

Developing Co-occurring Disorders Programs

For At-Risk Adolescent Populations

By

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In recent years residential treatment programs for adolescents have developed substance abuse programs to address the use of alcohol and other drugs among their residents; but there is still a missing component and that is addressing co-occurring disorders because many in this profession view substance abuse as separate from other mental disorders. If a program had a depression group the therapist would still address depression in individual psychotherapy, but for some reason this same logic is not applied to substance abuse. This article focuses on the methods I used to develop a program to address this discrepancy in treatment at a group home for 17 and 18 year old probation boys and also at a residential treatment facility for teen mothers and at-risk adolescent girls. I will also provide information regarding the evidence-based individual and group psychotherapy and staff training materials I used; most of which can be downloaded or ordered for free via the internet.

When I came on as a social worker/therapist for an agency that ran 11 six-bed group homes for probation boys the homes already had a chemical dependency department but they were still having a problem with boys AWOLing (Away Without Official Leave) and coming up positive for use of drugs in random urinalysis conducted by the Los Angeles County Probation Department. All of the agency's groups were held at the main office and met after school hours or in the mornings. After sitting in on several of the groups and meeting with the occupational therapy department I began developing a program to address co-occurring disorders based on the relevant literature I found through Psych INFO regarding evidence-based practice with similar populations.

Based on the literature review and my interactions with the clients I first wrote the mission statement, program philosophy and principles to provide a guide for development of the full program; that information follows:

MISSION STATEMENT

The Co-Occurring Disorders (CoD) Prevention and Recovery Program is designed to prepare adolescent boys for transitional living by addressing their mental disorders as well as their potential and current substance abuse problems through individual and group psychotherapy that is culturally sensitive and respectful of the client. The adolescents will increase their self-concept, self-efficacy, and coping skills through psychotherapy activities and applying the skills learned in session. The clients will also receive occupational therapy to assist them with developing independent activities of daily living skills, job preparation, resume writing, filling out employment applications, development of job skills, and college or trade school enrollment as well as an exploration of social and leisure activities.

PHILOSOPHY

The CoD Prevention and Recovery Program embraces a “No Fail” philosophy which views the challenges presented by the adolescents as opportunities for change. Recognizing that these adolescents are at risk and many have “fallen through the cracks” the CoD Prevention and Recovery Program is committed to providing collaborative and supportive treatment and care while recognizing the unique cultural needs of each adolescent.

PRINCIPLES

- Our service providers must be ever mindful of the fact that an adolescent’s behavior is separate from the adolescent’s identity; “bad” behavior does not mean

- a “bad” child. But consistent negative behavior may be an indication of a more serious mental or physical problem that should be addressed.
- Our service providers should also bear in mind that an adolescent’s past is exactly that, past. What matters is not what an adolescent has done but what he does.
 - In order to provide a high quality of life, we will ensure that the adolescents within our care are treated with respect, compassion, and dignity.
 - Our services are tailored to meet the needs of each individual adolescent and are inclusive of his history, experience, and culture.
 - Our services are strength-based and focused on each adolescent’s capabilities to accomplish his goals.

To develop the entire program I consulted with the director of occupational therapy who provided information regarding the services she could have her team provide and she agreed to have those services provided at the group home site rather than in the main facility the way the groups were then being offered. I then spoke with the Chief Operations Officer (COO) for group homes who stated that she wanted this program to be a “phase one” lasting approximately 90 days and should address skills development and alternatives to substance use/abuse to deal with symptoms of mental disorders to prepare the clients for transitional housing which is less restrictive and helps the clients to further develop the skills and responsibilities necessary to live on their own successfully. I was further informed that this program would be a model for the remaining 10 group homes but would be modified to meet the needs of that particular house’s clients. The COO also agreed to allow me to develop new psychotherapy groups for the program and have those groups meet at the group home site. The psychotherapy groups met Monday through Friday morning for 90 minutes. The psychotherapy groups were as follows:

Monday: 12-STEP RECOVERY DISCUSSION

This group served as an introduction to 12-step fellowships through reading and discussion of the “Big Book” of Alcoholics Anonymous (1995) and the Narcotics Anonymous (1991) “Basic Text”. This introduction will be augmented by outside 12-

step meetings. This was the only group that I wrote new materials to use during group. In this case I wrote an outline for “Big Book” study that highlighted particular passages of the book and explained their relevance and then discussed the issues presented with the participants.

Tuesday: ANGER MANAGEMENT

Using the Substance Abuse and Mental Health Services Administration (SAMHSA) published manuals *Anger Management for Substance Abuse and Mental Health Clients: A Cognitive Behavioral Therapy Manual* (Reilly & Shopshire, 2002) and the *Anger Management for Substance Abuse and Mental Health Clients Participant Workbook* (Reilly, Shopshire, Durazzo & Campbell, 2002), this group will aid the participants in recognizing anger cues and events that arouse anger. They will also learn how to implement anger control plans and cognitive restructuring through various homework exercises.

Wednesday: COPING SKILLS FOR A DIVERSE SOCIETY

This was a less structured group that concentrated on coping skills for daily living. Topics that were discussed in this group included the effects of stereotyping and prejudice, sexually transmitted diseases, HIV/AIDS, abusive relationships, effects of childhood trauma, and the effects of alcohol and other drugs on the brain and body.

Thursday: STRESS INOCULATION AND EMOTIONAL TRAUMA

This group was designed to address current stress in the lives of adolescents and provide them with the tools necessary to face adversity in their everyday lives. This group used materials developed and tested by Kaiser Permanente’s Center for Health Research. Through the use of *The Adolescent Coping with Stress Class: Leader Manual*

(Clarke & Lewinsohn, 1995) and the accompanying manual, *The Coping with Stress Course Adolescent Workbook* (Clarke, 1994) the participants will engage in further cognitive restructuring to address potential and present depressive symptoms and to aid the participants in managing symptoms of anxiety that will arise as they move into adulthood.

Friday: RELAPSE PREVENTION

For this group I used the books *How to Stay Clean and Sober: A Relapse Prevention Guide for Teenagers* (1991) published by Hazelton and the *Counselor's Manual for Relapse Prevention with Chemically Dependent Criminal Offenders* published by the Substance Abuse and Mental Health Services Administration (2005b). The participants learned about monitoring their feelings and their bodies as a means of making themselves aware of potential problems that may lead to relapse to substance abuse and criminal behavior. The group will also discuss family and other significant relationships and how they relate to their ability to remain clean and sober as well as danger zones and relapse warning signs.

This program was very successful with this population who were mostly marijuana abusers. Several of their residents were gang members, some were victims of child molestation and had been perpetrators as well and some were the children of gang members and substance abusers, which made family therapy an essential part of the program when the families were willing and involved in the boys' lives.

After getting the program started successfully at the boys' group home I then worked at a residential treatment facility for teen mothers and at-risk adolescent girls. When I came to the facility there was a serious problem with methamphetamine use

among the girls partly due to the fact that methamphetamine was readily available in the neighborhood. The use was so prevalent that the administrator of the on-grounds school thought that several of the girls were paranoid schizophrenics based on their behavior, which was the direct result of the use of methamphetamine and several girls told me that they were offered methamphetamine by other residents within 24 hours of their arrival at the facility. These girls were not girls they knew from other placements but strangers. Prior to my coming to the facility the director of clinical and residential services had contracted a Licensed Clinical Social Worker (LCSW) who was the director of an outpatient drug abuse recovery program to run groups with the girls that was unsuccessful and the LCSW left the agency. Following that the agency director contracted with an outpatient treatment center and had the girls transported to the center. Unfortunately, the girls would purchase drugs while at the outpatient center.

When I came to the facility I found out immediately that what I used at the boys' group home would not work with these girls due to their level of motivation. I reviewed the literature related to adolescent females, teen mothers and methamphetamine abuse through a search of the database *PsycINFO* and reviewed literature on the Stages of Change model developed by Prochaska and DiClemente (1982); which views the client's readiness for change on a continuum that includes the following stages: Pre-contemplation (Not yet acknowledging that there is a problem behavior that needs to be changed); Contemplation (Acknowledging that there is a problem but not yet ready or sure of wanting to make a change); Preparation/Determination (Getting ready to change); Action/Willpower (Changing behavior); Maintenance (Maintaining the behavior change) and Relapse (Returning to older behaviors and abandoning the new changes). Of course

relapse is not a necessary component and is put at the end because if an individual stops using without reaching the maintenance stage the individual is simply taking a break in use. Based on conversations with the facility and school staff, including line staff and teachers, conversations with the residents and based on my own observations I concluded that the majority of the girls were in the pre-contemplation stage and I began to review materials for the groups.

Due to the limits on scheduling I decided to do two weekly groups, one for the teen mothers and one for the at-risk adolescent girls. This set up also aided group cohesion since the teen mothers were housed on one floor and the at-risk girls were on housed on another. In addition to these basic groups I also contacted Narcotics Anonymous and arranged for a Hospital and Institutions (H&I) panel to come each week to speak to all of the girls and answer their questions about recovery. An H&I panel usually consists of three “panelist” or speakers who talk about their experience with drug abuse and recovery. After they share their experience the girls were allowed to ask questions for clarification, which is something that does not usually happen at Narcotics Anonymous meetings.

For the groups I utilized the book *Group Treatment for Substance Abuse: A Stages-of-Change Therapy Manual* (Velasquez, Maurer, Crouch & DiClemente, (2001) which contains group activities to address each of the stages of change and provided a good basis for group discussion and processing of feelings. I also utilized several videotapes covering alcoholism, children of alcoholics, methamphetamine use among teens and clips from the A&E documentary series *Intervention* as a means of psychoeducation and a basis for discussion of relevant topics. In the teen mothers’ group

I focused more on the interaction of mother and child when showing *Intervention* clips and other videos and lead discussions on how their drug use affected their children and would likely affect their children in the future. *Intervention* is a series that follows drug addicts while in their addiction, through an intervention with their family members and in most cases, follows the addict into treatment. I also used several of the *Intervention* “Follow up” episodes. This was useful to the girls because they could see that people who had been were they had been were able to recover. It also provided them with an overview of what can happen to them if they continue to use drugs (*Intervention* airs Sundays at 10pm EST on the A&E basic cable network).

In addition to the groups, I also conducted several staff trainings so that all staff had the basic information about co-occurring disorders, methamphetamine and detecting drug use. The staff trainings were a necessary component to aid the residents because the many staff members were unaware of the effects of methamphetamine on the brain and body and did not know how to detect if someone was intoxicated or had been abusing methamphetamine or other drugs. Many members of the staff were also unaware of the dangers of drug use and how drugs interacted with mental disorders and the medication used to treat it.

For these trainings I put together a PowerPoint presentation that included clips from the videos I used for the groups as well as additional information from the National Institute on Drug Abuse (NIDA) website (<http://www.nida.nih.gov/>), the Substance Abuse and Mental Health Services Administration (SAMHSA) (2005a) publication, *Substance Abuse Treatment for Persons with Co-Occurring Disorders*, photos of drugs of abuse and paraphernalia from the Drug Enforcement Administration (DEA) website

(<http://www.usdoj.gov/dea/>), photos of intoxicated individuals from the California Highway Patrol website (<http://www.chp.ca.gov/>) and additional videos and web-based materials from SAMHSA's National Clearinghouse for Alcohol and Drug Information (<http://ncadi.samhsa.gov/>).

The program was successful and most of the girls who attended group regularly were able to stop using drugs and work on recovery including going to outside Narcotics Anonymous meetings. Unfortunately, the residential treatment facility closed in December of 2005 due to the fact that the Department of Children and Family Services (DCFS) discontinued referring clients to long-term residential care and decided to send these girls to foster care or small group homes instead. This did make sense on the surface because the DCFS girls were placed with girls on probation and often were exposed to drugs and promiscuous behavior they would not have been exposed to otherwise. The downside is that they will probably not get the quality of care including psychotherapy, psychiatric care and drug abuse recovery groups that they would be readily available in residential care. The residential facility closed due to the fact that probation referrals alone would not provide sufficient funds to keep the facility open. The aftercare program did continue and I have been in contact with the aftercare coordinator and the majority of the girls who were in my groups have remained clean and are doing well especially those with children.

I currently work for Pacific Clinics' AB34 program. The AB34 program is a state and county funded program that aids severely mentally ill and homeless/incarcerated individuals most of whom have co-occurring substance use disorders. I have also done several staff trainings for AB34 using some of the same or similar materials I used for

staff trainings at the residential treatment facility, but I did not develop a co-occurring disorders program because there was already one in place that works well. The staff trainings addressed co-occurring disorders among severely mentally ill clients, medication-assisted therapies for alcohol and opiate and opioid dependence and I am currently developing another presentation on motivational interviewing. If the reader would like more information on the AB34 program, please refer to the AB34 website at <http://www.ab34.org/>. Also, if the reader has any questions or comments regarding this article, please contact me via email at wmjoiner@sbcglobal.net.

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