bipolar disorders, and there are grandparents on both sides who committed suicide, families that I see have concerns about whether their children have or will have the illness. Their children's behavior needs to be assessed, as assessment is a critical initial step before a treatment plan can be determined. Are there signs of hyperactivity with insomnia? When they don't sleep are they more energetic? Is the child aggressive? Does the child hear voices? If learning disabilities are present, are they meeting normal developmental

milestones? The initial assessment must include a consult with a neurologist and an EEG. Some of the children I work with also participate in research and receive MRIs.

After a thorough assessment a treatment plan must be developed. If a parent has responded to an agent such as Lithium and a nine-year-old child comes in for treatment of depression, the first appearance of depression is likely to be the beginning of a bipolar mood disorder. It is estimated that 20% to 40% of children presenting with depression will go on to be bipolar. A child with a known family history of bipolar mood disorder who presents with depression, with or without attention deficit disorder, should be suspected of having a bipolar mood disorder. That child may respond to a medicine like Lithium. Too often anti-depressants are prescribed to children who actually have bipolar disorders and this may cause cycling and make them worse. It is critical in any setting to provide a careful assessment first and then to prescribe appropriate medication.

Twenty percent of untreated people with bipolar disorder will commit suicide if they remain untreated. If a child has bipolar mood disorder, it is likely there is a diagnosed or undiagnosed relative. Sometimes it is a parent who may be abusing substances to self-medicate an untreated bipolar disorder or some other mood disorder.

Children with bipolar mood disorder are fearless high-risk takers. Adolescents can be grandiose, but these children are at another extreme. Their unsafe practices, whether it is driving an automobile, using illicit substances or dangerous sexual practices, can be significant.

Bipolar disorder is equally common in males and females. Adolescents with bipolar disorders tend to start substance abuse earlier. It is not uncommon for patients who have both mood disorder and substance abuse to say they started abusing at age nine or ten or eleven.

HISTORY

Structured interviewing is important in the assessment of adolescents. Use of a structured format ensures that questions are asked of the child and the caretaker as well. Areas such as ADD, learning difficulties, anxiety and substance use should be covered in an assessment. In

addition, if there appear to be some indication of mood disorder, then questions must be asked not only about unipolar depression but also about mania.

Most children and adolescents who have this illness have multiple diagnoses. They do not have only a mood disorder and attention deficit disorder and substance abuse; they may also have oppositional defiant disorder, conduct disorder, panic disorder, obsessive compulsive disorder and post traumatic stress disorder.

DEPRESSION

The criteria for depression from the DSM IV are uncovered by such questions as, "How is your sleep? Too much or not enough? How are your interests? Do you have guilty feelings? What about your energy? Your concentration? Your appetite? Are you losing weight, gaining weight? Do you feel agitated? Are you tired and unable to move?"

MANIA

In addition to asking about depression, possible symptoms of mania should be questioned. Many adolescents seen with serious substance abuse problems often have "mixed bipolar." They have depressive symptoms and manic symptoms at the same time. They may be distracted, as are those who have attention deficit disorder or any kind of depression. There may be an increase in goal directed activity. Suddenly these teens have three jobs; they are going to school; they are head cheerleaders; they are on the soccer team; they are presidents for their church youth group and many other things. They are doing a lot, more than one might expect or insist as a parent. This may be part of their mania and grandiosity. They may have racing thoughts or flight of ideas. They take part in activities with painful consequences, including substance abuse, running away and impulsive sexual practices. Hypersexuality is seen in males and females and can be seen in individuals and families where there has not been abuse or trauma.

Another early sign is sleeplessness. Some mothers say, "The first year my child never slept. Then after that he was the best sleeper in the world," or, "My kid slept beautifully until age four or nine or thirteen." It is not a predictor, but it is information that helps to understand

sleep/wake cycles. With this particular mood disorder there is a sleep/wake cycle reversal. Children who are night owls and prefer to be sleeping during the day or do not sleep at all should trigger the idea of possible bipolar mood disorder. Teenagers like to sleep, and they may choose to sleep from the middle of the night to late in the afternoon. That can be very normal. But those with the disorder are doing something not considered within the range of normal. They are in another league. It is chronic and it is disruptive. Talkativeness is another sign. A manic person cannot be interrupted. Often they talk incessantly. They may be difficult to follow. It is possible to see this in children as young as four years old.

Many children have what is called Bipolar II disorder. They have never had a full-blown manic episode but they have had multiple recurrent depressions and occasionally hypomanias. Too often, in today's standard of care, children with depression are considered unipolar, when in fact if the entire family history is looked at, they are really in the bipolar spectrum.

MEDICAL HISTORY

Medical factors such as seizure disorders and other behaviors such as substance abuse can mimic bipolar. It is difficult to know for sure that a child is bipolar if he has a seizure disorder and is substance abusing and there is a family history. Fortunately the medicines that are used for manic depression, such as anti-convulsants, are helpful. In addition, the twelve-step treatments and education may be used, and a neurological work-up should be part of the assessment.

Many things can mimic a psychiatric illness such as a medication reaction, trauma, substance abuse or seizures. The *American Academy of Child and Adolescent Psychiatry* reported a case of a young woman who became manic after having had head trauma. This phenomenon is called post-concussive mania. A very careful and thorough assessment must include a careful history taking as well as medical evaluation.

FAMILY HISTORY

Family history must be emphasized. If a child or adolescent presents with externalizing disorders, conduct disturbance, attention deficit hyperactivity disorder, and/or substance abuse, it

is important to learn if there is a relative who has been diagnosed with bipolar disorder. If so, it is best to be suspicious and watch. It does not mean they are going to have the same problem, but it should be in the differential diagnosis.

RAPID CYCLING

Rapid cycling is having four or more episodes in one year. An example is a patient who refuses to go onto Lithium, takes anti-depressants and a small amount of Adderall for her attentional difficulties, and describes herself as going through rapid cycling, ups and downs that occur many times in a week or even a day, which is referred to as ultra rapid cycling. A mood stabilizer might be more effective to reduce the cycling.

Children who have this illness may have been in the hospital not just a couple of times but also sometimes five or more times. It can take a long time to get an accurate diagnosis.

CO-MORBIDITY

It is rare to find an adolescent with only a substance abuse disorder. Usually there are multiple things affecting him or her. A child who cannot be excellent at school because of learning difficulties, cannot be excellent at sports, or excellent in his family because his family is not a nice place to be, or who has been abandoned and rejected, wants to be excellent at something. A child can get to be really good at substance abuse. That becomes his modus operandi. If this is the only arena where he can feel some sense of competence and gain some kind of good feeling in terms of peers and others, it is very hard to treat. It is very difficult to help the teen want to do something different.

Tim Wilens, MD looked at co-morbid conditions in his population of adolescents with and without substance abuse. Those with substance abuse had more diagnoses. Most had a psychiatric disorder before they got into the substance abuse and related problems.

In a sample of children with the diagnosis of attention deficit hyperactivity disorder, 22% met criteria for bipolar disorder. This was determined on the basis of structured interviews, though it was not confirmed at a later date by the psychiatrist.

Barbara Geller, MD, suggests that children or adolescents with language disorders, attention deficit disorder, oppositional defiant conduct disorder, or sexual abuse should be checked for bipolar disorder. Children or adolescents, who are very hypersexual, with no history of any sexual abuse, should be considered for bipolar disorder. With a teenager there is some overlap with schizophrenia. In a child with a psychotic depression and no diagnosis of bipolar, the most common cause of a psychotic depression is still manic depression, so it may be treated like that. Start with Lithium or Depakote, avoid antidepressants and consider an antipsychotic medication. This is particularly true if the family history is known or if there are relatives on these medicines.

Michael Strober, PhD, from UCLA feels that attention deficit hyperactivity disorder and bipolar disorder are part of the same spectrum. Developmental studies with imaging of children are showing that the brain does not work according to the DSM IV, and that the areas of the brain that are affected by these two illnesses are similar, with a lot of overlap. The neuro-circuitry and chemistry are similar. It may be that when a four to nine year-old is seen, it looks like attention deficit hyperactivity disorder, and when they are twelve or thirteen it begins to look like the mood disorder. There may be anxiety symptoms, and then other issues like substance abuse. The developmental stage of the child may play a role in the emergence of symptoms. A four year old may be hyperactive and aggressive. As the child matures into latency symptoms of anxiety may manifest. In adolescence the cognitive abilities of the child may allow the individual to display depressive symptomatology. It is not always a case of a pure diagnosis according to the DSM IV. It may be a series of emerging syndromes that evolve over the life cycle.

DIAGNOSIS OF ATTENTION DEFICIT HYPERACTIVITY DISORDER

The diagnosis of attention deficit hyperactivity disorder is a clinical diagnosis. There is no lab test. There are no neuro-psychological tests. It is very helpful to have a teacher and/or parents' reports and to observe the child in multiple settings, to ascertain whether they have attention deficit hyperactivity disorder. All the questions from the DSM criteria should be asked. In addition, before treating a child with any medication, there should be a baseline medical work-up, in order to rule out other medical problems such as hyperthyroidism, lead poisoning, Wilson's disease or seizure disorder. Depending on the symptoms reported an EEG might be

required. However, an EEG will not always show that there is a seizure disorder. A positive EEG is helpful, but it is more common that most of the children will have negative neurological work-ups. This is true even if they have had all kinds of exposure in utero or if it is known that the parent was a drug abuser, alcoholic or cocaine addict.

OTHER DIAGNOSES

Many disorders may resemble bipolar disorder. Regions of the brain, the limbic system, and the temporal lobe are connected. It is possible that symptoms of disorders such as temporal lobe epilepsy might resemble bipolar disorder. An anti-convulsant is an agent that calms the brain down. Some people have paradoxical reactions to medicines that are supposed to calm them down, so caution is in order. In particular, it is difficult to know how a younger person will respond to a particular medication. With the very young, the medicine in my clinical practice that has given some of the best results is Catapres (clonidine). Sometimes an anti-psychotic like Risperdal is used and it works better than the stabilizers. Depakote and Lithium are used in little children as well. These medicines are given only to parents or caretakers who will be compliant, get the lab work and administer them in an appropriate way. It is important to note that the medications we use in children are the same we use in adults. However, the clinical studies in children are very limited and data that supports clinical practice is usually behind what most of us do in practice. The FDA has called for increased testing of medications in children and adolescents. Extrapolating from adult studies is not good enough since we know children metabolize medications differently than adults. Studies however, in young subjects, are difficult because of ethical considerations related to informed consent as well as using placebos in a controlled study where a child has a serious mental illness.

PHARMACOLOGICAL TREATMENT

The effect of an anti-depressant on the brain is different from the effect of Lithium. Anti-depressants tend to be mood elevators. The anti-convulsants and Lithium are considered to be mood stabilizers. For some people, Lithium is a mood elevator. Many children who have been treated with anti-depressants are still depressed. They are more than depressed. They are psychotic. It is important to look at any diagnoses in the family of origin. But that is not possible with a child who may be adopted. It is a good idea to try Lithium to learn if the child suddenly

becomes better. Lithium is probably quieting something; it is known to have dopaminergic effects. Sometimes this is still more art than science, but giving agents that have a calming effect is preferred in this particular population.

Barbara Geller, MD has completed the only placebo-controlled study of Lithium with substance abusing adolescents and found that it was helpful. These children had bipolar disorder and substance dependence, primarily alcohol, while marijuana was secondary. Lithium was helpful.

Anti-depressants, whether they are SSRI's or the tricylics can actually make things worse. Some say you cannot make a diagnosis based on a response to medication. However, most now agree that if people switch from a depression to a mania on an anti-depressant, they are more likely to have a bipolar disorder. There are still many who would disagree. Stressors can cause a bipolar episode e.g., a medical illness, break-up with a boyfriend or girlfriend, death of a loved one, or medication exposure.

AGE DIFFERENCES

The initial episode looks different, depending on age. In a small child, depression may be the first thing seen. In an older adolescent, there might be more classic mania. Young children cycle very fast and are mixed. Parents will say that within one day, even within an hour, it is up and down. It changes often, day in and day out. It is chronic, continuous, and not episodic in the younger one. With adolescents and adults, in between the episodes, people do seem to function well. That leads to the question of whether an adolescent who responds to Lithium should be taken off it if he or she is doing really well. My personal feeling is no; this is a life threatening illness. Experience with the adult population, not the younger population, shows that people who have responded to Lithium and have been on it for thirty years go downhill when it is taken away. When it is readministered, they do not have the same response. If something is working, stay with it. Treat any side effects, but stay on the medicine. Like diabetics who need insulin to live, bipolar disorder requires medicines. Lithium is toxic, as are all these medicines, but with monitoring they are safe. It is safer to continue them than to take them away.

Children who take these medications can gain weight. Try to give options. Consult with a nutritionist and explore exercise before giving up if the medication is working. Thyroid function should be tested. If a child gets really bad psoriasis, try a switch to Depakote. Depakote, however, similar to the other medications causes weight gain.

Data from Brookside Hospital, where I used to run the child and adolescent programs, show that adolescents with a diagnosis of bipolar had more comorbid diagnoses. This was statistically significant. A bipolar individual has many systems in the brain that are awry. That is why it is important to calm the brain by first treating the bipolar disorder. Afterward, if there is attention deficit disorder, then treat that. If there is panic and anxiety, try something for that. If there are other learning difficulties, there must be remediation for that. If there is a history of trauma, then someone must help with that. Always start with the mood disorder and mood stabilization. That is the first line and the brain benefits from starting in that way.

About the Presenter

Triple board certified in Adult, Child and Adolescent Psychiatry and Addiction Medicine, Linda S. Zamvil, MD, is the Director of Ambulatory Mental Health and Addictions at Cambridge Health Alliance and Medical Director of Cambridge Psychiatric Services. She is recognized for her special abilities with adolescent co-occurring disorders at many institutions and community hospitals in the Northeast. She is a frequently invited speaker through out the northeast in mental health communities, primary care communities and educational systems. Dr. Zamvil's current research focuses on the treatment of bipolar disorders in adolescents and children.

Contact Information:
Linda S. Zamvil, MD, Director of Ambulatory Mental Health and Addictions
The Cambridge Health Alliance
Central St. Clinic
Department of Psychiatry
1493 Cambridge St.
Cambridge, Massachusetts 02139
Telephone (617) 591-6011

ADOLESCENT BIPOLAR DISORDER & SUBSTANCE ABUSE:

TREATMENT ISSUES

Presented by Linda S. Zamvil, M.D.

COMPLICATED CLINICAL AND NEUROCHEMICAL PICTURES

How do you intervene with an adolescent who has a mood disorder and substance abuse and other learning difficulties, which include attention deficit, and may be in the juvenile justice department because they have a conduct disturbance? They also may have anxiety disorders or are school phobic. The comorbidity that presents in complex clinical situations is more and more attributed to the neurochemical interrelationships present in the brain than was previously thought. The circuitry in the brain and the neurotransmitters are very complicated.

LACK OF EMPIRICAL TREATMENT KNOWLEDGE

Treatment for bipolar illness and substance abuse is done in a very systematic way with recognition that each adolescent is different and should be treated in an individualized manner. All the present literature and data available is primarily from adult studies. Even what we think we know often times does not work for children and there are disagreements among the professionals themselves. For example, there is one controlled anti-depressant study that has been done in children, a SSRI Prozac study found in an 8-week trial that Prozac was better than the placebo. Now, there are psychiatrists who think 8 weeks may not be enough time to show a switching from depression to hypomania or mania. This is based on the data that most kids with a depression may be within the bipolar spectrum. Data suggests that 20% to 40% of children who present with a depression will within 5 years time be diagnosed with bipolar disorder. Most of my colleagues, at least of half of them, would disagree and point out that it is just that their bodies are different that they respond differently. Even in adults not all of the medicines work or they work for a limited amount of time and then you have to find something new and different. Psychopharmacological treatment is often more art than science. It can be an extended process to find the right medicine for a child.

PSYCHOPHARMACOLOGICAL THERAPEUTICS

Being non-judgmental is very important when making psychopharmacological decisions. Present the literature, your opinions and rationale, your clinical practice, listen to the caregiver and the youth and then make recommendations. "I don't tell people what to do. I don't tell kids what to do. I don't tell their parents what to do. I make recommendations. I say this is what we know from the literature. I agree with this. I disagree with what this study says. This is my clinical practice. This is what seems to make sense. This has worked for me. This hasn't worked for me. You have family members who have been on this agent. This was beneficial to them."

Explain to the adolescent the consequences of their behavior. The adolescent needs to be able to own their own behaviors and the consequences of their behaviors in order to develop the awareness and motivation to change them and to follow treatment regimens. Provide them with information about the drugs they are using and the consequences of their behaviors.

Explain the whole process of recovery. Explain the process of recovery from substance abuse and from the mood episode, from a mania and from a depression. Review the physical and psychological effects and impact of the illnesses and that there is recovery. Spend time talking about stigma and how it affects them and their relationships with others.

ASSESSMENT

Assessment is of paramount importance. A thorough history, including lab work with thyroid function tests, a neurological evaluation, EEG and MRI, is needed. When you assess for what substances are being used, realize that it usually is not just one but multiple. Other drug use, such as cigarettes and coffee, should be evaluated. Symptoms through every developmental age need examination. Family histories need to be complete and the parents' own use and abuse patterns evaluated.

LEVELS OF CARE

Hospitalization is an option for youth that are a serious risk to themselves or others. It is also a place that a thorough and needed assessment can occur. Unfortunately, the availability of this level of care is limited. Other levels of care include partial hospital programs, intensive

outpatient programs, group therapy and individual counseling. Self-help is also very important as youth frequently depend on each other. Al-Anon and ACOA also are very helpful and are ways to introduce youth to issues of substance abuse. Participation in AA, NA, Cocaine Anonymous and Manic-Depressive Association groups should be encouraged, however, they frequently are geared toward adults. The 12-step community, for the most part, has become more accepting of the need for lifelong medications for those with a serious mental illness.

ABSTINENCE FOCUSED

The focus in the treatment should be on abstinence for the adolescent with chemical dependency, even though many adolescents will not be able to achieve abstinence. Relapse is to be expected in the adolescent and recovery should be seen as a process over time. As Mark Twain said, "Stopping smoking is easy, I have done it dozens of times." When relapse occurs the focus becomes one of getting the adolescent back on track and helping them learn from the relapse. Both chemical dependency and bipolar disorder are relapsing and chronic in nature. When people are diagnosed with a bipolar illness they should stay on the medications that are working. Side effects should be minimized but treatment is for a lifelong illness. For example, in a study of adults who had been on Lithium for 3 decades and the Lithium was discontinued, when they did have a relapse they did not respond as well to the Lithium the next time. Education about the need to remain on medication for continued effectiveness is a critical piece for continued compliance. However, most youth and adults when feeling better will want to try stopping. Treatment relationships should be maintained during these periods and the relapses dealt with quickly to get the individual back on the path to recovery.

THERAPY

There are a whole variety of therapies available that should be used with psychopharmacology. The type of therapy - behavioral, cognitive, supportive, case management or something else - is based upon the needs of the person.

COERCION

Teenagers do not walk into a hospital, stop using and comply with their medications. On top of that is the fact that bipolar illness is associated with very high-risk behaviors and very

aggressive behaviors. When the adolescent's behavior escalates to dangerous and threatening levels, the legal system is an appropriate intervention. The coercion and legal leverage through the correctional system is appropriate at these points and can be used. The correctional involvement, however, is not a replacement for treatment and many youth correctional services historically have lacked treatment.

MONITORING

Drug screens are important to monitor drug use and maintain honesty. They also are important when decisions about both privileges or rewards and sanctions or interventions are to be made. Moreover, as both bipolar illness and substance abuse often is episodic, relapses can be monitored through drug screens. Mood charts are useful to monitor changes in mood on a daily, weekly and monthly basis. They can aid in diagnosing mood disorders and be useful in self-monitoring and self-regulation.

PHARMACOLOGICAL TREATMENT FOR DEPRESSION

Treatment of the depression can be done with Lithium or Depakote. When a child has bipolar illness Lithium is a frequent choice. If they have a relative who has not responded to Lithium, then Depakote, Tegretol or another agent should be tried. There is also Neurontin (gabapenten) and Lamictal (lamotrigine); however, Stevens Johnson's syndrome is a potential side effect of Lamictal. MAOIs also are indicated for depression but compliance with diet is required to avoid hypertensive crises and dietary restrictions can be difficult for the adolescent. SSRIs are used cautiously and in small amounts as they have been found to trigger mania. SSRIs likewise should be discontinued promptly when the depression remits due to this risk of mania. If the depression can be ridden out without medication that may be the best solution. The concern about anti-depressants in general is that they cause rapid cycling, making the depression worsen or sending the child into a mania and quicker cycles.

PHARMACOLOGICAL TREATMENT OF PSYCHOSIS

All types of anti-psychotics can be useful, old ones and new ones. The newer anti-psychotic medications, though, have fewer side effects. However, if the child does not respond to

Risperdal (risperidone), Zyprexa (olanzapine) or Seroquel (quetiapine), an older medication such as Mellaril may be effective.

AGE OF ONSET

In children for whom there is tremendous loading for psychiatric illness in their families, bipolar illnesses have been found to be manifesting earlier. There is a theory, genetic anticipation, that some illnesses (one of which is mood disorders) are manifesting earlier because of how DNA and RNA are translated. Huntington's Choreia is the illness that is used to illustrate this phenomenon. It used to be an illness that showed up around mid-life, 40's or 50's. It now is occurring in younger aged people in their 20's and even teens.

OTHER TREATMENTS FOR BIPOLAR DEPRESSION

In adults there are treatments, such as sleep deprivation, where mania can be triggered. Adolescents need to be taught about sleep hygiene and the need to maintain regular and reasonable sleep and wake cycles. Medications may be used with caution and Klonopin (clonazepam) or other addictive drugs are avoided with people with substance abuse disorders.

Cognitive therapy, psychotherapy and ECT for psychotic depression are other appropriate therapies. ECT is not commonly used with adolescents. ECT also has been found to induce mania. ECT, however, is very effective in some instances, such as post-partum depression, where a quick response is desired and for individuals who do not respond to other treatments. ECT is used for psychotic depression. Bipolar disorder is the most common cause of psychotic depression, thus its implications for its use with bipolar illness.

TREATMENT FOR MOOD DISORDER

A past study I conducted was a flexible dose open trial of valproate with adolescent psychiatric patients meeting DSM IIIR criteria for bipolar; this was before the DSM IV criteria for bipolar. A variety of scales were used to assess mood, including the Beck depression inventory, the hopelessness scale, the teenager self-evaluation report, the clinical global assessment scale and the clinical global improvement scale. The scales were administered by

trained research staff on the first day of admission and subsequently every two weeks. Valproate was found to be effective in improving mood.

OTHER STUDIES AND ISSUES

A study that came out of Tewksbury State Hospital, where most of the people were bipolar with severe substance abuse but had never had the diagnosis. Over 40% of the unit population was bipolar. Many of them never received treatment for bipolar, although many had received substance abuse treatment. They were treated with Depakote; what was found was that there was an improvement in mood and sleep. There was no acne reported and nobody complained of nausea, a commonly reported side effect of Depakote or valproate. Tremors and sedation can occur and hypothyroidism is also reported.

Depakote has been felt by some to be helpful for people with substance abuse and bipolar disorders, more so than Lithium. However, the data is not available. The only study that is available is from Barbara Geller, MD in which she did a very rigorous test of Lithium in teenagers who were substance abusing. She found that it was better than placebo.

A study by Catherine Brady, MD, PhD, had nine subjects with substance abuse and bipolar illness. Of those nine persons, five had problems with alcohol, three had poly-substance abuse issues and one struggled with cocaine; again, these were all adults. It was an open label, non-blinded, non-controlled study. It appeared that the patients had a definite benefit from Depakote and minimal side effects.

ReVia (naltrexone) is another medication that has been used with people with alcoholism. Most young people, however, do not have alcohol dependence. More typical are issues of poly-substance abuse and some sort of psychiatric illness. Naltrexone (again in an adult study) has been shown to stop craving for alcohol. Over a 12-week time period, fewer adult patients taking the naltrexone relapsed versus those taking the placebo. Those on naltrexone also had lower craving scales.

PREGNANCY

When a woman becomes pregnant I stop Lithium in the first trimester. For those planning pregnancy I attempt to go without medications and introduce them in the second trimester. In terms of the literature, the risks of cardiac problems are so slight that I think most people feel that patients with severe bipolar disorder should not be taken off Lithium. If they get pregnant, they should be monitored with cardiac ultrasound. The odds are that it is not going to be an issue. Cardiac abnormalities are the biggest concern. Now the question is what do you do when a mom wants to breast-feed and she has to stay on her Lithium. This a more serious concern because everything goes through breast milk. For moms on Prozac we measure Prozac levels. People do not think that there are any problems, but again, these children are being studied long-term. There is not much data yet.

SUMMARY

Bipolar illness is a chronic relapsing illness that in adolescents is only starting to be studied. Interventions need to take a long-term perspective and the focus is on learning to live with the illness. Substance abuse may exacerbate the disorder and it clearly complicates the clinical picture and may be related in some fashion. Treatment needs to be directed toward both disorders and research on adolescents is needed. Adult models cannot be generalized in their entirety to the adolescent population.

About the Presenter

Triple board certified in Adult, Child and Adolescent Psychiatry and Addiction Medicine, Linda S. Zamvil, MD, is the Director of Ambulatory Mental Health and Addictions at Cambridge Health Alliance and Medical Director of Cambridge Psychiatric Services. She is recognized for her special abilities with adolescent co-occurring disorders at many institutions and community hospitals in the Northeast. She is a frequently invited speaker through out the northeast in mental health communities, primary care communities and educational systems. Dr. Zamvil's current research focuses on the treatment of bipolar disorders in adolescents and children.

Contact Information:
Linda S. Zamvil, MD, Director of Ambulatory Mental Health and Addictions
The Cambridge Health Alliance
Central St. Clinic
Department of Psychiatry
1493 Cambridge St.
Cambridge, Massachusetts 02139
Telephone (617) 591-6011

References

Butler, S.F., Arredondo, D.E. & McCloskey, V. (1995). Affective comorbidity in children and dolescents with attention-deficit hyperactivity disorder. *American Journal of Clinical Psychiatry, 7*, 51-55.

Geller, B., Cooper, T.B., Sun, K., Zimmerman, B., Frazier, J., Williams, M. & Health, J. (1998). Double blind and placebo-controlled study of lithium for adolescent bipolar disorders with secondary substance dependency. *Journal of the American Academy of Children and Adolescent Psychiatry, 37*(2), 171-178.

Kraeplin, E. (1976). *Manic-Depressive Insanity and Paranoia.* Translated by R.M. Barclay. Edited by G.M. Robinson. Edinburgh E & S Livingstone 1921. Reprinted Arno Press.

Deykin, E.Y., Levy, J.C. & Wells, V. (1987). Adolescent depression, alcohol and drug abuse. *American Journal of Public Health, 77*(2), 178-182.

Strober, M., Morrell, W., Lampert, C. & Burroughs, J. (1990). Relapse following discontinuation of lithium maintenance therapy in adolescents with bipolar I illness: A naturalistic study. *The American Journal of Psychiatry, 147*(4), 457-461.

Zamvil, L., Wechsler, V., Frank, A. & Docherty, J. (1993). Valproate in adolescents with bipolar disorder. *Bulletin, New England Council of Child and Adolescent Psychiatry, XXIII*(2).

Zamvil, L., Cohen, M. & Bishop, S. (1999). Response to an initial dose of divalproex sodium for the rapid stabilization of mania in young patients in an outpatient practice. *Bipolar Disorders an International Journal of Psychiatry and Neuroscience*, Supplement 1, Volume 1.