yes we can
YOUTH CLINICS
Addiction & Mental Healthcare

Treatment Method

2017

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Foreword

This document describes the treatment method of Yes We Can Youth Clinics (YWCC). It contains YWCC's mission and vision, a summary of the target group (Chapter 1), a theoretical substantiation of the treatment method (Chapter 2), a description of the evidence-based treatment methods used (Chapter 3), while Chapter 4 describes how these methods are implemented in the mental healthcare programme (see diagram on page 19). The treatment culture and the employees that implement this programme are described in Chapter 5. Chapter 6 clarifies quality control and the continued development of the method. The document concludes with a bibliography.

This document was drafted for YWCC employees and external partners, such as referring parties and/or other professionals, in order to gain insight into the foundation and implementation of the care that Yes We Can Youth Clinics has set up for the benefit of teenagers and young adults (hereinafter also referred to as 'fellows') and their parents/carers/guardians (hereinafter also referred to as 'parents').

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Contents

Foreword 5

Summary 9

1. Characteristics of the target group 13

2. The Social Competence Model and the Ten Actions 15
Theoretical framework of the Social Competence Model, general description 15
Interventions based on SCM 15
Ten Actions 16

3. Impact of the Yes We Can method, from theory to practice 19
Treatment objective 19
From theory to practice, applied methodology 19

4. Yes We Can care programme 21
Information programme 22
Intake 22
Clinical treatment programme 22
Family coaching & counselling programme 25
Aftercare programme 25

5. Treatment culture and employees 28
Introduction (need for residential help) 28
Treatment culture 28
Conferral and coordination 28
Composition of treatment groups 28
Multi-disciplinary treatment team 29
Job descriptions 29

6. Training, securing and developing of the Yes We Can methodology ... 30

Literature 31

Appendix 1: Drafting problem analysis for Social Competence Model (diagram) 33

Appendix 2: Overview of the Ten Actions 34

Summary

‘Stuck’ adolescents

The teenagers and young adults being referred to Yes We Can Youth Clinics (YWCC) all got stuck in their development and nearly all of them followed one or more counselling programmes in the past. They struggle with multiple issues that severly hamper them to function in life. 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, etcetera.

The Yes We Can Youth Clinics mission states: “When all else fails, Yes We Can Youth Clinics provides a solution for many teenagers and young adults aged 13 to 25 with behavioural disorders and/or addictions. We are unable to achieve that on our own. Successful treatment requires a serious effort and commitment from both the fellows and their parents. This collaborative approach by Yes We Can Youth Clinics proved to be a turning point in the lives of many teenagers and young adults.” Both fellows and parents are very happy with the effectiveness of YWCC (Mattern and Schiphof, 2013).

YWCC’s mission is implemented by following a distinctive treatment strategy: “The method used by Yes We Can Youth Clinics is based on the principle of positive group dynamics. Our 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, we develop new tools for them to get their lives back on track. We work with healthcare professionals and experience experts (counsellors) on the basis of unconditional acceptance of all those involved. We do not shun confrontation. We want to ensure that all problems can be discussed openly – and can actually be shared with us.”

YWCC offers an intensive clinical treatment programme regulated by a tight framework.
The clinic treats approximately 100 teenagers 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 8 weeks aftercare is catered for.
The teenagers and young adults partake in a daily programme of substantial activities, starting at 06:45 and ending at 21:30.

It consists of:

- four times a week group therapy and time to work in a personal workbook;
- three times a week one-on-one sessions with a personal counsellor;
- 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 in the evening an educational programme;
- lectures and an activity programme on weekends.

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 seperate 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 kids and their parents. After that moment, contact with the home front is possible again whilst 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 8 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.

From deadlock to development

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. The YWCC fellows 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. YWCC uses for instance **motivational interviewing** (Bartelink, 2013), **cognitive behavioural therapy (CGT)** (Zoon and Pots, 2011; Zoon, 2012; Foolen et al., 2013; Resultaten Scoren, 2012) **and group dynamics** (Van Reijen en Haans, 2008). In order to facilitate the stages of change for those at YWCC, the Ten Actions have been drafted. The **Ten Actions** connect theory with practice. Fellows qualify for treatment at YWCC 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, YWCC 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 YWCC 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. YWCC 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 kids 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 teenagers 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 teenagers 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 general framework.

Systemic

YWCC uses a context-oriented systemic approach. The 'care system' encourages commitment by means of a family coaching & counselling programme running parallel to that of the fellow. Parents will be taught to examine their own role as a caretaker and to determine which role they want to strenghten.

This requires four group sessions, bonding day at the clinic, a joint final meeting at YWCC 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 confrontational or accusatory. The parenting role has 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.

Multi-disciplinary treatment team

The programme is designed by a multi-disciplinary treatment team composed of healthcare psychologists, remedial educationalists, youth workers, coaches/group workers, counsellors (experience experts), nurses, addiction rehab physicians and psychiatrists. The team works with group dynamics, peer group learning experience, learning through experience, focused assignments and a great deal of mutual coordination. In addition to the more classically schooled professionals (psychologist, remedial educationalist, nurse, rehab physician and psychiatrist), group workers and experience experts are quick to recognise problem behaviour in teenagers and young adults. They identify this 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 and are responsible for an active day activity programme that encourages increased health. This teaches the fellows the effect of activity and structure in their lives, encourages positive behaviour and provides a 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, modelling).

YWCC offers a unique, carefully composed and practically feasible method that corresponds to and vibrates with the target group.

1. Characteristics of the target group

YWCC treats teenagers and young adults between 13 and 25 years old suffering from a wide variety of disorders and problem behaviours[1]. The inclusion and exclusion criteria are described in the intake module. The inclusion criteria consist of: oppositional defiant disorder; behavioural disorder (NAO); ADHD; depression, mood swings; impulse control disorder (including frequent gaming); eating disorder; cannabis and other 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, an adequate grasp of the English language, a participatory support system and an adequate climate to recover when returning home.

The exclusion criteria consist of: classic autism; untreated psychosis; heroin dependency; dissociative disorder; PTSD with extremely intrusive reliving; acute suicidal tendencies; severe attachment disorders; serious physical handicap; eating disorder with a dangerous BMI (if untreated).

Problem behaviour can be classified into externalising and internalising behaviour. Externalising problem behaviour is reflected by: defiant behaviour, aggressive or otherwise transgressive behaviour (stealing, lying, manipulating), school absenteeism, impulsive behaviour and disrupted family relationships. These will fit diagnoses such as behavioural disorders, oppositional and defiant behavioural disorders (ODD) and AD(H)D. Internalising problem behaviour is reflected by : mood swings, moodiness and self-harming behaviour with accompanying diagnoses such as depression, borderline personality disorder or an identity issue. In addition, fellows can get stuck in their development as a result of autistic tendencies and the experience of trauma. Many teenagers and young adults are abusing substances or have gotten addicted to them. Gaming or sex addiction also regularly occurrs. In almost every case, psychosocial issues and an unstable parenting environment are at stake: personal issues with the parents/carers themselves (such as depression, addiction, burn-out), often parents are divorced, fellows may have switched schools many times and on occasion there may even be instances of custodial outplacement. Between the fellow and their caretaking adults, a pattern has been created that aggravated the symptoms of illness.

The social and emotional level of teenagers and young adults differs. They go through a a crucial phase in life, during which period they transform from child to adulthood and during which the brain is still developing (‘puberty brain’). Experimenting is simply part of this phase in life; an orientation to primary impulses and experiencing difficulty in planning are all typical examples of this phase. At this time, there is also a high risk to develop addictions and behavioural disorders.

Behavioural 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. Teenagers and young adults are strongly focused on their often deviant peer 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 YWCC. To do so, a decision tree is used (for a more elaborate description, see the intake module). The next section outlines the Social Competence Model and the substantiation of the Ten Actions. The YWCC method is then explained in detail.

[1] The main diagnoses of these teenagers and young adults are: hyperactivity (17%), depression/mood swings (22%), behavioural disorder not otherwise specified or oppositional (23%), substance abuse/addiction/ dependence (29%) and other (9%).

2. The Social Competence Model and the Ten Actions

Theoretical framework of the Social Competence Model, general description

We speak of social competence if the skills of a person are balanced with the life tasks or roles he/she faces in life. During intake, a problem analysis is made whilst using the **Social Competence Model (SCM)** - (see Appendix 1).

The SCM 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/or 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

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. YWCC 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).

Interventions based on SCM have the following characteristics:

- A problem and competence analysis is drafted, also known as the 'competence profile':
- There is a structured approach. The programme is derived from the competence profile;
- There is a cognitive component in the programme: there is an active approach towards changing cognitive schemas, automatic thoughts and core beliefs. Programmes are geared towards changing attitudes, values and standards;
- The environment in which fellows live will be involved as much as possible. In case of outpatient treatment, we will work as much as possible in the environment in which the teenager or young adult actually lives. In case of residential treatment, we will actively involve the living environment of fellows as much as possible (at YWCC this means we will use a family coaching & counselling programme, bonding day, letters, telephone calls) and we will prepare them for a return to that environment. We will teach skills for the tasks set for that return, as derived from the competence profile.

In addition to the individual analysis, SCM can be complemented with a development perspective indicating general tasks and skills.

Ten Actions

The Ten Actions (see Appendix 2), integrate all separate components of theory and practice, providing both fellows and employees with an integrated systemic approach. The Ten Actions are meant to connect, expressed in a collective language to be used by fellows and counsellors alike. The Ten Actions are indicators of the process fellows are undergoing and they provide an insight into how the learning environment is being created. In general, all activities revolve around one Action per week.

In order for fellows to be able to change behaviour, acknowledgement of the issues and the intention to change are considered to be the required initial steps. A common pitfall for counsellors is to immediately focus on actions geared towards change, whereas the client is not ready for change yet, ensuring that the process of change will never even start. Past behaviour is familiar to clients; it has provided benefits and still does. They have yet to embrace the expectation that new behaviour offers a far better perspective. Motivation for treatment is a very important factor in determining its success (Bartelink, 2013)[2]. Motivational interviewing is a powerful method to accomplish this (Schippers and De Jonge, 2010). Motivational interviewing as applied by YWCC uses the circle of change. That circle is described by Diclimente and Prochaska (see e.g. Velicer et al., 1995 and 1996; Finnel, 2003). Change is categorised in several stages: pre-contemplation, contemplation, determination, action, maintenance, termination. When relapsing, the whole circle needs to be run through again (trial goes hand in hand with error, where error is closely followed by bouncing back). Relapse (temporary setback) to earlier stages is part of change; successful treatment creates an upward spiral which could in the end lead to permanent change (permanent exit).

The first three Actions are meant to put the stages of pre-contemplation, contemplation and determination into concrete action. The fourth Action is the moment when, viewed from the theoretical perspective of the circle to change, the first action to change (active change) is deployed (Actions 4 through 10 all fit the stage of active change). Fellows gain insights that past behaviour fails to work and builds up faith in the programme and the treatment team. The stage of active change has started.

Action 5 makes it possible to accept the problem behaviour. By sharing it with others, fellows are finally ready to face their actual behaviour. Shame and avoidance can finally be relinquished. Their own behaviour can therefore be accepted. This is a stage of internalising, mentalising and giving new meaning to behaviour again.

The first five stages have a strong focus on the individual and on self-acceptance. The fundamental trust and self-confidence are enhanced as a result, enabling the individual to reflect on their environment and relationships in a completely different way and invest in them. Actions 6 and 7 are geared towards this: after the ego, self-image and self-confidence have been fortified, the individual has been enabled to look outwards again and actually finds the space to explore how their behaviour has affected others. The individual would then be able to engage in balanced and reciprocal relationships and maintain them (a development task, befitting growing up). Through Action 8, when growth in social and emotional development (Abraham, 2005[3]; Bartels, 2001) takes place, an individual is able to take responsibility again, identify their own part and act on it. The newly acquired skills are applied in the day programme, so fellows make a start at integrating them into daily life.

Action 9 is about making an aftercare plan to prepare for potential risk situations, aiming to secure development and growth. Through Action 10, which is the start of budding self-confidence, the confidence is created that you can make a difference for someone else. By putting such things into practice, self-confidence and self-respect grows, enabling the individual to take on a role in society again (development task).

[2] Motivation and acceptation are also at the very centre of Acceptance and Commitment Therapy (Blackledge et al., 2009; Hayes et al., 2006)

[3] When documenting development, we use the Development Profile by Abrahams as background information. It is an empirically developed instrument, based on generally accepted development theories, like Piaget, Bowlby and Erickson.

3. Impact of the Yes We Can method, from theory to practice

Treatment objective

The objective of the treatment is to get teenagers and young adults out of their self-destructive rut. By acquiring healthy coping behaviour and processing emotional themes, these teenagers 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 by the YWCC 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, YWCC will provide specific recommendations.

From theory to practice, applied methodology

With the YWCC methodology, 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 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 effects of the stages of the circle to change (circle, as described by Prochaska and Diclimente). The descriptions of the twelve steps from the twelve-step approach have been the source of inspiration for the **Ten Actions**. The Ten Actions follow the basic structure of the twelve steps and have been tailored specifically to the YWCC target group: teenagers and young adults with behavioural disorders and/or addictions[4].

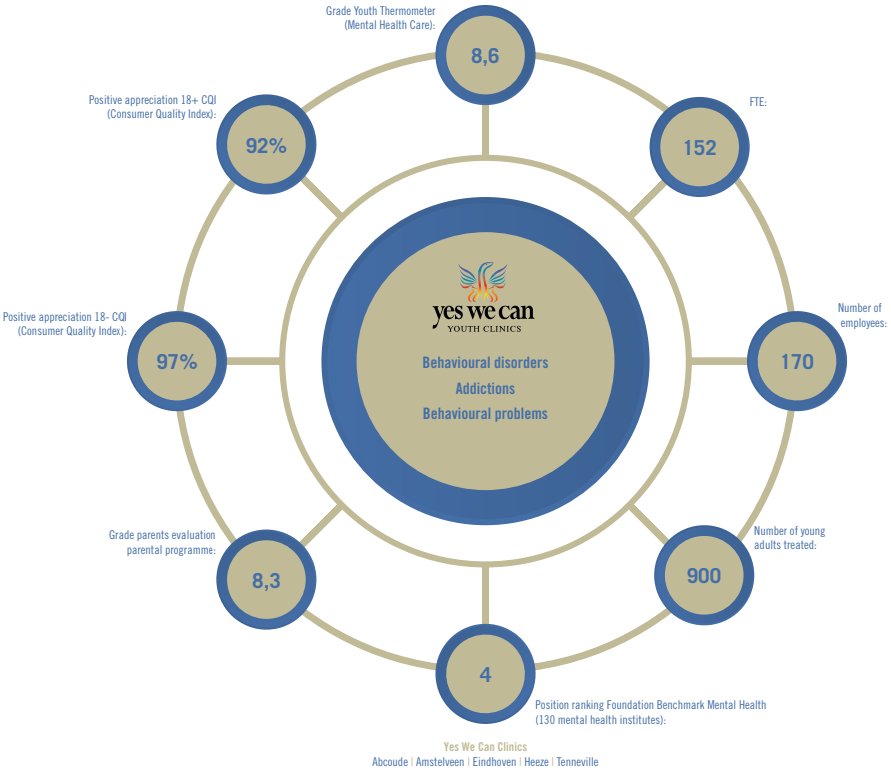
In the intervention, we use **Cognitive Behavioural Therapy** (CBT). In the Yes We Can methodology, destructive cognitive patterns in these teenagers and young adults are being supplanted by more positive cognitions (cognitive restructuring). We are dealing here with the individual version (with the therapists) as well as the group version (with counsellors in collaboration with therapists). Both the individual and group version are indicated by the NJI (Dutch knowledge institute for teenagers and young adults) as effective methods (Zoon and Pots, 2011; Zoon, 2012; Foolen et al., 2013; Resultaten Scoren, 2012).

In addition to CBT, **motivational interviewing** is used (Schippers and de Jonge, 2010; Bartelink 2009 and 2013). Motivational interviewing is a client-focused, directive method, focused on increasing the intrinsic motivation to change behaviour by exploring the ambivalence (doubt regarding the problem behaviour or the addiction).

Group dynamics are also used (Van Reijen and Haans, 2008). The treatment is both systemic and contextual. Observational learning is also a major element.

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 (therapists, counsellors and coaches/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 coaches/group workers have an exemplary role.

We also use health-enhancing interventions (medical and psychiatric treatment), supplemented in individual cases by specific methods, such as mindfulness, elements of schema therapy and ACT (Acceptance and Commitment Therapy).



[4] Similar adaptations have been made before, see for example Morgenstern et al., 2002; Steigerwald and Stone, 1999).

4. Yes We Can care programme

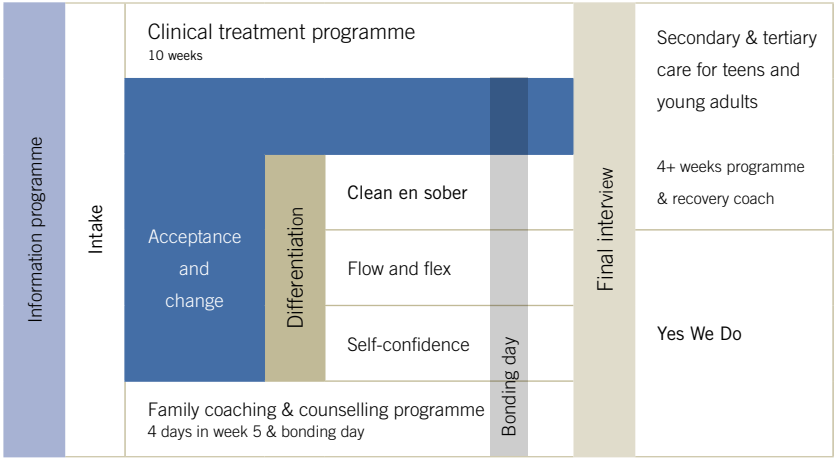
The contents of this treatment are described in the **care programme**[5]. The care programme is divided into five components. These components are composed of 1 or more care modules. There are generic (attended by everyone) and specific modules. The individual treatment plan describes the individual 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 YWCC.

The five components of the care programme are:

1. information programme
2. intake
3. clinical treatment programme
4. family coaching & counselling programme
5. aftercare programme

Schematic overview of the care programme, in a chronological format



[5] For a more specific description of what a care programme entails, see Van Yperen et al., 1999.
We adhere to the definition of care paths as used by the European Pathway Association (http://www.e-p-a.org).

Information programme

One evening per month, an information session is organised for parents/carers/guardians, family, interested parties and professionals. The objective of this session is to provide more background information on YWCC and explain the specifics of problem and addiction behaviour in more detail. We will also provide a more in-depth explanation on the methodology, providing extensive details on the programme 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 discussion 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, Yes We Can Youth Clinics collaborates closely with the Be Aware foundation in providing information to secondary schools. Classmates of YWCC fellows are given information on behavioural disorders, behavioural problems and addictions. 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.

Intake

Prior to clinical treatment, an outpatient intake by a multi-disciplinary 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 & 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.

Clinical treatment programme

A. Care path for 'acceptance and change'

All fellows start with this care path, regardless of diagnosis and treatment objective.During intake, it is decided whether the teenager or young adult is eligible for clinical treatment (triage, 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 treatment. The learning circle by Prochaska and Diclimente 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, we 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. Next, we 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 YWCC programme: there is a common structure (treatment period is ten weeks and each week is focused on a specific Action) and fellows all follow the same modules (guided by the individual treatment plan during implementation).

The following general modules are used in this care path:

- medical and psychiatric treatment module
- group treatment module
- individual treatment module
- activity programme module
- workbook module
- community meeting module
- bonding day module

After three weeks of clinical treatment, the willingness to change, diagnostics and **treatment objectives** are discussed in a **multi-disciplinary treatment meeting**, supplemented 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 (differentiation). These run parallel to the care path on 'acceptance and change' which continues to run during the entire treatment process.

The specific care paths are:

B. Care path 'clean and sober': focused on addiction issues
   Based on symptomatic behaviour and diagnosis in the field of addiction issues, an assessment is made whether to add specific modules to the treatment.
C. Care path 'flow and flex': focused on externalising behaviour and autism issues
   Based on symptomatic behaviour and diagnosis in the field of behavioural disorders, oppositional defiant disorders, ADHD, PDD-NOS, attachment issues or mild mental disabilities, an assessment is made whether to add specific modules to the treatment.
D. Care path 'self-confidence': focused on internalising behaviour
   Based on symptomatic behaviour and diagnosis in the field of depression, eating disorders, anxiety disorders, post-traumatic stress disorders, personality issues, conversions, an assessment is made whether to add specific modules to the treatment.

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**, we work towards a relapse prevention plan and an assessment is made which type of aftercare needs to be started.

Family coaching & counselling programme

Family coaching & counselling programmes run parallel to the 5th week of treatment from Monday to Thursday or Tuesday to Friday. It consists of four full days under supervision of a family coach & 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/her family after not having communicated with them for 5 weeks. Group and/or individual sessions are coached by family counsellors with expert experience.

We will use psycho-education, motivational interviewing, cognitive behavioural therapy (CBT), transactional analysis (TA) and attachment-based family therapy (ATBT).

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 fellow.

The objective of a family coaching & counselling programme is to provide parents insight into their issue-enabling family patterns and their own share/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 & counselling programme, parents expand their range of skills. Consider for instance the enabling of autonomous development (development tasks for fellows) and setting boundaries (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 teen/young adult from a position of restored trust in their own ability to change and in the confidence that the fellow will also take responsibility for his/her own behaviour.

Aftercare programme

A. Final evaluation

After clinical treatment, fellows and parents will be invited for a thorough evaluation. A final letter is drafted and recommendations will extensively be discussed.

B. Secondary care

After having completed 10 weeks of clinical treatment, fellows face the most critical phase in their process. They have rebuilt self-confidence, are motivated again, feel more energetic and are ready to make new plans. At the same time, some may feel insecure because they may have changed, but their (social) environment did not. Now it is time for them to focus on their purpose in life. What do they want to achieve and how will they implement such plans?

Secondary care starts right after our clinical programme. Located in a less isolated area, the teens and young adults spend a minimum of 4 weeks in a residential setting, gradually getting used to the "normal" world again. In addition to a great number of group sessions, 1-on-1 sessions and a lot of sports activities, they will also slowly start to pick up daily life: going shopping, seeing a movie, walking through a city, meeting other young people, going to a restaurant, having a cup of coffee in a café, exercising in a fitness club. It all seems so simple. But after spending 10 weeks in total isolation from the outside world in our intensive treatment programme, going back home can be very confronting, causing old behaviour and convenient habits to recur. The lack of a safe environment and continuous supervision of care professionals could lead to relapse. We help fellows to deal with these challenges towards a full return to society. A clear, attainable programme is created for them to follow at home, if needed supervised by a Recovery coach.

C. Yes We Do

Dutch fellows can voluntarily take part in our Yes We Do programme (maximum 8 to 12 weeks). Having returned home, fellows will have assumed their roles in life again (as a student, a colleague, a member of the family, a friend, etcetera). During group sessions, various ways to apply 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 (modelling/identification figure), setting standards for behaviour, discussing norms and values. Experience experts might be invited to speech. Assessed issues, competence analysis and treatment objectives are all used as input for the group sessions (SCM). Core beliefs are challenged (CBT) and the motivation to permanent change is brought to attention (motivational interviewing). The Ten Actions are used to quickly and identifiably turn learnings into actual action. Wherever possible, we also refer to self-help groups. YWCC mediates for fellows abroad to access similar Yes We Do programmes, however executed by local partner organisations.

D. Letter at the end of care

When either primary or secondary care ends, a letter is drafted to the GP and any other follow-up counsellors.

E. Aftercare for parents

Subsequent to clinical treatment, all Dutch parents can access unlimited aftercare. In 90-minute group meetings, led by a family counsellor with expert experience, parents discuss how to apply newly acquired insights and skills at home. Focus lies on experiential learning amongst guardians. In addition, parents are encouraged to remain taking responsibility for their own stake in family dynamics, to ask for help when aligning with the fellow at home and to visit self-care groups for continued support. YWCC mediates for parents abroad to access similar aftercare programmes, however executed by local partner organisations.

5. Treatment culture and employees

Introduction (need for residential help)

From the perspective of SCM, it is important that Yes We Can treatment takes place in a different environment and that fellows reside in a group. The fellow's situation should be as such that there is no space for acquiring new skills in their current environment (influences from the environment are too strong, combined with the skills he/she lacks). The only way to progress is by removing the fellow from their familiar environment, creating space for their own development and that of their parents. In the clinic, fellows are taught skills that they can start using in their own environment upon their return. Treatment is geared towards a return, ensuring that fellows are better equipped to handle their personal environment. The presence of other young people in similar conditions, in combination with the activity programme, help fellows to put newly acquired skills directly into practice. This allows for the opportunity to learn from each other[7].

Treatment culture

YWCC works with mixed composed groups of teenagers and young adults in a team assembled from multiple disciplines. YWCC's guiding principle is the unconditional acceptance of the individual. YWCC creates a stimulating programme and an environment in which fellows are able to acquire new skills, to practice, integrate and apply them. The treatment plan engages in a working relationship with the fellows from a holistic perspective. The team makes an effort to really get to know them, feeling at liberty to use their personal life story in a functional way. Core values are respect, openness, honesty and willingness are our core values.
We also place great value on the ability to identify your own stake, openly discussing your issues and taking responsibility.

Conferral and coordination

Every working day, once during the multi-disciplinary meeting and once during conferral, coordination takes place. These moments connect the various treatment components and disciplines to each other and enable the creation of an intensive learning environment and a safe treatment climate.

Composition of treatment groups

The treatment groups are composed of a mix of issues and gender, making it an accurate reflection of society. This offers the opportunity to learn from each other in a broad perspective. The groups are open: clinical treatment lasts 10 weeks and every week eight to ten new fellows are added to the mix. They are divided into six treatment groups. The three care paths allow the option to emphasise per individual and to make choices for a thematic group selection (specific modules) and/or specific individual modules that often can be implemented in a one-on-one therapy session.

Multi-disciplinary treatment team

YWCC works in a multi-disciplinary fashion, allowing various disciplines to bring their specific contribution to the fore. Together they shape the entire specific Yes We Can treatment.

Job descriptions

The job descriptions in short:

- Therapists have individual meetings with fellows/parents using elements of CBT and motivational interviewing. In addition to the general treatment objectives (which are valid for all fellows), there is also a great deal of attention to more individual treatment objectives. The therapist monitors progress, directs and coordinates the individual treatment.

- Counsellors lead the group meetings, using elements of CBT, creating self-awareness. Group sessions always are in service of the individual treatment objectives and of creating and sustaining a safe treatment environment.

- Coaches/group workers lead the other activities of the teenagers and young adults. In addition to ensuring safety, coaches/group workers play a role in promoting health and serve as key role models for the fellows. The coaches/group workers carry out assignments for the therapists and counsellors and report back on them. This allows fellows to practice their skills in a controlled and safe environment.

- Nurses and rehab physicians take care of the physical aspects, provide psycho-education on healthcare and addiction (in close collaboration with the experience experts) and administer medication-based treatments.

- Primary therapists/psychiatrists hold the final responsibility and are qualified to provide (individual) treatment directives. They lead the diagnosis, set objectives and monitor the progress of all treatment.

[7] Bringing the teenagers and young adults together is one of the strengths of the YWCC programme. Teenagers and young adults in a residential environment can also adopt negative behaviour from each other, but that risk is particularly present when there is a lack of observation and supervision (there is always ample observation and supervision at YWCC); if there is a lot of unstructured time without activities (fellows will have a full daytime activity programme at YWCC); and if there is an aggressive environment (at YWCC we have an open and supporting atmosphere). Because YWCC works with an open intake, newly admitted fellows will enter a clinic in which most of the teenagers and young adults present have already been in treatment for a couple of weeks. The newly admitted fellows will enter a new peer group with other teenagers and young adults that are farther along in the development process. These are teenagers and young adults that have already learned new behaviour, handle their illness better and can serve as examples. In the Yes We Can programme, clients from week 10 are linked with newly admitted fellows who can serve as their mentor (for a discussion of these themes we refer to Simons-Morton and Farhat, 2010; Huefner et al., 2009; Gifford-Smith et al., 2005).

6. Training, securing and developing of the Yes We Can methodology

All employees are trained in the Yes We Can methodology during an introduction programme. A two-part training, taking two half-day sessions, is organised multiple times per year. This training focuses on knowledge, skills and attitude. Due to this, all YWCC employees have a thorough insight and knowledge of the methodology.

To ensure the quality of the methodology, a system has been set up to increase expertise, including peer-to-peer coaching sessions. The effect of the methodology is evaluated regularly, providing input for a new round of improvement and development. A structural study on the methodology's effectiveness is being set up. A database is being filled and hypotheses are being drafted, closely connected to the theoretical foundations and objectives of the organisation. The detailing of the theoretical foundation and the set-up of the effectiveness study have been executed in collaboration with ITS Radboud and Prakticon, both parts of the Radboud University Nijmegen.

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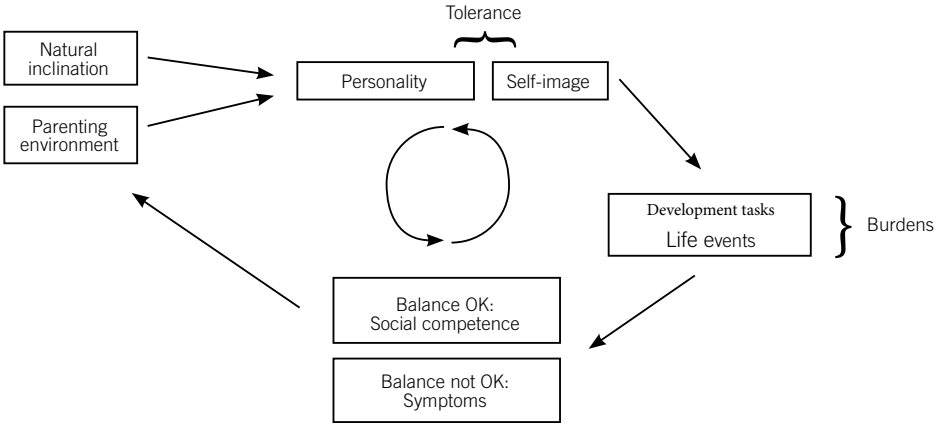
Appendix 1: Drafting problem analysis for Social Competence Model (diagram)



Appendix 2: Overview of the Ten Actions

Action 1:	We admit we are powerless over our problems and that because of this our lives 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
Action 10:	Whenever we can, we help others who suffer in similar circumstances

yes we can
YOUTH CLINICS
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