

Promoting Youth as Problem Solvers

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NATIONAL CLEARINGHOUSE ON CHILD
ABUSE AND NEGLECT INFORMATION

Developed by:

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100-1000

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For:

Institute for Families at the University of Denver

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This one day training includes the following materials

- 1. Trainer curriculum**
- 2. Participant handouts**
- 3. Curriculum Assessment (a paper/pencil exam for participants designed to help the trainers learn how well the curriculum is working in helping participants gain knowledge covered in the training)**
- 4. A satisfaction/opinion evaluation form**

Promoting Youth as Problem Solvers: Supporting Youth in Coping with Mental Health and Substance Abuse

ORIENTATION

Welcome the group to the training and introduce. Explain the purpose, referring to a pre-printed flip chart:

Mental Health Concerns and Substance Abuse among Youth

- What is known
- What adults are concerned about
- What youth are concerned about
- How youth use help
- Framing your interactions and interventions based on these perspectives

Explain that in this training we will be following this path: an overview of what is known about substance abuse and mental health concerns among young people in America, what youth are concerned about and what are adults concerned about, some ideas about how youth best use help from others, and finally, how to use this information to work with youth.

Go over “rules of the road” (e.g., confidentiality, respect for others, taking responsibility for learning, having fun), mileage reimbursement, lunch, restrooms etc.

Refer to Handouts 1 and 2 (the agenda and competencies) discuss these using the following points:

In this training we will focus on ways to better understand and help youth within the context of both their and our views about mental health and substance abuse. Our focus generally will be on older youth, i.e., those who are 17-21 and transitioning out of foster care into transitional living situations or on their own. We will be looking at various perspectives held by both youth and adults with regard to mental health and substance use, misuse, and abuse. We will explore how principles of youth development can be used in helping youth make decisions, use resources, and take action to promote their own health and mental health. We will cover the basic resources available and where there are gaps in the continuum of care.

INRODUCTIONS

Ask participants to introduce themselves, giving name, count, agency and the nature of the work they do with youth. Ask them to identify one or two concerns they have about working with youth as related to mental health and substance use. Record these on the flip chart and refer back to them whenever the training addresses them.

Activity 1: WHAT DO YOU KNOW: OPENING QUIZ

Refer to Handout 3. Some of what is known about youth and mental health and substance abuse comes from a variety of studies, some of them national in scope. Handout 3 is a set of questions based on data from various studies about adolescents. Take a few minutes and answer them and we will talk about this as a way of getting into what is known about youth and these issues. You won't be turning this in. Give them about 15 minutes for this. Then go over this by asking for their answers and providing the correct answers using the Trainer Notes at the end of the curriculum. Ask them what they think are the implications of findings. Elicit their ideas based on their experience in working with youth, asking periodically for what they think the issues are, how they think youth see the issues, and what theses perspectives have meant for them in how they frame their interactions with youth. The purpose is to draw out some examples and get them thinking about the main learning points: 1) tuning into the perspectives and learning styles of youth as well as adults and 2) using both to find ways to help youth find their own coping and problem solving strategies.

Activity 2: WHAT THE PROFESSIONALS SAY

Tell participants that we are going to spend some time clarifying what professionals say about mental health and substance abuse concerns faced by youth. Ask participants the following: When you think about mental health and substance abuse diagnoses, which do you tend to find most common among young people with whom you work? Record on flip chart and then refer to Handout 4 and go over these, making sure

everyone has a common understanding of these. Put the following terms on the flip chart:

- Behaviors
- Interventions
- Youth reactions

As you cover each diagnosis, ask for descriptions of youth with whom they have worked: what behaviors do they see, what kinds of interventions are made (e.g., therapy, meds, supports) and, finally, how do the youth tend to see these diagnoses and these interventions.

Similarly, ask about use of alcohol: record on the flip chart their experiences with youth with regard to the following:

- Patterns of use
- Interventions
- Youth reactions

Ask: What drug and alcohol use patterns do you see: what substances are youth using these days? What interventions are there for drug and alcohol use? What are common youth reactions to the use of drugs and alcohol and interventions to prevent or reduce use?

Refer to Handouts 5 and 6, covering the material to insure that participants have a common knowledge about drugs and drug use patterns. Then cover Handout 7, focusing discussion on signs of abuse that are common in adolescents. Ask for examples from their work with youth. During this, refer back to examples they gave. Ask for new ones. The purpose of this is to ensure a common minimum understanding among the participants of common diagnoses concerning mental health and substance abuse concerns among youth.

Activity 3: PERSPECTIVES OF YOUTH AND ADULTS ABOUT WHAT IS IMPORTANT

To work effectively with youth whom we believe have substance abuse or mental health issues, it is important to be aware of what we think is important and what they think is important. Sometimes these are similar, sometimes not. Read **Handout 8: Derrick**, a scenario in which there are varying perspectives about what is important. Then read the questions at the end and jot a few notes down answering them. After you have done this, we will talk about these perspectives and the

implications for interventions. *After they have read about Derrick and answered the questions, facilitate a plenary discussion using the Trainer Notes as a guide.*

Trainer Notes on Derrick:

➤ **What are Derrick's beliefs about**

○ **The diagnosis of bipolar disorder and how he can deal with it**

Derrick acknowledges that his "highs and lows" may have come from his father. But he believes meds aren't needed and that he can help himself if he gets depressed (exercise, spend time with friends, make himself be outgoing) or if he gets hyper or, as he says, manic (exercise, take a sleeping pill, and maybe even smoke a J again). He says "I know I shouldn't be drinking, I get too wasted, but I can control smoking marijuana; I can keep it down to a once-in-a-while thing."

○ **The diagnosis of ADHD and how to best deal with it.**

Derrick doesn't deny ADHD but he sees it as "no big deal" and says he can force himself to concentrate if he has to. He hates the Ritalin and refuses to take it. He sees it as poison.

○ **The diagnosis of substance abuse and how to best deal with it.**

Derrick acknowledges that he had a pattern of binge drinking and he says "I know I shouldn't be drinking, I get too wasted." He may think that drinking won't be a problem for him as long as he can continue to use marijuana.

➤ **What are the professionals beliefs about Derrick's various diagnoses and how he can best handle them?**

The psychiatrist and the RTC counselor believes that Derrick would do best if he would regularly take and accept the fact that he needs Lithium. They are worried that the upcoming transition to living in an apartment will be stressful and the meds will help. The teachers wish he would take Ritalin, at least until he passes the GED. However, other counselors at the RTC favor letting Derrick try to get along without the Lithium. They say that it is clear he won't take it after he leaves and so the RTC and psychiatrist ought to support him trying to get

along without in now, while there are still adults to help him.

➤ **What are the mother's beliefs about Derrick's various diagnoses and how he can best handle them?**

Derrick's mother generally sees all medication as poison. She won't take any herself and she thinks Derrick is right to refuse. She thinks that his plans for helping himself in other ways makes sense.

➤ **What are some ways to address differences of opinion so as to be helpful to Derrick managing them?**

Like many older youth in the system, Derrick has quite different views about 1) the nature of his mental health and substance use and 2) ways to keep himself healthy. It may be best to let Derrick take a med break while he is still at the RTC in order to monitor it better.

It may be useful to encourage Derrick to take the GED while he is still at the RTC. If he does not pass, then he may be more open to resuming Ritalin for a short time. Derrick has many ideas about how to keep himself healthy without meds. Working with Derrick to integrate some of these into his routine might help him to establish patterns that will be beneficial once he leaves the RTC. Enlisting his mother's support for these might help Derrick. Derrick is a youth who likely will benefit from the transition program because he will need support for a period of times as he tries to get along without Lithium. Once before, Derrick was helped by youth who called the RTC when he was suicidal. Thus, it will be important to ensure that Derrick is upfront with his new roommates about help that he may need.

Activity 4: YOUTH VIEWS

Note, you will need to order a video tape for this section. It is called "In Our Own Voices: Foster Youth Tell of Life in Care" from Third World Majority in Oakland, CA telephone 510 682-6624. The video has ten digital stories developed by foster care youth; two are used in this section.

As we see, youth can have different views about what is important in relation to issues of mental health and substance use, misuse and abuse. We

are going to watch a videotape of two youth speaking about their lives, including mental health issues. They are youth who were part of the California Youth Connections Program who developed a video called “In our Own Voices: Foster Youth Tell of Life in Care”. As you watch the first one, done by a young woman named Reina, think about the following questions (*write on flip chart*):

- How do you think she would describe her own mental health?
- What would she say contributed to both her problems and her strengths?

Show the first story on the videotape (Reina) and facilitate a discussion using the Trainer Notes below.

Next, show the fourth story on the video tape (Jennifer) and facilitate a discussion based on the same questions, again using the Trainer Notes.

Trainer Notes on Digital Stories

Reina:

- **How do you think she would describe her own mental health?**
Reina might describe herself as sad, vulnerable, and insecure some of the time. She also might describe herself as resilient, able to keep going despite feelings of rejection and the sadness and insecurity that comes with this.
- **What might she say contributed to both her problems and her strengths?**
Reina might say that being given up for foster care contributed to her vulnerability and that never quite feeling accepted by her foster mother contributed to her feelings of sadness and insecurity. However, she also speaks of loving her foster mother and she might say that this has helped her be resilient and hopeful for the future.

Jennifer

- **How do you think she would describe her own mental health?**
Jennifer would speak of her mental health in terms of her feelings, NOT in terms of the labels that other people gave to her feelings and behavior. Like many youth, Jennifer is highly

resistant to labeling, feeling not only that it is depersonalizing but also condemning.

➤ **What would she say contributed to both her problems and her strengths?**

Jennifer speaks about the diagnoses given to her at various points as though they were chains that kept her imprisoned. She acknowledges that her life experiences contributed to problems but she sees the psychiatric labels as particularly oppressive. She sees her strengths in terms of having the fortitude and help to resist the labeling and find her own path in spite of it.

Facilitate a discussion about youth and the labeling that is part of psychiatric diagnosis. Draw out opinions. You may want to emphasize the point that psychiatric intervention and psychotropic medication is extremely helpful to many youth but that many youth, given their developmental stage, are highly resistant to labeling and to medications. To many youth, psychiatric labels are highly stigmatizing. While this is true of adults as well, it is particularly difficult for youth whose normal and healthy developmental path often involves focusing on opportunities and possibilities rather than acknowledging limitations.

Activity 5: HOW YOUTH USE HELP

Most of us are more likely to use help under some conditions than others. To a large extent there are some universals: no matter what our age or circumstances, most of us tend to use help better if we are treated with respect, if we trust the helper, and if we believe the assistance that is offered is relevant to what ever it is that we need help with. It is also true that some factors affect each of us in how we use help. Certainly our experience with previous help is a powerful indicator of how we will use help in the future. So is our age stage. Take a look at Handout 10 for some points about how youth best use help and at Handout 11 for how the developmental factors of this age stage (adolescence and young adulthood) might affect how young people use help.

Facilitate a discussion about the points on this handout, giving and asking for examples of incorporating what is known about youth development into working with older youth on mental health and substance use issues.

Activity 6: RESOURCES

Note, for this activity a list of local resources should be developed. For use in Colorado, see the Institute for Families website of resources for youth at ifduonline.org.

One of the difficulties in working with youth who have substance abuse or mental health issues is being able to access services for them. Handout 12 is a partial list of services available, at least in some parts of the state. Let's go over this and talk about which ones you are familiar with, which you use and some of the barriers in accessing them. *Facilitate this discussion, recording resources on flip and encouraging them to record them on the handout as well.*

Activity 7: PROMOTING YOUTH AS PROBLEM SOLVERS

Given what is known about resources and how youth use help, let's look at a few situations in which youth with substance abuse or mental health issues are close to or in the midst of transition. First, let's go back to Derrick's case. Do you have additional thoughts about how youth development principles and characteristics of youth development might influence how you would help promote Derrick's ability to make decisions that help him with issues of substance use and mental health? *Facilitate this discussion using the Trainer Notes.*

Trainer Notes on Derrick

- Medication: Derrick needs to be involved in planning and decisions, e.g., whether he is going to keep taking the Lithium and monitoring his experience in not taking it if that is what is decided. An opportunity to practice and learn how to manage his feelings and behavior could be helpful to Derrick. Perhaps Derrick, with help from a counselor and support from the RTC staff and his mother, could develop a plan for implementing his ideas about how to help himself if he experiences "highs and lows." This planning could include "if-then" (contingency)

planning and support for relapse (setbacks seen as learning opportunities).

- GED and Truck Driving School: Derrick needs to be involved in a clear plan about his GED. This is an important goal to Derrick, as is getting into a truck driving school. Perhaps his time in the on-grounds school of the RTC could better spent if Derrick and his counselor and teachers developed a specific plan. Derrick's peer may be helpful to him in working towards this – it might be helpful for him to share his goal and plan with them in order to get their support.

Let's look at some additional youth. *Put participants in small groups.* You will be working in small groups on a scenario from one of the following handouts: 13-15. Read over the scenario and respond to the questions on Handout 16. Select a reporter to present your ideas to the group. *Give participants about 15 minutes to read their scenario and answer questions and then facilitate report outs using the Trainer Notes.*

Trainer Notes on Arturo, Tiffany and Max

Name of Youth Arturo

1. What do you view as the main issues related to mental health or substance abuse?

Arturo's main issue is depression and perhaps anxiety. He says that he sets fire as a hobby to "calm down." It doesn't appear that anxiety has been explored with Arturo. Arturo does not appear to have a substance abuse problem. Arturo's self management of his medication may not be helping him to deal with depression adequately despite what he believes. While his drinking does not appear to be a problem now, youth who are depressed may use alcohol to self-medicate, so this could be a risk factor for Arturo.

2. What effects do these issues have on the youth – particularly in relation to how the youth is making his or her way in transitioning and learning independent living skills? Do you think the young person sees it the same way and if not, how?

Arturo's depression (and perhaps anxiety) may be stalling him in terms of finding an occupation. He says he is unhappy in trade school and stays only because being in school is a requirement for receiving financial assistance through the Independent Living Program. His interest in being a fire fighter is not realistic; he has a juvenile record of fire setting. Arturo doesn't see things this way, however. He says that he thinks he just hasn't landed on something that interests him in terms of work.

3. What might be some ways to work with this youth to promote his/her ability to deal with mental health or substance abuse concerns? Use Handout 10 and 11 as references – to what degree do your ideas utilize youth development principles and youth developmental characteristics?

- Since Arturo wants to manage his medication against the psychiatrist's orders, it makes sense to encourage Arturo to monitor how his own regime is working if he doesn't take it. It might help to work with Arturo on coming up with a way to track when he takes his meds, how much he takes, and why he decides to take them then and why he decides to quit. This would put the responsibility in Arturo's hands and also provide some information to Arturo and his worker about patterns related to how he is feeling and how he is managing his meds.
- Encourage Arturo to let his psychiatrist know what he is doing in terms of taking meds and also to discuss any anxiety he has.
- Since Arturo is unhappy at school and this may be both triggering and reflecting depression, engage him in a discussion of ways to explore other possibilities for education that might interest him and also keep him eligible for IL financial assistance. Perhaps some vocational testing might help, identifying both his interests and his strengths. Encourage him to visit other technical training programs. Be clear with him that his juvenile record of setting fires will keep him from being hired as a fire fighter.

Name of Youth **Tiffany**

1. What do you view as the main issues related to mental health or substance abuse?

Tiffany has PTSD and anxiety, due at least in part to the trauma of her sister's death and being blamed by her father. She refuses psychotherapy because she feels the same old issues are rehashed. Her therapist says Tiffany shuts down when she is asked to problem solve about being on her own when the Bensons move. Tiffany is highly reliant on things that make her feel secure, like her Paxil meds and living with the Bensons. Tiffany does not have a substance abuse problem.

2. What effects do these issues have on the youth – particularly in relation to how the youth is making his or her way in transitioning and learning independent living skills? Do you think the young person sees it the same way and if not, how?

Tiffany is being hampered by her PTSD and anxiety in terms of taking the next step towards independence. While she is making progress with her education and has a plan for further education after high school, she is stuck when it comes to planning on where she will live when the Bensons leave. Tiffany doesn't see this as being stuck. She says the timing isn't right – she should be allowed to get through the next big milestones, graduation from high school and settling into community college, before she has to think about it.

3. What might be some ways to work with this youth to promote his/her ability to deal with mental health or substance abuse concerns? Use Handouts 10 and 11 as references – to what degree do your ideas utilize youth development principles and youth developmental characteristics?

Tiffany is “stuck” in part because of fear of being insecure in the future. Often the best way to reduce fear of insecurity is to explore ways to make the future secure. The Bensons and/or Tiffany's worker could engage Tiffany in activities to see what her future might be like, including looking at apartments near the college or on a bus line; visiting the college, sitting in on classes, and meeting the art department faculty; and finding out about art student events and attending them. Tiffany would benefit from forming new social relationships. Perhaps the Bensons' church could help with this. Tiffany needs to be encouraged to be proactive in these endeavors because to take action is a form of taking control.

Name of Youth **Max**

1. What do you view as the main issues related to mental health or substance abuse?

Max has depression and it is unknown how long this has been a concern. Max may have been grooming his sister for sexual abuse and he may have been a victim as a child. There are no known substance abuse concerns.

2. What effects do these issues have on the youth – particularly in relation to how the youth is making his or her way in transitioning and learning independent living skills? Do you think the young person sees it the same way and if not, how?

Max is feeling very much “on hold” in transitioning towards independence because of the allegations of sexual abuse and being in the RTC. The adults who work with him agree. His depression is likely contributing to this.

3. What might be some ways to work with this youth to promote his/her ability to deal with mental health or substance abuse concerns? Use Handouts 10 and 11 as references – to what degree do your ideas utilize youth development principles and youth developmental characteristics?

Whatever the outcome of the sexual abuse allegations, Max will need to continue to work on transitioning. He is correct that a diagnosis of depression may well keep him out of the U.S. armed services and this cannot be reversed now that it has occurred. However, it will not be good for Max to shut down all planning. It would be helpful to engage Max in planning for the parts of his transition that do not affect and are not affected by the allegations of sexual abuse. This includes skills such as finding an apartment, work readiness, finishing high school or getting a GED, vocational testing, and finding and getting a job. At the RTC he can work on housekeeping and food preparation skills as well as relationship skills with his peers and counselors. Max can be engaged in identifying what he wants for his future and what IL skills will help him achieve this. While he shouldn't be encouraged to minimize or ignore the issue of sexual abuse, he should be encouraged to work on other areas of his life.

Activity 8: Embedded Evaluation

Administer the embedded evaluation, explaining that this is not a test of them but of the curriculum. Process the answers with them and then have them turn in the test forms without changing any answers (or print the quiz on NCR paper so that one copy can be turned in and the other kept). Wrap up by asking about issues still on their minds and respond to these. Ask them to complete the evaluation form and collect any reimbursement forms.

Trainer notes on Opening Quiz (**Handout 3**)

What Do We Know about Youth Mental Health and Substance Use

The U.S. Department of Health and Human Services conducts a periodic, national household survey on drugs and alcohol. Recent findings* indicate what trends over the last 10 – 15 years among teenagers (12-17):

1. a decrease in alcohol use
 an increase in alcohol use
 little or no change

Comparing 1985 to 1998 the rate of teen drinking dropped from 41% to 19 percent and the rate of binge drinking from 22% to 8%. However, by the time youth reach age 17, 35% report drinking in the last 30 days.

2. youth begin drinking at earlier ages than they used to
 the age of first drink hasn't changed much over time
 youth begin drinking somewhat later than they used to

The mean age has dropped from 18 to 16 from 1968 to 1996.

3. youth who drink don't use drugs more than other youth
 youth who drink use drugs less than other youth
 youth who drink use more drugs than other youth

Forty percent of current alcohol users use illicit drugs and the percentage goes up to 69% for binge drinkers. The most common is marijuana (46% of heavy drinkers). Hallucinogens and inhalants were used by 16% and 13% of heavy drinkers, respectively.

4. Among the 35% of 17 year olds who are current drinkers, what percent report **binge** drinking (5 or more drinks 1-4 times) or **heavy** drinking (5 or more drinks per occasion on 5 or more days) in the last 30 days

- 25%
 50%
 75%

5. Which ethnic group has the highest rate of problem drinking among older teenagers?

African Americans

Anglos

Hispanics

Anglos are somewhat over-represented among binge and heavy drinkers given their numbers in the population. They account for 80% of this group of teenage drinkers but less than 75% of the population.

6. Which of these problem behaviors are self-reported as **highly** associated with binge and heavy drinkers among teenagers (meaning they are at least twice as likely to report this than teenagers who drink less or don't drink at all)?

Suicide thoughts and gestures

Stealing

Destroying property

Physically attacking others

Arrested

Driving under the influence of drugs or alcohol

For each of these behaviors heavy and binge drinkers were 2-4 times more likely to report this than were youth who did not report heavy or binge drinking.

7. Many studies have shown a high correlation between youth drinking and mental health issues. Do you think youth who are heavy and binge drinkers are aware of the symptoms of mental health issues in themselves?

Yes, quite a bit

Yes, but just a little

No

Youth who drink heavily or binge drink report the following:

➤ **4 times more likely than non-drinkers to be among those with clinical range withdrawal complaints (e.g., unhappy, sad, depressed).**

➤ **3 times more likely than non drinkers to be among those with clinical-range attention and thought problems (e.g., doing**

things others thought were strange, obsessive and compulsive behaviors and thoughts)

- 2 times more likely than non drinkers to be among those with clinical-range social problems (e.g., not getting along with peers).

Note that in the confidential telephone survey that was the basis for this question, that young people appeared to be quite open about symptoms of mental health concerns. Keep this in mind as we go thru this training; there are some critical things to think about in relation to how aware youth are about these experiences, feelings and behaviors versus how some feel about mental health labels and services related to “mental health and mental illness”.

8. What is the relationship between drinking by age 14 and later use of alcohol?+
- No significant relationship between early drinking and later drinking.
 - More likely to have substance abuse problem than those who first drink later in life.

Comparing people who begin drinking before age 15 with those who wait until at least age 21, the early drinkers are 4 times more likely to develop alcohol dependency and more than twice as likely to develop alcohol abuse in adulthood.

9. What estimated percentage of all adolescents (not just those in foster care) have emotional problems serious enough to warrant a diagnosis?#
- 6-7 %
 - 13-14%
 - 20-21%
 - over 25%

This figure continues to rise over time, perhaps because of an acceptance of mental health concerns in society and/or that more youth are exposed to mental health resources.

10. Depression is the most common diagnosed mental health concerns among adolescents.#

Yes
 No

About 1/3 of youth in various psychiatric settings are so diagnosed.

11. Estimated percentage of juveniles in Colorado youth corrections custody with serious emotional disturbance is[^]

11%

18%

24%

Also, 67% are estimated to have some form of mental health problem

*Janet Greenblatt, "Patterns of Alcohol Use Among Adolescents and Associations with Emotional and Behavioral Problems", National Clearinghouse for Alcohol and Drug Information, March, 2000

+ Grant and Dawson, 1977

Maurice Blackman, "You Asked about Adolescent Depression" Canadian Journal of CME, May 1995

[^] Colorado DYS data from 1999

Trainer Notes on Closing Quiz

Promoting Youth as Problem Solvers: Supporting Youth in Coping with Mental Health and Substance Abuse

Using your handouts, answer the following:

For questions 1- 6, check one answer only

1. The trend in adolescent alcohol use is first using at
 - a. ___ a younger age and using more
 - b. X a younger age but using less
 - c. ___ an older age but using more
 - d. ___ an older age and using less

The mean age has dropped from 18 to 16 but the rate of teen drinking has also dropped from 41% to 19%. Also, binge drinking among all adolescents has dropped from 22% to 8%.

2. Among older adolescents who drink, which of the following statements is most true:
 - a. ___ only a small percentage are drinking to a point of danger
 - b. ___ a high percentage drink to a point of danger
 - c. X about half drink to a point of danger

Of the 35% of 17 year olds who say they drink, 1/2 are binge or heavy users.

3. Among adolescents you work with, which youth are more likely to have drinking problems?
 - a. X Anglos
 - b. ___ Hispanics
 - c. ___ African Americans
 - d. ___ Ethnicity doesn't differentiate drinking patterns among adolescents.

Anglo youth drink at higher rates than these other ethnic groups.

4. Heavy drinking by youth is correlated with
 - a. ___ more mental health symptoms but little self-awareness
 - b. ___ about the same rate of mental health problems as other youth

- c. X more mental health symptoms and general self-awareness of this

The national household survey data indicate that heavy and binge drinking youth acknowledge symptoms in a confidential setting in which there are no consequences. However, there is a general feeling among adults who work with youth that while they may acknowledge symptoms, they tend to react to and reject labels associated with those symptoms.

5. Denial, minimization, and avoidance when accompanied by flashbacks and hyper-vigilance are indicators of:
- a. borderline personality disorder
 - b. conduct disorder
 - c. depression
 - d. X post traumatic stress disorder

Flashbacks is the giveaway here – associated only with PTSD.

6. Post traumatic stress disorder is
- a. equally likely to be brought on by child abuse or genetic factors
 - b. X more likely to be brought on by child abuse than genetic factors
 - c. more likely to be brought on by genetic factors than child abuse
 - d. more likely to be brought on by brain injury during traumatic events

For questions 7 - check ALL that apply

7. Bipolar affective disorder is
- a. X more common in females than males during adolescence
 - b. X there is a strong genetic factor
 - c. X often misdiagnosed as depression
 - d. X in adolescence often misdiagnosed as Conduct Disorder or Oppositional Defiance Disorder

8. Depression in adolescents

- a. X is characterized by both withdrawal and irritability
- b. is about equally represented among males and females in adolescence
- c. X tends to manifest differently among males and females in adolescence
- d. is most accurately explained in terms of repressed traumatic life events

Depression is twice as common in adolescent girls as boys and while there are life events that lead to depression, there is no indication that repression of traumatic life events is the deciding factor. There may be a biochemical component that predisposes females to depression as well as societal factors such as gender expectations for coping with problems.

9. Substance dependence and abuse
- a. X are diagnoses of mental disorder
 - b. are diagnosed primarily in terms of amount and frequency of use
 - c. X rise to the level of addiction when use becomes compulsive

The Diagnostic and Statistical Manual of Mental Disorders includes these diagnoses. Amount and frequency are not part of the diagnoses.

10. List three ways in which youth tend to use help (from Handout 10). Then give an example of each by describing a situation in specific terms (hypothetical or from youth you know)
- a. A Way Youth Uses Help (give both the number and the description from Handout 10)

Your example (be specific, don't just give a definition of the way)

- b. A Way Youth Uses Help (give both the number and the description from Handout 10)

Your example

- c. A Way Youth Uses Help (give both the number and the description from Handout 10)

Your example

Promoting Youth as Problem Solvers

Trainee Handouts

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For:

Institute for Families at the University of Denver

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**Handout 1
AGENDA**

8:30 – 9:00	Welcome, Overview and Introductions
9:00-9:20	What Do You Know
9:20 -10:30	What the Professionals Say
10:30-10:45	BREAK
10:45- 11:15	Youth and Adult Perspectives
11:15 – 12:00	Youth Views: The Digital Stories
12:00 – 1:00	LUNCH
1:00 - 1:45	How Youth Use Help
1:45- 2:15	Finding and Using Resources
2:15 – 2:30	BREAK
2:30 – 3:45	Promoting Youth as Problem Solvers
3:45-4:30	Exercise, Evaluation and Wrap-up

Competencies and Objectives

- Competency 1 Able to identify common issues of concern related to mental health and substance use from the perspectives of both adults and youth.
- Competency 2 Able to identify resources for mental health and substance abuse issues.
- Competency 3 Able to use youth development principles to help youth use resources, make decisions, and deal effectively with mental health and substance use issues.

Handout 3

What Do We Know about Youth Mental Health and Substance Use

The U.S. Department of Health and Human Services conducts a periodic, national household survey on drugs and alcohol. Recent findings* indicate what trends over the last 10-15 years among teenagers (12-17):

1. a decrease in alcohol use
 an increase in alcohol use
 little or no change

2. youth begin drinking at earlier ages than they used to
 the age of first drink hasn't changed much over time
 youth begin drinking somewhat later than they used to

3. youth who drink don't use drugs more than other youth
 youth who drink use drugs less than other youth
 youth who drink use more drugs than other youth

4. Among the 35% of 17 year olds who are current drinkers, what percent report **binge** drinking (5 or more drinks 1-4 times) or **heavy** drinking (5 or more drinks per occasion on 5 or more days) in the last 30 days
 25%
 50%
 75%

5. Which ethnic group has the highest rate of problem drinking among older teenagers?
 African Americans
 Anglos
 Hispanics

6. Which of the following problem behaviors are self-reported as **highly** associated with binge and heavy drinkers among teenagers (meaning they

are at least twice as likely to report this than teenagers who drink less or don't drink at all)? (Check all that apply)

- Suicide thoughts and gestures
- Stealing
- Destroying property
- Physically attacking others
- Arrested
- Driving under the influence of drugs or alcohol

7. Many studies have shown a high correlation between youth drinking and mental health issues. Do you think youth who are heavy and binge drinkers are aware of the symptoms of mental health issues in themselves?

- Yes, quite a bit
- Yes, but just a little
- No

8. What is the relationship between drinking by age 14 and later use of alcohol?+

- No significant relationship between early drinking and later drinking.
- More likely to have substance abuse problem than those who first drink later in life.

9. What estimated percentage of all adolescents (not just those in foster care) have emotional problems serious enough to warrant a diagnosis?#

- 6-7 %
- 13-14%
- 20-21%
- over 25%

10. Depression is the most common diagnosed mental health concerns among adolescents.#

- Yes
- No

11. Estimated percentage of juveniles in Colorado youth corrections custody with serious emotional disturbance is

___ 11%

___ 18%

___ 24%

*Janet Greenblatt, "Patterns of Alcohol Use Among Adolescents and Associations with Emotional and Behavioral Problems: National Clearinghouse for Alcohol and Drug Information, March , 2000

+ Grant and Dawson, 1977

Maurice Blackman, "You Asked about Adolescent Depression" Canadian Journal of CME, May 1995

^ Colorado DYS data from 1999

Some Mental Health Concerns Among Youth

Post Traumatic Stress Disorder (PTSD)

- Source: David Barlow (ed) Clinical Handbook of Psychological Disorders, 2nd Edition, Guilford Press, New York, 1993
- Characteristics: **Re-experiencing** previous trauma, e.g., flashbacks, generalized terror or fear, anxiety
Avoidance through denial, minimization, numbing, or by avoiding thinking or talking about event and/or staying away from reminders such places and objects and people associated with the traumatic event(s). Numbing response may be seen as stupor, derealization, depersonalization, feeling detached.
Increased arousal such as hyper-vigilance, difficulty concentrating, difficulty falling or staying asleep, exaggerated startle response, irritability and outbursts of anger.
- Etiology: Traumatic/terrifying experiences, e.g., physical or sexual abuse, neglect leading to traumatic incidents, witnessing violence, or being threatened.

Conduct Disorder

- Source: "Facts for Families #33, American Academy of Child and Adolescent Psychiatry, January, 2000
- Characteristics: Group of behavioral and emotional problems in children and youth involving behaving in socially unacceptable ways, including one or more of the following:
- Aggression to people or animals
 - Destruction of property
 - Deceitfulness
 - Stealing
 - Violating rules
- Many have co-existing conditions such as mood disorders, anxiety, PTSD, substance abuse, ADHD, or thought disorders.

Etiology: Possible factors include child abuse, other types of traumatic life events, brain damage, school failure, or genetic vulnerability.

Oppositional Defiant Disorder

Source: Disorder Information Sheets, PyschNet-UK

Characteristics: Pattern of uncooperative, defiant and hostile behavior toward authority figures that does not involve major antisocial violations but is beyond typical age-stage behaviors and lead to impairment in functioning.

Etiology: Factors may include traumatic or upsetting life events or genetic predisposition. Children and youth diagnosed this way have a higher rate of family history of disruptive behavior disorders, substance-use disorders or mood disorders.

Depression

Source: David Barlow (ed) Clinical Handbook of Psychological Disorders, 2nd Edition, Guilford Press, New York, 1993
Dianne Marcotte "Gender Differences in Adolescent Depression" Sex Roles: A Journal of Research, July, 1999

Characteristics: A mood disorder characterized by sadness, helplessness (more in females), hopelessness, withdrawal, irritability, lethargy, and/or sleep disturbances.

Females twice as likely as males to be diagnosed as depressed in adolescence. They tend to experience "interpersonal depressive style": fear of abandonment, helplessness, chronic feelings of incompetence and low self-esteem. Adolescent males are more likely to experience "self-criticism depressive style and externalizing disorders", meaning they also self-criticize but act out their depression aggressively.

Etiology: Possible factors include traumatic or upsetting life events or brain biochemistry imbalances.

Bipolar Affective Disorder

Source: James Chandler, "Bipolar Affective Disorder (Manic Depressive Disorder) in Children and Adolescents"

Characteristics: A mood disorder in which there is a swing (cycling) from feeling up (mania) to down (depression). Moods may be primarily up or down or both equally. The ups and downs are often characterized by the following behaviors:

Mania

- Inflated self-esteem, grandiosity
- Decreased need for sleep
- Increased talkativeness, feeling pressure to keep talking
- Racing thoughts, flight of ideas
- Distractability
- Increased, incessant activity
- Risk taking for pleasure experiences

Depression

- Lethargy
- Withdrawal
- Sadness
- Sleep disturbances

Half of adults had onset before age 17. In adolescents it is more common in males but this reverses by adulthood. Rapid cycling is more common in younger people.

Etiology: Strong genetic association. Some drugs can induce mania (e.g., steroids). Some people (including children and youth) who are misdiagnosed as depressed and given antidepressants develop mania. In rare cases infections and hyperthyroidism can cause mania. Street drug highs can be mistakenly diagnosed as mania. Some children and youth who have a bipolar condition are misdiagnosed as Oppositional Defiant Disorder or Conduct Disorder. Bipolar disorder can mimic ADHD, when in fact some have both disorders. Nearly all children and youth with bipolar disorder also have ADHD (but not the reverse).

Borderline Personality Disorder

Source: David Barlow (ed) Clinical Handbook of Psychological Disorders, 2nd Edition, Guilford Press, New York, 1993

- Characteristics: A pervasive pattern of instability and dys-regulation across emotional, behavioral, cognitive and interpersonal domains. An inability to regulate/modulate emotional reactions. More common in females both in adolescence and adulthood. Common symptoms:
- Emotional responses are highly reactive
 - Episodic depression, anxiety, irritability, and anger
 - Extreme impulsivity
 - Self-destructive (high incidence of suicide gesturing)
 - Brief (and non-psychotic) dissociation and delusion (goes away when stress is reduced)
 - Difficult, chaotic and intense relationships with others; often “split” helpers and other people in life between the good and bad, reversing these periodically
- Etiology: There is a high incidence of childhood sexual abuse reported by people with this diagnosis. Other traumatic early childhood life events may also lead to inability to regulate/modulate emotions.

Diagnoses of Substance Problems

A. The DSM Typology

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IVR) addresses “Substance Use Disorders” in two major categories: “Substance Dependence” and “Substance Abuse”.

Substance Dependence: “a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems.” Three or more of the following diagnostic criteria must be present:

1. Tolerance: Need for more of the substance to get high or getting less high on the same amount
2. Withdrawal: Experiences withdrawal symptoms consistent with the particular substance or takes the same or a closely related substance to avoid withdrawal.
3. Increased dosage Person takes more over a period of time
4. Cutting back Person wants to or tries to cut down or stop using the substance
5. Use activities Lots of time involved in obtaining, using and recovering from use of the substance
6. Gives up things of importance Substance use interferes with life activities
7. Health concerns Substance use continues even when health problems arise that are related to substance use.

Substance Abuse: “a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances.” There is recurrent use and one or more of the following has occurred within a 12 month period:

1. Failure to fulfill major obligations (failing school)
2. Use occurs in situations which could be hazardous (e.g., driving)

3. Legal problems (e.g., arrests for substance-related disorderly conduct)
4. Social or interpersonal problems (e.g., arguments with parents about drug use)

B. The Use, Misuse and Abuse Typology

Another typology is that of “Use, Misuse” and Abuse” (Gary Fisher and Thomas Harrison, Substance abuse: Information for School Counselors, Social Workers, Therapists, and Counselors, Allyn and Bacon, 1997)

Use	Ingesting alcohol or other drugs without negative effects
Misuse	Using alcohol or other drugs with negative consequences
Abuse	Continued use of alcohol or other drugs despite negative consequences.
Addiction	Compulsive use of alcohol or other drugs with negative consequences. Can't stop.

Drug Classification

Source: Gary Fisher and Thomas Harrison, Substance abuse: Information for School Counselors, Social Workers, Therapists, and Counselors, Allyn and Bacon, 1997

Central Nervous System Depressants

Effects: Low doses: relaxation and calmness, muscle relaxation, disinhibition, anxiety reduction. Impaired judgment and reflexes. Lowered pulse rate and blood pressure.
Higher doses: sedation, drowsiness, slurred speech, staggering, sleep and coma

Types: Alcohol
Prescribed and over the counter drugs for anxiety, sleep disturbance, seizure control, colds, allergies and coughs.

Barbiturates: Seconal (reds, red devils)

Nembutal (yellow jackets)

Tuinal (rainbows)

Amytal (blue heaven)

Phenobarbital

Non-barbiturates:

Doriden (Goofballs)

Quaaludes (ludes) (illegal in US)

Miltown

Equinil

Benzodiazepines:

Valium

Librium

Dalmane

Halcion

Xanax

Ativan

Over-the counter

Nytol
Sominex
Cold and allergy meds
Cold medicines with alcohol,
scopolamine or antihistamines

Central Nervous System Stimulants

Effects: Sense of euphoria, self-confidence, psychomotor stimulation, alertness, mood elevation. Suppress appetite and combat fatigue. Eventually tremors, sweating, flushing, rapid heart beat, anxiety, insomnia, paranoia, convulsions, heart attack, stroke. No satiation point so use can quickly escalate.

Types: Cocaine (coke, blow, toot, snow)
Smokeable cocaine (crack, rock, base)
Ritalin and Cylert
Preludin
Caffeine
Nicotine
Amphetamines
 Methamphetamine (Crank, meth, crystal)
 Benzadrine (crosstops, black beauties)
 Dexedrine (Christmas trees)

Hallucinogens

Effects: Altered state of consciousness (perceptions of visual, auditory, olfactory and tactile senses)
Increased awareness of inner thoughts and impulses
Rise in pulse and blood pressure
With PCP, may be increased suggestibility, delusions and depersonalization.

Flashbacks for many years
Types: LSD (acid, fry)
Psilocybin (magic mushrooms, scrooms)
Morning glory seeds (heavenly blue)
Mescaline (peyote, mesc)
STP (serenity, tranquility, peace)
MDA (ecstasy)

PCP (angel dust, hog)

Cannabinols

Effects: Euphoria
Enhanced sense of taste, touch and smell
Relaxation
Increased appetite
Altered sense of time
Impaired immediate recall
Increased pulse rate and blood pressure
Dilated eyes, reduced intraocular pressure
Dry mouth
Slowed motor skills and reaction time
Paranoia, feeling out of control
Adverse lung functioning over time
Suppresses immune system

Types: Active ingredient is THC
marijuana (grass, pot, weed, joint, reefer, dubie)
Hashish
Charas
Bhang
Ganja
Sinsemilla

Inhalants and Volatile Hydrocarbons

Effects: Reduced inhibition
Euphoria
Dizziness
Slurred speech
Unsteady gait
Drowsiness
Nitrates – altered consciousness and increased sexual pleasure
Giddiness
Headaches
Loss of consciousness and death due to lack of oxygen
Respiratory arrest
Cardiac failure
Damage to liver, kidneys, brain and lung

Types: Gasoline

Kerosene
Chloroform
Airplane glue
Lacquer thinner
Acetone
Nail polish remover
Model cement
Lighter fluid
Carbon tetrachloride
Fluoride- based sprays
Metallic paints
Amyl nitrites (poppers)
Butyl and isobutyl (locker room, rush, bolt, quick silver, zoom)
Nitrous oxide (laughing gas)

Anabolic Steroids

Effects: Build muscle and body mass
Increase aggressiveness, competitiveness and combativeness
Contra-acts blood anemia and endometriosis.
Over time long term effects can be:
 coronary artery disease, jaundice, liver tumors
 in males: atrophy of testicles, impaired sperm production,
 infertility, early baldness, acne and enlarged breasts.
 in females: facial and body hair

Types: All are synthetic drugs resembling testosterone
For humans:
 Depo-Testosterone
 Durabolin
 Danocrine
 Halotestin

For animals but used illicitly by humans:
 Fininject 30
 Equipoise
 Winstrol
 Delatestryl (not legal in US)
 Testex (not legal in US)
 Maxibolan (not legal in US)

Drugs Used in Treatment of Mental Disorders

Mental Disorder	Drugs	Desired Effects
Schizophrenia and other Psychotic disorders	<u>Major tranquilizers</u> <u>Phenothiazines</u> including Thorazine, Compazine, Stelazine, Prolixin, Mellaril <u>Non-phenothiazines</u> (Navene and Haldol)	Psychomotor slowing Emotional quieting Indifference to external stimuli Control agitation and hallucinations and reduce disturbed thinking and behaviors
Affective Disorders Depression	Anti-depressants (3 types) MAO inhibitors (Marplan, Nardil, Parnate) Tricyclics (Tofranil, Elavil, Sinequan) "Second-generation" (Prozac, Wellbutrin, Zoloft)	Elevate mood, increased physical activity, improved appetite, reduced insomnia, reduce suicide ideation
Bipolar Anxiety	Lithium Paxil	Reduce manic states Reduce anxiety
ADHD	Ritalin Cylert	Improved concentration Reduced impulsivity

Signs of Adolescent Substance Abuse

Change in behavior

- School attendance and performance
- Fighting
- Withdrawal from family
- Defiance
- Verbal abuse
- New friends who seem the same as above
- Music and dress associated with drug users
- Stealing, dealing

More money and resources

Appearing high

Former friends are worried, angry at youth

Derrick

Derrick will be 18 in two months. He is living now in a Residential Treatment Center (RTC) and is preparing to transition to an apartment where two youth who left the RTC several months ago now live. He will continue to participate in the county's Transition and Independent Living program including attending counseling sessions. He is studying for the GED and hopes to enroll in a truck driving school. He plans to continue working at the fast food restaurant where he has been employed for four months.

Derrick has been in and out of foster care several times in his life. At age 6 he was removed for neglect because his single mother was taking drugs and not supervising him. His life-long difficulties in school first surfaced during this foster care stay and he was diagnosed as ADHD. He was prescribed Ritalin which the foster parents said helped him. He returned home after his mother completed in-patient substance abuse treatment and had been clean for 4 months. He continued to have problems at school but his mother refused to give him Ritalin, saying she felt it was poisoning him.

When Derrick was 12, his mother was incarcerated for forgery and Derrick lived in foster care for 6 months until his mother was released and he was returned to her. During this time Derrick's difficulties at school escalated and he was diagnosed as Oppositional Defiant Disorder. He was treated in individual therapy for three months and put back on the Ritalin; his behavior improved somewhat. He says that when he returned home he stopped taking the Ritalin for good.

At age 16 Derrick was placed for a third time due to conflict with his mother and to his arrest for possession of marijuana and stealing a car. He had dropped out of school. A substance assessment at that time indicated that Derrick had been using marijuana since age 12 and that his current pattern was to smoke two-three times daily. He acknowledged a pattern of binge drinking, i.e., getting drunk once a week, sometimes to the point of passing out. He said he drank only beer. His mother said that his room constantly smelled of pot and that she knows he drinks to a dangerous level because she has found him passed out in the front yard on several occasions.

During the past 14 months in the RTC, Derrick has undergone the substance abuse treatment program provided by the RTC and is believed to have remained substance free except for a week seven months ago when he ran and admitted to binge drinking and smoking dope. He still refuses to take Ritalin, saying he doesn't care whether or not he has a hard time paying attention, its just no big deal, he can make himself concentrate as long as he has to in order to get through school. The teachers at the on grounds school say that he struggles with attention issues but is able to get through the school day and complete most of his school work. They wish he would take the Ritalin because they feel it would help him get over the hurdle of passing the GED.

When he ran seven months ago, Derrick was picked up after some youth called the police. They told the police that Derrick was drunk and high and threatening to kill himself. Derrick was hospitalized before returning to the RTC. He was diagnosed with depression and prescribed Zoloft. However, over the next month he became increasingly agitated and slept little. He cut on himself and was re-hospitalized. He was then diagnosed as Bipolar and put on Lithium. His mother's description of his father (whose whereabouts have been unknown since Derrick's birth) indicated to the psychiatrist that Derrick's bipolar disorder is likely genetic. The psychiatrist explained that bipolar disorder, when misdiagnosed as depression and treated with anti-depressants, can sometimes lead to an escalation of symptoms in a person whose true illness is bipolar disorder. Since then Derrick has been relatively stabilized, although he is still sometimes oppositional, particularly about the meds, which he hates because they make him feel "blah". RTC staff must watch Derrick closely when he takes the Lithium because he has attempted to "cheek" it several times. This is a major issue in the plans to move to the apartment. Derrick is saying "When I turn 18 and get out of here, you can't make me take it. Why don't you just let me try getting along without these meds?! I'll be ok. You all think you know what's best for me but you don't!"

Derrick is anxious to be living on his own. He is sick of the routines and rules of the RTC. He believes that he can pass his GED since he has come close to passing practice tests. He vacillates about his diagnosis of bipolar disorder. He says he has always heard from his mom that his dad would

have highs and lows and maybe he is this way too. But, even if he is, he firmly believes the meds aren't necessary and that he can do helpful things for himself if he gets depressed (exercise, spend time with friends, make himself be outgoing) or if he gets hyper or, as he says, manic (exercise, take a sleeping pill, and maybe even smoke a J again). He says "I know I shouldn't be drinking, I get too wasted, but I can control smoking marijuana; I can keep it down to a once-in-a-while thing."

Derrick's counselor at the RTC sat in on a meeting Derrick had with the psychiatrist who prescribed the Lithium. Both told Derrick that it is critical that he stay on this med because it is really helping him. They said that his transition to living on his own is going to be stressful and he needs to be feeling his best. However, in team meetings at the RTC several staff have argued that Derrick ought to be allowed to go off the Lithium while he is still in the RTC so that he can learn how he is affected. They say that everyone knows he is going to go off it first chance he gets and that he should do so while he is still living with people who can help him.

Derrick's mother, who comes for family therapy weekly at the RTC, says that generally she thinks most medication is "slow poison" and that over the long run it will harm Derrick's body and maybe even his mind. She tells him that he needs to work on these alternative ways to manage his substance abuse and his mental health problems. She says she thinks it all goes back to his lousy childhood. She says she is sorry about that but she thinks Derrick can get past it by living a clean and active life. She says that when she was in substance treatment some of the patients tried Anabuse but she thinks they didn't do so well, they just stayed addicted. She says that although she herself has had several relapses, these have been short-lived and she has never lost her job. She is determined to stay off substances by will power.

QUESTIONS

- What are Derrick's beliefs about
 - the diagnosis of bipolar disorder and how he can deal with it
 - the diagnosis of ADHD and how to best deal with it.
 - The diagnosis of substance abuse and how to best deal with it.

- What are the professionals beliefs about Derrick's various diagnoses and how he can best handle them?
- What are the mother's beliefs about Derrick's various diagnoses and how he can best handle them?
- What are some ways to address differences of opinion so as to be helpful to Derrick managing them?

**How Youth Use Help
A Youth Development Perspective**

Youth use help in learning and achieving when

1. They are involvement in planning and decision-making
2. There is a mentoring relationship in which they feel supported and cared about
3. Both the experiences for learning and the perspectives held by the adults are *normalizing* for the youth.
4. They feel like they are being treated with respect
5. They feel they are being listened to
6. There are opportunities to practice and learn (sometimes involving a manageable level of risk)
7. There are “if-then” rehearsals (thinking through the likely consequences of various actions and planning with this in mind)
8. Key resources are available
9. Setbacks are seen as learning opportunities
10. The youth has opportunities for new roles and responsibilities
11. There is opportunity for peer support
12. They are guided to build on their strengths
13. Incremental progress is acknowledged and valued

**Key Youth Developmental Characteristics
Affecting How Youth Use Help**

- ❖ Peer oriented, desire to be accepted by peers

- ❖ Sense of infallibility

- ❖ Rejection of adult and authority figure control

- ❖ Drive towards finding sense of self

- ❖ Desire for experience

- ❖ Desire for recognition and respect

Handout 12

**Resources for Supporting Transitioning Youth in Managing Their
Substance Abuse and Mental Health Issues**

Arturo

Arturo is 18 years and 9 months. He has been in the Department's custody for nearly two years. At the time he came into care two years ago, he had been released from a detention facility for having set a series of fires in alleys in his neighborhood – at that time he was placed in a Residential Treatment Center (RTC). While at the RTC he was diagnosed with depression and prescribed Wellbutrin. He participated in the Independent Living program and at 18 entered the Transition program in which he is getting financial support and continues to participate in Independent Living programming including individual and group counseling. Arturo lives with another youth in an apartment. He attends a trade school and has changed his focus recently from machinery repair to electronics. Arturo works 20 hours per week at a convenience store.

Arturo had been in foster care in childhood from age 8-9 following sexual abuse by a live-in uncle and lack of protection by his mother due to her drug dependency. At age 9 a grandmother was located when she moved to this state from Mexico and she took custody. Arturo received treatment (both individual and group) for sexual abuse from age 8-10. At age 10 Arturo moved with his grandmother to another area of the state.

In the 5 months that Arturo has been living in the apartment, the caseworker and Independent Living worker have become increasingly concerned about what they see as Arturo's risky behavior. He laughingly talks about frequently setting small fires to relieve boredom and stress. He says these are always on the concrete patio and pose no danger. Arturo's roommate says he thinks Arturo is weird about this fire stuff; he gets a big kick out of waving around burning objects: paper rolls, dry leaves, rope. Arturo says he thinks everyone is making something over nothing – this is just like a hobby, it calms him down, gets his mind off the stuff that is bugging him. He says that it has always been this way – the fires in the alley were just for fun; he was always careful. He says "I bet lots of people do little things like this, they just aren't open about it. The world is full of closet deviants."

Additionally, Arturo refuses to take the Wellbutrin except on his terms. He says that he can tell when he needs some – he starts getting moody and so he

takes them for awhile and then he quits. He says he doesn't believe that a steady dose is necessary – he thinks it's a good drug but he can manage it himself. He sees his moodiness as “just normal, like all teenagers are and besides I've had a crappy life and its no wonder I get moody, it's not an illness or anything.” His workers see him as increasingly depressed and frustrated. He tells his worker that he drinks two or three bottles of beer several evenings per week but never to the point of intoxication. His roommate confirms this.

Arturo sees his problems in school as being a result of studying something he is uninterested in. He knows he has to be in school to get the particular type of financial assistance he is receiving but he doesn't want to be in school. Arturo does not have a learning difference or ADHD and he has a normal range IQ. He passed his GED on the first try. Arturo doesn't have any idea what he wants to do but he knows he isn't interested in either of the things he has studied at the trade school. Recently he has wondered aloud about whether he ought to get on with a wildfire fighting crew. He has been surfing websites about wildfires and hotshot crews and talks knowledgably about the issues. He says with irony in his voice, “they ought to take me in a minute – I know more about fire than any recruit.”

Tiffany

Tiffany is 18 ½ and she has been living in the Benson foster care home since age 15. She entered foster care following her parents' arrest for operating a meth lab and the death of her toddler sister from a meth lab explosion.

Tiffany was traumatized by the event – she had, in her words, been obsessed about making sure her little sister did not get near the lab, which was in the garage. However, one day while Tiffany was lying on the couch listening to music on her headphones, her sister woke from a nap and wandered out to the garage. It is unclear what set off the explosion since no adults were present, however, the child died.

Tiffany has been wracked by guilt, especially since her father blamed her for her sister's death. She has been diagnosed at various times over the past 3 ½ years with PTSD and Generalized Anxiety Disorder. She says she thinks that she does have PTSD but that the best way to handle it is to think about happier things. She has been compliant with medications and is now doing fairly well on Paxil. Both she and the adults who work with her see her as highly emotionally dependent on the Bensons. She has resisted or in some way blocked efforts to move away from them. She will graduate from high school soon and wants to go to college. She would like to go to the community college near the Bensons and continue to live with them. The Bensons, who have done well with Tiffany, but never wanted to adopt her, are fine with this arrangement for only six more months. They have been planning to retire and move to a retirement community founded by their church and they have put this off because of Tiffany. They want to see Tiffany "on her own two feet." They say they will always be available to her but they need to get on with their lives.

Tiffany was in treatment for 1 ½ years for PTSD and anxiety at the mental health center. She refused psychotherapy after that time saying that the therapist just keeps bringing up the same things over and over. However, she is highly compliant about the Paxil. Once, when her prescription was low, she became very agitated about getting it refilled immediately. She keeps the meds bottle in the kitchen and asks the Bensons to watch her taking it every day. She says she can manage it herself but she feels comforted by them watching her take it.

Tiffany's therapist feels like Tiffany shuts down in treatment, refusing to problem solve about current issues because she won't address the fact that the Bensons are going to move. Tiffany has told the adults in her life that she feels like a brick wall comes up whenever she tries to look at her life beyond the time when the Bensons leave. She says she just is not ready to be planning for this and can everyone please just wait until she graduates from high school and gets settled into community college?

When asked to envision her life in the future, Tiffany says she sees "a painting like the Norman Rockwell ones; it is of a bright white house and there is a picket fence around it. It has a painting studio and I am there painting big pictures, like of summer flowers. My husband will be nice to me and he will make enough money so I don't have to work." She loves now to draw and paint bright, reassuring pictures of children, animals and nature. She sees her doing this in her ideal future. She wants to study art in community college. Both she and the Bensons say that she is happiest and most content when she is drawing or painting.

Max

Max is approaching his 18th birthday. Until recently he was living with his uncle and aunt who have been licensed to provide foster care to Max and his two younger sisters for the past 1 ½ years. The three children came into care because their grandmother, who raised them, had a stroke. Their mother had lived off and on with her mother, the children's grandmother, since Max was born. None of the children's fathers has been involved in their lives. Their mother is currently incarcerated for homicide, having stabbed the younger girl's father during a fight nearly ten years ago.

Last month Max was moved to a Residential Treatment Center (RTC) because he had been caught showing the younger girl pornography on the internet and it was determined this had been going on for almost two months. There were no allegations of touching but all of the adults involved felt he was grooming her. Since moving to the RTC Max has been evaluated and has been diagnosed with depression. He has been prescribed Wellbutrin and began taking it just a few days ago. He is frightened, sullen and irritable. He denies everything about the situation, saying his sister had been walking in on him when he was looking at porno and wouldn't leave so he just let her stay and ignored her. He says that his aunt and uncle are prudes and they are using this as an excuse to get him out of the house and just keep the girls, who they like a lot better. He has been stonewalling in his therapy sessions, saying that they are just trying to get him to confess so they can jail him. He says he wouldn't take the meds if he could get out of it. His therapist says that some of the testing (e.g. the Thematic Apperception Test – TAT) indicates there may be issues of childhood abuse, perhaps sexual, but is not sure. Max will not speak about his early life, saying the therapist will use whatever he says against him.

Max's legal situation is unclear. His case is being investigated and it is possible but unlikely that the DA will file charges against Max as an adult. Max says he isn't talking to anybody about anything until that is known.

Max had been planning to leave his aunt and uncle's home when he turned 18. He has participated to some degree in the Independent Living classes offered by his county Child Welfare Agency and the worker said he has been

making some progress in some of the hard skill areas such as interviewing for jobs and managing his checkbook. However, she sees him as guarded and afraid of revealing too much of himself – even before the allegation.

Max is unsure what he wants to do but is leaning towards going into the armed services. He likes the idea of being on his own, being treated like an adult. He is fearful that the allegation could interfere with this plan. Also, when he was prescribed Wellbutrin he became very angry, saying that the Army wouldn't take him if they thought he was nuts.

The RTC staff describe Max as a young person “on hold” – he seems to be paralyzed by events in his life now. They wonder how to “unlock” him.

WORKSHOP EVALUATION

Promoting Youth

Date:

Trainer:

I. Please mark your top two reasons for attending this workshop.

- Thought it might be interesting/fun Recent change in job duties/clients
 Day away from office Wanted to know more about this area Having difficulty with this area
 I was told to attend I needed training hours Other (specify) _____

II. Your Education

Highest level: high school/GED Associate's Degree Bachelor's Master's Doctorate

If you have Bachelor's or higher: Social Work Related degree (psych, counseling)
 Other (specify) _____

III. Trainer Feedback

	Strongly Disagree	Disagree	Agree	Strongly Agree
The trainer				
1. Knew the subject area	___	___	___	___
2. Was prepared and organized	___	___	___	___
3. Related well to the group, answered questions, and responded to concerns	___	___	___	___
4. Provided enough explanations and examples.	___	___	___	___
5. Involved us in analyzing skills	___	___	___	___
6. Used visual aids to illustrate points	___	___	___	___
7. Motivated me to want to try to out the training ideas on the job	___	___	___	___
8. Modeled cultural sensitivity	___	___	___	___

IV. Workshop Content

	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know
1. Subject matter was at right level	___	___	___	___	()
2. Content is compatible with my agency's philosophies and policy.	___	___	___	___	()
3. My agency will support me in using this training on the job	___	___	___	___	()
4. I learned specific job-related knowledge and/or skills	___	___	___	___	()
5. I will use knowledge and/or skills on the job	___	___	___	___	()
6. I will be able to do my job better because of this training	___	___	___	___	()
7. Youth will benefit from my taking this workshop	___	___	___	___	()

Please explain any Strongly Disagree, Disagree or Don't Know Ratings

V. Competencies

This course has included the following competencies. Has your knowledge and/or skills increased in these areas after completing this training?

	Strongly Disagree	Disagree	Agree	Strongly Agree
1 Able to identify common issues of concern related to mental health and substance use from the perspectives of both adults and youth.	_____	_____	_____	_____
2 Able to identify resources for mental health and substance abuse issues.	_____	_____	_____	_____
3 Able to use youth development principles to help youth use resources, make decisions, and deal effectively with mental health and substance use issues.	_____	_____	_____	_____

Promoting Youth as Problem Solvers: Supporting Youth in Coping with Mental Health and Substance Abuse

Exam

Using your handouts, answer the following:

For questions 1- 6, check one answer only

1. The trend in adolescent alcohol use is first using at
 - a. a younger age and using more
 - b. a younger age but using less
 - c. an older age but using more
 - d. an older age and using less

2. Among older adolescents who drink, which of the following statements is most true:
 - a. only a small percentage are drinking to a point of danger
 - b. a high percentage drink to a point of danger
 - c. about half drink to a point of danger

3. Among adolescents you work with, which youth are more likely to have drinking problems?
 - a. Anglos
 - b. Hispanics
 - c. African Americans
 - d. Ethnicity doesn't differentiate drinking patterns among adolescents.

4. Heavy drinking by youth is correlated with
 - a. more mental health symptoms but little self-awareness
 - b. about the same rate of mental health problems as other youth
 - c. more mental health symptoms and general self-awareness of this

5. Denial, minimization, and avoidance when accompanied by flashbacks and hyper-vigilance are indicators of:
 - a. borderline personality disorder
 - b. conduct disorder
 - c. depression
 - d. post traumatic stress disorder

6. Post traumatic stress disorder is
- a. equally likely to be brought on by child abuse or genetic factors
 - b. more likely to be brought on by child abuse than genetic factors
 - c. more likely to be brought on by genetic factors than child abuse
 - d. more likely to be brought on by brain injury during traumatic events

For questions 7 - check ALL that apply

7. Bipolar affective disorder is
- a. more common in females than males during adolescence
 - b. there is a strong genetic factor
 - c. often misdiagnosed as depression
 - d. in adolescence often misdiagnosed as Conduct Disorder or Oppositional Defiance Disorder
8. Depression in adolescents is
- a. characterized by both withdrawal and irritability
 - b. about equally represented among males and females in adolescence
 - c. tend to manifest differently among males and females in adolescence
 - d. is most accurately explained in terms of repressed traumatic life events
9. Substance dependence and abuse
- a. are diagnoses of mental disorder
 - b. are diagnosed primarily in terms of amount and frequency of use
 - c. rise to the level of addiction when use becomes compulsive

10. List three ways in which youth tend to use help (from Handout 10). Then give an example of each by describing a situation in specific terms (hypothetical or from youth you know)

a. A Way Youth Uses Help (give both the number and the description from Handout 10)

Your example (be specific, don't just give a definition of the way)

b. A Way Youth Uses Help (give both the number and the description from Handout 10)

Your example

c. A Way Youth Uses Help (give both the number and the description from Handout 10)

Your example