

# PARTICIPANT MANUAL

**Co-occurring Substance Use**

**and Mental Health Disorders**

**in Adolescents: Integrating**

**Approaches for Assessment and**

**Treatment of the Individual Young**

**Person**

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# MODULE 1: BRIEF OVERVIEW OF CO-OCCURRING DISORDERS

## **Goal:**

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

## **Learning Objectives:**

Discuss the association between substance abuse and psychiatric illness

Describe general statistics and trends among the adolescent population

## **Content Outline:**

Evolving Field of COD

- trends
- etiology
- facts
- trauma
- trends

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

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 He is being re-evaluated in the 11th grade because he is depressed and has become increasingly withdrawn, sad and tired.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

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

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

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

### HIS DIAGNOSIS WAS:

- Axis I    Major Depression
- Conduct Disorder
- ADHD
- Polysubstance Abuse and Dependence
- PTSD
- Axis II    Oppositional Traits
- Axis III    R/O Partial Complex seizures

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

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

### COMMENT

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



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

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

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

### INITIAL DIAGNOSIS:

Axis I      Major Depressive Disorder  
              R/O Panic Disorder  
              Possible Dissociative Disorder

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

After several weeks of treatment, Gina admitted to heavy use of marijuana and ecstasy. She stated that her symptoms had not started until she began using these drugs. As treatment progressed, she admitted to more antisocial abnormal behavior, including ignoring her daughter and going out with friends to do drugs and attend parties. She demonstrated additional pathology in treatment that focused on her overinvolvement with male patients. This was successfully confronted and treated.

### FINAL DIAGNOSIS;

Axis I      Polysubstance Abuse,  
              Major Depressive Disorder

### COMMENT:

In hindsight, it is evident that she should have received counseling from the time her pregnancy became known. The fact that she had become pregnant should have raised concern that she was experiencing other problems in addition to her early sexual activity, including possible substance use. The second point at which she could have been helped was when she made her 1st suicide attempt. She should not have been released from the hospital without outpatient therapy.

Her antidepressant intolerance can also be found in people with panic disorders. The most striking thing about the case is that substance abuse was not initially diagnosed because Gina presented with clear depressive symptoms, had made a suicide attempt and had a negative drug screen. It was only after the passage of time and start of counseling that she admitted she had used drugs and that the drugs had probably caused most of her symptoms. This demonstrates that it is very important not to make snap judgments or diagnoses when treating adolescent psychiatric patients because they may be substance users denying their illness.

# MODULE 2: BEST PRACTICE

## **Goal:**

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

## **Learning Objectives:**

Discuss the disadvantages of sequential and parallel models.

List the six guiding principles for integrated treatment.

Describe the critical components in the delivery of services.

List the 4 levels of program capacity

Discuss the components for fully integrated treatment.

## **Content Outline:**

Traditional Approaches

- sequential
- parallel

Integrated Treatment

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



## MODULE 2 HANDOUTS: BEST PRACTICES ACHIEVING INTEGRATED TREATMENT WORKSHEET

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

### BASIC

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

### INTERMEDIATE

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

### Advanced

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

### FULLY INTEGRATED

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

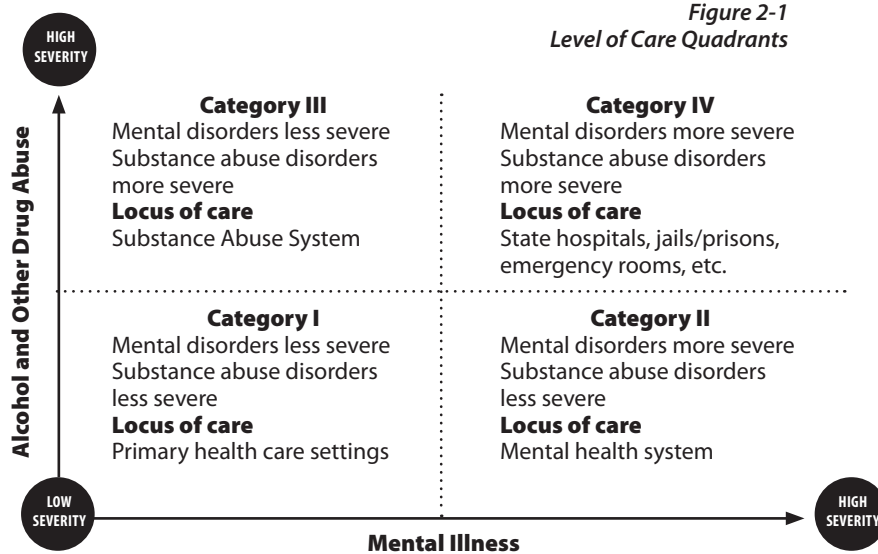
**Please make a check mark along the continuum which best represents your agency's current provision of services:**

- Basic
  Intermediate
  Advanced
  Integrated



## MODULE 2 HANDOUTS: LEVEL OF CARE QUADRANTS

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



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

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

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

**QUADRANT IV:** Quadrant IV is divided into two subgroups. One subgroup includes individuals with serious and persistent mental illness (SPMI) who also have severe and unstable substance use disorders. The other subgroup includes individuals with severe and unstable substance use disorders and severe and unstable behavioral health problems (e.g., violence, suicidality) who do not (yet) meet criteria for SPMI. These individuals require intensive, comprehensive, and integrated services for both their substance use and mental disorders. The locus of treatment can be specialized residential substance abuse treatment programs such as modified therapeutic communities in State hospitals, jails, or even in settings that provide acute care such as emergency rooms.

# MODULE 3: ADOLESCENT DEVELOPMENT

## **Goal:**

To provide clinical information on the complex developmental period.

## **Learning Objectives:**

Demonstrate increased empathic understanding of adolescents

Describe “Normal” and “Maladaptive” adolescent development

Discuss developmental theories regarding separation/individuation and moral development

List major stages and tasks of adolescence

List key aspects of biopsychosocial issues and changes

## **Content Outline:**

Normal Development

- changes
- tasks
- behaviors/attitudes
- challenges

Mental health and substance abuse affect maturation

## MODULE 3 HANDOUTS: ADOLESCENT DEVELOPMENT — REMEMBERING ADOLESCENCE

My best friend was \_\_\_\_\_

\_\_\_\_\_

We liked to talk about \_\_\_\_\_

\_\_\_\_\_

We worried about \_\_\_\_\_

\_\_\_\_\_

The best things for me/my friends were \_\_\_\_\_

\_\_\_\_\_

I/we coped with the stress by \_\_\_\_\_

\_\_\_\_\_

Drugs and alcohol were viewed as \_\_\_\_\_

\_\_\_\_\_

My parents represented \_\_\_\_\_

\_\_\_\_\_

Other adults were generally seen as \_\_\_\_\_

\_\_\_\_\_

The hardest part of being a teenager is \_\_\_\_\_

\_\_\_\_\_

The best part of being a teenager is \_\_\_\_\_

\_\_\_\_\_

I knew who and how to ask for help \_\_\_\_\_

\_\_\_\_\_

# MODULE 4: SUBSTANCE ABUSE

## Goal:

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

## Learning Objectives:

List the DSM IV diagnostic criteria

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

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

## Content Outline:

Substance Disorders

- neurobiology
- DSM adult criteria
- adolescent criteria

Adolescent Use

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

Clinical Qualities

## MODULE 4 HANDOUTS: RISK FACTORS

### BUKSTEIN (1995)

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

##### 1. *Peer factors*

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

##### 2. *Parent/family factors*

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

##### 3. *Individual Factors*

- a. Early childhood characteristics such as conduct disorder and aggression
- b. Poor academic performance/school failure
- c. Early onset of substance use, especially prior to 15
- d. Positive attitudes/beliefs about substance abuse
- e. Risk-taking/sensation-seeking behavior
- f. High tolerance of deviance/nonconformity relative to traditional values

- g. Positive expectancies regarding the effects of substances
- h. External locus of control
- i. Extroversion
- j. Low self-esteem
- k. Poor impulse control
- l. Anxiety/depression
- m. Impaired coping skills
- n. Interpersonal/social difficulties
- o. Traumatic experiences (e.g. childhood physical or sexual abuse)

##### 4. *Biologic Factors*

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

##### 5. *Community/social/cultural factors*

- a. Low socioeconomic status
- b. High population density
- c. Low population mobility
- d. Physical deterioration
- e. High Crime
- f. Increased unemployment
- g. Deviant norms, which condone abuse of substances
- h. High alienation of the citizens
- i. Availability of substances

## MODULE 4 HANDOUTS: SCAVENGER HUNT

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

# MODULE 5: MENTAL HEALTH

## **Goal:**

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

## **Learning Objectives:**

Reduce misconceptions regarding psychiatric disorders

Increase precision of diagnostic considerations and treatment planning

Increase knowledge and ability to communicate about these disorders across disciplines

Increase appreciation for the relationship of these disorders with SUD

## **Content Outline:**

Review of:

ADHD

Learning Disorders

ODD

Conduct Disorder

Mood Disorders

Anxiety Disorders



## MODULE 5 HANDOUTS: DSM DISORDERS REFERENCE LIST

### THIS IS AN OVERVIEW LIST FOR PARTICIPANTS REFERENCE ONLY

#### DSM DISORDERS USUALLY DIAGNOSED IN INFANCY & CHILDHOOD

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

#### OTHER DISORDERS USUALLY OCCURRING IN CHILDHOOD, ADOLESCENCE & ADULTHOOD

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

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

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

## MODULE 5 HANDOUTS: MENTAL HEALTH DISORDERS

### OTHER DIFFERENTIAL DIAGNOSTIC CONSIDERATIONS

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

Pre-natal Induced Disorders  
Maternal cocaine ingestion prior to birth  
FASD primarily FAE  
Maternal / Paternal alcohol and/or other drug use prior to conception  
Congenital, Physiological and Environmental  
Lead ingestion  
Hepatic disease  
Hyperthyroidism  
Hypothyroidism  
Seizure D/O  
Migraine D/O  
Sensory Deficit Disorders; Medications  
Substance Induced Cognitive / Functional Impairments  
Age appropriate over-activity

# MODULE 6: ASSESSMENT

## **Goal:**

Present integrated approach and method for assessment.

## **Learning Objectives:**

Describe basic assumptions underlying the assessment process

Describe the domains, strategies and tools of assessment

Discuss the value and application of assessment

## **Content Outline:**

Purpose of Assessment

Assumptions

Importance of Therapeutic Alliance

- Common Factors

Assessment Domains

- Data Collection
- Parent/Guardian Issues
- Biologic Measures
- Archival Records

Standardized Tools

Time Frames

5 Stages of Assessment

- screening
- diagnostic
- level of care
- multidimensional services
- measurement

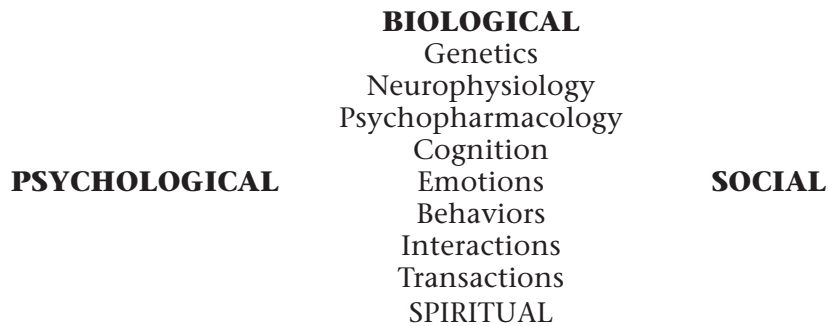
Step wise procedure

- multiple domains
- general to specific

ASAM dimensions

# MODULE 6 HANDOUTS: ASSESSMENT

## BIOPSYCHOSOCIAL MODEL (SANDS, R., 1991)



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

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

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

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

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

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

## MODULE 6 HANDOUTS: CASE 4

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

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

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

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

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

## MODULE 6 HANDOUTS: CASE 5

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

While on the unit Jessica presented with a great deal of hostility and unbridled anger that manifested in her constantly cursing everyone out. Staff referred to Jessica between themselves as “that angry bitch” evidencing strong negative counter transference feelings. She dressed in a highly provocative manner contradictory to the unit dress code and attempts by the staff to redirect her behavior. She would often glamorize and brag about her promiscuity and sexual conquests, much to the chagrin of the male staff and male patients. Since being on the unit and “clean” her

roommates reported to staff that they often heard her crying in her bed after waking up panicky and frightened from a nightmare. She wrote Journal logs that often left staff feeling shocked at her rage, hostility and the language that she used. Below is an example of one of her log entries three weeks into treatment:

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

## MODULE 6 HANDOUTS: CASE 6

SHERRY is a 17 year-old Latina who lives outside of a major city. She used cocaine for several years, and was introduced to it by her boyfriend at the time. She has a history of using marijuana, ecstasy on occasion and alcohol as well.

Sherry has lived on her own for the last year, choosing to stay at Covenant House (NYC Runaway Shelter) when she could no longer stay with friends. Her counselor at Covenant House referred her to the substance abuse treatment program where you perform for the evaluation. Upon meeting Sherry, you begin to take a history to learn more about her background. She gives you a flood of information and you struggle to keep up with her as you take notes. She tells you that she has been “on her own” since leaving home at the age of 16 because she could no longer handle the arguments and restrictions that her family was trying to impose on her. She stated that she grew up in a loving but strict family where she was the youngest of six children. Also living in the home is her grandmother who suffers from severe depressive episodes, often taking to her bed “for the winter”. Sherry reports that some of her brothers drank a lot but she hid her own drug and alcohol use from the family. She stated that she has tried most drugs, but prefers cocaine because “even though I’m pretty fast it calms me down.”

Sherry denied any current suicidal ideation but re-

ported a suicidal attempt at the age of 14 while in a depressive episode. Now she reports feeling good, and “wanting to get myself straightened out because I have a lot of plans.” She reported that she wanted to write a book about her experiences at home and on the road on her own. She felt it would be good as a guide for other runaways who “might not have to go through what I did”

Sherry reported that she had been doing well in school up until high school, when she began to have trouble concentrating and frequently became argumentative with teachers. She recognized that she used too many drugs and indicated that her goal was to “cut back so that I can function better.”

When asked for permission to contact her family she refused to provide her family’s name or number for a collateral contact, declaring herself an “emancipated person, you know...” She indicated that she would be taking legal action to officially separate herself from her family of origin. During the history, Sherry hinted at abuse but refused to go into any detail. A urine drug screen and breathalyzer was taken just prior to her entering the interview and indicated she had a BAC of .08 and was also positive for marijuana and cocaine. An initial medical examination by the intake nurse also indicated high blood pressure, diaphoresis and slight tremors.



## MODULE 6 HANDOUTS: CASE 7

STEPHEN is a 15 1/2 year old Caucasian male and high school sophomore. He was recently suspended from school due to testing positive for marijuana and also being in possession of marijuana broken up into small glassine bags. The local authorities detained Stephen and he was being charged with possession of marijuana and possession of marijuana with intent to distribute.

Stephen's family history reveals that both of his parents were highly successful, his father as a stockbroker and his mother as a physician. Stephen reported that he always felt under a great deal of pressure for academic excellence and always felt that whatever he did wasn't good enough.

During his early elementary school years and most of his junior high school years he excelled academically, always being in the highest groups and was also a gifted tennis player making a name for himself in the junior leagues. He was described as gregarious and funny often to the point of being reprimanded in school for being a class clown. Despite his fooling around his parents were always amazed at how easy school seemed to be for him commenting that he would get A's without ever opening a book. On the other hand his parents reported being very frustrated that he never seemed to get things done when they asked no matter how many times he got into trouble at home or at school. They stated that although he was disciplined for the behaviors, he never seemed to learn from it. Over time this began to create great a deal of tension and arguments between him and his parents.

In the middle of the 1st marking period of his freshman year of high school, in which he was in all honors classes, his parents received numerous progress reports that indicated he was close to failing all of his subjects except for math, his favorite subject. Reports indicated that he failed to turn in any of his homework and was unprepared for quizzes and tests. When confronted by his parents he simply stated "it was no big deal".

Stephen began to become more and more secretive often locking himself in his room playing video games and listening to music. Any time his parents asked whether or not he had homework he would snap at them saying "I got it done at school I told you I would do better. If you keep bugging me I'm not going to want to do it." He appeared to be more recalcitrant, oppositional and argumentative, stating that more and more things didn't matter, his classes were stupid and the teachers didn't know anything. He further indicated that the teachers were such idiots that they couldn't keep any notes straight and that they lied about him not turning in his homework to cover for themselves for losing it. At the same time his parents reported that he began missing practices for tennis and Stephen later notified them that he was not going to rejoin the team stating it was getting boring and he didn't have any competition and he was beyond what the coach had to offer.

By the end of his freshman year Stephen had completely shut down in school and was acting out more at home. Throughout the summer before his sophomore year, Stephen escalated his oppositional and defiant behavior, disregarded curfews, snuck out at night and had several underage drinking incidents involving the police that were handled quietly.

## MODULE 6: INTRODUCTION

### Integrated Multidisciplinary Adolescent Assessment

Assessment represents the process for understanding the individual adolescent as a unique person in the context of the Biopsychosocial and spiritual developmental process of adolescence. As described in the module detailing adolescent development, there are many complexities inherent in the normal course of development. However, adolescents who must also deal with additional disorders, whether they are congenital and/or acquired in the course of their development, have a considerably more difficult process to negotiate riddled with greater risk potential. The balance of resiliencies and competencies versus liabilities and challenges is precarious. Therefore, assessment takes on an even more critical role in the effort to gain understanding in the service of designing, planning, implementing, monitoring and reevaluating care and treatment. It stands to reason that given the multi-dimensional, multi-systemic, multi-environmental, multi-social and that multi-contextual world of the adolescent; a quality assessment must be COMPREHENSIVE and MULTIDISCIPLINARY.

### Assessment must be understood as a dynamic and evolutionary process and not a static event.

This module has been designed to familiarize participants with the essential components of a comprehensive, multidisciplinary and integrated adolescent assessment which is essential in meeting the needs of adolescents with substance use and co-occurring psychiatric/mental health and/or other associated disorders. The module will present the information and material from a variety of perspectives including but not limited to: theoretical underpinnings; pragmatic operational assumptions; recognized structural formats; clinical data collection; and application and clinical experience.

**MODULE 6 HANDOUTS:  
CASE STUDY WORKSHEETS**

**CASE STUDY WORKSHEET**

Case: \_\_\_\_\_

MENTAL HEALTH SYMPTOMS AND TREATMENT	SUBSTANCE ABUSE SYMPTOMS AND TREATMENT	INTERACTION

Impressions: \_\_\_\_\_  
\_\_\_\_\_

**LIFETIME TIMELINE**

AGE	EVENT	RESPONSE	CONSEQUENCES

Impact of Family, Gender, Culture on Course of Illnesses: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MODULE 6 HANDOUTS:  
CASE STUDY WORKSHEETS**

**STRENGTHS, RESOURCES, TALENTS**

Review all psychosocial domains. Include past, present that exist for the person individually, in relationship to others and the community.

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**PROVISIONAL DIAGNOSIS**

AXIS I		CRITERIA
AXIS II		

**LEVEL OF CARE**

SEVERITY OF ILLNESS	IMMINENCE OF RISK	SUGGESTED LEVEL OF CARE

# MODULE 7: RECOMMENDATIONS FROM EVIDENCE-BASED APPROACHES

## **Goal:**

Provide overview of effective treatment program characteristics and evidence-based strategies

## **Learning Objectives:**

Identify at least 4 effective treatment program characteristics

Describe at least 2 of the 5 Evidence-Based interventions

Discuss why family involvement improves outcomes

List the 5 steps to an integrated treatment process

## **Content Outline:**

Key elements

Research-based interventions

- MET
- Family Based
- Behavioral
- CBT
- Community Reinforcement

Characteristics of Culturally Competent Programs

5 Steps to Integrated Treatment Process

Recommendations for Practice

## MODULE 7 HANDOUTS:

### MOTIVATIONAL ENHANCEMENT THERAPY (MET)

This approach has been used both as a stand-alone, brief intervention (for example, among adolescents presenting to emergency rooms with alcohol-or drug-related injuries) and it has been integrated with other modalities such as CBT (Monti et al., 2001).

MET is a client-centered approach that helps patients resolve ambivalence about engaging in treatment and strengthen motivation to build a plan for change. MET has been shown to improve treatment commitment and motivation and reduce substance abuse and risky behaviors (for instance, drunk driving and unsafe sex).

Utilizing MET techniques is particularly important in working with adolescents, as they are generally resistant to more directive approaches and are often ambivalent about committing to abstinence. (Drug Strategies, 2002; National Institute on Drug Abuse, 1999).

### FAMILY-BASED INTERVENTIONS

Family based interventions include structural-strategic family therapy, parent management training (PMT), multisystemic therapy (MST), and multidimensional family therapy (MDFT).

These interventions are based on family systems theory and share the assumption that dysfunctional family dynamics contribute to adolescent SUD and related problems. In practice, clinicians perform a functional analysis to identify problem behaviors, and relationship patterns that are then targeted with restructuring interventions.

Parents are taught better monitoring skills and basic behavioral management principles to improve their adolescent's behavior and reduce drug abuse together with strategies to improve overall family functioning and sustain the gains of treatment (Drug Strategies, 2002; Wagner et al., 1999).

### BEHAVIORAL OR PSYCHOSOCIAL INTERVENTIONS

Research on behavioral/psychosocial interventions has made significant advances in the past decade. Controlled trials now provide good evidence that several psychosocial treatment approaches can be effective in treating adolescent SUD and other associated problems. Some of these interventions are based on modalities that have been effectively used with adults and modified substantially to make them developmentally appropriate for adolescents (Deas et al., 2000; Drug Strategies, 2002; Wagner et al., 1999). Among the modalities with substantial research support are: Behavioral therapy; Cognitive Behavioral therapy (CBT); and Community Reinforcement Approach (CRA). Brief descriptions of each follow.

### BEHAVIORAL THERAPY

These approaches are based on operant behavioral principles that include rewarding behaviors or activities that are incompatible with drug use and withholding rewards or applying sanctions when drug use or other targeted behaviors occur. This provides a constructive reinforcement system to help promote desired behaviors and eliminate those related to drug use. Urine monitoring to detect drug use is indispensable to linking consequences as closely as possible to the targeted behaviors.

Studies of adolescents indicate that it is important both to provide individual behavioral therapy and to involve the family in treatment. Behavioral therapy has been shown to help adolescents become drug free and to improve problems in other areas, such as employment, school attendance, family relationships, conduct problems, and depression (Azrin et al., 1994; National Institute on Drug Abuse, 1999).

Behavioral therapies have also demonstrated great success in decreasing drug use and altering behaviors. These include both individual and group formats aimed at:

- enhancing self-efficacy,
- increasing problem-solving and decision-making skills;
- increasing specific skills for communicating effectively, managing anger, regulating mood, coping with stressors, and preventing relapse.

Relapse prevention is accomplished by supporting the person to anticipate and avoid high risk situations, identify triggers, reducing association with drug-using peers, and engaging in enjoyable activities that are incompatible with substance abuse.

## MODULE 7 HANDOUTS:

### COGNITIVE BEHAVIORAL THERAPY (CBT)

Cognitive Behavioral Therapy is based on learning theory and has been shown to be effective in treating adolescent SUD (Drug Strategies, 2002; Wagner et al., 1999). Although there is more empirical support for individual CBT, preliminary studies indicate that group CBT may also reduce adolescent substance use and improve other problem behaviors (Kaminer et al., 1998).

Treatment manuals have been developed for courses of weekly CBT ranging from 5 to 16 weeks. Features common to most CBT models include:

- Employing motivation-enhancing techniques to establish a strong treatment alliance and improve treatment engagement and retention;
- Performing a functional analysis to identify patterns of substance use, skill deficits, and dysfunctional attitudes and thinking that then become specific targets of intervention;
- Enhancing coping strategies to effectively deal with drug craving, negative moods, and anger;
- Strengthening problem-solving and communication skills and the ability to anticipate and avoid high-risk situations; and
- Identifying enjoyable activities incompatible with drug use.

New skills and coping strategies are initially taught and practiced during therapy sessions, then applied to the patient's daily life in "homework" assignments, with a review of successes and setbacks the following week (Drug Strategies, 2002; Wagner et al., 1999).

### COMMUNITY REINFORCEMENT APPROACH (CRA)

The Community Reinforcement Approach (CRA) "is a broad-spectrum behavioral treatment approach for substance abuse problems... that utilizes social, recreational, familial, and vocational reinforcers to aid clients in the recovery process" (Meyers and Smith 1995, p. 1).

This approach uses a variety of reinforcers, often available in the community, to help substance users move into a drug-free lifestyle. Typical components of CRA include (1) functional analysis of substance use, (2) social and recreational counseling, (3) employment counseling, (4) drug refusal training, (5) relaxation training, (6) behavioral skills training, and (7) reciprocal relationship counseling.

In the very successful approach developed by Higgins and colleagues for cocaine-dependent individuals (Higgins et al. 1991, 1994), a contingency management component is added that provides vouchers for staying in treatment. The vouchers are redeemable for items consistent with a drug-free lifestyle and are contingent upon the patient's provision of drug-free urine toxicology specimens.

Thus, CRA and CBT share a number of common features, most importantly, the functional analysis of substance abuse and behavioral skills training. CBT differs from CRA in not typically including the direct provision of either contingency management (vouchers) for abstinence or intervening with patients outside of treatment sessions or the treatment clinic, as do community-based interventions (job or social clubs). NIDA Therapy Manuals for Drug Addiction; Cognitive Behavioral Approach



## **MODULE 7 HANDOUTS:**

### **PARENTING TASKS ADOLESCENT WITH SUBSTANCE ABUSE PROBLEMS**

**(Wallace, Estroff, 2001)**

- Helping their child to remove him-or herself from a negative substance abusing peer group and to create an alternate positive peer group instead.
- Helping their adolescent defuse a crisis.
- Helping the adolescent remove him-or herself from access to or temptation to use alcohol and other drugs.
- Helping the adolescent understand any emotional pain he or she is feeling.
- Using the family therapist to improve family functioning and resolve the adolescent's reactions to family dysfunction.
- Providing tutorial help aimed at promoting success when the adolescent is failing in school.
- Providing structure, predictability, and setting limits when the adolescent is out of control.
- Helping the adolescent design a self-concept building program when he or she has a damaged self-concept.
- Helping their child to have a basic understanding of the need for treatment when he or she doesn't want help.
- Making choices for their teenager when he or she is making bad choices, but only until the teenager can make decision on his or her own.
- If the family is part of the problem, including the family in the solution of the problem.

## MODULE 7 HANDOUTS:

# CULTURALLY COMPETENT TREATMENT SYSTEMS — NATIONAL GAINS CENTER FOR PEOPLE WITH CO-OCCURRING DISORDERS

### Online Curriculum / Case Example

*Please read the following description of the Evergreen Mountain Holistic Living Program and indicate which goals for a culturally competent treatment program are in place in this facility.*

#### Evergreen Mountain Holistic Living Program

The Evergreen Mountain Holistic Living Program is a community-based intervention program for youth involved with the juvenile justice system. The multilingual and multiethnic team of highly trained mental health professionals consists of case managers, therapists, psychologists, and psychiatrists. The treatment team provides a Multi-Systemic Treatment (MST) approach to treating 12- to 17-year-old youth who have had at least two admissions to detention, have a history of serious emotional or behavioral problems and violent or aggressive behavior in the past two years, or meet DSM-IV criteria for substance abuse.

The family works with an MST therapist to identify strengths and areas of need. Before discharge, families are connected with churches, schools, local businesses, and community centers to develop positive, productive community activities, such as jobs, recreation, and community service. Families also work closely with probation counselors to identify potential roadblocks to success and to build the probation plan.

Family counseling usually takes place in the home. Focus is placed on reducing conflict, supporting the role of parents and caretakers, and improving communication at home. Individual counseling addresses the mental health and emotional needs of the youth. Anger management, interpersonal communication, and impulse control are addressed to help youth stay out of trouble. Complete drug and alcohol screening is provided to determine the role of substance use in the problems experienced. When needed, psychiatric consultation and psychological testing are available. To provide continuous aftercare support, youth are offered group support programs such as skill-building, recreation, and prevention of drug and alcohol abuse.

Throughout the year, MST therapists participate in continuing education programs conducted by members of the community who provide information about the cultures and resources of the diverse communities that surround Evergreen Mountain. Continuing education sessions include topics such as religious practices, family customs, occupational hazards, and recreational and academic opportunities.

The Evergreen Mountain Holistic Living Center is an active participant in the Coalition for Understanding, a multicultural organization created to educate the population about the various cultural traditions that support strong family relationships and connections with the rich traditions of the diverse communities throughout the State.

## MODULE 7 HANDOUTS:

### CULTURALLY COMPETENT TREATMENT SYSTEM GOALS

(PLEASE CHECK ALL THAT APPLY.)

- Promote an environment which attracts, retains, and fosters a diverse and multicultural staff.
- Facilitate and encourage cross-cultural communication.
- Ensure the development and implementation of cross-cultural diversity, knowledge, empathy and respect in policy, planning, and service delivery systems.
- In partnership with the treatment service provider community and the community at large, seek and receive knowledge, information and resources to improve awareness, empathy and respect of the various community collectives.
- Provide bold and innovative leadership through advocacy for diversity and cross-cultural knowledge, empathy and respect.

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### ASSESSING THE AGENCY'S POTENTIAL TO SERVE ADOLESCENTS WITH CO-OCCURRING DISORDERS

1. What are the current strengths of services offered with respect to COD?	
2. What services are immediately available to meet client needs?	
3. What services could be added within the program?	
4. What services are available from the community that would enhance recovery?	
5. How can the physical environment convey recovery orientation?	
6. How well are outside agencies meeting clients' needs?	
7. What resources are needed to enhance service delivery for COD?	
8. What staff skills can be increased?	
9. Can additional expertise be accessed through consulting agreements or similar arrangement?	

## MODULE 7 HANDOUTS:

### TREATMENT CHARACTERISTICS

STRENGTHS	
GAPS	
NEEDS	

# MODULE 8: CROSS SYSTEM COLLABORATION

## GOAL:

Identify barriers to and strategies for cross system collaboration

## Learning Objectives:

Describe at least 3 program and clinical barriers.

Discuss obstacles for clients in accessing treatment services.

Define consultation, collaboration, integration.

Identify 4 local strategies that have been implemented in programs throughout the country.

## Content Outline:

Barriers

- Program Issues
- Clinical Issues
- Client Issues
- Minority Youth Issues

Areas of Convergence

Key Lessons

Replicable Strategies

Actions towards Integration

## MODULE 8 HANDOUTS: COLLABORATION

Each program matches services to individuals with co-occurring disorders based on their treatment needs. For example, some programs provide continuity-of-care case management services for substance using individuals with serious mental illnesses. Other programs might include residential addiction programs for individuals with serious addiction and trauma disorders.

Although new resources are always needed, the CCISC helps identify how current resources can work more efficiently by designing programs to be co-occurring disorders capable from their inception. In addition, the CCISC encourages use of any best practice intervention or program for either mental illness or substance use disorder, provided that the intervention is designed to be offered routinely in an integrated manner to individuals with co-occurring disorders.

### **Integrated Treatment Philosophy.**

The CCISC treatment philosophy is based on eight best-practice treatment principles that reflect consensus among clinical experts (CMHS, 1998). These principles emphasize the need to acknowledge co-occurring disorders as an expectation, to consider both substance abuse and mental disorders as primary disorders, and to develop program structures and interventions that accommodate each individual's needs.

No one program or intervention is right for all people with co-occurring substance use disorders and mental disorders. For any individual at any point in time, interventions must be matched to the status of the individual - from diagnosis to phase of recovery and from needs/strengths/contingencies to level of care requirement (CMHS, 1998). Finally, the measure of success is based on an individual's treatment goals. At any point in time, success may be defined by acute stabilization of symptoms, movement through stages

of change, skill development, or reduction in substance use.

Practice guidelines based on this model have been adopted by the State of Arizona and by the Illinois Behavioral Health Recovery Management project. Minkoff has developed a "12-Step Program for the Implementation of the CCISC," and Minkoff and Cline (2001, 2002) have developed a toolkit to facilitate this process, including tools to evaluate system fidelity, program capability, and clinician competency. These tools are beginning to be used and evaluated in systems change initiatives throughout the U.S. and Canada.

Consultation refers to the traditional types of informal relationships among providers from referrals to requests for exchanging information and keeping each other informed. The framework calls for particular attention to the consultation relationship during identification, engagement, prevention, and early intervention activities.

Collaboration is essential when a person who is receiving care in one treatment setting also requires services from another provider. Collaboration is distinguished from consultation on the basis of the formal quality of collaborative agreements, such as memoranda of understanding or service contracts, which document the roles and responsibilities each party will assume in a continuing relationship. For example, parties must ensure that they can share information without violating Federal Law 42 C.F.R. Part 2 on confidentiality (see appendix for more information). This will require the client to give written authorization for release of information to all providers.

Integration denotes "those relationships among mental health and substance abuse providers in which the contributions of professionals in both fields are moved into a single treatment setting."

## MODULE 8 HANDOUTS: COLLABORATION

### INNOVATIVE SYSTEMS INTEGRATION STRATEGIES

Many states and communities already have begun to implement innovative systems integration strategies. While approaches varied by state, important commonalities in their efforts can help guide other states interested in developing effective system-level strategies for addressing the needs of individuals with co-occurring disorders. Among (NASMHPD/NASADAD, 2002) these commonalities are:

- A shared vision and expectations concerning co-occurring disorders treatment that staff were encouraged, supported, and expected to follow.
- A comprehensive service system - based on an integrated services model that has been tailored to respond to local needs - that is capable of responding to all or most of the needs of individuals with co-occurring mental and substance abuse disorders, including the presence of other concurrent health issues.
- Staff expectation that individuals with co-occurring symptoms and disorders would be the rule rather than the exception among individuals needing services. This expectation is coupled with the ability to screen and assess for related conditions, such as HIV/AIDS, a full range of physical and/or sexual abuse, brain disorders, physical disabilities, etc.
- Cross-trained staff taught to be culturally competent in both mental health and substance abuse disciplines, while continuing to work within their fields of expertise. Care delivered as part of a multidisciplinary team that features shared responsibility for clients.
- Client-centered services that engage individuals who are at various stages of acceptance and recovery.

Comprehensive Continuous Integrated System of Care (CCISC)

The Comprehensive Continuous Integrated System of Care (CCISC) is a model designed to join the mental health and substance abuse treatment systems (and other systems, potentially) in an effort to develop a comprehensive, integrated system of care for people with co-occurring disorders (Minkoff, 2001, 1991). This model includes work derived from the Clinical Standards and Workforce Competencies Project (Minkoff, 2001; CMHS, 1998).

CCISC, identified by SAMHSA as an exemplary practice, is at various stages of implementation in no fewer than 15 state and regional systems (CSAT, in press), including Arizona, Maine, New Mexico, Oregon, and Florida. CCISC is applicable to systems of any size ranging from an entire state to a local service network or agency, and may be extended to include linkages with systems such as corrections and homelessness services.

#### Integrated System Planning

Because co-occurring disorders are an expectation in all parts of the service system and are associated with poorer outcomes and higher costs, the CCISC model requires that both funding and services be planned specifically based on those assumptions. As a consequence, all service programs are designed to be “co-occurring capable programs,” meeting minimum standards of capacity. Some programs are designed to be “co-occurring enhanced”; e.g., they have the capacity to respond to co-occurring substance abuse disorders and mental disorders in inpatient psychiatry units.



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- Kumpfer, K.L., Alvarado, R., Tait, C. & Turner, C. (2002). Effectiveness of school-based family and children's skills training for substance abuse prevention among 6-8 year-old children. *Psychology of Addictive Behaviors* 16(45), 565-571. Description and an effectiveness study of Project SAFE (Strengthening America's Families and Environment) used with 655 1st graders in 12 rural schools as a randomized trial with a universal population.
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- Monti, P.M., Colby, S.M. & O'Leary, T.A. (Eds.) (2001). *Adolescents, alcohol and substance abuse: reaching teens through brief interventions*. New York: The Guilford Press, 350 pgs. A highly useful book that examines a number of issues in current practice and research. Chapters examine adolescent development and its relationship to interventions; harm reduction; assessment; risk factors; motivational enhancement and interviewing; skills training; family therapy; co-morbid psychiatric conditions; internet use in prevention and treatment; and research for improving brief interventions.
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- Osher, F.C. & Kofoed, L.L. (1993). Treatment of patients with psychiatric and psychoactive substance abuse disorders. *Dual diagnosis of mental illness and substance abuse: Collected articles from H&CP [American Psychiatric Association]*, 11-16. Presents a conceptual model emphasizing four phases of treatment, their components, and how these are useful in working with persons with severe and recurrent psychiatric disorders who also have substance use disorders.
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- Riggs, P.D. (1998). Clinical approach to treatment of ADHD in adolescents with substance use disorders and conduct disorders. *Journal of the American Academy of Child & Adolescent Psychiatry* 37(3), March, 331-332. This article cites Attention-Deficit/Hyperactivity Disorder as co-occurring in 30-50% of adolescents having both a Substance Use Disorder and Conduct Disorder and advises careful diagnosis using a time line (including establishing the presence of ADHD prior to age 7) and adequate treatment of all diagnoses, including medications such as pemoline or bupropion that have both efficacy in treating ADHD and lower abuse potential than the psychostimulants. [See also Riggs et al (1996). An open trial of pemoline in drug-dependent delinquents with Attention-Deficit Hyperactivity Disorder, 35:8, August, pp. 1018-1024 and Riggs et al (1998). An open trial of bupropion for ADHD in Adolescents with Substance Use Disorders and Conduct Disorder, 37:12, December, pp. 1271-1278, in the same journal.]
- Riggs, P.D. (in press). Treating adolescents for substance use and comorbid psychiatric disorders. A very useful description of practical clinical guidelines for integrating assessment and treatment of substance use disorders with specific co-occurring psychiatric disorders is presented.
- Riggs, P.D., Baker, S., Mikulich, S.K., Young, S.E. & Crowley, T.J. (1995). Depression in substance-dependent delinquents. *Journal of the American Academy of Child & Adolescent Psychiatry* 34(6), June, 764-771. Findings that depression in conduct-disordered males often begins in preadolescence and may co-occur more frequently with co-morbid Attention-Deficit/Hyperactivity Disorder (beginning prior to Conduct Disorder). Additionally, 75% of the depressed young males also had an additional Anxiety Disorder (as opposed to 25% of non-depressed conduct-disordered youth in the study). All youth in the study were in long-term residential care and all had Conduct Disorder and a substance use disorder. Twenty-one percent of them were also diagnosed with Major Depressive Disorder or Dysthymia. This subset of boys also had more substance dependence diagnoses, more ADHD, PTSD, and anxiety disorders and had tended to develop conduct symptoms earlier than the non-depressed youth in the study.
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- Riggs, P.D. & Davies, R.D. (2002). A clinical approach to integrating treatment for adolescent depression and substance abuse. *Journal of the American Academy of Child & Adolescent Psychiatry* 37(12), December 1998, 1271-1278. This was a 5 week study on boys in residential treatment with conduct disorder, substance use disorders and co-morbid attention-deficit/hyperactivity disorder. There were decreases in the mean Conners Hyperactivity Index score and their study points out the need of a larger controlled study.
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## USEFUL WEBSITES

Alcohol and drug webliography. (2002). *Substance Use & Misuse* 37(12-13), 1751-1784. [No authorship indicated.] Presents a listing of Internet/World Wide Web resources for information re: rehabilitation.

Atlantic Information Services (AIS) is a commercial site more useful for program managers or anyone trying to keep up with what managed care organizations are thinking about and/or recommending for practice (and how it may affect you). Find at [www.aishealth.com](http://www.aishealth.com)

Join Together Online is found at <http://www.jointogether.org> and reprints or provides links to articles and websites including those targeted to adolescent treatment systems.

Medscape is a very useful website for updates in new psychotropic medications, including youth and substance use. Find at <http://www.medscape.com>

The National Association for the Mentally Ill (NAMI) is useful and includes co-occurring disorders, youth, etc. Find at <http://www.nami.org> A list of commonly prescribed psychotropic medications including both brand and generic names is at <http://www.nami.org/egi-bin/printfy1.egi?/helpline/medlist.htm>

National Institute on Drug Abuse (under the National Institute of Health [NIH]) co-sponsors the Gainesville site where one can keep up with the properties of the more common drugs of abuse at <http://www.cornerdrugstore.org/CommonDurgsPage.htm> NIDA also has an interactive curriculum for grades 9-12 (free)\

Entitled "The Brain: Understanding Neurobiology Through the Study of Addiction" that can be located at <http://www.drugabuse.gov/Curriculum/HSCurriculum.html>

National Institute of Health website also connects to the National Library of Medicine where one can locate the Treatment Improvement Protocols (TIP) published by the Center for Substance Abuse Treatment (CSAT). These are located at <http://hstat.nlm.nih.gov/hq/Hquest> by following the search protocol. Of particular use are *Series 31: Screening and Assessing Adolescents for Substance Use Disorders* and *Series 32: Treatment of Adolescents with Substance Use Disorders*.

National Institute of Mental Health (also under NIH) information regarding medications for mental disorders can be found at <http://www.nimh.nih.gov/publicat> with suffixes of [/medmenu.cfm](#) [/medicate.cfm](#) [/index.cfm](#) and especially [/childmenu.cfm](#)

More information on AD/HD and the Multimodal Treatment Study can be found at <http://www.nimh.nih.gov/events/mtaqa.cfm>

Office of National Drug Control Policy (ONDCP) under the Executive Office of the President, lists facts and websites at [www.whitehousedrugpolicy.gov](http://www.whitehousedrugpolicy.gov) including many links by topic Very useful for counselors is the extensive list entitled "Street Terms: Drugs and the Drug Trade" that lists over 2300 street terms for specific drugs and activities.

President's New Freedom Commission on Mental Health, for either a summary or the full commission's report, is found at <http://www.mentalhealthcommission.gov>

Public Health of Seattle and King County has very useful materials for parents and young people (and linkages) found at <http://www.metrokc.gov/health/atodp/media.htm>

Substance Abuse and Mental Health Services Administration (SAMSHA website) also has links to many useful sites. One of these sites is The National GAINS Center for People with Co-Occurring Disorders in the Justice System, viewable at <http://www.gainsctr.com> where one can find information about the overall population and topics such as juveniles with co-occurring disorders in the justice system, cultural competence resources (including assessment tools), and an on-line tutorial in modular format entitled *Working Together for Change: Co-occurring Mental Health and Substance Use Disorders Among Youth Involved in the Juvenile Justice System*, published by the GAINS Center and the University of Washington in 2001.

