

What Research Tells Us About the Treatment of Adolescent Substance Use Disorders

**Prepared for the Governor's Conference on Substance Abuse
Prevention, Intervention, and Treatment for Youth**

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How this Report is Organized

Pages 2 – 11 of this report briefly overview the prevalence of substance abuse in Illinois and the nation as well as the multiple problems among youth who come to treatment. This section also provides an overview of the major treatment approaches that have been studied to date. If your reading time is greatly limited we recommend reading the first 12 pages of this report. It will provide you with a good overview of what research tells us about treatment for adolescent substance use disorders.

This bulk of this briefing report is devoted to summaries of adolescent treatment effectiveness studies. In preparing to write this report we surveyed the peer-reviewed journals in substance abuse to find these studies and subsequently reduced each one to an easy-to-read two or three page summary. Each of the 16 summaries uses a standardized format that includes: 1) Contact information for the Principal Investigator; 2) Program objectives; 3) Description of the treatment program; 4) Study participant description; 5) Research design; 6) Outcomes; and 7) References. These studies start on page 12.

Authors' Notes

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We are continuing to expand this work and welcome comments and/or additional studies. Please direct them and/or any questions to Janet Titus, Ph.D., Chestnut Health Systems, 720 West Chestnut, Bloomington, IL 61701, Phone: 309-829-1058, ext 3410, Fax: 309-829-4661; or E-mail: jtitus@chestnut.org.

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Introduction

America's concern with its youth and substance abuse is by no means a modern day problem. In the mid-19th century, adolescent alcohol, tobacco, and other drug use came to be identified as a problem. In his book, Slaying the Dragon: The History of Addiction Treatment in America, William White points out that this national concern led to the development of minimum drinking age laws, mandatory school temperance education laws, youth temperance literature, and the inclusion of young people in several sobriety-based support groups and "inebriate homes and asylums." In addition, special efforts were made to prevent abuse by enrolling school-aged youth in groups like the "Children's Crusade," a popular grassroots movement which persuaded youth to sign a pledge to be abstinent. For the most part these concerns were limited to alcohol abuse. Few instances of youth treated for marijuana or "hard" drugs can be found in the literature until the late 1960's. Since then a virtual explosion of concern over adolescent drug abuse has been witnessed in the United States.

The overall purpose of this paper is to summarize research from substance abuse journals to provide an understanding of what treatment approaches have been studied and their relative effectiveness. This paper is organized in six sections designed to give the reader a brief overview of: 1) the prevalence of substance abuse in our nation and state; 2) complicating conditions that adolescents with substance use disorders have when they come to treatment; 3) an overview of promising approaches in the literature; 4) a brief report of what we know about the effectiveness of treatment for adolescent substance use disorders; 5) some conclusions and thoughts on future directions; and 6) summaries of promising programs.

Prevalence of Substance Abuse In the Nation and Illinois

There is an abundance of information on contemporary drug abuse by adolescents (age 18 and under). Many states, including Illinois, survey youth as do several national studies. Of the national studies, those funded by the National Institutes of Health (Monitoring the Future Study) and the Substance Abuse and Mental Health Administration (National Household Survey on Drug Abuse) are the most authoritative. A brief synopsis of important facts from these surveys follows:

- After drug use peaked for adolescents in 1979/1980, the country experienced a decade of declining drug use among youth until the early 1990's.
- Adolescent drug use started increasing in the early 1990's and continued to do so until 1997. During this time, adolescents perceived lower risk of harm from drug use. This trend was true in Illinois and nationally.
- When we speak about drug use among adolescents, we are primarily talking about tobacco, alcohol, and marijuana – these drugs are known as the "gateway" drugs and account for the vast majority of adolescent drug use.

- Of the small percentage of youth who abuse “hard drugs,” such as Cocaine, Heroin, and amphetamines, virtually all of them started with the gateway drugs.
- Close to half of youth in grades 10 – 12 have used marijuana at least once in their lives.
- More than 1 out of 3 youth in grades 10 – 12 have used marijuana in the past year.
- Within the past two years, gateway drug use (tobacco, alcohol, and marijuana) among adolescents has begun to decline, although still remains disturbingly high. Illinois students reported “past 30 day use” at the time of a 1998 survey as follows:

Tobacco – 28% (Nearly 3 out of 10 students)

Alcohol – 41% (Over 4 out of 10 students)

Marijuana – 20% (2 out of 10 students)

- For grades 8 – 10, Illinois students’ drug use was higher than the national average.
- Among adolescents entering substance abuse treatment, marijuana is the primary drug of abuse.
- The age of first marijuana use has decreased from over 18 in the 1960’s to 15 – 17 years of age in the late 1970’s and 1980’s to under 15 in the late 1980’s and 1990’s. We should all be concerned about this disturbing trend because the odds of having marijuana dependence as an adult are six times higher for those who start using marijuana before the age of 15 than for those starting after age 18.
- Despite the rise in substance use and the potential for long-term consequences, fewer than 10% of adolescents reporting substance use disorder symptoms in the past year have ever received treatment.

Co-occurring Problems and Treatment Placement

Adolescents presenting for substance abuse treatment almost never enter as a “self-referral.” Instead, they are typically referred by a parent, juvenile justice system official (judge, probation or parole officer), school official, child welfare worker, or representative of some other community institution. Accordingly, they may enter treatment with multiple problems (legal, mental health, etc.) Depending on the severity of the substance use disorder and related problems, counselors will make a determination as to which level of treatment the client should be placed. In Illinois, treatment organizations are required to follow the patient placement guidelines set forth by the American Society of Addiction Medicine (ASAM Patient Placement Criteria II, 1996). Briefly, these guidelines require that clients who enter outpatient treatment (usually 1-3 hours per week of treatment) have fewer symptoms of dependence and other problems than those who enter intensive outpatient treatment (16 hours per week of treatment or more). Likewise, clients entering intensive outpatient treatment have less severe and fewer

problems than those entering residential treatment. Thus, the ASAM criteria require counselors to follow the principle of providing the least restrictive care needed to assist the client.

In a recent study of two adolescent treatment providers in Illinois, it was found that nearly 3 out of 4 (73%) outpatient and residential clients were involved with the criminal justice system. Most similarities between the outpatient and residential clients ended, however, with criminal justice involvement. The statistics reported below illustrate two important points: 1) adolescents with substance use disorders have additional problems; and 2) counselors do indeed select the type of treatment based on the severity of these problems.

Adolescents age 12 –18 Symptoms of Severity	<u>Outpatient</u> N=54	<u>Residential</u> N=217
Prior Substance Abuse Treatment Episodes		
None	59.3%	24.0%
One	24.1%	32.3%
2+episodes	16.7%	43.8%
Drug Use (Past 90 days)		
Weekly Alcohol Use	3.7%	32.7%
Weekly Marijuana Use	40.7%	63.6%
Weekly Crack/Cocaine Use	1.9%	11.1%
Weekly Heroin/Opiod Use	1.9%	5.1%
Weekly Other Drug Use	5.6%	16.1%
Alcohol Severity		
No Use	1.9%	1.4%
Use	31.5%	18.9%
Abuse	51.9%	35.5%
Dependence	0.0%	6.0%
Physiological Dependence	14.8%	38.2%
Drug Use Severity		
No Use	0.0%	0.9%
Use	24.1%	3.7%
Abuse	33.3%	23.5%
Dependence	3.7%	7.8%
Physiological Dependence	38.9%	64.1%
Mental Health		
General Mental Distress	27.8%	48.8%
Post Traumatic Stress Disorder	42.6%	54.1%
Attention Deficit Hyperactivity Disorder	66.7%	76.4%
Conduct Disorder	42.6%	70.7%
Sexual Risk (Past 90 days)		
No Sexual Partners	38.9%	27.2%
One Sexual Partner	35.2%	32.7%
Multiple Sexual Partners	25.9%	40.1%
Unprotected Sex	40.7%	47.0%

These statistics reveal a disturbing and challenging fact: adolescents with substance use disorders presenting for treatment are typically involved with the criminal justice system and often have co-occurring emotional and other problems. It is important for treatment programs to assess the extent of such problems and provide or arrange for additional counseling to address them. It is equally important to coordinate services with other organizations (e.g., Probation Department) involved in the client's life in order to achieve coordination of services and care.

What are Current Adolescent Treatment Approaches?

Current approaches to the treatment of adolescent drug use fall into four main modalities: 12-Step, Behavioral, Family-Based, and Therapeutic Communities. Each views the problem of adolescent substance use -- its etiology, maintenance, and resolution -- from a slightly different angle (Bukstein, 1995; Winters, Latimer, & Stinchfield, 1999).

The 12-Step approach -- also known as the *Minnesota Model* or the *Alcoholics Anonymous(AA)/Narcotics Anonymous(NA)* approach -- is the most widely used model in the treatment of adolescent drug abusers. Based on the tenets of AA and basic psychotherapy, the 12-Step model views "chemical dependency" as a disease that must be managed throughout one's life, with abstinence as a goal. The backbone of 12-Step treatment is "step work", a series of treatment and lifestyle goals that are worked in groups and individually. The first three steps help the adolescent to be more honest, decide to stop using drugs and alcohol, and choose a new lifestyle. Steps four through nine, the "action steps", help adolescents continue to be honest, develop and implement an action plan for a changed lifestyle, and correct past wrongs where possible. Steps ten through twelve are the "growth steps" and encourage adolescents to continue to work a recovery program throughout their lives. Typically the first five steps are covered in the treatment program, while steps 6 through 12 are addressed in aftercare and ongoing involvement in community self-help groups. Step work provides the basic structure for treatment and recovery.

Other components of 12-Step programs include group therapy (the primary mode of treatment delivery in 12-Step programs), individual counseling, lectures and psychoeducation, family counseling, written assignments (including step work), recreational activities, participation in aftercare, and attendance at AA/NA meetings in the community. Counselors in 12-Step programs are often recovering substance users and serve as powerful role models for living a drug-free life. Although once available only in residential settings, 12-Step treatment is now widely offered in both residential and outpatient settings.

Behavioral approaches focus on the underlying cognitive processes, beliefs, and environmental cues associated with the adolescent's use of drugs and alcohol and teach adolescents coping skills to help them remain drug-free. Whether called Behavior Therapy, Cognitive Therapy, or Cognitive-Behavioral Therapy, all behavioral approaches view substance abuse as a learned behavior rooted in the adolescent's cultural context (family, peers, social institutions, etc.) that defines drug-related beliefs and behaviors. The goal of behavioral approaches is to teach adolescents to "unlearn" the use of drugs and to learn alternative, prosocial ways to cope with their lives. In particular, given behavior is mediated by thoughts and beliefs, cognitive-behavioral techniques attempt to alter thinking as a way to change behavior. Behavioral techniques are used in residential and outpatient settings as part of group or individual therapies.

A commonly used behavioral intervention focuses on the development of coping skills. Particular skills to be taught are introduced and modeled. Using examples from the adolescents' lives is crucial to help engage them and convince them of their practical utility. Specific skills vary by program but may include drug and alcohol refusal skills, resisting peer pressure to use drugs and alcohol, communication skills (nonverbal communication, assertiveness training, negotiation and conflict resolution skills), problem-solving skills, anger management, relaxation training, social network development, and leisure-time management. New behaviors are tried out in low-risk situations (e.g. during group therapy role plays, individually with a counselor) and eventually are applied in more difficult, "real-life" situations. Homework assignments are common, such as trying out a new behavior or collecting problem situations to discuss during therapy. Staff and parents should provide positive reinforcement for the use of new behaviors.

"Behavioral contracting" is another technique used in behavioral approaches. The adolescent and counselor agree on a set of behaviors to be changed and develop weekly incremental goals for the adolescent. As each goal is reached, the adolescent is highly praised or otherwise reinforced. Behaviors are explicitly defined on the contract, with criteria and time limitations noted.

Family-based approaches acknowledge the critical influence of the adolescent's family system in the development and maintenance of substance abuse problems. Most techniques are based on four family therapy models - Structural, Strategic, Functional, and Behavioral - alone or by combining effective parts of a number of models.

From the family therapy perspective, adolescent substance abuse is a symptom of maladaptive family relationships, interactions, and expectations. The family is viewed as a collection of sub-systems (e.g., parents, kids, etc.), each with a variety of roles. Ideally, boundaries between sub-systems are permeable enough for, say, an adolescent to feel comfortable seeking input from a parent on an important issue, but not so permeable that the boundaries between parent and child (e.g. who is the parent, who is the kid) are blurred. Problems arise when boundaries and roles are not clear or are inappropriate for a given family sub-system.

Techniques used by family therapists include observing the interactive patterns between members by encouraging them to speak directly to each other, pinpointing problems in interactions and their underlying relationship problems, and helping families improve their relationships. Techniques to clarify family roles and boundaries help families change maladaptive interaction patterns. The therapist's use of "reframing" or "relabeling" problem behavior - defining problem behavior in a new way - leads to new insights and opportunities to mend or develop relationships. Given the importance of day-to-day communication patterns between members, most family models stress the importance of having the entire family present for therapy.

Therapeutic communities (TCs) are long-term residential programs reserved for adolescents with the most severe substance abuse and related problems. The traditional duration of stay is at least 15 months, although some TCs have adopted shorter lengths of stay based on progress (6-12 months). The philosophy behind the TC is that substance abuse is a disorder of the entire person resulting from an interruption in normal personality development and deficits in interpersonal skills and goal-attainment. Thus, in order for an adolescent to learn to change, he is steeped in a drug-free lifestyle that integrates the behaviors, affect, values, and life choices of that lifestyle. The social organization of the TC serves as a family surrogate for the adolescent and provides a therapeutic, supportive environment for the adolescent to mature and grow.

Life in a TC is highly structured, with days scheduled from early morning through the evening. Days are filled with school classes and tutoring, peer group and individual therapy, recreation, jobs, and occupational training. Management of the TC is the responsibility of the residents, and all adolescents are assigned a job. Through progress and productivity, adolescents rise through the job hierarchy to positions of management or coordination. Participation by a family member is often a part of the TC experience. As in 12-Step programs, counselors and primary staff at TCs are often ex-clients who have been successfully rehabilitated in TCs.

Is Adolescent Treatment Effective?

Research on the effectiveness of adolescent treatment is in its infancy. Few rigorous evaluations of effectiveness have been done, and of those studies that do exist, many have methodological problems that make definitive conclusions difficult if not impossible. The earliest studies of treatment effectiveness were large-scale national efforts that included adolescent samples (Sells & Simpson, 1979; Hubbard, et al, 1985), but it has only been within the past 10 to 15 years that treatment effectiveness research has focused exclusively on outcomes for adolescents.

Despite the problems of early efforts in adolescent treatment research, a few very broad statements on outcomes are possible. First, treatment works. Across all studies, decreases in adolescent drug use and associated problems have been observed following treatment. Studies comparing outcomes for adolescents who attend and complete treatment versus those who do not attend or fail to complete treatment typically show positive outcomes for the attenders/completers and less positive outcomes or no change for those who do not. However, no single treatment modality stands out as reliably superior to another - most have demonstrated positive outcomes, and it is unknown which modality or combination of modalities will work best for given individuals.

A second broad outcome of adolescent treatment research is that relapse rates for adolescents following treatment are high. Social pressure to use drugs is strong in adolescent culture, and few treatment programs offer ongoing aftercare or support to buffer the effects of returning to the "real world". It is possible that the positive outcomes observed in treatment would be sustained if post-treatment recovery maintenance services or booster sessions were a normal part of treatment. While the idea of periodic "booster sessions" is appealing, the practicality of getting adolescent clients to reliably attend such services is not yet known. Additionally, maintenance or booster sessions may not be reimbursable under several managed care and other insurance plans.

Third, retention in treatment programs is problematic, with drop-out rates ranging from 20-50+% across studies. Given outcomes for treatment completers are typically better than those for non-completers, efforts at treatment engagement and retention need more attention. There is some evidence that family-based treatments can yield high treatment engagement and retention rates (Liddle & Dakof, 1992), but there have been no direct comparisons of treatment engagement and retention across modalities and no single modality stands out as superior. Treatment completers and non-completers may vary on important psychological dimensions (Kaminer et al., 1992), but even studies that have followed completers and non-completers show that non-completers *can* reduce their use, although typically not to the same degree as completers (Alford et al, 1991; Winters et al., 1999).

Fourth, long-term outcomes for adolescents who complete treatment are unknown. Although a handful of studies have follow-up periods of up to two years, typical follow-up extends no longer than twelve months after treatment.

Adolescent substance abuse is a complex problem with multiple causes, leading many to believe that the most effective treatments will be those that combine aspects of all treatment modalities to fit the individual needs of an adolescent and his life situation. Unfortunately, current health care management practices and downsizing of services pose a threat to matching the most appropriate care to the needs of clients. For example, clients with high problem severity and a poor recovery environment may be denied access to residential care or approved only for sub-therapeutic lengths of stay. In a recent study of a residential versus outpatient 12-Step program, Winters, et al. (1999) found no difference in outcomes between adolescents treated in residential versus outpatient settings. However, severity of the adolescents' drug problems had nothing to do with their placement in these settings. Rather, placement was dictated by what a given adolescent's insurance company policy would support, leading to inappropriate placements for many adolescents and no average difference in severity between the inpatient and outpatient groups. Fortunately for citizens of Illinois, treatment programs are required to follow the placement criteria of the American Society of Addictive Medicine (1996), which matches the intensity of treatment to the severity of the adolescent's drug use and related problems.

Adolescent Research Studies Currently Underway in Illinois

One of the reasons it is impossible to say which treatment modality works better than another is that until very recently, there have been no large-scale efforts to experimentally compare more than two or three treatment approaches against each other. In the near future, however, the field will be in a position to make such statements, owing largely to a national study currently underway and led by researchers at Chestnut Health Systems. The Cannabis Youth Treatment (CYT) project (Dennis, Babor, Diamond, Donaldson, S.Godley, Tims, et al., 1998), funded by the Center for Substance Abuse Treatment (CSAT), is the largest multi-site randomized field experiment of adolescent treatment ever undertaken -- largest in terms of the number of adolescents treated and the variety of treatments being tested. The purpose of the study is twofold: (1) to determine the overall clinical effectiveness, cost, and cost-effectiveness of five promising adolescent treatment approaches targeted at reducing/eliminating marijuana use and associated problems in adolescents, and (2) to provide validated models of these approaches to the treatment field. Researchers from four well-respected treatment and academic institutions (Chestnut Health Systems in Bloomington and Madison County, Illinois; Operation PAR in St. Petersburg, Florida; the Addiction Research Center at the University of Connecticut in Farmington, Connecticut; and the Child Guidance Center of the Children's Hospital of Philadelphia (University of Pennsylvania) in Philadelphia, Pennsylvania) are collaborating on the treatment and management phases of the project, while economists from the University of Miami in Miami, Florida are leading the study of costs and cost-effectiveness. To date, no studies on the costs and cost-effectiveness of adolescent treatment have been done.

The CYT study focuses on five experimental treatments organized under two research arms, both comparing a strong five-session brief intervention with two more intensive interventions. In the "incremental arm", each subsequent intervention builds upon the features of the previous intervention. Treatments in the incremental arm include: a brief five-session treatment (MCB5;

Sampl & Kadden, 1998); a second intervention in which additional group sessions are added to the five-sessions (MC12; Webb, Scudder, & Kaminer, 1998); and a third intervention in which family sessions are added to the second intervention, thereby creating a longer-term group intervention with family support (FSN; Bunch, Hamilton, Tims, Angelovich, & McDougall, 1998). In the “alternative arm”, the same brief five-session intervention is compared with: a longer individualized approach for the second condition (ACRA; Meyers, Smith, S. Godley, M. Godley, & Karvinen, 1998); and an individualized family therapy approach for the third (MDFT; Liddle, 1998). While both of the latter involve more exposure/resources, they also involve different approaches. To date, nearly 500 adolescents have been randomly assigned to one of the five treatments, treatment completion rates are in the 80% range, and follow-up interview rates through 9 months post-treatment exceed 95%. CYT is awaiting word on further funding to continue longer-term follow-up. Results from this initial phase of the study are expected in September, 2000.

Another research project currently underway at Chestnut Health Systems addresses the need for research on the effects of providing concentrated aftercare services for adolescents discharged from residential treatment. The Assertive Aftercare Project (AAP) is a five year randomized field experiment funded by the National Institute on Alcoholism and Alcohol Abuse (Godley, Godley, & Dennis, in press). The purpose of this study is to learn whether an assertive approach to aftercare (home-based intervention and case management services) is more likely than standard aftercare to 1) link clients to needed aftercare services in their community; and 2) decrease drug use and related problems. This study will examine the extent to which the AAP and Standard Aftercare conditions achieve these outcomes at three, six, and nine months after discharge from residential care.

The AAP model is a combination of a behavioral intervention based on the Adolescent Community Reinforcement Approach (ACRA) and case management procedures. The ACRA model seeks to replace drug using behaviors with prosocial alternative behaviors. It also uses communication skills training, problem solving, relapse prevention skills, access to recreational and other prosocial activities, and job-finding procedures to help the client maintain recovery. The case management component provides transportation, advocacy, linkage, and monitoring to assist the client in obtaining needed services in the community.

To date the project has enrolled 72 clients across both conditions; of these, 53 have completed participation. The follow-up rate for these clients at three, six, and nine months post discharge is well over 90% across all intervals. The AAP project is funded through May, 2002 and outcome results are anticipated closer to that time.

Research Studies with Adolescents in other States

As this paper is being written there are several research studies in progress in other states. At the University of New Mexico in Albuquerque, Dr. Holly Waldron is comparing the effectiveness of brief Functional Family Therapy to Cognitive Behavior Therapy. At the University of South Carolina, Dr. Scott Henngeler is starting a new study of Multisystemic Therapy enhanced with elements from the community reinforcement approach aimed at juvenile drug court clients. At the University of Miami, Dr. Howard Liddle continues to evaluate the effectiveness of Multi-Dimensional Family Therapy with adolescent substance abusers and their families. In a major new initiative started last year, the Center for Substance Abuse Treatment (CSAT) is studying five existing exemplary adolescent treatment programs using quasi-

experimental research designs. Five residential treatment programs were selected: 1) La Canada Program, Tucson, AZ; 2) Thunder Road, Inc, Oakland, CA; 3) Phoenix Academy, Los Angeles, CA; 4) Mountain Manor Treatment Center, Baltimore, MD; and 5) Dynamic Youth, Brooklyn, NY. Each of these programs is paired with a program evaluation team to study treatment process and outcome over a three year period. In addition to these five programs, CSAT plans to add several additional adolescent treatment programs around the country to this study group in FY-2000.

The final section of this document outlines the majority of research efforts to date on the effectiveness of adolescent treatment. The study summaries are arranged by the primary modality being showcased: 12-Step, Behavioral, Family-Based, and Therapeutic Communities. These studies represent the bulk of research-validated knowledge on adolescent treatment effectiveness.

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Studies Highlighting the Effectiveness of Twelve Step Programs

Alcoholics Anonymous/Narcotics Anonymous Model for Inpatient Treatment of Adolescents

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Program Objective

The aim of the study was to evaluate the outcome effectiveness of an adolescent inpatient treatment program based on Alcoholics Anonymous/Narcotics Anonymous (AA/NA) philosophy and steps. Results from those adolescents who completed the program were compared against those who dropped out of the program.

Treatment Program

The intervention was set in the adolescent 50-bed unit of an inpatient chemical dependency unit in a general hospital. The treatment was delivered in two phases: inpatient treatment (45 days) and aftercare in a halfway house (45 days).

The inpatient treatment had three components: individual counseling; group therapy; and lectures, films, and AA/NA speakers. *Individual counseling* sessions for each adolescent were held three to five times per week for 30 minutes to one hour each. During individual sessions, adolescents reviewed their lives, their history of drug use, adverse consequences that have resulted from their drug use, and specific “character defects” (AA language for personality traits such as egocentricity, self-deception, self-delusion, manipulation, impulsivity, etc.). Adolescents were encouraged to think of chemical dependency as a disease that cannot be cured but can be managed, accept that they had “lost control” over their use of chemicals, and to work through the 12 steps of AA/NA. *Group therapy* was held five times per week with approximately eight adolescents per group. Adolescents engaged in open, honest self-assessments by interacting with others who were similar to them. They also discussed the content of films or lectures they had seen. Peer feedback on how the adolescent appeared to be doing in treatment as seen by the other members was also offered. Once per day, all adolescents attended a presentation involving either a *lecture, film, or speaker*. Lectures covered topics such as medical, psychological, or social-legal aspects of drug abuse. Speakers were from AA/NA who described their lives -- their drug problems, it’s impact on their lives, and their recovery.

The halfway house offered a structured environment and emotional support to help the adolescent make the difficult transition from treatment back to the “real world”. Each day, adolescents attended school in the treatment center, participated in group therapy, attended two lectures, participated in leisure awareness, and were encouraged to attend an AA/NA meeting on their own.

While their children were in treatment, family members were encouraged to participate in a once-per-week family therapy program to help family members improve communication skills that would be needed once the adolescent joined their family again.

Participants

- A total of 157 adolescents (62% boys, 38% girls) who ranged in age from 13 to 19 years (average age 16.2 for boys and 15.8 for girls) participated in the study.
- Adolescents in the study were those consecutively admitted to the unit and diagnosed as “chemically dependent” on the basis of a chemical use history and related negative consequences, a physical exam and lab tests, and a psychological exam.
- Marijuana and alcohol were the most-mentioned drugs-of-choice. Marijuana was identified as the drug-of-choice by 62% of boys and 41% of girls, while alcohol was identified by 25% of boys and 41% of girls as the drug-of-choice. Far smaller percentages of boys and girls identified other drugs as their drug-of-choice. However, a large number of adolescents had “used and liked” a wide range of drugs on at least one occasion. Adolescents reported using their drug-of-choice at relatively high frequencies (several times a week to every day).
- The average length of time that adolescents had been using drugs was 16.9 months for boys and 16.5 months for girls.
- Family income was slightly skewed to the higher income levels with 29% of participants coming from homes with incomes of \$40,000 or above.
- All families reported their adolescent’s chemical use had contributed to significant family problems such as violent arguments and fights that involved physical acts or destruction of property.
- Seventy-one percent of the adolescents had legal problems - 44% had been charged with possession, 43% had been charged with a theft, and 38% had run away from home.
- Sixty-one percent of the adolescents had been suspended from school because of their chemical use behavior, and 55% admitted their grades were now lower than they were the previous year.
- Most adolescents (94%) reported their best friends used alcohol and marijuana, and 74% reported they had a friend who had been arrested in the past.

Research Design

- About three weeks after intake, adolescents were interviewed on their personal, family, social, academic, legal, and drug use histories.
- At six, twelve, and twenty-four months after leaving treatment, adolescents were interviewed on their present living conditions, school and work, social-legal history, drug use, and involvement in AA/NA.
- At least one family member was also interviewed at each of these time periods to provide additional and corroborative information on the adolescent.

Outcomes

- Six months after treatment, program completers had a far higher abstinence rate than did non-completers. For completers, 71% of the boys and 79% of the girls were abstinent or essentially abstinent. For non-completers, only 37% of the boys and 30% of the girls were abstinent or essentially abstinent. Regarding general behavioral functioning, 45% of treatment completers were abstinent-essentially abstinent *and* successfully functioning in

school or a job and in family-social activities, while this was true for only 25% of non-completers.

- By one year post-treatment, abstinent/essentially abstinent rates for boy completers fell sharply to 48% and climbed to 44% for boy non-completers. For girls, rates fell only slightly with 70% of completers abstinent/essentially abstinent compared with only 28% of non-completers. Regarding general behavioral functioning, rates fell sharply such that 29% of treatment completers were abstinent-essentially abstinent *and* successfully functioning in school or a job and in family-social activities; this was true for 18% of non-completers.
- By two years post-treatment, abstinent/essentially abstinent rates fell further for boy completers, such that there was no significant difference between completers and non-completers (40% vs. 30%, respectively). For girls, figures fell somewhat for completers (61%). Girl non-completers reported a 27% abstinent/essentially abstinent rate. Regarding general behavioral functioning, rates continued to fall for completers, such that 27% were abstinent-essentially abstinent *and* successfully functioning in school or a job and in family-social activities. Rates for non-completers rose to 23%.
- Also by two years post-treatment, whether or not adolescents had completed treatment, 72% of adolescents who were abstinent-essentially abstinent were rated as socially adaptive, whereas only 33% of low frequency-intermittent users and only 37% of high frequency-chronic users were rated as socially adaptive.
- By two years post-treatment, 84% of the high-frequency AA/NA attenders were abstinent-essentially abstinent.

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12-Step Treatment Program for Adolescents

Principal Investigator

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Program Objective

This study aimed to evaluate the functioning of 142 teens for two years following inpatient treatment for drug and alcohol abuse. Outcomes were examined in relation to five major life domains: academic involvement, interpersonal problems, emotional well-being, family relations, and social and occupational functioning.

Treatment Program

- The intervention was based on the Alcoholics Anonymous 12-Step treatment approach.
- Program components included individual counseling, group counseling, therapeutic recreation, school programs, and family meetings.
- Following treatment completion, weekly aftercare meetings were provided.
- Average length of inpatient stay was 4 to 6 weeks.

Participants

- A total of 142 adolescents ages 12-18 (63% males, 37% females; average age 16 years; 83% Caucasian, 7% Mexican-American, 5% African-American, 5% other ethnic groups) participated in the study.
- Adolescents who met the American Psychiatric Association's criteria for psychiatric substance abuse were included in the study.
- Adolescents with major clinical diagnoses of depression, anxiety, or bi-polar disorders were not included in the study.
- Prior to treatment, the most frequently used drugs were marijuana and amphetamines, with cocaine also commonly used. Beer was the most frequently consumed alcoholic beverage, followed by hard liquor.

Research Design

- Participants who were consecutively admitted to two inpatient drug and alcohol treatment programs in San Diego, CA, and who met eligibility criteria were invited to participate in the study. Ninety eight percent of those eligible agreed to participate.
- Adolescents were interviewed and completed assessments at 6, 12, and 24 months after discharge from treatment on their use of drugs and alcohol, school/academic performance, peer and family relations, emotional and psychological functioning, and participation in occupational and recreational activities.
- A parent or other resource person independently consented to complete research instruments at all time points to provide corroborative information.

Outcomes

- Over 85% of the adolescents reported at least some substance use during the two year follow-up period. Adolescents were classified into five groups based on their pattern of use/non-use over the course of the two year follow-up. They were:
 - Abstainers (14%) - abstinent throughout the entire follow-up period;
 - Nonproblem users (13%) - minor relapses; sporadic use and no alcohol- or drug-related problems reported throughout the follow-up period;
 - Slow improvers (21%) - problematic use during the first 6 months, followed by decreased use or abstinence over the rest of the posttreatment period (abstainers or minor relapsers);
 - Worse with time (24%) - abstinent or minor relapsers during the first 6 months, followed by abusive drug and alcohol use thereafter (major relapsers);
 - Abusers (28%) - heavy or problematic use throughout the entire follow-up period.
- At the time of treatment entry, the “worse with time” group was significantly younger than adolescents in the other groups. The groups were not significantly different from each other on all other demographics (gender, ethnicity, socio-economic status, pre-treatment substance use).
- Teens with less drug and alcohol use posttreatment improved in their functioning emotionally, interpersonally, with their families, in school, in work, and in recreational activities. Abstainers consistently displayed the best psychosocial functioning after treatment.
- Examination of school participation revealed that adolescents who returned to substance use and those who became more severe with time accounted for the majority of dropouts, whereas the abstainers attended school regularly.

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Minnesota Model Approach to Treating Adolescents who Abuse Substances

Principal Investigator

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Program Objective

This study compares drug use outcomes for three groups of adolescent substance abusers: those who completed treatment under the Minnesota Model (either in residential or outpatient settings), those who did not complete treatment, and those on a waiting list for treatment.

Treatment Program

The treatment program consisted of both residential and non-residential units. The Minnesota Model program is based on the twelve steps of Alcoholics Anonymous and basic principles of psychotherapy. In this model, drug abuse is treated as a disease. Adolescents in the residential setting received treatment for four weeks, and those in the non-residential setting attended 30 sessions over six consecutive weeks (i.e. five days per week).

Treatment components included group and individual therapy, family therapy, lectures about the 12 steps, AA-based reading and writing assignments, school study sessions, and occupational and recreational therapy. Step work focused on the first five steps, which are intended to increase the adolescent's recognition that drugs were causing problems in their life, that a major lifestyle change was needed, and that support for change was available.

Families attended group sessions with other families on average one evening per week throughout the treatment.

At the conclusion of treatment, adolescents are expected to enter a half-year outpatient continuing care program. This program averages two to three meetings per week.

Participants

- A total of 245 12-18 year old adolescents (60% 16 to 18 years old, 56% boys, 44% girls) participated in the study.
- All adolescents had at least one substance abuse disorder as defined by the American Psychiatric Association (86% marijuana dependence, 77% alcohol dependence, 20% amphetamine dependence, 21% other drug dependence). The average number of substance use disorders was 2.2.
- All adolescents reported weekly or more use of at least one substance during the prior year, with most cases reporting at least weekly use of marijuana, alcohol, or both.
- Thirty-one percent of adolescents used alcohol or other drugs prior to the seventh grade.
- Twenty-eight percent of adolescents had been in drug abuse treatment before.
- Sixty-six percent of adolescents had at least one parent with a history of a substance use disorder.

- Eighty-two percent of adolescents had a history of or current co-existing psychiatric disorder (mostly ADHD, conduct/oppositional defiant disorders, and major affective disorders), and 65% had a history of counseling from a mental health provider.
- Fifty-two percent of adolescents had previous or current legal problems.
- Eighty-six percent of the adolescents were enrolled in school.
- Most adolescents were referred for treatment from another professional or service provider (52%). Other referral sources were a family member or relative (13%), school health official (10%), and the courts (5%).

Research Design

- Adolescents were not randomly assigned to the treatment and waiting list groups. Insurance coverage dictated whether the adolescent could attend treatment and, if so, in which setting (residential or outpatient). If the adolescent did not have health coverage for treatment, his name was put on the waiting list.
- Of the total group of 245, 140 (57%) completed treatment, 39 (16%) started but did not complete treatment, and 66 (27%) were placed on a waiting list for treatment given they did not have insurance and other funds were being sought.
- Of the 179 adolescent who went to treatment (completers and non-completers), 101 (56%) were sent to residential treatment and 78 (44%) were sent to outpatient treatment.
- At intake, adolescents who were sent to treatment were interviewed about the frequency of their drug use during the past 12 months and the past 6 months. They were re-interviewed at six months post-treatment (or post-departure for non-completers) and twelve months post-treatment (or post-departure for non-completers, and post-initial-assessment for those on the waiting list). The group on the waiting list was not interviewed at six months post-initial-assessment.
- Parent report measures and urinalysis were completed at the 12 month follow-up.

Outcomes

- There were no differences on important demographic variables or use of drugs between the group that was sent to treatment and those who were wait-listed.
- There were no differences in drug use at follow-up between those who attended residential and outpatient treatments.
- At the 6 month follow-up, 29% of those sent to treatment (completers and non-completers) were abstinent. This fell to 19% at the 12 month follow-up. If those with a minor relapse are combined with those who were abstinent, these percents climb to 54% (6 months) and 44% (12 months). Overall, frequency of drug use was significantly decreased from intake to post-treatment (6 and 12 months).
- At the 12 month follow-up, completers' outcomes (53% abstinent or minor relapse) were far superior to the non-completers' (15% abstinent or minor relapse) and waiting list groups' outcomes (27% abstinent or minor relapse). Drug use frequency was significantly lower for completers than for non-completers and those on the waiting list. The non-completer and waiting list groups did not differ significantly.

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Studies Highlighting the Effectiveness of Behavioral Programs

Behavioral Therapy for Adolescents

Principal Investigator

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Program Objective

This study aimed to test the effectiveness of a behavioral outpatient treatment program. Drug use outcomes of the behavioral program were compared with those of a supportive counseling program.

Treatment Programs

- a) Behavioral Therapy - The treatment program included a variety of behavioral therapy techniques, was highly prescriptive, and established high standards of conduct. Typical behavior therapy techniques employed included therapist modeling, rehearsal, self-recording of behavior between sessions, written therapy assignments, review of assignments in the session, and extensive praise from the therapist for the adolescent's progress.

Three major behavioral procedures composed the treatment. The *Stimulus Control* procedure was designed to eliminate situations in the adolescent's environment that led to drug use and to increase situations and activities that were not associated with drug use. Specific worksheets and planners were used: a "Safe" List, a "Risk" List, and a Daily Planner. The counselor reinforced the adolescent for time spent in "safe" activities and problem solved with the adolescent and parent on ways to increase time spent in "safe" activities and decrease time spent in "risky" activities. The *Urge Control* procedure was designed to interrupt internal thoughts/urges/sensations associated with drug use and then substitute them with competing internal/external stimuli. The *Social Control* procedure was designed to motivate and assist abstinence through the influence of "significant others", in this case, a parent. Parents assisted by promoting activities on the "safe" list and arranging alternatives to items on the "risk" list. They also drew up behavioral contracts with adolescents and rewarded them for drug-incompatible activities with things such as transportation, use of the car, time with a friend on the "safe" list, gifts, telephone or television privileges, privacy, etc.

Individual sessions were initially held twice per week for one hour until progress was apparent, at which time they dropped to once per week. Parents attended each session with the adolescent.

- b) Non-behavioral Treatment (Supportive Counseling) - The Non-behavioral program (control group) incorporated aspects commonly used in group therapy for drug abuse. The group process included expressions of feelings, initiation of comments, reactions to comments of other group members, description of one's drug use history, discussion of drug use experiences and feelings, and praise for abstinence-related desires. No specific directives were given by the counselor.

Group sessions for adolescents were held once per week for two hours, with individual sessions arranged on a case-by-case basis for those who were unable to make the group. Parents could attend the group one time per month.

Participants

- Twenty-six adolescents ages 13-18 (77% boys, 23% girls; average age 16 years; 81% Caucasian, 19% African-American or Hispanic) who had engaged in illegal drug use (other than or in addition to alcohol) during the previous month participated in the study.
- None were receiving any other psychological/psychiatric treatment.
- Nineteen percent had dropped out of school.
- Referral was by an agency or school (58%) or family (42%).
- Drug use at intake was principally marijuana (96%), followed by crack/cocaine (35%) and hallucinogens (31%). Many adolescents used more than one drug.

Research Design

- Fifteen adolescents were randomly assigned to the behavioral treatment and eleven adolescents were assigned to the supportive counseling. No preexisting differences existed between the two groups on any demographic characteristics.
- Each intervention had a one month pre-baseline assessment period during which no treatment took place. At the end of this one month period, adolescents entered one of the above treatments for a duration of six months.
- The adolescent's parent also completed research instruments to provide corroborative or additional information.

Outcomes

For adolescents in the behavioral treatment...

- The number of adolescents using drugs by the end of treatment decreased by 73%. Drug use was measured in three ways at each session: adolescent self-report, parent report, and urinalysis, and all three methods of measuring drug use showed substantial decreases during the course of treatment.
- The percent attendance at school or work increased significantly.
- Reported alcohol use decreased by about 50%.
- A large decrease in average scores on a depression measure were observed.
- Parent satisfaction with the youth increased from a pre-baseline rate of 42% to 72% overall satisfaction.
- Youth satisfaction with the parent increased from a pre-baseline rate of 69% to 85%, although the difference was marginally significant.

For adolescents in the non-behavioral treatment...

- The number of adolescents using drugs by the end of treatment decreased by only 9%. All three methods of measuring drug use showed only slight decreases, and the average number of days per month of drug use actually increased.
- The percent attendance at school or work decreased slightly.
- Reported alcohol use increased by about 50%.
- Only a slight decrease in average scores on a depression measure were observed.

- Parent satisfaction with youth remained unchanged at 50%.
- Youth satisfaction with the parent stayed the same at 63%.

The average number of treatment sessions received during the 6 month period was 15.1 for adolescents in the behavioral treatment and 14.9 for adolescents in the non-behavioral treatment. This difference was not significant.

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Cognitive-Behavioral Treatment

A Pilot Study Testing Two Approaches for Adolescents

Principal Investigator

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Program Objective

The purpose of this study was to determine which of two treatments, Cognitive-Behavioral Treatment or Interactional Treatment, would provide improved outcomes for adolescent substance abusers who also were diagnosed with a psychiatric condition.

Treatment Programs

- a) **Cognitive-Behavioral Treatment (CBT)** - The CBT approach views substance use as a learned disorder that arises when the adolescent attempts to cope with problems or meet needs in a maladaptive way. Because it is a learned disorder, it can be unlearned through the application of behavior modification techniques. Given the way one thinks affects one's behavior, CBT also targets the adolescent's thought processes and beliefs.

Treatment was composed of 12 weekly 90-minute group outpatient sessions. Each session was structured around a different topic that helped adolescents learn to identify triggers to their substance use and manage high-risk situations. Sample topics included alcohol and drug refusal skills, planning for emergencies, and coping with relapses. Techniques used during the sessions included training, presentations, modeling, role playing, and homework exercises.

- b) **Interactional Treatment (IT)** - IT is an insight-oriented outpatient group approach. Goals of the approach include exploring interpersonal relationships, fostering insight, and regulating affect, self-esteem, and self-care. The technique is delivered through interactions with group members.

Participants

- A total of 32 adolescents (ages 13 to 18 years) were recruited for the study.
- Participants were recruited from a partial hospitalization treatment program. The present study composed their outpatient aftercare treatment.
- All adolescents met the American Psychiatric Association's criteria for a psychoactive substance disorder.
- All adolescents had either an externalizing disorder (e.g., disruptive behavior) or internalizing disorder (e.g. anxiety or depression) as determined by the Diagnostic Interview for Children.

Research Design

- Seventeen adolescents were randomly assigned to CBT while fifteen were randomly assigned to IT.
- All 32 adolescents completed baseline measures of the severity of their alcohol use, drug use, psychiatric problems, problems with peers, family, or school, and legal problems. These same measures were collected at the 3- and 15-month follow-ups.

Outcomes

- The overall treatment completion rate was 47% (8 in the CBT group and 7 in the IT group).
- At the 3 month follow-up, adolescents who were in the CBT treatment significantly reduced the severity of their substance use compared with those assigned to IT.
- At the 15 month follow-up, no treatment group differences were observed on severity measures of alcohol use, drug use, psychiatric problems, problems with peers, family, or school and legal problems.

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Cognitive-Behavioral Treatment An Interim Report of Two Approaches for Adolescents

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Program Objective(s)

This purpose of this study was to determine which of two treatments, Cognitive-Behavioral Treatment or Psychoeducational Treatment, would provide improved outcomes for adolescent substance abusers.

Interventions

- a) **Cognitive-Behavioral Treatment (CBT)** - The CBT approach views substance use as a learned disorder that arises when the adolescent attempts to cope with problems or meet needs in a maladaptive way. Because it is a learned disorder, it can be unlearned through the application of behavior modification techniques. Given the way one thinks affects one's behavior, CBT also targets the adolescent's thought processes and beliefs.

Treatment was composed of 8 weekly 90-minute group sessions. Each session was structured around a different topic that helped adolescents learn to identify triggers to their substance use and manage high-risk situations. Sample topics included alcohol and drug refusal skills, planning for emergencies, and coping with relapses. Techniques used during the sessions included training, presentations, modeling, role playing, and homework exercises.

- b) **Psychoeducational Treatment (PET)** - The PET addressed the dangers of using drugs and alcohol. Adolescents viewed one to two videotapes per session that addressed the experiences and consequences of use. Group discussion followed on the content, quality, credibility, and message of the videos. Treatment was composed of 8 weekly 90-minute group meetings.

Participants

- A total of 76 adolescents (ages 13 to 18 years) were recruited for the study. Sixty-three adolescents entered treatment.
- Participants were recruited from a family therapy-oriented outpatient program (80%) and from the juvenile justice system.
- All adolescents met the American Psychiatric Association's criteria for a psychoactive substance disorder.

Research Design

All 63 adolescents completed baseline measures of the severity of their alcohol use, drug use, psychiatric problems, problems with peers, family, or school, and legal problems. Thirty-three adolescents completed these same measures at the 3 month follow-up.

Outcomes

- The overall treatment completion rate was 86%.
- At the 3 month follow-up, adolescents who were in the CBT treatment significantly improved on the severity of their peer problems as compared with those assigned to PET. In addition, a trend toward improvement on the drug and alcohol severity measures was observed for adolescents treated in CBT relative to those in PET.
- No additional treatment group differences were reported.

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Studies Highlighting the Effectiveness of Family-Based Programs

Family Therapy vs. Parent Groups for Treating Adolescent Drug Use

Principal Investigator

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Program Objective

The purpose of this study was to assess the effectiveness of two treatment methods for adolescents who abuse drugs: a Family Therapy Method and a Parent Group Method.

Treatment Programs

- a) Family Therapy Method - The Family Therapy Method was based on a model called “Functional Family Therapy” (Alexander & Parsons, 1982). This model assumes that behavior occurs in circular, reciprocal ways, and that behavior is best understood in the context of a relationship.

Techniques used in this method are: the positive relabeling and reattribution of family patterns of interaction; improving communication by making it clearer, more consistent and open, and less defensive; creating a safe atmosphere for disclosure, fostering self-esteem, instilling hope, encouraging responsibility, fostering trust, and providing feedback so that family members learn to see themselves as others see them. During therapy, the therapist uses positive relationship-building skills such as integrating affect and behavior, nonblaming, nonconfronting, demonstrating interpersonal warmth and acceptance, alleviating tension with humor, and the use of self and self-disclosure.

Sessions took place over 24 weeks (6 months).

- b) Parent Group Method - This program consisted of 24 weekly sessions and was based on a combination of a number of programs: a) the Parent Effectiveness Training (PET) method, b) the Parent Communication Project, and c) the Parent Assertiveness Training program. The PET program is based on principles of unconditional positive regard and active listening. Power is negotiated between parent and child rather than the parent or the child having all the power. Parents learn and practice active listening, nonblaming skills, constructive confrontation, “I” messages, and the “no-lose” method of resolving conflicts.

Individual counseling was made available for adolescents whose parents were randomly assigned to the Parent Group Method.

Participants

- A total of 135 adolescents aged 14 to 21 years (average age 17.9 years; 61% boys, 39% girls; 90% white, 10% non-white) and their families participated in all phases of the study.
- Adolescents had completed an average of 9.3 years of schooling, below the average expected for an average age of 17.9 years.

- The average frequency of use of marijuana during the month prior to treatment was about three times as great as the average frequency of use of alcohol.
- Prevalence rates of drug use in the three months prior to treatment were: alcohol (88%), marijuana (87%), amphetamines (52%), cocaine (28%), tranquilizers (23%), hallucinogens (22%), PCP (15%), and barbiturates (15%).
- Of the five friends each adolescent knew best, an average of 3.7 used marijuana, 3.9 used alcohol, and 2.4 used other drugs.
- Forty percent of the adolescents had been arrested at least once.
- Average years of school completed for mothers and fathers was between 12 and 13 years.

Research Design

- Of the 135 families participating in the study, 85 were randomly assigned to family therapy and 50 were randomly assigned to the parent group.
- Adolescents and their mothers completed measures at intake and approximately 9 months post-treatment.

Outcomes

- From pre-treatment to follow-up (a span of about 15 months), adolescents and their mothers in both groups reported significant improvements in adolescent drug use, parent-adolescent communication, family behavior, and adolescent psychiatric symptoms. There was no difference between the groups in the degree of improvement.

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Multisystemic Therapy Missouri Delinquency Project

Principal Investigator

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Program Objective

The purpose of the Missouri Delinquency Project was to investigate the effects of treatment by Multisystemic Therapy (MST) versus treatment by Individual Counseling (IC) for decreasing problems presented by serious, chronic juvenile offenders. The effects of MST vs. IC on substance-related arrests was investigated for four years post-treatment.

Treatment Programs

- a) Multisystemic Therapy (MST) - MST is based on the observation that substance use and other forms of antisocial behavior in adolescents are determined by many factors. Characteristics of the child, his family, his peers, school, work, and community at large are viewed as interconnected “systems” that interact with and reciprocally influence behavior of family members. Problem behavior can be maintained by troublesome interactions between one or any combination of these systems (thus, “multisystemic”). Thus, MST interventions are not limited to the adolescent, but target the adolescent’s and family’s problems within or between systems.

Given every case is different, treatment strategies include a variety of therapeutic approaches, including strategic family therapy, structural family therapy, behavioral parent training, and cognitive-behavioral therapy. A number of interventions are commonly used when targeting problems in or between the “systems”. At the family level, interventions include removing barriers to effective parenting (e.g. marital conflict, high stress, low social support, parental substance abuse or psychopathology), enhancing communication and closeness in family members, and increasing knowledge of parenting. At the peer level, strategies are developed for decreasing affiliation with antisocial peers and increasing affiliation with prosocial peers. In the school or at work, strategies are developed to increase school or vocational performance. In addition, individual counseling for the adolescent and parents can address cognitive-behavioral issues such as modifying the individual’s perspective-taking skills, problem-solving skills, and belief and motivational systems. Many of the interventions targeted at addressing problems between the adolescent and other systems (besides with parents) are delivered by the parent with guidance and support from the therapist. The treatment is intense in terms of time required and task (therapy homework is part of the treatment).

Therapy sessions are delivered in the home at times convenient to the family (including evenings and weekends), although other community locations (e.g. schools, social service agencies) are not uncommon. Therapists are available 24 hours a day, 7 days a week. However, direct contact time is fit to clinical need, so therapists typically spend more time with families in the early stages (daily if needed) and less time as the family progresses (no less frequent than once per week). The course of treatment typically lasts 3 to 5 months. Therapist case load is low (4 to 8 families).

In sum, MST addresses a broad array of barriers (e.g., in the family, in the community) in order to attain the family-defined treatment goals.

- b) **Individual Counseling (IC)** - This approach focused on the individual rather than on the systems in which individual lived. It was composed of an eclectic blend of a number of psychotherapeutic approaches, including psychodynamic, client-centered, and behavioral. Sessions focused on personal, family, and academic issues. Therapists supported the adolescent's need to change, giving feedback and encouragement.

Participants

- A total of 140 adolescents and their families participated in the study. This group comprises those who completed treatment in either MST or IC.
- Approximate demographic profiles of the adolescents include an average age of 14 years; 67% boys, 33% girls; and 70% Caucasian, 30% African-American.
- Adolescents and families were referred through the juvenile court system following the adolescent's recent arrest. All adolescents had at least two prior arrests, and the average severity of their most recent arrest was close to 12 on a scale from 1 (truancy) to 17 (murder). (A "12" falls between grand larceny (11) and unarmed robbery (13)).
- Over half of the families had two parent figures in the home (including biological, foster, step, and grandparents), and nearly 90% of adolescents lived with their biological mothers.
- Families were from a lower socioeconomic status.
- Approximately 13% of the sample had a previous arrest for a substance-related offense.

Research Design

- Seventy-seven adolescents and their families were randomly assigned to MST, while sixty-three adolescents were randomly assigned to IC. There were no significant differences between groups in terms of demographics.
- For four years following treatment, adolescents' arrest records were monitored for subsequent substance-related arrests.

Outcomes

- Duration of treatment varied by case. For adolescents and their families in the MST condition, average duration was 24 hours, while for adolescents in the IC condition, average duration was 28 hours.
- Only a small percent of adolescents who completed MST (4%) had a substance-related arrest during the subsequent four years. For those in IC, 16% had a substance-related arrest during the same time period. This difference is significant.

- Adolescents who received at least some MST (those who had dropped out of treatment and those who completed treatment) also had significantly fewer substance-related arrests when compared with their counterparts who received at least some IC (3% vs. 16%, respectively). This difference was also significant.

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Multisystemic Therapy Family and Neighborhood Services Project

Principal Investigator

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Program Objective

The purpose of the Family and Neighborhood Services Project was to investigate the effects of treatment by Multisystemic Therapy (MST) versus treatment by the usual services offered through the Department of Youth Services (DYS-US) for decreasing problems presented by serious/chronic juvenile offenders. The effects of MST vs. DYS-US on substance use following treatment was investigated.

Treatment Programs

- a) Multisystemic Therapy (MST) - MST is based on the observation that substance use and other forms of antisocial behavior in adolescents are determined by many factors. Characteristics of the child, his family, his peers, school, work, and community at large are viewed as interconnected “systems” that interact with and reciprocally influence behavior of family members. Problem behavior can be maintained by troublesome interactions between one or any combination of these systems (thus, “multisystemic”). Thus, MST interventions are not limited to the adolescent, but target the adolescent’s and family’s problems within or between systems.

Given every case is different, treatment strategies include a variety of therapeutic approaches, including strategic family therapy, structural family therapy, behavioral parent training, and cognitive-behavioral therapy. A number of interventions are commonly used when targeting problems in or between the “systems”. At the family level, interventions include removing barriers to effective parenting (e.g. marital conflict, high stress, low social support, parental substance abuse or psychopathology), enhancing communication and closeness in family members, and increasing knowledge of parenting. At the peer level, strategies are developed for decreasing affiliation with antisocial peers and increasing affiliation with prosocial peers. In the school or at work, strategies are developed to increase school or vocational performance. In addition, individual counseling for the adolescent and parents can address cognitive-behavioral issues such as modifying the individual’s perspective-taking skills, problem-solving skills, and belief and motivational systems. Many of the interventions targeted problems between the adolescent and other systems (besides with parents) are delivered by the parent with guidance and support from the therapist. The treatment is intense in terms of time required and task (therapy homework is part of the treatment).

Therapy sessions are delivered in the home at times convenient to the family (including evenings and weekends), although other community locations (e.g. schools, social service

agencies) are not uncommon. Therapists are available 24 hours a day, 7 days a week. However, direct contact time is fit to clinical need, so therapists typically spend more time with families in the early stages (daily if needed) and less time as the family progresses (no less frequent than once per week). The course of treatment typically lasts 3 to 5 months. Therapist case load is low (4 to 8 families). Adolescents and their families received an average of 36 hours of direct contact over an approximately four month period.

In sum, MST addresses a broad array of barriers (e.g., in the family, in the community) in order to attain the family-defined treatment goals.

- b) Department of Youth Services Usual Services (DYS-US) - This condition comprised the usual services that serious adolescent offenders received. Adolescents received court orders that included at least one stipulation (e.g., curfew, school attendance). Adherence to the court orders were monitored by probation officers, who met with each adolescent once per month.

Participants

- Data was available on a total of 47 chronic, serious juvenile offenders and their families. This group comprises those who had completed treatment as of the writing of the report.
- Adolescents all had severe behavior problems and were at imminent risk of being placed out of their homes due to a recent serious offense (either a violent or non-violent felony).
- The average age of adolescent participants was 15.1 years, boys comprised 72% of the sample (28% girls), and 74% were African-American (26% were Caucasian).
- Eighty percent of the adolescents lived with their biological mothers, while 47% lived with their biological fathers.
- Families were from a lower socioeconomic status, with 33% heads of household unemployed.
- No data was reported on pre-treatment use of drugs.

Research Design

- Of the group with complete data, 28 adolescent and their families had been randomly assigned to MST, while 19 had been randomly assigned to DHS-US. There were no significant differences between groups on demographic characteristics.
- Both prior to and following treatment, adolescents completed a self-report scale of soft drug use (alcohol, marijuana) and hard drug use (hallucinogens, heroin, cocaine), reporting how often they had used each drug during the previous three months.

Outcomes

- Following treatment, self-reported use of marijuana and alcohol was significantly lower for those adolescents who completed MST than for those who completed DHS-US.
- A very low base rate of hard drug usage (hallucinogens, amphetamines, barbiturates, heroin, and cocaine) prevented statistical analyses on that data.

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Multisystemic Therapy

An Outcome Study on Treating Adolescent Substance Abusers

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Program Objective

This study aimed to test the effectiveness of a family- and home-based therapy model. Outcomes related to drug use, criminal activity, and days in out-of-home placement were compared with those from the treatment usually available to adolescents in the community.

Treatment Programs

- a) **Multisystemic Therapy (MST)** - MST is based on the observation that substance use and other forms of antisocial behavior in adolescents are determined by many factors. Characteristics of the child, his family, his peers, school, work, and community at large are viewed as interconnected “systems” that interact with and reciprocally influence behavior of family members. Problem behavior can be maintained by troublesome interactions between one or any combination of these systems (“multisystemic”). Thus, MST interventions are not limited to the adolescent, but target the adolescent’s and family’s problems within or between systems.

Given every case is different, treatment strategies include a variety of therapeutic approaches, including strategic family therapy, structural family therapy, behavioral parent training, and cognitive-behavioral therapy. A number of interventions are commonly used when targeting problems in or between the “systems”. At the family level, interventions include removing barriers to effective parenting (e.g. marital conflict, high stress, low social support, parental substance abuse or psychopathology), enhancing communication and closeness in family members, and increasing knowledge of parenting. At the peer level, strategies are developed for decreasing affiliation with antisocial peers and increasing affiliation with prosocial peers. In the school or at work, strategies are developed to increase school or vocational performance. In addition, individual counseling for the adolescent and parents can address cognitive-behavioral issues such as modifying the individual’s perspective-taking skills, problem-solving skills, and belief and motivational systems. Many of the interventions targeted at addressing problems between the adolescent and other systems (besides with parents) are delivered by the parent with guidance and support from the therapist. The treatment is intense in terms of time required and task (therapy homework is part of the treatment).

Therapy sessions are delivered in the home at times convenient to the family (including evenings and weekends), although other community locations (e.g. schools, social service agencies) are not uncommon. Therapists are available 24 hours a day, 7 days a week.

However, direct contact time is fit to clinical need, so therapists typically spend more time with families in the early stages (daily if needed) and less time as the family progresses (no less frequent than once per week). The course of treatment typically lasts 3 to 5 months. Therapist case load is low (4 to 8 families).

In sum, MST addresses a broad array of barriers (e.g., in the family, in the community) in order to attain the family-defined treatment goals.

- b) Usual Community Services (US) - This condition comprised the usual services that adolescent drug offenders received. The youth's probation officers referred them to receive outpatient substance abuse services, which typically involved completion of a 12-Step program followed by weekly attendance at adolescent group meetings. Inpatient and residential treatment programs as well as mental health services were also available in the community.

Participants

- A total of 118 adolescent juvenile offenders (ages 12 to 17, average age 15.7 years; 79% boys, 21% girls; 50% African-American, 47% Caucasian, one each Native American and Hispanic) and their families participated in the study.
- All adolescents were recruited from the Department of Juvenile Justice and were on probation (formal or informal). They averaged 2.9 prior arrests.
- All adolescents met American Psychiatric Association criteria for psychoactive substance abuse or dependence, with 56% meeting criteria for abuse and 44% meeting criteria for dependence. In addition, 60% of the adolescents abused more than one drug.
- Drug use at intake was primarily marijuana and alcohol.
- Seventy-two percent of the adolescents had at least one additional psychiatric diagnosis (e.g., conduct disorder, social phobia, oppositional defiant disorder, major depression, etc.).
- Families were disadvantaged and reported low annual incomes (average range \$15,000-\$20,000).
- Eighteen percent of birth mothers and 56% of birth fathers reported problems with alcohol or drugs.

Research Design

- Adolescents and their families were randomly assigned to one of the two treatment conditions. A total of 58 were assigned to MST, while 60 were assigned to US.
- Data on drug use, criminal activity, and days in out-of-home placement were collected on the youths at three points in time: pre-treatment, post-treatment (approximately 5 months later), and 6 months post-treatment.

Outcomes

- During the four to five months of treatment, 98% of the MST families completed the full course of treatment, which averaged 130 days (range 61-252 days). In addition, the MST families received an average of 40 hours (range 12-187 hours) of treatment with the therapist.
- During this same time period (five months), 78% of the US families received neither substance abuse nor mental health services, 7% received mental health services only, 10%

received substance abuse treatment only, and only 5% received both mental health and substance abuse services. When they did receive services, low quantities were reported.

- At pre-treatment, the MST group reported significantly higher use of alcohol, marijuana, and other drugs than the US group.
- At post-treatment, MST adolescents' use of marijuana, alcohol, and other drugs was significantly reduced when compared to their pretreatment use. No difference in drug use was seen for the US group from pre- to post-treatment.
- At post-treatment, MST adolescents' use of marijuana, alcohol, and other drugs was significantly reduced when compared to adolescents' use in the US group. However, once adjusted for preexisting differences in use between the two groups, this difference disappeared.
- At 6 months post-treatment, for adolescents in the MST condition, incarceration was reduced by 46% and total days in out-of-home placement (e.g. incarceration, residential treatment, inpatient treatment) was reduced by 50%.
- No significant differences between the two groups were reported in criminal activity at post-treatment or 6 months post-treatment. However, for both groups, criminal activity was significantly decreased over time.
- From pre-treatment to 6 months post-treatment, adolescents in MST evidenced a 26% reduction in criminal arrests and a 19% reduction in recidivism. These reductions were not significantly different from those in the US condition.
- From pre-treatment to 6 months post-treatment, adolescents in MST had substantially fewer days in out-of-home placements (i.e., detention centers, jails, psychiatric or substance abuse hospitals, and residential treatment centers) than did adolescents in the US condition. A cost analysis revealed that MST program costs were offset by the reduction in out-of-home placements by 6 months post-treatment.
- Results reported above are more modest than is usually seen with MST interventions. It is possible that therapists' low adherence to the treatment protocol may explain the modest results.

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Family Systems Therapy vs. Adolescent Group Therapy vs. Family Drug Education

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Program Objective(s)

This study aimed to test the effectiveness of three different treatments for adolescents with substance use disorders: Family Systems Therapy, Adolescent Group Therapy, and Family Drug Education.

Treatment Programs

- a) Family Systems Therapy (FST) - The FST condition was based on an integration of Structural Family Therapy and Strategic Family Therapy. Families were seen weekly for 60 to 90 minutes by a team consisting of at least two therapists and a supervisor. One therapist interviewed the family while the others observed. Periodically the interviewer would consult with the other team members. The sessions concluded with an intervention delivered by the interviewer but based on the team's consult.

FST continued until the family and therapist perceived that treatment goals had been met. Thus, not all families received exactly the same total treatment time. Of those whose data was included in the data analysis, the number of sessions ranged from 7 to 15.

- b) Adolescent Group Therapy (AGT) - This treatment is representative of outpatient adolescent groups offered by hospitals and mental health centers. The group met weekly for 12 sessions of 90 minutes each. Adolescents were seen with their families for the first session, and remaining sessions were with the adolescents only. The treatment model was a blend of social skills training, cognitive development, and role theory. The treatment did not follow a 12-step model.

Discussions and interactions among group members were used to explore the nature of drugs, the effects of drug use on the lives of the adolescents, and to encourage a drug-free life style. Each session consisted of discussion of drugs and issues related to adolescence, group activities, and processing of group dynamics.

- c) Family Drug Education (FDE) - The FDE met twice weekly for six sessions, each lasting 2.5 hours. Groups of three or four families were seen together. Each session included a presentation of information on topics such as the nature of drugs, their effects on the body, the effects of drugs on adolescent behavior, and the effects of drug use on family functioning. Sessions also included a film on the topic of the day. Because the treatment was designed to be educational rather than psychotherapeutic, families were discouraged from talking about their problems or concerns that were unique to them.

Participants

- A total of 134 adolescents ages 11-20 (average age 15.4 years) and at least one of their parents living in the same household initially participated in the study.
- The ethnic/racial backgrounds of mothers were: white (68%), Mexican-American (29%), and African-American (2%). The ethnic/racial backgrounds of fathers were: white (74%), Mexican-American (23%), and African-American (3%).
- Adolescents were considered drug users if they had been arrested/detained for drug possession and/or intoxication by police (39%), identified by school officials (22%) or parents (39%), admitted drug use and/or displayed behavioral and physical signs of drug use, and used at least one other drug besides alcohol.
- The primary drug of choice in the sample was marijuana. Other drugs used were alcohol, amphetamines, barbiturates, and hallucinogens.
- Families were of low to moderate socio-economic status and parents had on average a high school education.

Research Design

- Adolescents and at least one parent completed measures prior to treatment (pretest), immediately after treatment (posttest), and 6 months after treatment ended.
- Of the original pool of 134 families who completed the pre-test measures, 40 were randomly assigned to FST, 52 to AGT, and 42 to FDE. No systematic differences between groups were found on important demographics. In addition, no differences were found between those families who completed treatment and those who did not.
- Data for the pre-to-post test comparisons are based on only those 82 families who completed treatment and the post-test measures: 31 in FST, 23 in AGT, and 28 in FDE.
- For the pre-to-post-to-6-month-follow-up comparisons, data from only 34 families are available.

Outcomes

- Drug use from pre-treatment to post-treatment decreased significantly for those in the FST when compared with drug use of adolescents in AGT and FDE.
- At the 6 month follow-up, the total sample of adolescents perceived that their communication with their parents had improved significantly. Parents did not share this perception.

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Family Therapy vs. Family Drug Education

Principal Investigator

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Program Objective

The purpose of the study was to test the effectiveness of two family-oriented outpatient treatment methods for adolescent substance abusers and their families: the Purdue Brief Family Therapy Model and the Training in Parenting Skills program.

Treatment Programs

- a) Purdue Brief Family Therapy (PBFT) Model - This treatment is a combination of the most effective elements of four family therapy models: Structural, Strategic, Functional, and Behavioral. The goal of treatment is to help the family system become a more healthy environment for all members by understanding and then modifying patterns of interaction that support adolescent substance abuse.

Specific treatment goals are: decreasing the family's resistance to drug treatment, redefining drug use as a family problem, reestablishing appropriate parental influence, interrupting dysfunctional family sequences of behavior, assessing the interpersonal function of drug abuse, implementing change strategies consistent with the family's interpersonal functioning, and providing assertion training skills for the adolescent and any siblings to resist peer pressure to use drugs.

The treatment was delivered over 12 sessions, and all family members were encouraged to attend.

- b) Training in Parenting Skills (TIPS) program - This intervention is also a 12-session family treatment, though the methods and goals are didactic rather than psychotherapeutic. The cognitive-based drug education program provides information to all family members about drugs, their effects, and methods they can use to help eliminate drug use. Drug abuse is viewed as a chronic problem that is cumulative, progressive, and potentially fatal.

Specific topics of instruction are: why adolescents use drugs, what drugs they use, and what a drug problem looks like; models of chemical dependency and how families become involved in the dependency process; what parents are responsible for and what they are not responsible for; feelings, defenses, conflict resolution, and communication regarding chemical dependency; and the recovery process for adolescents and family members.

Participants

- A total of 84 adolescents (out of 136 who were part of a larger study) and their families participated in this study. The teens and youths ranged in age from 12 to 22 years with an average age of 16 years, 81% were boys, and 19% were girls.
- More than half of the adolescents/families (51%) were referred from court, probation, and the police, 34% were from schools and agencies, and 15% were self and family referrals, mostly from a newspaper ad.
- Forty-three percent of the adolescents worked at least part-time.
- The average age of mothers and fathers was 41.5 years and 45 years, respectively. Single mothers comprised 29% of the sample, and single fathers comprised 7%.

Research Design

- Forty-four adolescents and their families were randomly assigned to and completed the PBST intervention, while 40 were randomly assigned to and completed the TIPS intervention.
- Measures of drug use and family functioning were completed before and after treatment. Urinalysis was used to corroborate self-reports of adolescent drug use.

Outcomes

- About one-half (46%) of the 84 adolescents significantly benefited from treatment.
- By the end of treatment, more than one-half (55%) of the adolescents in the PBFT made clinically significant decreases in their drug use. Only 38% of those receiving the TIPS treatment made similarly significant decreases.
- Measures of drug use at the end of treatment were significantly lower for adolescents in the PBFT intervention. There was no significant difference between the pre-treatment and post-treatment drug use scores of adolescents in the TIPS intervention.

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Multidimensional Family Therapy Adolescents and Families Project

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Program Objective

The purpose of this study was to examine the effectiveness of Multidimensional Family Therapy (MDFT) in reducing drug and alcohol use and associated problems among an adolescent sample. MDFT was tested against two other treatment approaches: Adolescent Group Therapy (AGT) and Multifamily Education Intervention (MFEI).

Treatment Programs

All treatments lasted up to six months, with a minimum of 14 sessions and a maximum of 16 sessions.

- a) Multidimensional Family Therapy (MDFT) - This outpatient family-based intervention views adolescent drug use as being determined by a network of influences, including individual, familial, peer, and community. Thus, in order to reduce drug use and increase prosocial behaviors, multiple pathways are targeted. The approach targets four major areas: 1) the adolescent's intrapersonal and interpersonal (with peers and parents) functioning, 2) the parent's intrapersonal and interpersonal functioning (e.g. parenting practices), 3) parent-adolescent interactions both during sessions and as reported by the adolescent and the parent, and 4) family members' interactions with extrafamilial sources of influence (e.g. probation officers, school personnel, child welfare personnel). Different modules guide assessment and intervention within each of these realms.

Treatment is viewed as a process of re-tracking the developmental processes of adolescents and families. Treatment is composed of an interconnected series of interactions between the therapist and the adolescent, the therapist and the parent(s), and the therapist and extrafamilial members (probation officers, school personnel).

Multiple generic themes of parent-adolescent conflict are introduced into the therapy sessions. The themes are different for the adolescent and the parent. Sample themes are drug abuse, past hurts and disappointments, ineffective parenting, individual skill deficits, abdication of parental responsibility, and deficits in adolescent-parent communication.

Some therapy sessions are with the adolescent alone, some with the parent(s), and some with adolescent and parent together. Adolescents' individual sessions focus on important developmental tasks, such as decision-making and mastery. They are taught problem-solving skills to help deal with life's stresses and are helped to communicate about their thoughts and

feelings. The parents' sessions deal with parenting styles, belief systems, and the consistency of their parental beliefs and practices.

- b) Adolescent Group Therapy (AGT; Concannon, McMahon, & Parker, 1990) - This outpatient intervention consisted of 90-minute meetings with six to eight adolescents and two therapists. Typical activities included presentations, discussions and group skill-building exercises. Particular emphasis was placed on the development of social skills (e.g. communication, self-control, self-acceptance, and problem-solving) and social support among group members.

The treatment was conducted in four phases. Phase one consisted of two pre-treatment meetings - one with the adolescent and his/her parents (to discuss group rules and procedures) and one with the adolescent alone (to gather personal history and introduce the adolescent to the process. As part of this meeting, adolescents completed a needs assessment and set personal goals. Phase two consisted of four structured sessions with activities designed to introduce the members to each other and facilitate self-disclosure. Personal difficulties were shared, information on consequences of drug use was presented, and communication skill-building exercises were employed. Phase three (sessions 5-12) focused on skill-building. Social skills (coping with stress, interpersonal problem-solving, and communication), drug refusal skills, problem-solving, communicating in the affective realm, and the development of prosocial behaviors were covered. Homework on skills practice was assigned and reviewed during the meetings. Phase four (sessions 13-16) allowed for refinement and practice of skills. Adolescents assessed their progress and relapse prevention and termination were discussed.

- c) Multifamily Educational Intervention (MFEI; Barrett, 1990) - This outpatient intervention consisted of 90-minute group meetings between three to four families over 16 weeks. Typical activities during the meetings included discussions, presentations, skill-building exercises, individual family problem-solving, and homework assignments. Goals included learning better ways to manage stress, improving family organization rules and limit-setting, improving family communication and problem-solving, and reviewing factors that put families and individuals at risk and factors that help them cope better with their lives.

The role of the therapist was that of teacher and facilitator. Each 90-minute meeting was arranged in three parts: 1) presentation of lecture material by the therapist, 2) group discussion, and 3) skill-building exercises (such as effective problem-solving, understanding natural and logical consequences of behavior, and constructive ways to express emotions). Families had workbooks and homework assignments.

Social support was enhanced through families teaching each other and using themselves as examples. Families were encouraged to bring food to share and celebrated goals throughout treatment. The group also functioned as an extended family for single parents and families who were isolated.

Individual crisis sessions were available for families in the case of emergencies (limited to two sessions during the 16 weeks of the treatment).

Participants

- A total of 95 adolescents 13 to 18 years (average age 15.9 years; 80% boys, 20% girls; 51% Caucasian, 18% African-American, 15% Hispanic, 6% Asian, 10% other ethnicity) who had been using drugs for at least three months participated in the study with their families. (This group represents those families/adolescents who completed treatment and all post-treatment assessments.)
- Adolescents and their families were recruited mainly from the juvenile justice system, followed by schools, health and mental health agencies, and the media.
- Fifty-one percent of the adolescents used more than one drug -- alcohol and marijuana on a daily basis, and other drugs (usually cocaine, stimulants, and hallucinogens) approximately once per week. The remaining 49% used alcohol and marijuana about three to four times per week.
- On average, the adolescents had been using drugs for 2.5 years.
- Sixty-one percent of the adolescents were involved in the criminal justice system.
- Family composition included 48% single-parent households, 31% two-parent households, and 12% step-families.
- Median income for families was approximately \$25,000.

Research Design

- 33 families were assigned to MDFT, 34 adolescents were assigned to AGT, and 26 families were assigned to MFEI. No significant differences between the three groups in demographic characteristics or other intake information was found.
- The adolescent and/or parent(s) completed assessments at intake, immediately after treatment ended, and again at six and twelve months post-treatment. Other records, such as school grades and treatment attendance, were also gathered on each adolescent.
- Information was gathered on drug use, problem behaviors (poor anger control, interpersonal problems, impulsivity, mood swings, antisocial behavior, aggressive behavior, sexual acting out), school performance, and attrition from treatment.

Outcomes

- From pre-treatment to post-treatment, all three groups significantly decreased their use of drugs and their acting out behaviors. In addition, the adolescents in the MDFT condition were significantly more improved in terms of reducing their use of drugs by the end of treatment than adolescents in the other conditions.
- From post-treatment through the six- and twelve-month follow-ups, all three groups significantly decreased their use of drugs and their acting out behaviors, with adolescents in the MDFT group showing the most improvement.
- By the time of the twelve-month follow-up, adolescents in the MDFT condition were significantly more improved in terms of reducing their drug use and in improving their grade point averages than adolescents in the Multifamily Education Intervention.
- The general pattern of results show improvement in adolescents in all three conditions, with those in MDFT showing the most improvement, followed by those in AGT, followed by those in MFEI.

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Conjoint Family Therapy vs. One-Person Family Therapy for the Treatment of Adolescents who Abuse Substances

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Program Objectives

- This study aimed to test the effectiveness of two forms of family therapy: Conjoint Family Therapy (CFT - in which the entire family attends therapy with the adolescent) and One-Person Family Therapy (OPFT - in which only one family member attends therapy).
- A second objective was to test the assumption that it is necessary for the entire family to attend most of the sessions in order to see improvements in family functioning and a reduction in the adolescent's drug abuse problems.

Treatment Programs

Both interventions fall within the wider arena of Structural Family Therapy. Structural Family Therapy views the family as a unique social system that establishes routine patterns of interaction when dealing with each other and the environment. It's these repetitive patterns of interaction that define a family's structural organization. When a family member expresses symptoms of dysfunction, the family typically expects that the member is "sick" and needs to be changed. However, the therapist focuses on the entire family, contending that although the family member may be a symptom-carrier, the entire family is under stress and the patterns of interaction in the family are also disrupted and/or dysfunctional.

Further, both family interventions are based on a form of Structural Family Therapy called "Brief Strategic Family Therapy" (BSFT). The techniques are "brief" in that the therapy is delivered within 12 sessions and "strategic" in that each session focuses on achieving planned goals using a planned strategy to promote new and more functional ways of interacting within families. BSFT is present- and future-oriented (rather than past-oriented). The therapist observes interactions, diagnoses those that are pathological, and plans strategies to restructure patterns of interaction to implement change.

- a) **Conjoint Family Therapy (CFT)** - This treatment represents "Brief Strategic Family Therapy as usual". Therapy was conducted with the entire family (or at least the majority of it) at most sessions. Families were seen for a maximum of 12 sessions of which not more than two individual (one-person) sessions were allowed.

Two major structural family therapeutic techniques used during therapy were *joining* and *restructuring*. *Joining* consists of two phases: forming an alliance with the family members (by supporting the family and tracking its patterns of communication) and enactment of the family's characteristic behaviors and interactions (by redirecting family members to interact with each other rather than with the therapist). The goal of establishing an alliance with

family members is to engender trust and support from the entire system. Restructuring consists of the therapist's attempts to promote, facilitate, and direct alternate organizations, arrangements, and interactional patterns. A number of techniques are used to restructure and reorganize family interactional patterns: reframing (relabeling a process, person, or event), reversals (coaching a family member to do/say the opposite of his/her usual response), detriangulating (breaking apart a "triangle" where two family members keep a third in a peripheral, unadaptive role), and challenging conflict avoidance (by magnifying small issues into a crisis).

- b) One-Person Family Therapy (OPFT) - This form of therapy takes place with only one family member. The technique is based on the "principle of complementarity", which states that if there is a change in one person's interactive behavior in the family, then the other members of the family must also change their behavior. The single family member was seen for a maximum of 12 sessions of which not more than two conjoint sessions were allowed.

Joining and restructuring were also used in OPFT, although they had to be modified somewhat to fit the therapeutic situation. For *joining*, the therapeutic alliance is formed with the single member, and the family's interactions must be represented by the single member through techniques such as the family member role playing several family roles, the therapist and family member role playing complementary roles, a blackboard to sketch the structure of relationships, and the empty-chair technique (another role-playing technique). Once the therapist understands and has identified the complementary unhealthy patterns of interaction, restructuring can begin. The *restructuring* must take place through the single family member rather than directly with the entire family present. First, restructuring of the single member's internal representation of family interactions takes place. Then, restructuring at the family level begins. A set of homework assignments are assigned to assure the single family member's new behaviors are rehearsed. The family member changes his/her behavior from the usual, expected dysfunctional pattern of interaction, hereby eliciting a reaction from family members and pressure to return to the "status quo". This could promote a family crisis. At this point, a conjoint family session may take place, although as noted above, no more than two were allowed.

Participants

- A total of 37 Hispanic adolescents ages 12 to 20 years (average age 17 years; 78% boys, 22% girls; 84% Cuban-American) and their families participated in the study.
- Most adolescents had completed 9th or 10th grade, but only 35% were continuing in school.
- Families for the study were recruited from the court and community agencies, public service announcements, and self-referrals.
- Families reported an average of 15 years in the United States and were from the lower and middle socio-economic strata.

Research Design

- Eighteen families were randomly assigned to CFT, while 19 families were randomly assigned to OPFT. Pre-existing differences between the groups included more severe behavior problems on two scales (delinquency, inadequate development) for the adolescents in the OPFT condition.

- Adolescents and family members were administered measures of clinical and family functioning at intake, treatment termination, and follow-up 6 to 12 months after termination.

Outcomes

- The OPFT treatment group received significantly more sessions than those in the CFT group. The difference is the result of the difficulty in retaining entire families in therapy. In the CFT condition, five families completed between four and seven sessions, while no OPFT clients completed less than eight sessions.
- From intake to termination, adolescents in both conditions improved significantly in their clinical status (including drug abuse, impulse control, behavioral disturbance, and subjective distress) and in behavior problems (including conduct problems, delinquency, personality problems, and inadequate development). In addition, family functioning for families in both conditions improved significantly. The preexisting differences between the two groups at the outset continued, with adolescents in the OPFT group having more behavior problems on two scales (delinquency, inadequate development) than those in the CFT group.
- For 24 families who had complete data from intake to termination to follow-up, adolescents in both conditions continued to show improvements in psychiatric status (including drug abuse) and behavior problems. Adolescents in the OPFT condition showed significantly more reduction in problem behavior (delinquency, inadequate development) and drug abuse than adolescents in the CFT condition. In fact, adolescents in the CFT group increased their behaviors in these three domains. Families in both conditions continued to show improvements in family functioning.

References

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Conjoint Family Therapy vs. One-Person Family Therapy for the Treatment of Adolescents who Abuse Substances: Phase Two

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Program Objective

This study was an extension of the earlier study. It aimed to further test the effectiveness of two forms of family therapy: Conjoint Family Therapy (CFT - in which the entire family attends therapy with the adolescent) and One-Person Family Therapy (OPFT - in which only one family member attends therapy).

Treatment Programs

- a) Conjoint Family Therapy (CFT) - see previous summary.
- b) One-Person Family Therapy (OPFT) - see previous summary.

Both interventions were delivered in the same way as in the earlier study, with the exception that families were seen for a maximum of 15 (rather than 12) sessions.

Participants

- A total of 35 Hispanic adolescents (average age 17 years, 77% Cuban-Americans) and their families participated in the study.
- Eighty percent of the adolescents identified marijuana as their primary drug, with 47% using it at least once per day and slightly more than 93% using it to some degree. The second-most used drugs in this group were alcohol and barbiturates.
- The average length of drug use among adolescents was 2.5 years.
- Twenty-one percent of adolescents had been arrested.
- The average grade completed by adolescents was the 10th.
- Families reported an average of 14.7 years in the United States and were from the lower socio-economic strata.

Research Design

- Seventeen families were randomly assigned to CFT, while 18 families were randomly assigned to OPFT.
- Adolescents and family members were administered measures of clinical and family functioning at intake, treatment termination, and follow-up 6 to 12 months post-treatment.

Outcomes

- Adolescents and families assigned to each treatment appeared to be equivalent in important demographic features.

- From intake to termination, adolescents in both conditions improved significantly in their clinical status (including drug abuse, impulse control, behavioral disturbance) and in behavior problems (including conduct problems, delinquency, personality problems). In addition, family functioning for families in both conditions improved significantly.
- For 20 families who had complete data from intake to termination to follow-up, adolescents and families in both conditions continued to show improvements in the adolescent's clinical status and in the families' functioning. Family functioning for those in the OPFT condition was slightly better at follow-up than for those in the CFT group.

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Study Highlighting the Effectiveness of Therapeutic Communities

Therapeutic Communities for Adolescents

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Program Objectives

The Center for Therapeutic Community Research recently led an investigation of six therapeutic community treatment programs across nine sites. The programs varied on a number of dimensions, including the demographic characteristics of the adolescents, the size of the programs, and the durations of stay. The aims of the study were to a) describe the profile of adolescent clients going through residential TC treatment, b) evaluate the effectiveness of the programs, and c) clarify the relationship between admission status, progress in treatment, and retention.

Treatment Programs

All programs were residential Therapeutic Communities (TCs). Although programs varied on factors such as setting (urban vs. rural), planned durations of stay (6 to 18 months), and the size of their staff, all shared the basic features of a TC. Typically two to four adolescents share a room and all are responsible for its order and cleanliness. The facilities also typically include a dining room, community room, and classrooms. The daily schedule is highly structured, including morning and evening meetings, classroom instruction, physical recreation, study time, work in jobs, therapy groups, seminars, and individual counseling. There is very little time to “hang out”. Family therapy may also be included as part of treatment, although this typically occurs later in the recovery process.

Participants

- All adolescents who were admitted to the six participating programs during the data collection period were invited to participate. Refusal rates across programs were low, averaging less than 5%.
- A total of 938 adolescents agreed to participate in the study across the six programs. Across the life of the study, though, this number dropped considerably.
- The demographic profiles of the programs varied widely (e.g., boys-only program, Hispanics-only program, mixed sexes and races programs). However, summarizing across all programs, the profile of the group included 76% boys and 24% girls; 49% Caucasian, 27% African-American, and 21% Hispanic; and 56% 16-17 year olds.
- Over three-quarters of the group was referred to treatment by a law-related source. For individual programs, 70% to 100% of clients were legal referrals in all but two programs.
- Adolescents reported a wide range of psychological difficulties. At some time in their lives, over 50% of the sample reported experiencing serious depression, over 40% had experienced serious anxiety, over 25% had had serious thoughts of suicide, and over 40% reported having had a difficult time controlling violent behavior. However, only a small fraction of these adolescents indicated that treatment for these problems was important to them.

- The primary drug of choice summarizing over all sites was marijuana (56%) followed by alcohol (20%). Crack and cocaine use were relatively low across all programs. However, the range of primary drug choices varied from program to program (e.g. a program serving Hispanic males had a considerable number of primary heroin abusers).

Research Design

Adolescents were administered a variety of self-report instruments at baseline, halfway through their program (month 3 to month 9, depending on their planned duration of stay), at 6 months post-treatment, and at 12 months post-treatment regardless of whether they left the program early or completed treatment.

Outcomes

- The dropout rate through the first 90 days in treatment was 33%. Another 12% left the program but returned.
- Halfway through their planned stay of duration, 45% of adolescents were still in treatment. Significant positive changes were observed on most indicators of psychological status, such as self-esteem and behavioral indicators (trouble controlling violent behavior, serious thoughts of suicide in the past 30 days).
- By the end of the treatment programs, about 56% of adolescents had dropped out.
- At 6 months post-treatment (N=358), significant reductions were observed for inhalants, hallucinogens, and methamphetamines. Also, more than 66% of the adolescents reported their alcohol use was either greatly reduced or at an abstinent level.
- No 12 month post-treatment outcomes are available at this time.

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