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Cannabis Youth Treatment Experiment

The Treatment Manual Series and other key clinical lessons

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Organization of Workshop

- Understanding the Implications of Adolescent Development for Substance Abuse Treatment
- Summary of CYT treatment series
  1. Motivational Enhance Treatment/Cognitive Behavior Therapy (MET/CBT5)
  2. Cognitive Behavior Therapy 7 (CBT7)
  3. Family Support Network (FSN)
  4. Adolescent Community Reinforcement Approach (ACRA)
  5. Multidimensional Family Therapy (MDFT)
- Summary of training, supervision and quality assurance model
- Staff Reaction to Manual-Guided Therapy

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Challenges of Doing Adolescent Substance Abuse Treatment

Dennis, M., Godley, S.H., Scott, C.K, Titus, J., White, W., Adams, L., & Godley, M. (Under review)

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Addiction

Normal Adolescent (12-17) and Young Adult (18-25) Development

- Biological changes in the body, brain, and hormonal systems that continue into mid-to-late 20s
- Shift from concrete to abstract thinking
- Improvements in the ability to link causes and consequences (particularly strings of events over time)
- Separation from a family-based identity and the development of peer- and individual-based identities
- Increased focus on how one is perceived by peers
- Increasing rates of sensation seeking/experimenting
- Development of impulse control and coping skills
- Concerns about avoiding interpersonal emotional or physical violence
- Realizing that they are not invincible to environmental risks (which are often less proximate or likely)

Conceptual Challenges to Address

- Most adolescents do <u>not</u> recognize their substance use as a problem and are being mandated to treatment (and are angry about it)
- Co-occurring problems (mental, trauma, legal) are the norm and often predate substance use
- Treatment has to take into account the multiple systems (peers, family, school, welfare, criminal justice) involved in their lives
- Adolescents have less control of their lives and recovery environment than adults
- Need to be creative in dealing with family and peer relationships because they are still central to the adolescent's self-identity and are not easily changed

Family, Peer Groups, and Community

- Families often play a pivotal role, but vary in their ability and willingness to help
- Peer groups are very powerful – but can have both negative and positive effects
- One or two very disruptive people can destroy a group and actually lead to worse outcomes
- Need to minimize confrontational approaches unless you have the time and control necessary to do them well and safely
- Less availability of aftercare, 12-step groups and peer based recovery support

Adapting Treatment Manuals/Materials

- Examples need to be reflect the substances, situations, and triggers relevant to adolescents
- Motivational strategies and consequences have to be reflect things of concern to adolescents
- Concepts need to be expressed in "concrete" (vs. abstract) terms to match developmental stage
- Curricula need to take into account individual differences in severity, co-occurring problems, and development – which often change during the course of treatment
- Need for treatment facilities that are physically durable and to have access to recreational facilities

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Treatment Series

1. Motivational Enhance Treatment/Cognitive Behavior Therapy (MET/CBT5)
2. Cognitive Behavior Therapy 7 (CBT7)
3. Family Support Network (FSN)
4. Adolescent Community Reinforcement Approach (ACRA)
5. Multidimensional Family Therapy (MDFT)

Goals of the CYT Treatment Series

1. To adapt promising manual-guided approaches for use with adolescents (12-17) who have cannabis use disorders (and who also use alcohol and occasionally other drugs) in 6- to 12-week ASAM level 1 outpatient settings.
2. Include all materials (e.g., theoretical background/key concepts, handouts, forms, training materials, quality assurance materials) so that they could be readily disseminated and used by others.
3. Evaluate their implementation, effectiveness, cost and benefit cost to guide policy and program planning.

Contrast of the Treatment Structures

Type of Service	MET/ CBT5	MET/ CBT12	FSN	ACRA	MDFT
Individual Adolescent Sessions	2	2	2	10	6
CBT Group Sessions	3	10	10		
Individual Parent Sessions				2	3
Family Sessions/Home Visits			4	2	6
Parent Education Sessions			6		
Total Formal Sessions	**5**	**12**	**22**	**14**	**15**
Case management/ Other Contacts			As needed	As needed	As needed
Total Expected Contacts	**5**	**12**	**22+**	**14+**	**15+**
Total Expected Hours	**5**	**12**	**22+**	**14+**	**15+**
Total Expected Weeks	**6-7**	**12-13**	**12-13**	**12-13**	**12-13**

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Treatment Series Volume 1

Motivational Enhanced Treatment/ Cognitive Behavior Therapy 5 (MET/CBT5)

Sampl, S., & Kadden, R. (2001)
University of Connecticut Health Center
Farmington, CT USA

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Individual MET Sessions 1 & 2
(50-75 min)

1. Feedback, Rapport-Building, Orientation to Treatment and Review of the Personalized Feedback Report
   - Peer reference norming
   - Tell me about…(endorsed symptoms of abuse and dependence)
   - Review reasons for quitting…ask which they think is most important
2. Review of Progress, Functional Analysis, Personalized Goal Setting, and Orientation to the Group Sessions

Group CBT Sessions 1-3
(50-75 Min)

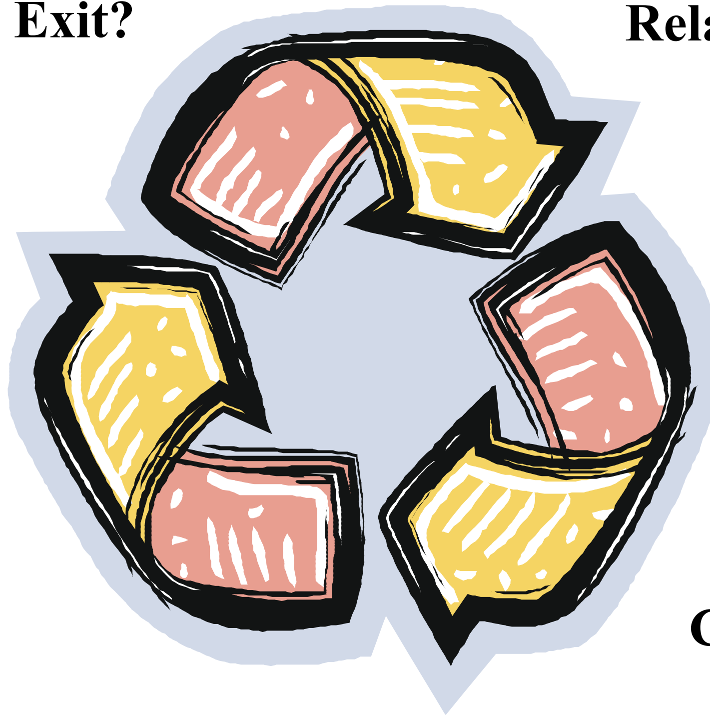
1. Marijuana Refusal Skills
2. Increasing Social Support and Pleasant Activities
3. Coping with Emergencies and Relapse

Plus 2 Random Urines over six weeks

Theoretical Basis of MET/CBT

- Roger's empathic listening and reflection therapy
- Prochaska & DiClemente's The Stages of Change Model
- Miller's Motivational Interviewing
- Miller & Rollnick's Motivational Enhanced Treatment (MET) approach from Project Match
- Monti's Cognitive Behavioral Therapy (CBT) from Project Match
- Stephens, R. S., Babor, T. F., Kadden, R., & Miller, M., MET/CBT Approach from the (adult) Marijuana Treatment Project

The Stages of Change Model



Permanent Exit?

Relapse?

Pre-contemplation

Maintenance

Action

Contemplation

Determination

CBT

MET

Assumptions of MET

- Therapist style is a powerful determinant of client motivation and change
- Change is more likely when the motivation comes from adolescent, rather than being imposed by the therapist, family, school, or court
- Need to show respect for the client and demonstrate understanding (vs. confrontation)
- Ambivalence about change is normal
- Change involves a process

Five Strategies of MET

1. Express Empathy
2. Develop Discrepancy
3. Avoid Argumentation
4. Roll with Resistance
5. Support Self-Efficacy

1. Express Empathy

Conveyed Non-verbally:

- eye contact
- body position
- facial expression

Conveyed Verbally
through reflections

Reflective Listening

- Open vs. Closed Ended questions…
  - "How often did you xxx…" vs. "Tell me about when you xxx..."
  - "How many of your friends use drugs?" vs. "How have your friends reacted to your going into treatment?"
  - "Have you had problems with xxx..?" vs. "Tell me about the problem you mentioned with xxx…?"
- Demonstrating understanding of what the client is communicating
  - *"It sounds like you . . ."*
  - *"So you . . ."*
  - *"It seems to you that . . ."*
  - *"It sounds like you're feeling . . ."*
- Avoid labeling, lecturing, preaching, shaming, ridiculing, warning, arguing, or threatening

2. Develop Discrepancy

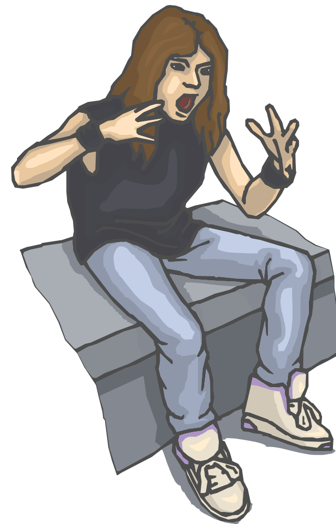
- Discrepancy is thought to be the engine that drives change
- Help the client describe the discrepancy between how their life is when abusing substances and how it was/could be without
- Often need help seeing the pattern of similar situations and drawing the link to consequences

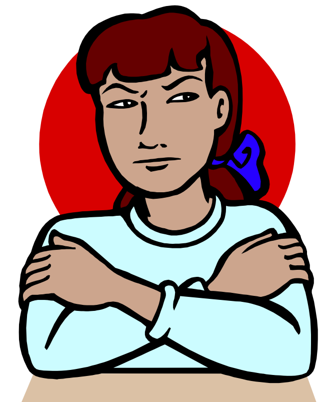
Facilitating the Risk/Reward Analysis

- Normalize ambivalence to encourage contemplation
- Help “tip the decisional balance scales” by:
  - Eliciting pros and cons of use and change
  - Emphasizing client choice and responsibility
- Elicit self-motivational statements, and summarize them

3. Avoid Argumentation

- Resistance is a cue to modify your approach
- Treat ambivalence (mixed feelings) as normal
- Use double-sided reflections





Strategies for Gentle Encouragement

- Establish rapport and build trust
- Raise doubts by:
  - Eliciting the client's perceptions of the problem
  - Providing feedback
  - Facilitating feedback of a significant other
- Avoid premature prescriptive advice
- Express concern, back off if necessary and keep the door open

4. ROLLING WITH RESISTANCE

- Don’t get rattled when the client says something against change
- Best response is empathy, plus **slightly** hopeful comment
- May need to use small steps (such as relapse sampling instead of lifetime commitment)

5. Support Self-Efficacy

- Reinforce any willingness:
  - to hear information
  - to acknowledge the problem
  - to take steps toward change
- Make the connection between previous successful change and potential to change the current problem

Assumptions of CBT

- Substance use is a learned behavior in which use becomes triggered by environmental stimuli, thoughts and feelings and is maintained by reinforcing effects.
- Individuals who wish to stop or reduce substance use need skills to cope with these triggers, as an alternative to drug and alcohol use.
- Effective learning of these new coping skills requires repetition and practice with feedback.

Structure of CBT Group Sessions

- Introduction and Rapport Building
- Review of Progress
- Introduction and Teaching Coping Skills
- In-Session Practice Exercise
- Assign Real-Life Practice Exercise
- Closing

CBT Session 1: Drug/Alcohol Refusal Skills

- Review Rationale:
  - Narrowing of Social Circle
  - Best to avoid high risk people
  - Need for refusal skills
- Teach Styles of Refusal
- Provide Rehearsal through Role-Play
- Describe Real-Life Practice exercise

CBT Session 2: Increasing Pleasant Activities

- Review Rationale: a positive alternative to smoking marijuana
- Discuss: Fun if not high?
- Brainstorm activities
- Ask them to commit to do one before the next session

CBT Session 3: Planning for Emergencies and Coping with Relapse

- Rationale: Preparation for high-risk situations increases likelihood of effective coping
- Brainstorm potential high-risk/emergency situations
- Give introduction to problem-solving skills
- Review that relapse is not uncommon and provides an important opportunity for learning
- Develop Emergency Plan for coping with lapse or full relapse

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Treatment Series Volume 2

Cognitive Behavior Therapy 7 Supplement (CBT-7)

Webb, C., Scudder, M., Kaminer, Y., Kadden, R., & Tawfik, Z. (in press)

University of Connecticut Health Center

Farmington, CT USA

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7 Supplemental CBT Sessions:

6. Problem-Solving Skills
7. Anger Awareness
8. Anger Management
9. Communication Skills: Assertiveness and Criticism
10. Coping with Cravings
11. Managing Negative Moods
12. Managing Thoughts about Marijuana

Assumptions Behind CBT Group Therapy

- Breaks through isolation
- Skill deficits are inter-personal in nature and need to be practiced to work
- Group is realistic yet "safe" setting in which to practice
- Provides additional opportunity to recognize problem and its link to consequences
- Provides therapists the opportunity to observe and provide feedback on inter-personal behavior
- More time in treatment is better

Tips for Using CBT in your Clinical Work with Adolescents

- Individualize with adolescent's concerns and avoid a cookbook feeling
- Monitor for boasting about antisocial behaviors, or excluding some participants
- Try to make it lively and interesting

Supplemental CBT Sessions 6-8

6. A five stage problem-solving model is presented consisting of (a) general orientation, (b) problem identification, (c) generating alternatives, (d) decision-making, and (e) verification.
7. Anger awareness skills, highlighting both internal and external cues and triggers.
8. Anger management skills, including the use of calm-down phrases and anger reducing thoughts.

Supplemental CBT Sessions 9-10

9. Communication skills, including active listening, assertiveness and positive ways of responding to criticism
10. Menu of coping options for cravings and urges for marijuana combined with a log exercise
11. Awareness of depressed feeling and their management through techniques like substituting positive for negative thoughts
12. Managing thoughts about marijuana, the 12 most common excuses for relapse and discussing termination.

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Treatment Series Volume 3

Family Support Network (FSN)

Hamilton, N., Brantley, L., Tims, F., Angelovich, N., & McDougall, B. (2001).

Operation PAR
St. Petersburg, FL USA

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FSN Structure

- Components are provided concurrently with MET/CBT5 and CBT7 (a.k.a., MET/CBT12)
- 6 Multi-family Parent Education groups including one-hour didactic sessions and brief discussions
- 4 home visits that are 90 minutes long and scheduled in weeks when family not meeting for group
- Case management that is provided throughout the episode and addresses individual family needs

Theoretical Bases of FSN

- Components recommended by panel of experts on comprehensive adolescent substance abuse Treatment (CSAT, 1993)
- Evidence that family support interventions improve treatment outcomes (Barrett et al., 1988; Brown et al., 1994
- Support for parent education approaches with at-risk adolescents (Paterson, 1986)
- Improved retention of adolescents in treatment when family is included (Henggeler, 1991; Liddle et al., in press)

Assumptions of FSN

- Retention in treatment and outcome will be improved if families participate in treatment.
- Substance abuse is multi-determined: family relationships are the most influential developmental context, so most potent target of intervention.
- Multi-component interventions that simultaneously target multiple risk factors will have the greatest chance of success.
- FSN is a cost-effective way to package key elements of family systems approaches (parent education, family support, improved communication).

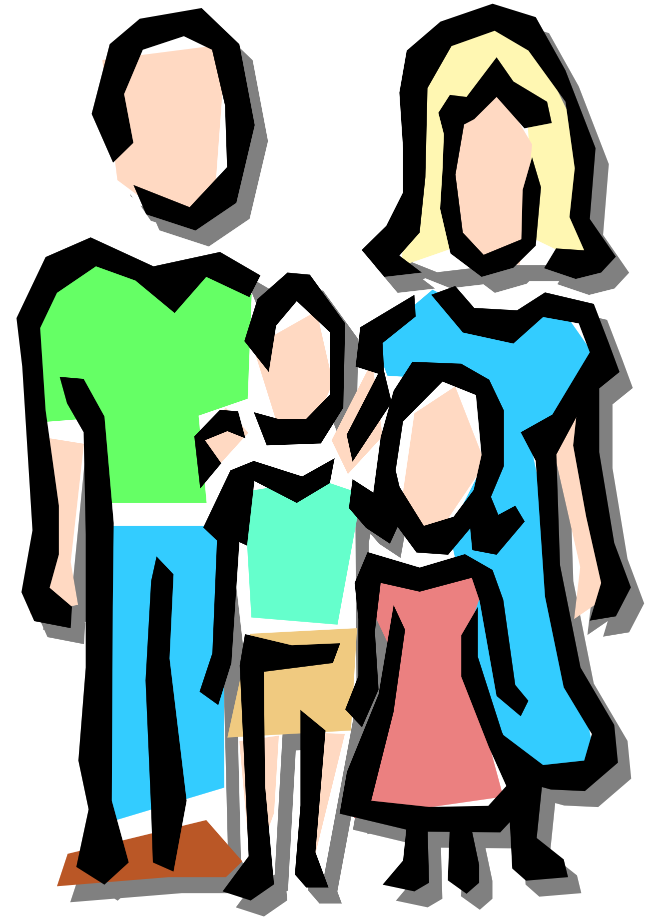
Goals for Family Components

- Include family in the recovery process
- Enhance family communication and general relationship quality
- Improve parents' behavioral management skills
- Increase adolescents' and parents' commitment to the recovery process

Parent Education Classes

(60 minutes didactic, 60 minutes discussion)

1. Adolescent development and parents’ role
2. Substance abuse/dependence
3. Recovery process and relapse signs
4. Family development and functioning (boundaries, limits, etc.)
5. Family organization and communication
6. Family systems and roles



Home Visit Family Sessions
(90 minutes)

1. Initial assessment and motivation-building
2. Focus on family roles and routines
3. Assess progress and build commitment to change
4. Continue to assess progress and build commitment

FSN Case Management

- Facilitate treatment attendance (reminders, transportation, childcare)
- Assessment of family needs
- Possible referral to needed community services

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Treatment Series Volume 4

Adolescent Community Reinforcement Approach (ACRA)

Godley, S. H., Meyers*, R. J., Smith*, J. E., Godley, M. D., Titus, J. M., Karvinen, T., Dent, G., Passetti, L., & Kelberg, P. (2001).

Chestnut Health Systems Bloomington, IL USA, and *University of New Mexico Albuquerque, NM USA

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ACRA Treatment Structure

- 10 Individual sessions with the adolescent
- 4 sessions with the caregiver
  - 2 individual sessions with the caregiver
  - 2 sessions with the caregiver and the adolescent
- ACRA is procedure based, not session based

Theoretical Basis for ACRA

- Operant Conditioning Model
- Skills Training
- Social Systems Approach
- Azrin, Sisson, Meyer & Godley Community Reinforcement Approach with alcoholics
- Meyers & Smith CRA adaptation for individuals concerned about the drinking of significant others
- Smith, Meyers, & Delaney adaptation of CRA for homeless people dependent on alcohol
- Higgins et al. combination of CRA with contingency management for treatment of cocaine addiction
- Azrin et al. adaptation of CRA to adolescents
- Catalano, Hops, & Bry's work on parenting practices

Assumptions for ACRA

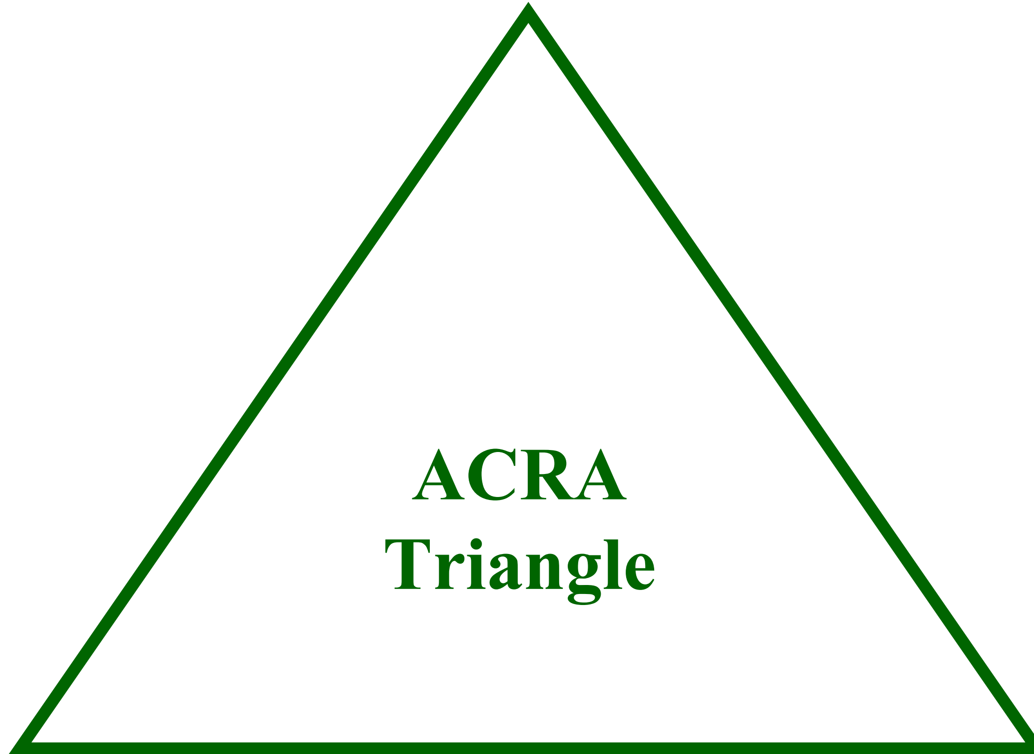
- For many adolescent marijuana users, their social environment encourages marijuana use
- The therapist needs to help the adolescent
  - recognize that their drug use is incompatible with other short- or long-term reinforcers (e.g., parental approval, staying out of criminal justice system, having a girl/boy friend)
  - maximize family/peer/community resources and activities to reward non-drug using behavior
  - increase alternative positive, non-drug related social/recreational activities
  - developing social skills (e.g., problem solving, drug refusal, etc.) will increase the likelihood of success in these endeavors.

Key Concepts

- Positive and enthusiastic approach
- Uses lay language
- Keeps it simple
- Flexible
- Uses role-playing
- Uses homework

Key Procedures

Goals of Counseling



Functional Analysis

Happiness Scale

Treatment Mechanisms

- Functional Analysis of Substance Use to identify the internal and external triggers that lead to substance use, document these behaviors and identify consequences of these behaviors.
- Functional analysis of pro-social behaviors that compete with substance use
- Skills training in relapse prevention, communication, problem solving, etc.
- Incorporation of above into a treatment plan
- Monitoring progress with the "Happiness" scale

Primary Goals

- Goals for Adolescents
  - Promote abstinence
  - Participation in pro-social activities
  - Positive relationships with family
  - Positive relationships with peers
- Goals for Caregivers
  - Motivate participation in ACRA
  - Promote adolescent's abstinence
  - Positive communication and problem-solving skills
  - Promote critical parenting practices

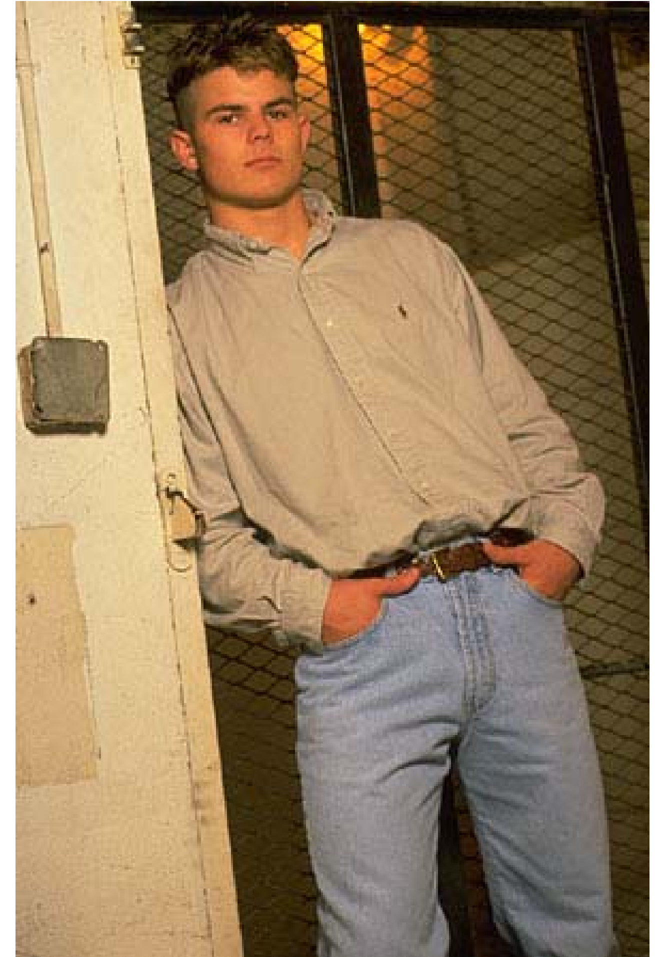
Goals of Counseling (Simplified Treatment Plan)

Problem Areas/Goals "In the area of ____ I would like:"	Intervention	Time Frame
1. marijuana use/non-use (circled: non-use) Not use for 1 month	Review relapse prevention procedures Take urine tests Do other things for fun	Next session 1 per month Weekly
2. alcohol use/non-use (circled: non-use) Not use for 1 month	" "	" "
8. recreational activities Bowl regularly + try new activities.	Talk w/ Mom about transportation. Review with counselor weekly	By next session Weekly
11. money management To have money when I need it	Not spend money on drugs Find a job Discuss money management with my counselor	Daily 2 weeks 2 weeks

Jack Doe (Participant Signature) 1/10/99 (Date) Tracy Kowena (Counselor Signature) 1/15/99 (Date)

Critical Parenting Practices

- Good modeling
- Increase positive communication
- Monitor the adolescent’s whereabouts
- Involvement in adolescent's life outside the home



ACRA "Happiness" scale

Session 2

		Completely Unhappy									Completely Happy
1.	Marijuana Use/Non-use	1	2	3	4	5	6	7	8	9	10
2.	Alcohol Use/Non-use	1	2	3	4	5	6	7	8	9	10
3.	Relationship with Boyfriend/Girlfriend	1	2	3	4	5	6	7	8	9	10
4.	Relationships with Friends	1	2	3	4	5	6	7	8	9	10
5.	Relationships with Parents/Caregivers	1	2	3	4	5	6	7	8	9	10
6.	School	1	2	3	4	5	6	7	8	9	10
7.	Social Activities	1	2	3	4	5	6	7	8	9	10
8.	Recreational Activities	1	2	3	4	5	6	7	8	9	10
9.	Personal Habits (e.g. getting up in the morning, being on time, finishing tasks)	1	2	3	4	5	6	7	8	9	10
10.	Legal Issues	1	2	3	4	5	6	7	8	9	10
11.	Money Management	1	2	3	4	5	6	7	8	9	10
12.	Emotional Life (my feelings)	1	2	3	4	5	6	7	8	9	10
13.	Communication	1	2	3	4	5	6	7	8	9	10
14.	General Happiness	1	2	3	4	5	6	7	8	9	10

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Treatment Series Volume 5

Multidimensional Family Therapy (MDFT)

Liddle, H. A. (in press).
University of Miami
Miami, FL USA

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MDFT Treatment Structure

- Setting the Stage (Sessions 1-3)
- Working the Themes (Sessions 4-8)
- Sealing the Changes (Sessions 9-12)

Theoretical Basis for MDFT

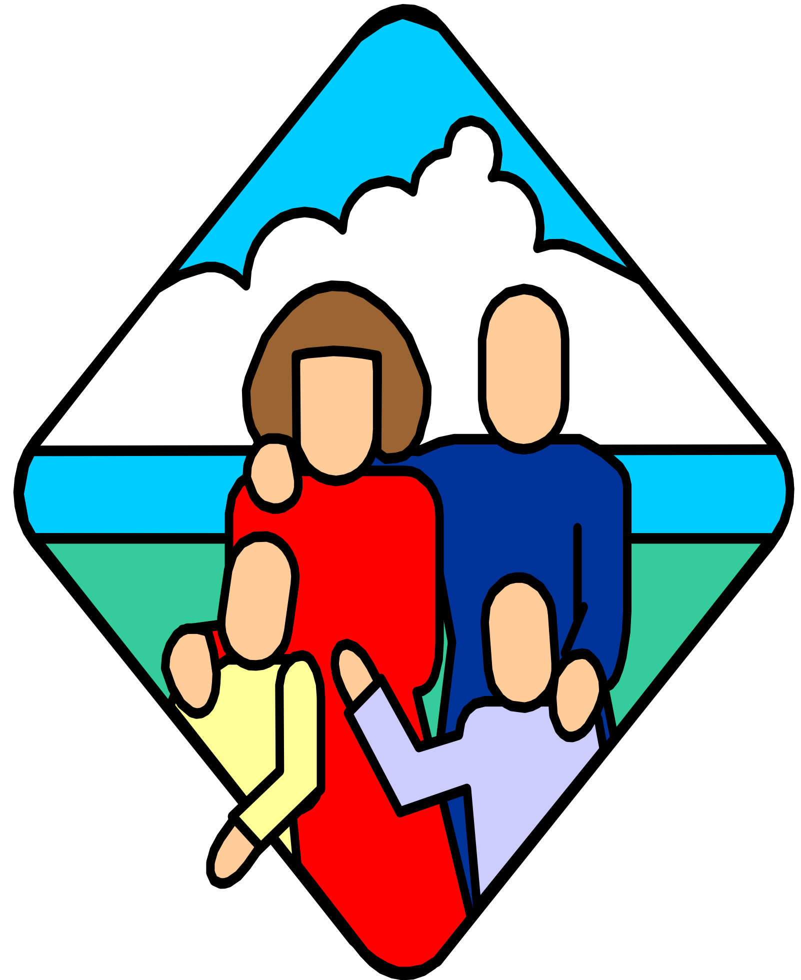
- Liddle's Multidimensional Family Therapy (MDFT) is a family-based, developmental-ecological, multiple systems approach to treating adolescent substance abuse
- Risk and protective factor framework
- Developmental psychology to provide conceptually and clinically practical input
- Structural and strategic family therapies to guide the therapist in working with the adolescent; the parents; family interactional patterns and the extra-familial systems (school, probation, medical)

Process and mechanism of change studies have illuminated core aspects of MDFT treatment

- Links between ***changes in parenting and reductions in adolescents' drug and behavior problem*** (Schmidt, Liddle & Dakof,1996)
- Improving initially poor ***therapist-adolescent alliance*** (G.M. Diamond & Liddle, 1996)
- Impact of using ***culturally specific themes to engage African American males*** in therapy (Jackson-Gilfort, Liddle & Dakof, in press)
- Family's in ***session patterns of change associated with parent-adolescent conflict resolution*** (G.S. Diamond & Liddle, 1996, 1998)
- Predictors of ***treatment completion*** (Dakof, Tejeda, & Liddle, 1998)
- ***Gender-based*** treatment issues (Dakof, 2000)

Assumptions for MDFT

- Adolescent drug abuse is contextual and multidimensional (interaction of person, family, social and environment over time)
- Substance abuse treatment can be delivered in the context of family therapy (instead of layering family therapy on top of it)



Goals and Mechanisms of Treatment

- Re-track the disrupted normative developmental processes and challenges in the teen's and family's life created by and reflected in drug use, behavior problems and family conflict.
- Assess and treat in four modules: adolescent, parent, family and extrafamilial (e.g., school, probation, medical).
- Therapist develops multiple working relationships with each family member and extrafamilial persons of influence.

Goals and Treatment Mechanisms with the Adolescent

- Meaning of drug taking and drug use behaviors
- Building a sense of competence
- Reducing involvement with deviant peer network
- Develop better coping skills regarding affective regulation
- Improved problem solving
- Increase participation in prosocial activities

Goals and Treatment Mechanisms with Parents

- Improving parenting practices
- Increasing social support
- Reducing psychiatric distress
- Restoring parental commitment
- Reducing drug use
- Dealing with economic stress

Goals and Treatment Mechanisms with Family

- Rekindle developmentally appropriate parental connection and commitment to the adolescent.
- Rekindle developmentally appropriate adolescent ***attachment*** to the parent.
- Increase family organization, warmth and emotional investment.
- These goals should lead to the reestablishment of the family as a developmentally facilitative context and improve interaction with extrafamilial systems.

MDFT Sessions 1-3: Setting the Stage

- Engage adolescent
- Engage parents
- Build alliances with all members of system
- Identify goals
- Develop themes
- Prepare for family conversations
- Focus on drug use
- Broaden focus on drug use to include other problems

MDFT Sessions 4-8: Working the Themes

- Adolescent Sessions
  - Trust/mistrust
  - Abandonment and rejection
  - Disillusionment and past hurts
  - Motivation and self-agency
  - Hopes or lack of hope for future
  - Credibility
- Family Sessions
  - Preparing adolescent and parents for session
  - Managing conversation in session
  - Shift from high conflict to affective issues
  - Help develop positive experiences/interactions with each other
  - Tie conversation and themes to drug use

MDFT Sessions 9-12: Sealing the Changes

- Preparing for termination
- Reviewing treatment work
- Preparing for future challenges: ***"What will you do when…"***

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Summary of training, supervision and quality assurance model

Angelovich[1], N., Karvinen[2], T., Panichelli-Mindel[3], S., Sampl[4], S. Scudder[4], M., Titus[2], J. & White[2], W. (2001).

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[2]Chestnut Health Systems, Bloomington, IL

[3]Children's Hospital of Philadelphia, Philadelphia, PA

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Treatment Series Appendix

Initial Foundations of Supervision

- Treatment teams: expert/authors, line clinical supervisor, staff
- Standardized treatment manuals including all forms and quality assurance procedures
- Centralized initial orientation and training
- Weekly calls to give therapist individual feedback, team meetings
- Local site therapist for logistical and emergency issues
- Monthly phone conferences of CYT therapy coordinators

Tools for Ongoing Supervision

- Audiotaping or videotaping of all sessions
- Self-monitoring questionnaires and service logs
- Supervisor ratings and feedback on every session until "certified" – thereafter, 2 sessions per month to avoid drift
- Additional written communication through manual updates and/or newsletters

Format of Ongoing Supervision

- Minimum of weekly supervision with ongoing cases
- Individual supervision
- Group supervision -- in person or via tele-conference
- Availability of clinical supervision to address emergencies
- Participation in local administrative meetings

Content Addressed in CYT Supervision

- Track ongoing progress
- Clinical emergencies
- Individualizing the approach to meet unique client/family needs
- Adherence to the manualized therapy
- Review of situations where it was necessary to deviate
- Improving retention in treatment
- Management of therapy groups
- Dealing with comorbid problems and disorders

Content Addressed in Clinical Coordinator's Cross Site Meetings

- Case load levels and logistics
- Review emergency situations and how they were handled
- Agreement on general clinical practices like when
  - Adolescents kept missing appointments
  - Came to treatment intoxicated
  - Were belligerent in individual, group or family sessions
  - Making up sessions
  - Referring to a higher level of care

CYT

Cannabis Youth Treatment Experiment

Clinical Psychology Science and Practice

Therapists reactions to manual-guided therapies for the treatment of adolescent marijuana users

Godley[1], S. H., White[1], W. L., Diamond[2], G., Passetti[1], L., & Titus[1], J. (2001).

[1]Chestnut Health Systems, Bloomington, IL

[2]Children's Hospital of Philadelphia, Philadelphia, PA

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

Purpose of the Study

- To see what we could learn about transporting the manuals from research to practice
- Validation from other therapists for those concerned that manuals are not feasible in practice

Common Pros and Cons raised about Manual-Guided Therapy

- Pros
  - Promote evidence-based practice
  - Improve quality of care
  - Provide important guidance for training and monitoring of therapists
- Cons
  - Do not allow for individualized treatment
  - Do not address a heterogeneous treatment population
  - Step-by-step fashion will produce negative effects

Methodology

Qualitative Interviews

- Therapist interviews consisted of 26 open-ended questions
- Supervisor interviews consisted of 27 open-ended questions
- 33 interviews were completed/transcribed
- Average interview time was one hour

Core Questions

- Compare/contrast doing therapy with/without a manual.
- Were there times when you deviated and why?
- How was manual-based therapy able to address individual needs?

Analyses

- One author read through entire transcripts to identify themes
- Second author reviewed critical questions and provided feedback on themes
- Trained 2 independent raters to code critical questions

Therapists Interviewed

- At least 3 from each intervention; total of 16 therapists and 3 CM
- Had used the manual from 1 to 18 months
- Age ranges from 24-55 with an average age of 37
- Average experience of 7 years in drug abuse counseling, services to adolescent, and services to family
- 10 had master's degrees, 6 had bachelor degrees, and 3 had doctoral degrees
- 5 had previous experience with manual-guided therapy

Structure, Consistency, Focus

- All 19 therapists said that therapy manuals provided structure and consistency
- 6 of the therapists noted it helped them prepare for a session
- 6 therapists noted it helped them focus during a session
- 4 out of 6 supervisors talked about how manual-guided therapy helped improve quality control

Restrictiveness of Manuals

- 57% noted some aspect of restrictiveness
- 42% said it limited their ability to respond to individual needs
- Cut across all interventions, but highest percent (70%) were in MET/CBT inter.
- Comments were most commonly in relation to group

Comments about Groups

- “Groups sort of have a life of their own and each one is different.”
- The most frequently voiced concern, with the CBT groups, was that the prescribed timing for particular topics did not always fit the group’s needs or a particular group member’s needs when they were timed to occur.

Exception

- 4 therapists discussed how they were able to incorporate their personal style and individualize the treatment. Examples:
  - the use of the check-in time at the beginning
  - choosing role-play situations related to circumstances of the group

Flexibility

- 74% indicated the manual they used was flexible enough to address individual needs
  - All of those using ACRA and MDFT
  - All but one of those using FSN

Deviations from the Manual

- 6 said they never deviated; 2 said they weren't sure if they had
- The most common reason given (41%) was the need to address serious issues
- All but one who talked about deviating were from the MET/CBT conditions

Therapists wanted...

- Overview of the treatment philosophy
- Explanation of the use of assessment information
- Detailed step-by-step descriptions of procedures
- Specific content related to drug use
- Language and examples appropriate for adolescents

Therapists wanted...

- Samples of therapist-participant dialogue
- Examples of completed clinical paperwork
- Guidance regarding family interaction
- Explicit directions about when it is appropriate to deviate from the manual

Dissemination

Manuals are being

- distributed for free by CSAT
- being used in various courses around the country including
  - California School of Professional Psychology,
  - CSAT's Addiction Technology Transfer Centers (ATTC),
  - City University of New York,
  - Indiana University,
  - University of Akron,
  - University of San Francisco
- Manuals currently being used at the following institutions:
  - CHS Central and Southern Illinois are using a)MET/CBT5 used as brief/early intervention as part of its Strengthening Communities for Youth (SCY) project and b) ACRA manual used as part of therapy and assertive aftercare

Dissemination (Continued)

- Clermont Recovery Center, Clermont OH is Using MDFT
- Jackson Memorial Hospital/University of Miami Medical Center, Miami, FL is using MDFT as part of a partial hospitalization program
- Larkin Street Youth Services, San Francisco, CA is implementing MET/CBT5 and CBT7 (a.k.a. MET/CBT12)
- Operation PAR, St. Petersburg, FL is using MET/CBT5, CBT7 and FSN manuals as part of an IOP program in a targeted capacity expansion grant
- Phoenix House, NY is using MET/CBT5, CBT7 and FSN manuals as part of its SCY project
- The Village, Miami, FL is comparing its outpatient program to MDFT-guided therapy

Dissemination (Continued)

  - Warren E. Smith Health Center, Philadelphia, PA is implementing MET/CBT12 as a treatment component of an adolescent co-occurring disorders program
- They are also being implemented by several municipalities and statewide systems including:
  - Butler County, OH is using the ACRA manual as part of therapy and assertive aftercare
  - The State of Connecticut is implementing MET/CBT5 and MDFT in a series of pilot child welfare projects
  - The State of Vermont is using the MET/CBT5 manual as a minimum standard of care statewide, with MET/CBT12+FSN the next higher level of care
- Part of a the formation of a Society for Adolescent Substance Abuse Treatment Effectiveness (SASATE)

Contact and Additional Information

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Manuals and Additional Information are Available at:

CYT: www.chestnut.org/li/cyt/findings
NCADI: www.health.org/govpubs/bkd384/
PETSA: www.samhsa.gov/centers/csat/csat.html
(then select PETS from program resources)