Implementation of positive group dynamics for adolescents and young adults: Case study and programme evaluation of a Dutch clinic

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When individuals succumb to the grip of an addiction, it is extremely difficult to quit on their own. They would rely on the advice and support of family, friends and professionals. The dynamic is such support and journey toward recovery has been explored by this research through a case study. Yes We Can Youth Clinics (YWCYC) aims to provide a solution for many young people aged 13 to 25 with behavioural disorders and/or addictions, which is more effective when there is collaboration among the adolescents and young adults together with their parents. The method used by YWWC is based on the principle of positive group dynamics wherein their approach and programme is individualised, systemic, and tightly structured. Furthermore, YWCYC works in collaboration with healthcare professionals and experience experts (counsellors) on the basis of unconditional acceptance of all those involved. Successful care should integrate the treatment of co-morbid symptoms and involve families and relatives in the therapeutic process.

Keywords: addiction, behavioural disorders, drug addiction, rehabilitation programme, adolescents

Adolescents are at a turning point in their lives (on the cusp between childhood and adulthood) and have several 'life tasks' or roles to work through. Adolescents and young adults being referred to the Yes We Can Youth Clinics (YWCYC) all got stuck in their development. Nearly all of them followed one or more counselling programmes in the past. They struggle with multiple issues that severely hamper them to function in life. They lack motivation for treatment and the measure of suffering varies. On occasion, their environment is more bothered by the problems than the fellows themselves, there is often little awareness the issue is actually a problem and there is a budding willingness to change. Problem behaviour can manifest itself in several ways: a degree of moroseness and suicidal tendencies, aggressiveness, abuse and trauma, attachment issues, eating disorders, self-harm, criminal tendencies, skipping school, isolation combined with retreating to the bedroom and gaming, unemployment, issues with lover boys and prostitution, sexual and physical abuse, substance addiction, among others.

YWCYC provide solution for many young people aged 13 to 25 with behavioural disorders and/or addictions. The Yes We Can Youth Clinics fellows or the young adults and adolescents have grounded to a halt, unable to perform the roles and tasks appropriate to this phase in their development. The deadlock is visible in the presence of behavioural disorders and/or signs of illness. The Social Competency Model (SCM; Bartels, 2001) indicates that deadlock can be comprehended and addressed by using methods that have proven to be very effective for the target group uses for instance motivational interviewing (Bartelink, 2013), cognitive behavioural therapy (CGT; Zoon & Pots, 2011;) and group dynamics ().

Successful treatment requires a serious effort and commitment from both the fellows and their parents. This collaborative approach by YWCYC proved to be a turning point in the lives of many adolescents and young adults. The method used by YWCYC is based on the principle of positive group dynamics. The approach is individualised as well as systemic and we use a tightly structured programme. This way, fellows and their parents gain insight into their behaviour and its origins. Based on this, new tools are developed for these young adults to help them to get their lives back on track. YWCYC works with healthcare professionals and experience experts (counsellors) on the basis of unconditional acceptance of all those involved. The clinic ensures that confrontation is not shunned and that all problems can be discussed openly and can actually be shared with the professionals.

THEORETICAL FRAMEWORK

There is social competence if the skills of a person are balanced with the life tasks or roles he faces in life. During intake, a problem analysis is made while using SCM which is based on acquiring social skills the juvenile has yet to learn sufficiently, the lack of which has contributed to the problem behaviour. In this approach, the lack of skills is compared to the life tasks that the juvenile (and family) has had to endure, thus arriving at a competence and deficiency profile. A person is considered socially competent when they are 'ready' for their life tasks befitting their level of development and circumstances. The life tasks are made even harder by stressors, mental issues or risk factors and are lightened by resilience and protective factors. Environmental factors can add to the load or lighten it. Skills also include an outlook on life, core values and cognitive schemas targeted to 'life' in general, themselves and others. A teenager or young adult with serious behavioural problems and addictions will be faced with some tasks that seem impossible or very hard to handle. The issues of these youngsters could be seen as a consequence of imbalance.

Interventions based on SCM have a number of characteristics. First off, by means of intervention, a competence profile needs to be compiled: which skills and tasks are present? How does the imbalance look like? Next, a training programme will be developed to improve skills, assuring tasks and life tasks become manageable again. In a preventive sense, SCM means that an attempt is made to prevent problem behaviour from escalating. The focus is primarily on creating conditions for optimal development, such as providing adequate care and a continuous, stable and safe environment, both

physically and socially, presenting adequate examples related to behaviour, values and standards and enabling constructive relations with their peers. YWCYC creates a safe treatment environment by providing a programme within a firm framework, constructed by multiple disciplines. Also, several treatment interventions will be worked out and acquired. SCM is based on social learning, including observational learning (learning by examples). The model is also based on cognitive behavioural therapy. Two levels are distinguished: the core beliefs people have (often subconsciously) and the automatic thoughts (these are immediate, initial thoughts, often originating from core beliefs).

We speak of social competence if the skills of a person are at balanced with the life tasks or roles he faces in life. During intake, a problem analysis is made while using the social competence model (SCM), which is based on acquiring social skills the juvenile has yet to learn sufficiently, the lack of which has contributed to the problem behaviour. In this approach, the lack of skills is compared to the life tasks that the juvenile and the family have had to endure, thus arriving at a competence and deficiency profile.

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Ten actions: The framework within the community

In order to facilitate the stages of change for those at YWCYC, the 'Ten Actions' have been drafted that connect theory with practice. The ten actions are as follows: Action 1: We admit we are powerless over our problems and that because of this our live become unmanageable; Action 2: We are willing to believe that the help of others empower us to change; Action 3: We make the decision to accept the help of others; Action 4: We make an inventory of everything and everyone that angers and annoys us; Action 5: We share this with ourselves, our therapist and our group counsellor; Action 6: We make a list of all the people we have hurt and/or damaged; Action 7: We share this with ourselves, our therapist, our counsellor and those we trust; Action 8: We make it a habit to take good care of ourselves and make amends immediately after we have acted wrongly; Action 9: We work with the group, therapists and group counsellor to create an aftercare plan that will enable us to continue to grow; and, Action 10: Whenever we can, we help others who suffer in similar circumstances.

Fellows qualify for treatment at YWCYC when having received a lot of (non-resolving) treatment in the past or when being stuck as other treatments in their own environment have no chance of succeeding anymore. By temporarily taking the fellows out of their environment, YWCYC breaks through the deadlocked situation, replacing the comfort zone with a new situation that is geared towards acquiring a new mind-set and a new set of skills. The guiding principle at YWCYC is the unconditional acceptance of the individual. Treatment is based on a holistic perspective and it involves the entire life story of both fellows and parents. YWCYC teaches them new skills and holds them accountable for their own actions.

The admission period of ten weeks in the clinic lightens the task load for both fellows and parents. The children are temporarily exempt from the pressure to perform at school (by the time they register for treatment, the majority no longer attends school anyway) and they no longer need to be accountable to their parents. This immediately provides more 'space' to learn, experience emotional growth and train skills, directly putting them into practice in an environment with many other adolescents and young adults. The symptoms of their disorders will be diminished.

With their newly acquired skills, they will return to their own living environments, where they can continue to learn and develop. The admission of these adolescents and young adults also provides relief for the parents/carers and for their living environment: coexistence had become practically impossible and may even have been harmful. This period apart provides an opportunity to reflect, to realise the impact of their own behaviour and to allow for the time to change, so they can contribute to a positive development when fellows return to the fold. Both fellows and parents are given individual treatment objectives, as described in the individual treatment plans. This way, specified in a tailor-made treatment programme, individual issues are carefully looked-after and generic help is governed within a more general framework.

Clinical treatment programme

YWCYC offers an intensive clinical treatment programme regulated by a tight framework. The clinic treats approximately 120 adolescents and young adults at any given time. The clinical treatment period is ten weeks. Parallel to that process, parents also follow an intensive programme (approximately 20 hours). Subsequent to that, a minimum of 10 weeks aftercare is catered for. The adolescents and young adults partake in a daily programme of substantial activities, starting at 6.45am and ending at 10.30pm. It consists of five times a week group therapy, time to work in a personal workbook every day, a minimum of three times a week one-on-one sessions with a personal therapist, daily activities aimed at implementing newly acquired behavioural skills, share meals, the end-of-the-day ceremony and consult with the medical staff if needed, a weekly community meeting, a theme discussion and every evening an educational programme, lectures every day, a sports programme every day.

The clinic treats adolescents and young adults between 13 and 25 years old who are suffering from a wide variety of disorders and problem behaviours. The inclusion and exclusion criteria are described in the intake module. The inclusion criteria consists of oppositional defiant disorder, behavioural disorder, ADHD, depression, mood swings , impulse control disorder, eating disorder, drug dependencies, disrupted parent-child relationship. Intensive clinical treatment will be organised, using the dynamics of the group. For this reason, some supplementary conditions for treatment apply: suitability for groups, some measure of emotion regulation, some degree of self-reflection, some willingness to change, and an adequate grasp of the English language, a participatory support system and an adequate climate to recover when returning home. The social and emotional level of adolescents differs. They go through a crucial phase in life, during which period they transform from childhood to adulthood and during which the brain is still developing. Experimenting is simply part of this phase in life; an orientation to primary impulses and experiencing difficulty in planning are typical examples of this phase. At this time, there is also a high risk to develop addictions and behavioural disorders. These issues can ingrain themselves and there is a chance that personality development will not always progress in a balanced way, increasing the risk of developing a personality disorder. Adolescents and young adults are strongly focused on their often deviant group and allow their behaviour to be strongly influenced by their peers. Awareness of the issue and insights are often limited, while motivation to seek treatment and change is often ambivalent at best. The intake includes a check whether the issues fellows are dealing with, comply with the inclusion criteria and whether there has been an indication for treatment at the clinic. To do so, a decision tree is used.

During the first five weeks, there will be no contact with the home front and that includes no telephone calls. This creates the necessary space to acquire new skills in a new environment. Parents also follow a separate group programme. In the fifth week, a special ‘bonding day’ is organised in the clinic. During this very emotional day, insights are shared openly and a renewed connection is established between the children and their parents. After that moment, contact with the home front is possible again while clinical treatment is continued and further steps are taken to prepare a proper return to society. Subsequently, fellows can embark upon an aftercare programme: during a period of 10 weeks they receive extra care in terms of continued group sessions, 1-on-1 sessions, sports and outdoor activities like

going to the cinema or exercising in a fitness club. Aided by their relapse prevention plan, they are counselled to practice their newly acquired skills. This secondary programme is geared towards the provision of practical support and reactivation.

The impact of transitional and coordinated care programme

The contents of this treatment are described in the care programme. The care programme is divided into five components. These components are composed of one or more care modules. There are generic (attended by everyone) and specific modules. The individual treatment plan describes the individual treatment objectives, ensuring that the generic modules are also tailored to each person. The Care Path 6 provides a step-by-step description of the care and decision-making process within a defined time frame. Four care paths are described for clinical treatment. The modules compose the care programme. This provides an evidence-based treatment approach for a specific group of patients. The modules are substantially described according to a fixed format (frame of reference; objective; target group; method; who/what/where/when; attainment target; harmonisation) and these can be accessed upon request at YWCYC.

YWCYC mission states: 'When all else fails, the clinic will provide a solution for many young people aged 13–25 with behavioural disorders and addictions. We are unable to achieve that in our own. Successful treatment requires a serious effort and commitment from both the fellows and their parents. This collaborative approach by YWCYC proved to be a turning point in the lives of many adolescents and young adults.' Both the fellows and parents are very happy with the effectiveness of YWCYC (Mattern & Schiphof, 2013). Furthermore, the clinic's mission is implemented by following a distinctive treatment strategy: 'The method used by YWCYC is based on the principle of positive group dynamics whereby the approach is individualised as well as systemic and they use a tightly structured programme. This way, fellows and their parents gain insight into their behaviour and its origins. Based on this, they develop new tools for them to get their lives back on track. They work with healthcare professionals and experience experts (i.e., counsellors and therapists) on the basis of unconditional acceptance of all those involved. They do not shun confrontation. They want to ensure that all problems can be discussed openly – and can be actually shared with them.'

One evening per month, an information session is organised for parents, carers and guardians. The objective of this session is to provide more background information about the clinic and explain the specifics of the problem and addiction behaviour in more detail. The clinic will also provide a more in-depth explanation of the methodology, providing extensive details on the programmes in the clinic. In addition, specific attention is paid to the parents' role in the recovery programme. It will be an interactive evening with plenty of room for discussions and questions, providing both former fellows and parents the space to share experiences as well. On average, an information session is visited by approximately 150 people. In addition, YWCYC collaborates closely with the Be Aware Foundation in providing information to secondary schools. Classmates of YWCYC fellows are given information on behavioural disorders. By providing information to classmates and teachers, the re-entry of fellows after treatment will be much easier. This also contributes to increased knowledge on addiction, behavioural problems and the additional hazards.

Prior to clinical treatment, an outpatient intake by a multidisciplinary team will take place. The problem behaviour will be analysed and a full diagnostic investigation will take place. When a client fits the inclusion criteria for treatment, does not fit the exclusion criteria and the care system is willing to enter the parallel family coaching and counselling programme, the intake team will give a positive indication for clinical treatment. A treatment plan is drawn up, including: the provisional diagnosis, provisional treatment objectives for the fellow, and treatment objectives for the care system.

All fellows start with the care path, regardless of diagnosis and treatment objective. During intake, it is decided whether the adolescent or young adult is eligible for clinical treatment (i.e., triage and indication assessment). A provisional diagnosis is drafted during intake and individual treatment objectives are defined. To actually initiate the change and subsequent treatment, it is necessary that the fellow makes the actual decision to start the course of the treatment. The learning cycle (which was introduced by Prochaska and DiClemente) indicates that several stages need to be completed: from contemplation to change, to gaining insights and ultimately acting on that desire to change. This is the first stage of treatment. During the start of clinical treatment, in close collaboration with the fellow, the clinic will investigate the particulars of the problem behaviour, what it has gained them, but also what it has cost them.

Systemic approach within the care system

YWCYC uses a context-oriented systemic approach within the care system that encourages commitment by means of a family coaching and counselling programme running parallel to that of a fellow. Parents will be taught to examine their own role as a caretaker and to determine which role they want to strengthen. This requires four group sessions, bonding day, a joint final meeting at the clinic, and the option for weekly aftercare. Due to the symptoms of the illness and behavioural disorders of their child, their role as a parent has often changed significantly. They have adopted the concerns of their children or started to act more or less been abandoned in order to keep some semblance of peace in the house. Parents are taught to look at their own behaviour from a distance and consciously re-establish their parenting role. During treatment, they re-connect to their child again.

The programme is designed by a multidisciplinary treatment team composed of health psychologists, educational psychologists, youth workers, coaches, counsellors and psychiatrists. The team works through group dynamics, peer group learning experience, focused assignments and a great deal of mutual coordination. In addition to the more contemporary professionals, group workers and experts are quick to recognise problem behaviour among teenagers and young adults. They identify it in such a way that it directly appeals to them. This makes fellows realise they are understood and it enables them to better accept the reflections. Most of the group workers have been trained in pedagogical sports (e.g., Sagoo, 2017) and are responsible for an actively day activity programme that encourages improved health. This teaches the fellows effect of activities and structures in their lives, and encourages positive behaviour and provides platform to put newly acquired skills into practice. They learn how to express themselves, explore their boundaries and have options to carry out focus assignments. The group workers act as positive role models (exemplary behaviour, encouraging healthy activities and modelling). The clinic offers a unique carefully composed and practically feasible method that corresponds to and resonates with the target group.

Impact: From theory to practice

The objective of the treatment is to get adolescents and young adults out of their self-destructive rut. By acquiring healthy coping behaviour and processing emotional themes, these adolescents and young adults can regain their self-respect and set new learning objectives. Positive choices can be made again, encouraging stagnated development to start again. After clinical treatment, these fellows, supported through the aftercare programme, will be capable of integrating their new insights and skills into their daily life. Because the parents are attending a parallel programme, it is also possible to break the patterns at home which enabled past behaviour. If, after clinical treatment, there is need for immediate supplementary treatment, the clinic will provide specific recommendations. With the clinic's technology, problem behaviour is mapped using the theory of SCM. The balance between skills and life tasks has been disrupted and that imbalance has brought symptomatic behaviour into the foreground. This obstructs development. When the new skills are acquired, it is possible to start growing and

developing. Problem behaviour will fade into the background. Ten Actions are used to enable change and development. These are effect of the stages of the circle to change (Prochaska & DiClemente, 1986). The descriptions of the 12 steps from the 12-step approach have been the source of inspiration for YWCYC's Ten Actions, which follow the basic structures of the 12 steps and have been tailored specifically to the clinic's target group. In the intervention, they use cognitive behavioural therapy (CBT). In their methodology, destructive cognitive patterns among these adolescents and young adults are being supplanted by more positive cognitions such as cognitive structuring (Nasir, 2005).

During the start of the treatment, in close collaboration with the fellow, the clinic will investigate the particulars of the problem behaviour, what it has gained them, but also what it has cost them. This approach generates insights into the background of the behaviour. Then, the clinic will work towards a motivation to change, to take that first step in creating a new perspective. It is necessary for every fellow to have gone through every single stage of change and its subsequent actions. This is reflected in the YWCYC programme: There is a common structure (treatment period is 10 weeks and each week is focused on a specific action) and all the fellows follow the same modules (guided by the individual treatment plan during implementation). Soon, after three weeks of clinical treatment, the willingness to change, diagnostics and treatment objectives are discussed and assessed if necessary. A competence profile is drafted. To some extent, the treatment objectives and competence profiles are tailored to the individual. This is reflected in the individual treatment plan with its individual treatment objectives. Parts of it will return in the generic treatment objectives and competence profiles, as these are related to general development tasks meant for all teenagers and young adults. Depending on the issues, specific modules from three separate care paths will be added, providing tailored care (i.e., differentiation). These run parallel to the care path on 'acceptance and change' which continues to run during the entire treatment process. After five weeks of clinical treatment, a connection with the care system is re-established. During bonding day, the treatment of both fellows and parents converge again. During weeks 9 and 10, the clinic will work towards a relapse prevention plan and an assessment is made to identify which type of aftercare needs to be implemented.

Group dynamics are also used since they have been known to be effective among adolescents (Haller, Gallagher, Weldon, & Felder, 2000). The treatment is both systemic and contextual. Observational learning is also a major element (Goubert, Vlaeyen, Crombez, & Craig, 2011). Fellows are placed in a stable and safe environment, in which they are able to learn from (and with), peers and the various care providers such as therapists, counsellors and group workers. By using the strength and dynamics of the group ('the community'), a learning environment is created. Teenagers and young adults learn strongly from each other and group workers have an exemplary role. The clinic also uses health-enhancing interventions (e.g., medical and psychiatric treatment), supplemented in individual cases by specific methods such as mindfulness, elements of schema therapy and acceptance and commitment therapy (ACT).

Family coaching and counselling programme

The family coaching and counselling programme run parallel to the fifth week of treatment from Monday to Thursday or Tuesday to Friday. It consists of four full days under supervision of a family coach and counsellor. The most special day, bonding day, takes place in the clinic on either Wednesday or Thursday. During this day, the fellow will, for the first time, be reunited again with his family, after not having communicated with them for five weeks. Group and individual sessions are coached by family counsellors with expert experience. The clinic will use psychoeducation (e.g., Bautista, Relojo, Pilao, Tubon, & Andal, 2018), motivational interviewing, cognitive behavioural therapy, transactional analysis and attachment-based family therapy.

Treatment of both parents and fellows are aligned with each other. Carers are motivated to take responsibility for their changed role as a guardian and to commit to a permanent recovery programme for both themselves and the fellows. This is important to further promote not only the mental health but the overall well-being of the fellows (Relojo, 2018). The objective of the family coaching and counselling programme is to provide parents insight in the issue-enabling family patterns and their part in it, providing fertile grounds for making the choice to change. Mapping the supporting behavioural patterns is also important to enable a positive change in the family dynamics and to contribute to the recovery environment in the family. Within the family coaching and counselling programme, parents expand their range of skills. Consider for instance the enabling of autonomous development (i.e., development tasks for fellows) and setting boundaries such as parenting role. By reflecting on their own behaviour, parents are able to direct their behaviour in favour of a constructive communication pattern, assuming this pattern supports the recovery process of both the fellow and the family system. By assuming responsibility for their own behaviour, parents develop the self-confidence to take on the responsibility of the family again and to use a type of communication that befits the age of the fellow. It also creates the space to enter a renewed relationship of attachment with the fellow from a position of restored trust in their own ability to change and in the confidence that the fellow will also take responsibility of his behaviour.

Aftercare programme

After clinical treatment, fellows and parents will be invited for a thorough evaluation. A final letter is drafted and recommendations will be extensively discussed. After having completed 10 weeks of clinical treatment, fellows face the most critical phase in their process. They have built self-confidence again, feel more energetic and are ready to make new plans. At the same time, some may feel insecure because they many have changed, but their social environment did not. Now it is time for them to focus on their purpose in life. Secondary care starts right after the clinical programme. Located in a less isolated area, the fellows spend a minimum of four weeks in a residential setting, gradually getting used to the 'normal' world again. In addition to a great number of group sessions, one-on-one sessions and a variety of sports activities; they will also slowly start to pick up daily life: going shopping, seeing a film, walking around the city, meeting other people, going to a restaurant, having a cup of tea, or exercising in a club. It all seems simple, but after spending 10 weeks in total isolation from the outside world in the intensive treatment programme, going back home can be very challenging, causing old behaviour and convenient habits to recur. The lack of safe environment and continuous supervision of care professionals could lead to relapse (Guttman, 2018). Thus, the clinic helps the fellows with these challenges towards a full return to society; a clear attainable programme is created for them to follow at home, or if needed, they will be supervised by a recovery coach.

Dutch fellows can voluntarily take part in the Yes We Do programme which runs for 10 weeks. Having returned home, fellows will have assumed their roles in life again (as a student, a colleague, member of the family, a friend, etc.). During the group sessions, various ways to apply their newly acquired skills are discussed, as well as how to use the relapse prevention plan. Counsellors take on a supporting role, acting as a role model, setting standards for behaviour, discussing norms and values. Experts might be invited to share speech. Also, assessed issues, competence analysis and treatment objectives are all used as input for the group sessions. Core beliefs are challenged and the motivation to permanent change is brought to attention through motivational interviewing. The Ten Actions are used to quickly identify ways to turn what they have learned into action. Wherever, possible, they are also referred to self-help groups. YWCYC mediates for fellows overseas to access similar programmes, no matter how they are executed by local partner organisations. When either primary or secondary care ends, a letter is drafted to the general practitioner and any other follow-up counsellors. Subsequent to clinical treatment, all Dutch parents can access unlimited aftercare. In a 90-minute group meeting, led by a family counsellor, parents can discuss how to apply newly acquired insights and skills at home. Focus

lies on experiential learning among guardians. In addition, parents are encouraged to remain taking responsibility for their own stake in the family dynamics, to ask for help when aligning with the fellow at home and to visit self-care groups for continued support. The clinic mediates for parents abroad to access similar aftercare programmes, no matter how they are executed by local partner organisations.

IMPLICATIONS

Ever since drug addiction first emerged as a recognised medical condition, a huge number and variety of different treatment methods have emerged. A drug rehabilitation programme may necessarily last for only a few months, but rehabilitation is much more than just a 90-day fix. Recovery is a process that evolves through motivation and support of the client. Dependency on and misuse of drugs and alcohol is a major cause of offending. As such, rehabilitation clinic like YWCYC works in partnership with other agencies to deliver an effective programme.

The purpose of this case study is to highlight the practices of a Dutch rehabilitation clinic, with the core aim that it will be used as a comparison tool for other similar organisation. The form of comparison is important to ensure that the clients can have optimum recovery at their chose rehabilitation clinic. It is also important to take into account other approaches. For instance, alternative sentencing drug rehabilitation programs provide a venue to efficiently deliver integrated hepatitis and other prevention services.

Considering the vast number of high-risk persons in drug rehabilitation, probation, parole, and inmate release programs, an opportunity exists to greatly expand hepatitis services (Gunn et al., 2005). Also, Bishai et al. (2008) estimate the value that clients place on methadone maintenance and how this value varies with the effectiveness of treatment and availability of case management. We provide the first estimate of the price elasticity of the demand for drug treatment.

Drug alcohol rehabilitation is extremely vital as this offers each individual the chance or hope that they will still improve their lives. Through the treatments provided to cure their physical, emotional and mental disorders, they are going to learn from their experiences and that they will notice that drinking alcohol and taking prohibited medication is not ideal for their mental health and well-being.

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