Adolescent Substance Abuse and Crisis Intervention

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What is an effective approach with substance-dependent adolescents who present in crisis? How can social workers, counselors, and health professionals engage treatment-resistant youths? What actions can be utilized to develop a plan of care that youths will find challenging and worth participating in? This article seeks to answer the questions posed through application of Roberts’s Seven-Stage Crisis Intervention Model. Specific attention is given to a case application of Roberts’s model in conjunction with strengths-based perspective and solution-focused treatment approaches. [Brief Treatment and Crisis Intervention 5:19–33 (2005)]

KEY WORDS: adolescence, substance abuse, mental illness, crisis intervention, comorbidity.

This article examines the application of Roberts’s Seven-Stage Crisis Intervention Model (Roberts, 2000, in press) with adolescents who have complex cases of mental illness, substance dependence, and remarkable complicating factors. Today’s adolescents are faced with unprecedented access to substances of abuse; to complex peer interactions; and to challenges within the home, community, and legal environment that can sometimes be overwhelming.

The first case reviewed is that of Jonathon M., a 16-year-old with a history of mental illness and drug abuse. Jonathon’s case has a remarkable legal history, one that has complicated his receiving consistent treatment for his emergent comorbid mental illness and substance abuse. Jonathan has been adjudicated by the juvenile court seven times in the past 3 years and is facing additional serious legal consequences.

In the second case, Stacy is a 15-year-old Latina girl currently being held at the county youth correctional facility. Her family history indicates that her father is incarcerated in a maximum-security prison and that Stacy was beaten by her alcoholic mother’s boyfriends periodically from age 10 to 12. Stacy
stated that her mother and mother’s boyfriend sexually abused her at age 12. Her mother admitted that she punched and slapped Stacy on numerous occasions because of her alcoholism and explosive anger.

Each case demonstrates the application of Roberts’s seven-stage model to treatment-resistant adolescents who present in crisis but are reluctant to engage in treatment. Specific attention is given to interventions based on a strengths-based perspective and on solution-focused approaches.

Overview

According to the National Household Survey on Drug Abuse, from a representative sample of 68,929 youths aged 12 to 17, 10.8% reported current use of illicit drugs in 2001. This is an increase from the 9.7% rate reported in 2000. Among this age group in 2001, the percentage using illegal drugs was higher for boys (14.4%) than for girls (10.2%; Substance Abuse and Mental Health Services Administration, 2002).

Within the representative sample of 68,929, the 30-day prevalence rate of using any illicit drug is the highest among 12th graders (25.7%), second among 10th graders (22.7%), and lowest among 8th graders (11.7%). By the 8th grade, 50.5% of youth reported having tried alcohol, and 23.4% reported that they had already drank to the point of intoxication. But what about other drugs? As high as 10.2% of the population of 8th graders reported use of amphetamine compounds, and when all illicit drugs were considered, 14.8% of 8th graders reported trying some illicit substance other than cannabis.

To calculate the consequences of drug use, the Drug Abuse Warning Network is utilized to measure the number of persons seeking emergency-department treatment for drug-related emergencies. From 1999 to 2001, the total drug-related emergency-department episodes increased from 17.1% of patients aged 12 to 17 (from 52,685 to 61,695). Within this population of 61,695, 16,516 indicated cannabis use; 3,509, cocaine; 1,253 methamphetamine; and 843, heroin (Substance Abuse and Mental Health Services Administration, 2002).

In addressing the complicated issue of juvenile drug abuse, assessment and treatment approaches vary widely across the United States. The number of adolescents aged 12 to 17 admitted to treatment facilities demonstrated an increase of approximately 20% between 1994 (109,055 admissions) and 1999 (131,294 admissions). Within this population, cannabis accounted for 60% of all admissions for youth in 1999. Of all adolescent admissions, 51% involved the use of both alcohol and cannabis, and 71% were male. It is important to note that this latter figure was strongly influenced by cannabis-abuse admissions in which 76% were male (Substance Abuse and Mental Health Services Administration, 2001).

According to the Drug Abuse Monitoring Program, the number of juvenile court cases involving drug offenses more than doubled between 1993 and 1998. During 1998, juvenile courts in the United States handled an estimated 192,500 delinquency cases in which a drug offense was the most serious charge (U.S. Department of Justice, 2001). According to the Federal Bureau of Investigation’s Uniform Crime Reports data (1999), there were 139,024 persons under the age of 18 arrested for drug violations.

Case 1

Jonathon M. is a 16-year-old who has a long history of mental illness and drug abuse. Jonathon also has a remarkable legal history, one that has complicated his receiving consistent treatment for his emergent comorbid...
mental illness and substance abuse. Jonathan has been adjudicated by the juvenile court seven times in the past 3 years:

First charges: Jonathon was charged with possession of a weapon—a fourth-degree crime committed 2 months before his 14th birthday; he pled guilty and was given 1-year deferred disposition, contingent on his attending school and having a 9 PM curfew.

Almost 2 years later: He was charged with possession of drug paraphernalia, drug possession, and consumption of alcohol by a minor. He was given 1-year probation and required to attend school, maintain a part-time job, submit to random urinalysis, respect a 9 PM curfew, have no contact with codefendants, and pay a monthly $40 fine.

1 month later: He was charged with possession of alcoholic beverage by a minor; he pled guilty, and his original 1-year probation term was extended by 1 month with the same conditions as mentioned, but he was given 30 days to find a part-time job.

7 months later at age 16: Jonathon was charged with burglary, theft, criminal mischief, possession of drug paraphernalia, and possession of burglary tools. He pled guilty to burglary, theft, and possession of drug paraphernalia, and the other two charges were dismissed. Jonathon received an adjudication to 2 years of probation; he had to attend and complete a 90-day Daytop Village drug treatment program; he was ordered to remain drug-free and attend Narcotics Anonymous meetings twice a week; his driving privileges were suspended for 6 months; and he was required to get As and Bs in all school subjects (with his grades being mailed to the juvenile court by the school).

Approximately 5 weeks later: He was charged with escape while being transported by bus from the Daytop Village residential drug program to the probation office for family counseling.

The latest charge was possible violation of probation. The probation officer and judge agreed to give Jonathon one final chance because he seemed remorseful and admitted that he was “cheeking” his antipsychotic medication Zyprexa and Depakote, which were supposed to help with his impulsivity and emotional problems. The probation officer told Jonathon and his parents that if there were one more violation of probation, he would be incarcerated for a period of 6 months to 1 year. Jonathon was classified by the child study team as ED (emotionally disturbed) and as a multiply disabled client who has a short attention span, low reading ability, and attention-deficit/hyperactivity disorder.

Jonathon practices the Catholic religion and believes in a Higher Power. He stated that he hoped his faith would facilitate his recovery. Jonathon resides with both his parents, and he has one younger brother, age 14. Unfortunately, both his mother and younger brother suffer from neurofibromatosis, and his father is legally blind and suffers from obsessive compulsive disorder. His mother works in a local supermarket, and his father is disabled and does not work. Jonathan first took marijuana at the age of 13, and by age 14 he was experimenting with cocaine and ecstasy on “several occasions.” At age 15, heroin became his drug of choice. He snorted it for several months and then began shooting it.

On his return to Daytop drug treatment center, he admitted that heroin was consuming him, and he gave specific dates during a
3-month period that he was “shooting up.” He cooperated in the program for 60 days and recently told the social worker that he was aware that he had been injecting “poison” into his body. He indicated that his former girlfriend never took drugs and had tried to help him. He wanted to get back together with her and return to living with his parents. He still had cravings for heroin as well as nicotine but indicated that he would like to change and return to finish high school. His latest adjudication resulted in a suspended sentence and 3 years of probation (Roberts and Yeager, 2004).

Application of Roberts’s Seven-Stage Crisis Intervention Model

Stage 1: Plan and Conduct a Crisis Assessment (Including Lethality Assessment). In this stage, the most critical first step in applying Roberts’ Seven-Stage Crisis Intervention Model is conducting a lethality and bio-psychosocial risk assessment. This involves a relatively quick assessment of the number and duration of risk factors, including imminent danger and availability of lethal weapons, verbalization of suicide or homicide risk, need for immediate medical attention, positive and negative coping strategies, lack of family or social supports, and current drug or alcohol use (Eaton, in press; Eaton and Roberts, 2002; Roberts, 2000).

In assessment of Jonathan’s case, the social worker was met with remarkable resistance, including argumentative statements designed to push away the worker. Complete assessment also indicated defensiveness and high levels of anger and frustration. However, there was no indication of suicidal or homicidal ideation. Jonathan was clearly oriented in all spheres and was able to clearly state the reasons for his presentation to the Daytop program. There was concern regarding the fragmented nature of previous approaches to management of Jonathan’s mental illness and emergent substance use disorder. Therefore, a medical assessment was conducted that included a brief summary of the presenting problem, any ongoing medical conditions, current medications (names, dosages, and time of last dose) to facilitate continuity of care according to Roberts and Yeager (2004). Assessment of Jonathan’s case did not indicate a need for special care. While there were potential withdrawal symptoms present, they were not severe enough to require inpatient hospitalization; instead, the management of withdrawal would be managed in the outpatient setting. Jonathan’s mental status examination did indicate the presence of paranoid thought processes, but again, these thoughts were not significant enough to require inpatient hospitalization and thus would be managed within the residential treatment environment.

Stage 2: Establish Rapport and Rapidly Establish Relationship. Jonathan’s resistance made the establishment of rapport difficult. In this case, the process focused on establishing the relationship. Jonathan and his social worker came to an agreement quickly on Jonathan’s role in his treatment. To accomplish this rapid establishment of the relationship, the Daytop social worker indicated to Jonathan,

Our relationship is one of my providing resources to you and helping you to chart a new path for your life. I am a reporter of progress, success, or resistance and failure. The choice is clearly up to you. My role here is to offer assistance and to document what actions you take. It’s all up to you.

To this Jonathan responded,

You’re just like all the rest; you don’t give a shit about me or my problems. You are just here to collect a paycheck and nothing more.
Jonathan’s worker provided a nonreactionary response to minimize the resistance and to reinforce the collaborative nature of the relationship:

It’s your choice to believe whatever you want to believe. Only time will tell what either of us is going to do.

**Stage 3: Identify Major Problems (Including the "Last Straw," or Crisis, Precipitants).** When examining Jonathan’s perception of the major problems, the social worker became aware of Jonathan’s belief that he would never get out of the system. This was identified when the social worker picked up on Jonathan’s irrational belief that he had become a “throwaway kid.” When questioning what Jonathan meant by this statement, the social worker uncovered the anger of the last straw facing Jonathan and the merging of his substance abuse and mental illness.

Social worker: What is it you mean when you say . . . “throwaway kid”?

Jonathan: It’s what you hear on the street, you know when it costs too much to fix a kid, the system has a way of taking care of the problem. They just throw you into the system, where you never get out, you never get a chance, and you always remain at the bottom. There is no way out for throwaway kids. I knew that’s what was going on . . . I saw it in the court, in the assessment, in the eyes of the “po-po” when they picked me up. They knew I was dope sick and that I was too broken to fix, that’s why they sent me to this shit house.

Social worker: So what would it take to convince you that you aren’t a throwaway kid?

Jonathan: Signs, clear signs that someone, somewhere was willing to make something good happen. I don’t know what that is, but I’ll know it when I see it. And it is not someone giving a bunch of pills that don’t do nothing but make me some sort of a zombie!

**Stage 4: Deal with Feelings and Emotions (Including Active Listening and Validation).** The social worker had begun to enter Stage 4 when hearing Jonathan’s fears and concerns. Jonathan demonstrated his awareness that there were many problems to address. In his own way, Jonathan indicated his awareness of his mental illness and substance dependence. He also indicated in his statements that he was aware that he was on the verge of a very long period within the criminal justice system.

Rather than address the feelings of anger and frustration that Jonathan was displaying, the social worker began to address the active defense structures that posed a barrier to Jonathan’s assumption of self-responsibility for his treatment. The social worker began to chip away at Jonathan’s rationalizations that drug abuse and theft were the only ways to make it in his environment.

Social worker: So you say everyone you know uses . . . Can you give me an example of someone who didn’t?

Jonathan: Yea, there was this hottie I knew. She was all sweet and shit, she didn’t use. She knew me, she knew the score, so it didn’t work out between us.

Social worker: So there was someone you knew who didn’t use, and you could have connected with her.

Jonathan: Yep.
Social worker: Do you think your using scared her away?

Jonathan: I guess.

Social worker: Well, I just wanted to see if there were any straight people out there who you could connect with, clean and sober. Sounds like this girl is one.

Jonathan: That may be, but she’s not there for me now . . .

Social worker: That’s right, but who had more to do with that—you or her?

Taking away the rationalization permitted Jonathan and his social worker to get to the emotions of hurt and loss that Jonathan was experiencing—not only the hurt and loss of a potential relationship but also the hurt associated with his substance dependence, potential withdrawal, and an emerging awareness that his mental illness was going to have a profound impact on his future. Jonathan was able to voice his fears of being an outcast and his frustration of never having anyone whom he connected with in his life. He shared clearly how he had always felt different and that “using” was a way that he felt he connected with people. He was now beginning to see that this was one factor that was contributing to his being isolated from those he wanted to connect with and from a potential future if he were able to attain sobriety. But the mere mention of sobriety sent Jonathan into a rage, with his stating, “I’m not going to be one of those old men losers you see at those meetings!”

Stage 5: Generate and Explore Alternatives.

At the first opportunity, Jonathan’s worker began to explore alternatives to his perception of being a loser at a 12-step meeting. Applying a solution-focused approach, the social worker asked Jonathan what he thought he would be doing in a year if he were out of the program and his legal problems were gone. Jonathan responded,

I think I’d like to travel across the U.S. on a chopper, not needing anyone or having anything but the road. That’s all I would need. I don’t need no one or nothing but me and my bike.

The worker had been watching the Discovery Channel television series American Choppers, and he went to his supervisor and to request purchasing the series on DVD. The worker next utilized this common interest to introduce Jonathan to the show. Jonathan and the worker built their sessions around each show. They discussed the bikes in each show, how each bike was more than a machine; it something that represented each person on the show, whether the person was one of those who were making the bike or was one for whom the bike was being built. Next, the worker introduced Jonathan to Jessie James and the West Coast Choppers, custom motorcycle builders featured on the show. Again, the worker and Jonathan watched the shows and discussed the meaning of each machine and the people it represented.

Once sufficient time had passed, the worker indicated to Jonathan the history of Paul Sr. and Paul Jr. in American Choppers and Jessie James. The worker shared that all had experienced problems with substance dependence and that Jessie James had experienced remarkable problems with the law. The worker asked Jonathan what his life story would look like if he were able to build a custom chopper? Next, the worker asked Jonathan to draw the bike that would represent him and to describe what remarkable life events would be documented in his life story and how he would have accomplished these as the persons in the American Choppers television series did.

Jonathan was able to identify specific steps that would need to be attained to be able to
build his future as a custom bike maker. Within his plan were four key elements:

1. To not use drugs
2. To get his head straight
3. To learn how to work on bikes
4. To build on his artistic abilities

Stage 6: Develop and Formulate an Action Plan. Jonathan and his social worker built a plan of action consisting of documenting his life history—both positive and negative aspects—in accord with his new goals, including

1. How he had responded to challenges in the past
2. How he would have liked to have responded to the same challenges
3. What he would need to do differently to accomplish his new life goal

Jonathan and his social worker established a plan from this assignment for Jonathan to attend Narcotics Anonymous (NA) meetings and to attend weekly therapy sessions, including medication management. Additionally, Jonathan was connected with vocational programming focusing on auto body and mechanics. Soon, Jonathan was excelling in his vocational rehab. He was attending meetings and bringing updated versions of his future custom chopper. With each session the plan for recovery became clearer and clearer.

Jonathan’s Case Analysis

Jonathan’s road to recovery was difficult. He reported that the Ultram, given to assist with his outpatient detoxification, was of minimal assistance. Jonathan indicated that many days he was “dope sick” and would have rather stayed in bed. However, he remembered what his counselor had said about doing nothing—that it is the quickest way to sticking a needle in his arm again. Jonathan’s most difficult day came when the girlfriend he had hoped would help with his recovery said she did not want to live her life with a “junkie.” Jonathan indicated that he felt as though there were no reason to stay clean. During the same time, he was given an assignment by his counselor to list the right and wrong ways that he was treating his disease. Jonathan indicated that living his life for himself became extremely clear and that the prospect of stealing to support his dope craving was no way to live his life. At the same time Jonathan began an atypical antipsychotic medication. While he indicated feeling somewhat groggy at first, he admits that over time he began to see that this medication was helping. His grades began to improve gradually, and he was able to focus and concentrate for possibly the first time in his life.

Jonathan became active briefly in NA but transitioned to Alcoholics Anonymous (AA), stating that the “war stories” in NA were killing him. Jonathan indicated that he experienced remarkable cravings for a 6-month period. He knew that remaining around persons telling dope stories would eventually lead him to a hit. So Jonathan sought out a new support group. His social worker suggested a noon AA meeting. It was in this AA group that Jonathan found a Vietnam vet who had a history of heroin use. Jonathan and his new friend and sponsor became very close. They worked through all of the 12 steps just as the Big Book of Alcoholics Anonymous suggested. There was an immediate bond between Jonathan and his sponsor, Hank. Jonathan began to hang with his new friend and talk Harley Davidson motorcycles. Since their initial meeting, Jonathan has attained full-time employment at a local body shop and has tentatively enrolled in auto mechanic school in autumn term. He has solidified not only his program of recovery but also his spiritual beliefs, despite Hank’s
agnostic perspective on life. Perhaps the most
telling activity in recovery was when Jona-
than’s sponsor hooked him up with what to
most people looked like a pile of junk, but to
Jonathan, the rusted and beat-up old Harley
was the most beautiful restoration project he
had ever seen. Jonathan indicates he is now
staying clean out of the benefits, not living his
life as he had done previously, in fear and
craving. Jonathan indicates that there are still
tough times, but his life is certainly better than
it was a year ago.

On his 1-year anniversary, Jonathon shared.
He shared his frustration with his lack of
progress and with his disappointment in the
false hope and promise of his medications. He
shared his sadness, loss, and the realization that
persons who are addicted often hurt those they
love the most by rejecting their offers to help.
He acknowledged that persons who are ad-
dicted understand what they want only after
they have lost those they love. Jonathan shared
that, despite his mental illness and his addiction
and in spite of himself, his life will continue and
that, most importantly, he is responsible for
making the most of it with the tools given to
him by those whom he only recently met but
who have treated and understood him as if they
were family.

Case 2

Stacy is a 15-year-old Latina girl currently
being held at the county youth correctional
facility. Her family history indicates that her
father is incarcerated in a maximum security
prison and that Stacy was beaten by her
alcoholic mother’s boyfriends periodically
from age 10 to 12. Stacy stated that her mother
and mother’s boyfriend sexually abused her at
age 12. Her mother admitted that she punched
and slapped Stacy on numerous occasions
because of her alcoholism and explosive anger.

At 13 years of age, Stacy was admitted for
inpatient adolescent treatment after exhibiting
polysubstance dependence including, but not
limited to, amphetamines, hallucinogens (in-
cluding LSD and ecstasy), cannabis, and
alcohol. Furthermore, she displayed suicidal
ideation and running away from a group home.
Stacy has a 2-year history of out-of-home
placements as a result of abusing drugs,
engaging in sexually promiscuous behavior,
becoming pregnant and giving birth (baby
girl at age 14), self-mutilating (i.e., cutting her
arms, leg piercing, and piercing her nipples),
and cursing out the school principal (which led
to school suspension). One month after her 15th
birthday, she savagely cut (with a box cutter)
a former girlfriend because she saw her making
out with her boyfriend. When she arrived at
the assistant principal’s office, she slashed the
assistant principal and was subsequently ar-
rested. Stacy told the arresting officer that she
had to cut the assistant principal’s face because
she does not like people who wear suits and
ties. She kicked out the window in the police
car while being transported and had to be taken
to the emergency room, where she received 16
stitches for her injuries.

Every time Stacy goes home to her mother’s
house, she goes back to abusing drugs and
alcohol, cutting out of school, getting into
fights, breaking curfew, and spending several
nights away from home without notifying
anyone. Her probation officer recently learned
that Stacy was part of a gang.

Stacy’s probation officer indicated that Stacy
is an adolescent experiencing a series of crises,
that she is on a destructive path and has no
family support system. Her mother was re-
cently diagnosed as HIV positive, and her
father was expected to be in the state
penitentiary for another 5 to 8 years.

The probation officer recommended place-
ment in a residential treatment facility
for 2 years with intensive substance-abuse
counseling, anger management sessions, and mental health counseling (Roberts and Yeager, 2004).

**Stacy’s Case Analysis**

As one might expect, Stacy’s transition into a residential treatment program was not a smooth one. Stacy’s oppositional defiant stance led to several remarkable conflicts between Stacy, her peers, and staff of the facility. Within days of admission, Stacy attempted suicide. This attempt consisted of 38 cuts to her arms and legs, combined with ingesting 30 acetaminophen tablets. Stacy was transported to the local hospital, where lavage was performed. Once stabilized, Stacy was transferred to the inpatient psychiatric facility. Within 24 hours, Stacy found herself in four-point restraints after hitting one of the staff, breaking his nose. Following this act of violence, the unit crisis team responded. Six men were required to secure and transport Stacy into the restraint room.

**Application of Roberts’s Seven-Stage Crisis Intervention Model**

**Stage 1: Plan and Conduct a Crisis Assessment (Including Lethality Measures).** Upon admission to the hospital, Stacy demonstrated a severity level of 10 on a scale of 1 to 10 for potential self-harm. Initially, given the nature of suicidal ideation and demonstrated determination to harm herself, Stacy was placed in five-point restraints.

**Stage 2: Establish Rapport and Rapidly Establish Relationship.** While in restraints, Stacy met her social worker, Amy, who presented to discuss Stacy’s history and to develop an ongoing plan for care. Amy very carefully explored the history of Stacy’s abuse and tragic upbringing. Nearing the end of the session, Amy sought to establish rapport with Stacy by stating,

You’re sitting on top of a lot of anger, hurt and frustration . . . . What steps do you think we can take to begin to deal with this anger?

Stacy responded,

It really doesn’t matter . . . . I know I’m always going to have pain. My life is all about pain and I’m the person who can deal with all the assholes out there like you who think you can fix people, well I’m not broke, and if I wasn’t in these leather handcuffs I’d just kick your ass and be done with you!

Amy suggested to Stacy that her attempts to push her away would not work. She made this statement come true by visiting with Stacy for 10 min every hour of her shift while Stacy was in restraints. Slowly, Stacy became less argumentative to her time with Amy, and by the end of the day Stacy had contracted to not lash out toward staff. She had been placed on medications (Haldol and Ativan) at the time of restraint. These were discontinued, and Stacy was placed on an atypical antipsychotic medication.

**Stage 3: Identify Major Problems (Including the “Last Straw,” or Crisis, Precipitants).** Utilizing the strengths-based perspective, Amy began to explore with Stacy the skills that Stacy had to address her situation. Stacy was able to identify that she was a fighter, and she agreed with Amy that she should fight to make things right in her life. In exploring the precipitants of the case, Stacy indicated that she felt she had nowhere to go. She indicated that everyone in her life who was important were either going to die or leave her. She reported learning of the father’s arrest, her mother’s illness, and her
breaking up with her boyfriend all in the same afternoon. Stacy voiced,

I don’t know what happened, I just snapped. Next thing I know I’m strapped to this bed with people around me I don’t know asking a bunch of questions I couldn’t answer ... then you came in.

Stage 4: Dealing with Feelings and Emotions. Amy listened intently as Stacy outlined the issues in her life. Amy was very impressed with Stacy’s ability to discuss her problems and to clearly link her life circumstances to the rage and frustration she was experiencing. On several occasions, a pause in the interview was necessary as Stacy became overwhelmed with the complex reality of her situation. However, on each occasion, the overwhelming emotions were soothed by the reassurance of Amy that Stacy had indeed found the right place to begin to address the problems of her life. Nearing the end of the session, Amy asked Stacy if she could trust her enough to be willing to work with her to develop a plan for recovery. Not knowing who to trust, Stacy reluctantly agreed.

Stage 5: Generate and Explore Alternatives. Building on this simple premise, Amy and Stacy began working together to identify major life problems. Stacy was clearly victimized through years of abuse and was responding to her physical and emotional pain. Issues such as anger, frustration, hurt, and loss were all explored. Amy and Stacy worked closely to explore and begin dealing with Stacy’s volatile feelings and emotions. Within 2 weeks, Stacy’s self-inflicted injuries had healed to the extent that she was able to begin utilizing the hospital gym as a physical release for her anger and frustration. Stacy’s day was balanced with proper nutrition, group therapy, individual sessions, medication management, medications, music and art therapy, and support groups.

Stage 6: Develop and Formulate an Action Plan. Within the 3rd week of the hospitalization, Amy and Stacy began to address plans for her return to the residential treatment facility. The plan included two transitional visits to the day treatment group, followed by debriefing sessions to address any issues that presented. Finally, Stacy was discharged back to the residential treatment program. Within the discharge conference, Stacy agreed to give this facility a chance, something she acknowledged had not occurred in the past. Stacy acknowledged that she had much to live for and that she and Amy had constructed a plan to work toward vocational training and parenting courses, potentially leading to the return of her daughter, combined with ongoing medication management, therapy, and support group attendance.

The transition to the residential treatment program was not without incidence. Over the next 2 years, Stacy was rehospitalized on three occasions, each following an act of violence toward self or others. Eventually, Stacy was able to enter the transitional teen program and was able to successfully establish independent living. Stacy and Amy always returned to the action plan established on the initial admission, with the agreement that the plan was not the problem, that compliance with the agreed-on goals had been lacking, and that reconnection with the plan would eventually lead to Stacy’s achieving her stated goals.

Stage 7: Establish Follow-Up Plan and Agreement. Follow-up for Stacy was keeping in contact with Amy via mail at her place of employment. Stacy and Amy corresponded weekly for approximately 3 months. As time progressed, contact between the two began to diminish as is frequently the case when the treatment plan is effective. Stacy indicated that
she just became so busy there was not any time or reason to connect with Amy; however, she knew if there were ever a need, she would be able to connect with another. There was never a time again when she would have to feel so alone.

**The Role of Drugs**

In each case there is a remarkable history of drug dependence in combination with mental health issues. It is important for care providers to be familiar with current drugs of abuse. Therefore, in closing, a discussion of current designer drugs and others is presented in an effort to provide familiarity with emerging trends in adolescent drug use.

**Designer Drugs**

Designer and club drugs are the latest rage among the young adult population. The term *designer drugs* stems from the fact that these substances are modified versions of FDA-controlled substances (Knox, 2005). The end result includes drugs that, because of their redesign, are often not technically illegal. The process is that of staying one step ahead of the Drug Enforcement Administration and other law enforcement agencies (Glennon, 1996; Kirsch, 1986). Typically, designer drugs are developed clandestinely in illegal labs, and the trend has recently been toward combining various substances to heighten their sexual side effects. Recent toxicology results have demonstrated some very interesting combinations, including one considered by a client as a “new designer combination” of methylenedioxyamphetamine, sildenafil citrate (Viagra), and diazepam (Valium).

**Methylenedioxyamphetamine (MDMA).** MDMA is also known as ecstasy, XTC, X, Adam, clarity, and lover's speed. It was developed in the early 20th century as a weight-loss medication but was not used secondary to the remarkable side effects of the drug. MDMA was utilized briefly in the 1970s by psychiatrists to assist “their patients to emote.” While this was successful, the side effects were simply too great for psychiatric practice (Kosten & Price, 1992; Lister, Grob, Bravo, & Walsh, 1992). Side effects of this drug can include malignant hyperthermia, leading to muscle breakdown and kidney and cardiovascular system failure. The result can be heart attacks, strokes, and, most commonly, seizures. MDMA is considered highly neurotoxic, and prolonged use can result in long-lasting and possible permanent damage to the neurons that regulate the release of serotonin (McMann & Ricaurte, 1995; McCann, Ridenour, Shaham, & Ricaurte 1993). Common adverse side effects include, but are not limited to, sweating, rapid and irregular heartbeats, fatigue, muscle aches, involuntary muscle contraction, and insomnia. Drug-induced psychosis has been reported with the use of this drug in persons with a family history of psychiatric illness (Concar, 1997; Johnson, Letter, Merchant, Hanson, & Gibb, 1988).

Because of the psychosexual effects of the combination designer drugs, they are quickly becoming the favorite of today’s youth. Initially, the emergence of the club drugs were popularized at “raves,” large parties with many party goers engaging in the use of this type of drug. That is not to say that all that attend raves are using this substances, for some raves are about music and interactions without the use of mood-altering substances. Increasingly, the use of club drugs, as with any substances, are migrating to personalized groupings. Unfortunately, this drug class is continuing to grow in popularity among the high school and college population (Roberts and Yeager, 2004).

**Methamphetamine.** Frequently referred to as speed, ice, meth, crystal meth, and glass, among other names. This drug is available in various forms and can be smoked, snorted, ingested, or
Methamphetamine has maintained a consistent popularity, with approximately 9.4 million Americans having tried this drug. Methamphetamine stimulates an excess of dopamine, which creates a remarkable feeling of euphoria during the state of high and can last for several hours when taken orally. When smoked or injected, the high is much shorter but extremely intense. There is a crash following the use of this drug similar to the crash associated with crack cocaine (Concar, 1997). Methamphetamine use is associated with serious health consequences, including potential cardiac and neurological damage; more common side effects include memory loss, agitation, aggression, violence, and at times psychotic behavior (Davis, Hatoum, & Walters, 1987; Grinspoon & Bakalar, 1983; Kirsch, 1986).

**Ketamine.** Sometimes called special K, K, vitamin K, and cat, this drug is an injectable anesthetic mostly used by veterinarians. Ketamine is very similar in effect to phencyclidine (PCP) and is known for inducing dreamlike hallucinations. The greatest danger lies in one’s getting hurt while on the drug as a result of essentially being anesthetized. Severe side effects can occur at high doses and include delirium, amnesia, impaired motor function, high blood pressure, depression, and potentially fatal respiratory problems. Ketamine is most frequently produced as a liquid or powder. In its liquid form, it can be injected intramuscularly (a method common on the East Coast and West Coast) or dropped into the eye. The powder form can be snorted or smoked with cannabis or tobacco (National Institute on Drug Abuse, 2001).

**Inhalants**

Within the juvenile drug group, one particular drug of abuse cannot be overlooked: inhalants. This drug group covers a variety of products, of which a large number can be found in the home. These include, but are not limited to, adhesives, aerosols, solvents, and food products (e.g., vegetable oil spray and whipped cream). This group includes gasses, most specifically nitrous oxide, in the form of “whippets,” compressed nitrous oxide designed for use in the food industry as propellant for whipped cream, found in “head shops,” stores that sell drug paraphernalia (Bruckner & Peterson, 1977; Office of National Drug Control Policy, 2001; Rosenberg & Sharp, 1992).

Inhalants are quickly absorbed into the bloodstream and are distributed throughout the brain and body, affecting the central and peripheral nervous systems. Some effects can be long term. Chronic use has demonstrated structural brain changes. Early teens and young adults are the largest-growing population using inhalants because the drug is freely available at home and many of its users have limited access to other drugs or the means to purchase other drugs (Garriott, 1992; Rosenberg & Sharp, 1992; Zacny et al., 1996). The drug’s connection with crime is limited primarily to users’ shoplifting to obtain inhalants, as the majority of these substances are not illegal and are readily available in any grocery store for under $5.

**Opiates**

In the previous wave of heroin and opiate dependence in the late 1960s, the thought of needle use served as a powerful deterrent to many would-be heroin users. Today, that simply is not the case, as the heroin on the street now is much more refined, providing the opportunity to snort it or smoke it. The changes in processing heroin have made the drug popular with persons under the age of 18. This was further fueled by the popularity of “grunge,” or Seattle sound groups, of the mid-to-late 1990s—for example, Kurt Cobain of Nirvana. This increased popularity has also been driven by the irrational belief that snorting
or smoking heroin is less likely to cause addiction (Maisto, Galizio, & Connors, 1999).

Pulse Check, an agency that monitors trends of drug use across the United States, indicates that, as of November 2001, heroin is beginning to replace cocaine in most major cities as the most frequently used illicit drug. Additionally, 10 cities consider heroin the second most commonly used illicit drug in their communities. These cities span the country, ranging from Baltimore to Philadelphia, Portland (Oregon), El Paso (Texas), Chicago, and Denver (Colorado), to name a few (Office of Drug Control Policy, 2001).

Recent estimates indicate that over 2.4 million people have used heroin at some point in their lives, with 87% of that population under the age of 26. Additional information indicates that severe medical consequences secondary to heroin abuse are expanding (Roberts and Yeager, 2004). The Drug Abuse Warning Network has indicated that heroin-related emergency room visits have doubled since 1998. Within the past year, Oxy Contin (the pharmaceutical opiate oxycodone) has emerged as a popular opiate among many across the United States. However, this drug is cost prohibitive, as the opiate-dependent individuals' tolerance quickly exceeds financial ability to maintain the dependence (Office of National Drug Control Policy, 2001; Substance Abuse and Mental Health Services Administration, 2001).

Currently heroin prices appear to be relatively stable. The most commonly reported heroin street sales unit is 0.1 g, with prices ranging from $10 to $120, depending on the type and purity of the drug. The most common type of heroin across the nation is reported to be South American white heroin. The drug is sold in various forms—such as in capsules, known on the street as pills, for approximately $10; at the gram level, for $150 to $300; and as an eight ball, or 1/8 oz (3.9 g), for $400 to $600, depending on purity (Office of National Drug Control Policy, 2001).

Medical consequences of chronic heroin abuse include scarred or collapsed veins, bacterial infections of blood vessels and heart valves, abscesses, and other soft-tissue infections. There are also remarkable correlations to kidney and liver disease. Related complications include lung disease with various types of pneumonia and tuberculosis. There is also a high correlation with the onset of infectious diseases within the intravenous heroin population; these most commonly include HIV/AIDS and hepatitis B and C (Holmberg, 1996; Substance Abuse and Mental Health Services Administration, 2001).

Persons using heroin report short-term effects of what can be characterized as a “rush,” or a surge of a generally pleasing warm sensation, followed by clouded mental functioning. At times there is the presence of nausea and vomiting; however, most frequently, extreme fatigue and relaxation occur. Many users report an emergence of energy following the use of heroin; however, as use progresses, the feeling of well-being stems from the realization that the pain of pending withdrawal will be going away (Luce, 1972).

Physical dependence on heroin and other opiate substances develops quickly, and withdrawal may occur within a few hours after the last use of the drug. Characteristic withdrawal symptoms include restlessness, insomnia, diarrhea, vomiting, cold flashes, and muscle and bone pain. Withdrawal symptoms typically last from 5 to 7 days; however, long-term or protracted withdrawal symptoms can last for months after the last opiate use (National Institute of Drug Abuse InfoFacts, 2001).

Conclusion

There is no panacea and no easy answers on how to solve the drug abuse problem prevalent among adolescents and young adults.
throughout society. All too often, youths become so obsessed with getting a short-term high, rush, or euphoric feeling that they ignore the consequences—namely, repression of cognitive thought processes, temporary psychosis, hallucinations, suicide attempts, violent assaults, memory loss, depression, high blood pressure, neurological damage, and potentially fatal respiratory problems. In this article we have examined the connection between adolescent drug abuse and the juvenile justice system. We have applied two cases of youthful drug abusers who repeatedly committed crimes due in large part to their drug addictions. We then examined risk assessments and treatment plans applied to the two youths in acute crises. Finally, we documented the neurological and psychiatric damage from the use of club drugs, metamphetamine, ecstasy, PCP, ketamine, cocaine, and heroin. No one can predict whether the increased prevalence of drug abuse and drug-induced psychoses and other mental illnesses, in combination with crime and delinquency, will continue to increase or decrease among youths in the future. What we do know is that it is critically important to arm ourselves with the latest information and knowledge from evidence-based studies so that we can provide the most effective treatment to youths with comorbid substance abuse and mental illness. The major challenge is developing comprehensive mental health and crisis intervention services for the many thousands of youths with comorbid substance abuse and mental illness who are brought to juvenile court or are committed to juvenile institutions or residential facilities.

References


