

Treating Teens:

A Guide to Adolescent
Drug Programs

Introduction

Substance abuse is a pervasive problem among American adolescents. According to the 2001 Monitoring the Future national survey of adolescent drinking and drug use, more than half of all high school seniors have used illicit drugs. So, too, have one in four eighth graders. Adolescent drinking is also a significant problem. One in three high school seniors report being drunk at least once in the past month, as do one in five tenth graders.

Many teens need treatment, yet treatment is even more scarce for adolescents than for adults. According to the National Household Survey on Drug Abuse, 1.1 million youths ages 12-17 needed treatment for an illicit drug problem in 2001, but only one in ten actually received help, compared to one in five adults.

Why is adolescent drug treatment so scarce? The fundamental reality is that teens with substance abuse problems have generally been overlooked. Relatively few programs are designed specifically for adolescents. Many teens who do get treatment participate in programs built on adult models

that do not take into account the developmental differences between adolescents and adults. Moreover, a lack of federal funding as well as ever-shrinking managed care benefits provide very limited coverage for drug treatment. Many parents simply cannot afford to get the kind of help their children need. For some, the only way to find treatment is through the juvenile justice system, which in recent years has become the single largest source of youth referrals to treatment.

Treating Teens: A Guide to Adolescent Drug Programs is designed to help parents, counselors, doctors, probation officers, judges and other concerned adults make better informed choices about treatment for teens. The need to find treatment often comes in crisis situations, where decisions must be made quickly and little useful information is available. Parents and other adults may not know where to turn for practical guidance or for suggestions on what to look for in a program. At this moment of crisis, they also are least likely to trust their own common sense. As a result, treatment decisions are often based on anecdotal reports about

programs rather than a clear assessment of what kind of program might be best for the individual child.

Treating Teens discusses teen drinking and drug use in the larger context of adolescent development. Many teens who experiment with alcohol and other drugs incur little lasting damage and emerge successfully into adult roles. Others, however, face acute risks of injury, death, and addiction. Some also become involved in criminal activity that results in court supervision or incarceration. Substance abuse can effectively derail teens from negotiating critically important developmental tasks, such as getting an education and learning essential social skills. In addition to addressing a teen's substance abuse and other problems, treatment programs must often help them master the challenges of adolescence so that they can move forward into productive adulthood.

Treating Teens provides a framework for understanding what we have learned in the past decade about what works in adolescent drug treatment.

Drug Strategies, working with a distinguished advisory panel of nationally recognized experts, has identified nine key elements that contribute to treatment effectiveness. These elements, which reflect our best effort to bring together both current research and clinical practice, form the conceptual basis of the guide.

Treating Teens discusses the nine key elements in detail to increase understanding of the range of concerns programs should address when treating adolescents. In addition, the guide provides current, reliable information on 144 adolescent drug programs across the country and takes an in-depth look at seven promising programs that reflect a variety of treatment approaches. *Treating Teens* also provides practical resources, such as hotline numbers to find treatment in each state, definitions of frequently used treatment terms and ten important questions to ask when selecting a program. Additional detail about each of the 144 programs, including how they address the nine key elements, is available at www.drugstrategies.org

Methodology

As the first step in developing this guide, Drug Strategies research staff conducted a complete search of the professional literature on treatment of adolescent substance abuse. In addition, we interviewed more than a dozen adolescent treatment experts currently engaged in research in order to obtain new information not yet published in peer reviewed journals.

To provide overall guidance for the project, we assembled a Teen Treatment Expert Advisory Panel comprised of twenty-two members, whose names are listed on the inside back cover. The Panel included leading academics, clinical researchers, treatment providers and adolescent development experts. Working with the Panel, we undertook a comprehensive review of program elements that research and practice suggest are critically important in providing effective adolescent treatment.

We then conducted lengthy structured telephone interviews with Panel members to discuss key elements and to explore central issues in developing treatment specifically designed for ado-

lescents. The Panel met in Washington, D.C., on June 1, 2001, to discuss the content of the guide and the selection of key elements.

After extensive further communication with Panel members, Drug Strategies convened a smaller working group in Washington, D.C., on April 10, 2002. Consensus was reached on nine key elements which are discussed in depth later in this guide. Panel members noted that although strong research data are not yet available, these elements currently represent the best understanding of what works in adolescent treatment.

To observe how the key elements are implemented in practice, Drug Strategies undertook to identify exemplary programs across the country. First, we asked the Panel to suggest programs to which they would refer a family member or close friend. Second, we contacted twenty national organizations, such as the American Medical Association, the American Academy of Pediatrics, the National Institute on Drug Abuse and the American Society of Addiction Medicine. Third, we asked state alcohol and drug

abuse agency directors in all fifty states and the District of Columbia to identify what were in their opinion the five best adolescent substance abuse treatment programs in their states. In eight states and the District of Columbia, no exemplary programs were identified by either the state agency, our advisory panel, or a national organization. (These states are Alaska, Delaware, Georgia, Michigan, Missouri, Nebraska, Nevada, and Texas, as well as the District of Columbia.)

This three step process produced a total of 144 recommended programs. Drug Strategies sent each program an extensive survey instrument requesting specific information, such as number of clients, treatment approach, average length of stay and cost. Our staff subsequently conducted structured, taped telephone interviews with all 144 programs. Combining information from the survey instrument and the telephone interviews, we prepared profiles of each program. Each profile (some with additional questions attached) was sent to the respective program, asking for comments regarding the profile's accuracy. Follow-up letters were sent to programs

that did not respond, stating that if no response was forthcoming within a specific period, Drug Strategies would have to assume that the draft profile was accurate and acceptable for posting on the website. The information gathered from this process has been incorporated into individual program profiles available on our website.

Drug Strategies selected for site visits seven programs which reflect both geographic diversity and a range of therapeutic approaches. For each program, our staff prepared a structured site visit form, based on the written survey, telephone interview, and other program materials. Site visits included a tour of the facility, observation of activities, interviews with the director and staff, and conversations with clients and families. Drug Strategies does not endorse or take responsibility for any of the treatment programs included in this guide.

A complete list of sources as well as the survey instruments and site visit forms are available on Drug Strategies' website at www.drugstrategies.org

Adolescent Treatment Research and Evaluation

Evaluation is critically important in order to answer the central question about adolescent treatment: Does it work? Does the program or treatment approach actually reduce a teen's alcohol and other drug use? Very few programs evaluate their own effectiveness, particularly in terms of long-term results. Evaluation is an expensive, lengthy process, particularly when it is done well.

Research on adolescent treatment is still in its infancy. Research funding has focused almost entirely on adult addiction and treatment effectiveness.

Moreover, the small number of adolescent treatment studies that have been done often have had methodological problems that make definitive conclusions very difficult. These problems include small sample sizes, lack of control groups, poor follow-up rates, failure to include treatment dropouts in the results, lack of randomized assignment and different assessment techniques. A recent comprehensive review by the Addiction Centre Adolescent Research Group in Canada, published by the American Psychological Association, identified 53 adolescent treatment studies in the past three decades—of which

only 21 were methodologically sound enough to justify analyzing their results. Overall, these studies found significant reductions in adolescent substance use and related problems in the year following treatment.

Completion of treatment, including continuing care as an extension of treatment, appears to be particularly important. A major evaluation funded by the National Institute on Drug Abuse (2000) of adolescents treated in therapeutic communities found significant reductions in drug use and criminal activity at one year follow-up. This is particularly significant because more than half the group had been mandated to treatment by the criminal justice system. Completion of treatment was the most consistent predictor of positive outcome. In 2001, the Drug Abuse Treatment Outcome Studies for Adolescents (DATOS-A), an evaluation of more than 1,100 adolescents treated in residential, inpatient and outpatient programs, reported significant reductions in drinking, marijuana use and criminal activity as well as improved school performance and psychological adjustment. Better outcomes were reported for those who remained in treatment longer.

To address the need for rigorous evaluation in the field, the Federal Substance Abuse and Mental Health Services Administration (SAMHSA) launched two important adolescent treatment research projects: Cannabis Youth Treatment Program (CYT) (1997-2001) and Adolescent Treatment Models (ATM) (1998-present). CYT is the largest evaluation ever conducted with adolescent marijuana users in outpatient treatment. (Most adolescents—about 70 percent—are treated for substance abuse in outpatient settings rather than in residential programs.) CYT evaluated five promising treatment approaches, and found that they were all effective in reducing adolescent marijuana and other drug use during treatment and a one-year follow-up period. In addition, the study showed a decrease in family, school and behavioral problems.

The ATM project supports evaluations for ten different potentially exemplary programs, which combine a variety of treatment approaches. Client outcomes and cost are evaluated in a consistent manner which allows for comparisons with the CYT approaches. Effective

models will be codified into manuals for replication and further study. Preliminary findings show significant reductions in substance use and related problems for ATM program participants. Additional data on both CYT and ATM evaluations will be reported through January 2004.

Very little rigorous research has been conducted which compares the relative effectiveness of different types of adolescent treatment. To date, no one approach to treating adolescents appears to be superior to others. However, recent research suggests that certain program elements are related to successful outcomes. These include family involvement in therapy; retaining adolescents in treatment until completion; comprehensive services that address educational, vocational, psychological and legal concerns; experienced, empathetic staff; aftercare as part of the continuum of care; and encouraging parent and peer support for the adolescent's efforts to stay drug free. These factors are reflected in the nine key elements of effective adolescent treatment identified by the Teen Treatment Expert Advisory Panel which are described in detail in this guide.

Key Elements of Effectiveness

Both treatment research and clinical practice suggest that certain elements are critically important to the effectiveness of adolescent drug programs. Drug Strategies, guided by our Teen Treatment Expert Advisory Panel, has identified nine key elements which form the conceptual framework for this guide. These elements are:

- **Assessment and Treatment Matching**
- **Comprehensive, Integrated Treatment Approach**
- **Family Involvement in Treatment**
- **Developmentally Appropriate Program**
- **Engage and Retain Teens in Treatment**
- **Qualified Staff**
- **Gender and Cultural Competence**
- **Continuing Care**
- **Treatment Outcomes**



Assessment and Treatment Matching

Screening is the first step in finding the appropriate kind of help for a teen with substance abuse and other problems. Treatment experts recommend that programs use standard screening instruments which have been rigorously evaluated for reliability and validity. Three such screening instruments are: Substance Abuse Subtle Screening Inventory (SASSI); Problem Oriented Screening Instrument for Teenagers (POSIT), and Personal Experience Screening Questionnaire (PESQ). They briefly explore a range of possible problem areas, such as substance use, physical and mental health, educational or vocational status, family and peer relationships and delinquency. In addition, a short, six-question screening test, known as CRAFFT, provides a useful tool for clinicians and primary care physicians to determine if their young patients need further help.

After the initial screening has been completed, an in-depth assessment of both the teen and the family might

be needed. Comprehensive assessment should have three components: medical, psychiatric, and family. Two standard assessment instruments that have been independently tested and recommended by treatment experts are the Comprehensive Addiction Severity Index for Adolescents (CASI-A) and the Global Assessment of Individual Needs (GAIN). These assessments explore in depth the teen's educational situation, learning disorders, substance use, peer relationships, risk behaviors, legal history, psychiatric status, and family issues. Many programs do not use standard, nationally recognized screening and assessment instruments and rely instead on questionnaires they develop in-house.

Assessment should explore the many interrelated factors that affect the teen's life, including family functioning, school performance, peer relationships and socioeconomic issues. Understanding a teen's psychiatric and psychological history is also critical. More than two-thirds of all teens currently in treatment have mental health problems of some kind.

Conduct disorder, depression, anxiety, post-traumatic stress and attention deficit hyperactivity disorder are often closely related to substance abuse; indeed, many teens with these problems turn to alcohol and other drug use as a form of self-medication to make themselves feel better.

Exploring the nature and severity of drug use helps identify what level of treatment is appropriate. Measuring the client's motivation to change and willingness to make the effort required is also important. Assessment can help treatment providers distinguish between problem drug users and those who are already drug dependent. The assessment should include a thorough medical examination to determine whether physical and biomedical conditions may relate to the adolescent's substance abuse. Some teens referred to treatment may already be deeply involved with alcohol and other drugs, while others may be in earlier, more experimental stages of use. For those teens who have not yet developed serious problems, less intensive care outside the formal treatment

system may be appropriate, such as involvement in community recreational and educational programs as well as possible participation in Twelve Step meetings geared to adolescents and other self-help groups. Some high schools provide onsite group counseling on alcohol and other drug use through Student Assistance Programs (SAP).

Assessment provides a basis for determining if the adolescent's needs match the services available at the particular program as well as the level of treatment intensity. Many adolescent treatment programs use the American Society of Addiction Medicine's *Patient Placement Criteria for the Treatment of Substance-Related Disorders* as a tool for matching clients with the appropriate level of care. For example, a teen who is in the early stages of substance abuse who does not also have mental health disorders should not in most cases be placed in treatment with seriously addicted adolescents whose problems may be far more severe. Whether an adolescent should be treated in a residential rather than outpatient program depends both on the severity of the

youth's problems and on how well he or she can function within his or her family, school and community. The assessment should be reviewed periodically and revised as needed in order to provide continued guidance in light of the teen's progress.

A summary of screening and assessment instruments, prepared by Dr. Ken C. Winters, Director, Center for Adolescent Substance Abuse, University of Minnesota, is available at www.drugstrategies.org



Comprehensive, Integrated Treatment Approach

Substance abuse is often just one of a number of problems an adolescent may have. More than half of all adolescents in treatment have co-occurring mental disorders, like depression, anxiety, conduct disorder and post-traumatic stress. Almost half are involved with the juvenile justice system. Many also have learning disabilities and health problems, including sexually transmitted diseases, as well as serious problems in school and at home.

It is often difficult to know whether an adolescent's substance abuse is a response to other problems, like depression, or whether it has triggered or exacerbated other problems, like school failure. Nonetheless, providing comprehensive, integrated treatment services improves the likelihood that the adolescent will be able to reduce both drug use and other problem behaviors.

An effective treatment plan, developed collaboratively by the counselor with the adolescent and his or her family, should address the adolescent's problems comprehensively rather than concentrating solely on curtailing substance abuse. Various social systems shape the daily life of adolescents: family, peers, school, and for some, welfare and criminal justice. Compared to adults, teens have relatively little control over their environment, including where they live, their economic status, access to transportation and community support services.

Programs should offer a wide range of services, or connect adolescents and their families to these services in the community. These include psychi-

atric care; health care which also addresses sexual health; family counseling; home visits; parent education; recreational activities; and remedial or regular education classes, which should be on-site for residential programs. Flexibility, availability and actively matching the adolescent's needs to services are central to the comprehensive approach.

Good treatment programs should strive to expand the adolescent's horizons and aspirations through alternative activities, including art and music, and by connecting teens to mentors in the community who will encourage emotional and intellectual growth. In addition, programs should maintain close links with the adolescent's family, home school, and where necessary, the juvenile justice system. Case management and coordination of care are critically important in making sure the adolescent and his or her family are receiving services that will contribute to treatment success. Continuing care is also essential to provide social support and necessary services after the adolescent leaves the treatment program.



Family Involvement in Treatment

Parents are the dominant reality in the lives of most adolescents; a teen's close relationship with parents is a powerful protective factor against various problem behaviors, including substance abuse. Parents also are primary providers of financial support, including medical insurance if any.

Many experts believe that family influence plays a key role in the development and continuation of an adolescent's substance abuse and other problems. Engaging parents—or in the absence of parents or other family, the responsible caregiver—increases the likelihood that a teen will stay in treatment and that treatment gains will be sustained after treatment has ended. A recent study of adolescents who stop using drugs without formal treatment reports that the three most important factors in their success are parental involvement, new friends, and motivation.

Involvement of the teen's family in the treatment process is critically important for treatment success; indeed, some research suggests that the more the family is involved, the better the treatment outcomes will be. Family involvement may range from telephone conversations with counselors to participation in group meetings. Some programs have therapists observe adolescents and their families interact in a variety of settings, pinpoint problems and help improve relationships. Techniques to clarify family roles and to reframe problem behavior can lead to new insights as well as opportunities to mend relationships. Families are asked to examine their own use of alcohol and other drugs, and to address their substance abuse problems through treatment if necessary. Some programs involve intensive interventions with adolescents and their families in their daily lives, not only at the program facility, but also at home, school, probation office and workplace. Teaching the family the skills required to manage and to parent more effectively as well as to access community services, including the criminal justice and mental health systems, helps strengthen the entire family system.



Developmentally Appropriate Program

Traditional treatment programs are designed for adults with serious, long-term alcohol and other drug problems. Relatively few programs specifically address the developmental needs of adolescents. Although adolescent treatment capacity has recently begun to expand, particularly in the criminal justice system, only a small percentage of teens with substance abuse problems can easily obtain help.

Treatment experts agree that adolescent programs can't just be adult programs modified for kids. Adolescence is a period of rapid developmental change involving major biological, behavioral and cognitive transitions. Teens are beginning to move away from family-based to peer-based identity on the way to defining who they are as individuals. They are also ready to try new things, even if they involve risks. Drinking and drug use, particularly marijuana, may be part of this experimentation. For some teens, substance abuse may pose acute risks of injury or overdose; for

others, it may escalate into serious dependence, triggering in turn a wide range of other problems.

In a practical sense, adolescent programs must address a number of different contexts which shape the teen's environment, such as school, recreation, peers, welfare, medical care, juvenile court or probation. Legal constraints also play a role: youth, unlike adults, are required to attend school and they cannot legally purchase alcohol or tobacco.

Many youths have other difficulties in addition to substance abuse, such as learning and attention deficit problems, depression, and trauma resulting from physical or sexual abuse. Counselors and program officials must collaborate with many community systems in order to provide teen clients a continuum of care they could not manage for themselves.

Most teens don't seek treatment on their own, and may not think they have a problem. In contrast, adults are usually more motivated since they

often seek treatment when they “hit bottom” after many years of heavy drinking and drug abuse. Adolescent programs need creative techniques to engage and retain teens in treatment by making activities relevant to their concerns. One outpatient program, for example, gives teen clients disposable cameras to take photos of friends, families, and other things in their lives which then become a basis for generating group discussion. Program materials should use concrete rather than abstract examples that are meaningful, particularly in terms of imminent effects.

Some researchers question whether the traditional Twelve Step approach, which is incorporated into the majority of adolescent treatment programs, is relevant or developmentally appropriate for this age group. For example, many adolescents do not see themselves as addicts or alcoholics and cannot see the relevance of a lifelong commitment to abstinence. This is natural because most young people have been using for a relatively short period of time and still enjoy the experience. The Twelve Step model also requires acceptance of individual

powerlessness and belief in a higher power. Many adolescents resist this concept, primarily because during adolescence, they are learning to assert their own power, separate from family and peers.

Some Twelve Step programs adapt their approach to make it more amenable to a young person’s perspective. For example, the goal of lifelong abstinence is replaced with the goal of abstinence until the young person is mature enough to make an adult decision about the legal use of alcohol.

Certain aspects of the Twelve Step model can be particularly attractive to teens, such as flexibility in meeting times, no cost, and provision of social support. A recent study of adolescents in Twelve Step programs found that those who participate in meetings which include others in their own age group report better outcomes, probably because these youth-oriented groups share similar problems and do not focus on less relevant issues, such as employment concerns and marital relations.



Engage and Retain Teens in Treatment

Most teens who begin treatment do not complete the process. Three in four adolescents in outpatient programs and two in five youths in residential treatment failed to complete 90 days of treatment, according to a new nationwide study by University of California at Los Angeles (UCLA) researchers that tracked 1,167 teens in outpatient, residential and short-term inpatient treatment. These high dropout rates point to the central importance of designing programs that engage teens and keep them in treatment. Youths who complete treatment reduce their substance abuse and delinquent activity substantially as well as show marked improvement in school, work, and social relations.

Few teens seek treatment on their own; most are referred or coerced by parents, school, or the juvenile justice system. Many teens who enter treatment do not think they have a problem and they may see treatment as part of an adult agenda to curtail their independence. Engaging the teen

in active program participation is particularly important in outpatient settings where the majority of teens are treated.

Beyond the challenge of retaining teens in treatment is the deeper question of motivating them to make their own internal commitment to change. This change involves emotional recovery as well as an expanded vision of alternative, enriched ways to function without relying on alcohol and other drugs. Both program content and experienced staff play a central role in this transformation.

Creating at the outset a therapeutic alliance—a climate of trust, confidence and acceptance between the teen and counselor—is vitally important. Qualities in therapists that foster this alliance include flexible, intelligent thinking, good interpersonal skills and genuine empathy. Creative program content is also important in engaging teens in treatment. One approach to overcoming a client’s initial resistance involves having the therapist help the teen think about areas of his or her life that are not going well, problems with family and friends, feelings about

self, and pressure from the juvenile justice system, so that he or she can see that treatment can help make his or her life better in a number of ways. Through this process, the teen takes ownership of the treatment plan rather than resisting it as externally imposed by others.

Treatment for teens has to have tangible, concrete aspects and outcomes if the teen is to remain engaged. Some programs develop reward systems, such as giving vouchers for drug-free urine tests. Still others provide services in sites that might be more convenient to teens and their families, including home visits or probation offices, and provide transportation where necessary. Programs can also offer activities that deal with sexuality, pregnancy and parenting—critical issues for many teens. The key is to find ways to make treatment relevant to the everyday concerns of the adolescent so that he or she will be motivated to make the necessary effort to change fundamental behavior patterns.

Parents' perceptions and attitudes strongly affect whether a teen enters and remains in treatment, according

to a new study of teens involved in the juvenile justice system who regularly use drugs and have multiple school problems. Parental recognition that there is a serious problem increases the likelihood that the child will stay in treatment, perhaps because these parents are more motivated to seek help than are parents who minimize these problems. Parental expectations about their children's educational potential are also critically important in treatment engagement. Parents who believe their children can ultimately overcome their problems and be successful in school make a powerful difference even when faced with difficult circumstances.



Qualified Staff

Adolescents with substance abuse problems usually also have other problems, such as delinquency, depression, anxiety, or attention deficit disorder. In order to address these problems effectively, programs should engage staff with training and experience in diverse areas. Professional staff who recognize psychiatric prob-

lems, understand adolescent development and are able to work effectively with families are critically important to treatment success. In addition, counselors should have practical experience in dealing with adolescents and be responsive to the way young people think. They should also model positive adult behavior within appropriate boundaries (rather than blurring the lines between themselves and their young clients).

Referrals to treatment by doctors, judges, and other adults are often based on personal knowledge of the quality of the program staff. Although professional training and credentials are vitally important, positive, caring staff attitudes are also important in connecting adolescent clients to the treatment process. The rate of staff turnover and client dropout is also instructive: stability probably means an experienced staff and adolescents who engage with the program.

The strength of the therapeutic alliance—the relationship between the teen and his or her counselor—greatly influences the extent to which the program will be able to motivate

change. A low staff to client ratio encourages closer therapeutic relationships. In outpatient programs, experts suggest that one counselor treat no more than 20-25 adolescents; in intensive outpatient, one counselor should have no more than 10-15 clients, and in residential programs, one counselor should be responsible for no more than 4-8 adolescents.

Very few states in their certification standards for treatment programs require that staff have any specific knowledge or experience in treating youth. In the absence of state standards, counselor qualifications vary widely from program to program. Some programs require their professional staff to have a college or graduate degree. Some also require state certification in addiction counseling. A few programs have staff with cross-training in both substance abuse and mental health treatment.

Regular clinical supervision by more experienced staff is important in providing guidance and ongoing training for counselors. Supervision also helps ensure that staff-client interac-

tions are optimally productive. In order to provide quality treatment, clinical supervision and team meetings should take place at least once or twice a week for outpatient programs and three to five times a week for residential, inpatient programs. Treatment programs should have arrangements in place with local hospitals in the event of emergencies or the need for crisis counseling.



Gender and Cultural Competence

Most drug treatment programs were originally designed for adult white male addicts, not women, teenagers or minorities. Today, treatment experts agree that programs should recognize both gender and cultural differences in their treatment approach. Gender and cultural competence is essential in developing a successful therapeutic alliance between the teen and the counselor. This trust is especially important for gay and lesbian adolescents who might not otherwise be willing or able to address key aspects of their identity. This trust is also critical for adolescents and families with mixed racial and cultural identities.

Recent research points to significant differences between male and female adolescent drug users. Although alcohol and other drug use is now widespread among both teenage boys and girls, boys tend to drink and to use drugs more heavily and more often. Boys involved in substance abuse are also more likely to have conduct disorders, including aggressive, disruptive and even violent behavior. Special issues in designing treatment for adolescent males include learning how to change disruptive behaviors, understanding the responsibilities of becoming an adult, HIV risks, date rape and experiencing rites of passage from adolescence to manhood.

Once girls start using drugs, they are more likely than boys to become dependent on alcohol and other drugs. The earlier girls begin using, the more severe their problems will be. This suggests that for girls, early intervention is particularly important. Girls who have substance abuse problems frequently also have severe family problems. Their parents may be disengaged, erratic or abusive. The majority of girls in drug treatment report having been abused sexually or physically, often by family members or older friends.

Girls who drink and use drugs may also have serious mental health problems, which can involve a "double dose" of symptoms, including both internalized anxiety, depression and post-traumatic stress disorder as well as aggressive, disruptive behavior. Depression and trauma in girls usually precede drug use; many teenage girls say they use alcohol and other drugs to make themselves feel better. Abandonment, abuse and depression are key issues girls must address in treatment.

Many co-ed programs provide effective care to girls, particularly if programs provide the opportunity for participating in single-sex groups as well as female counselors for individual sessions and program material developed for girls and young women. Teenage girls often strive for approval from males rather than focusing on their own problems. They may be reluctant to talk freely in front of men about their own sexual experiences, which many regard as shameful. In addition, safety is a central consideration. Programs must insure that girls are physically safe as well as free from sexual and psychological harassment.

Although research is still limited, many experts believe that a lack of understanding of cultural differences may affect the ability to treat minority youth effectively. National studies of Latino adolescents indicate that ethnicity and acculturation are likely to impact various aspects of treatment. Drug use among Hispanic teens increases with the length of time they are in the United States. Cultural factors, which traditionally have kept immigrant teen drug use low, include the central importance of the family as a source of social support, traditional gender roles, and close ties to religion and spirituality. These cultural restraints weaken as children become fully integrated into the dominant North American culture, which often distances them from their more traditional families. Some programs specifically designed for Hispanic teens and their families, like Brief Strategic Family Therapy (BSFT) in Miami, Florida, have adapted the process of engaging teens in treatment to the ethnic culture of individual families. Retention rates are significantly higher than in outpatient programs that do not reflect this cultural competence.



Continuing Care

Three in four adolescents relapse in the first three months following treatment. Gains that teens make in treatment can quickly disappear if they do not have support at home and in the community. Continuing care services include relapse prevention training, follow-up plans and referrals to community resources as well as periodic check-ups one month, three months and one year after completing treatment.

Treatment programs should educate teens to recognize and deal with factors that lead to relapse. What are the triggers that set off cravings for alcohol and other drugs? Which friends are more likely to encourage a return to substance abuse? In what ways can the community and the family play positive, supportive roles? In addition, the program should help the teen think through what to do if relapse occurs. Specific steps, like calling a hotline, a friend, or a Twelve Step sponsor, can be helpful in limiting further substance abuse after relapse. For teens under the supervision of the juvenile justice system, relapse can result in more

severe sanctions. Teens referred to treatment by the juvenile court are usually required to have urine tests during their probation. If the tests are positive for drug use, the teen can be sentenced to a longer, more intense period of probation or to incarceration in a juvenile facility.

Programs vary widely with regard to continuing care. Most programs provide referrals to community resources, including Twelve Step meetings and other self-help groups, and group therapy where available. Less frequently, programs develop a continuing care plan while the teen is still in treatment. Some programs provide ongoing services, including counseling, education, and continuing contact with probation officers. Some also have counselors who follow up with teens who have completed the formal treatment program. For example, the Matrix program in Rancho Cucamonga, California, conducts its outpatient treatment program at the local YMCA, where teens and their parents meet for group and individual therapy. Exercise and participation in other YMCA activities are built into the program, so that teens become engaged in drug-free recreational alternatives which they can continue after they complete treatment.



Treatment Outcomes

Drug Strategies, guided by our Teen Treatment Expert Advisory Panel, has identified "Outcomes" as one of the nine critical elements in developing effective adolescent drug treatment. However, at present, very few programs conduct evaluations of any kind. Evaluations are expensive and require a high level of specialized research expertise. In addition, follow-up data on teens who have participated in treatment are often difficult to obtain, particularly for those who have dropped out. Nonetheless, results from a number of methodologically sound studies conducted during the past decade are encouraging: most adolescents who participate in treatment report significant reductions in substance use and related problems in the year following treatment.

In the absence of formal outcome evaluations, what other information can shed light on the effectiveness of particular programs? Despite its limitations, adolescent treatment research does offer strong evidence that treatment completion is closely linked to positive outcomes. It remains unclear whether this has more to do with treatment or with the client's own motivation. But

the consistently strong relationship between completion and good outcomes makes retention rate a valuable indicator of program effectiveness. How many clients drop out? How long do others stay? How many actually complete treatment? Very few programs can point to results from rigorous evaluations, but every program should be able to provide accurate, intelligible data on client retention and completion.

Other important indicators should also be available. As part of the clinical process, adolescent treatment programs should routinely measure clients' progress: Do regular urine tests come back clean (i.e., no drug use)? Is school performance improving? Is aggressive, disruptive behavior diminishing? Are family relationships improving? In short, a program should be able to document changes in the trajectory of their clients' lives both while they are in treatment and at periodic intervals in the year following treatment.

A survey of adolescent drug treatment studies and major findings, compiled by Dr. Michael L. Dennis, Senior Research Psychologist, Chestnut Health Systems, is posted at www.drugstrategies.org

Program Descriptions

This section presents summary information on 144 adolescent treatment programs located in 42 states across the country. The programs are grouped by region: Northeast (30 programs in nine states); Midwest (30 programs in nine states); South (48 programs in 13 states); and West (36 programs in 11 states). More than 80 percent of the programs here have been in operation for at least 10 years; nearly 40 percent of them have been running for at least 20 years. More detailed information on each of the programs can be found at www.drugstrategies.org

Based on the information made available to Drug Strategies, programs offering services that appear to be exceptionally strong in any of the key elements of effectiveness are identified by no more than three icons placed directly under the program's name. (If space permitted, a few programs would merit four or more icons.) Program selection and information gathering are described in Methodology. Definitions of the terms used below can be found in Teen Treatment Terms.

National Accreditation

Government licensing and accreditation requirements for adolescent substance abuse treatment programs vary from state to state, making it difficult to compare programs across the country. However, three organizations evaluate a wide range of healthcare, rehabilitation and human services programs nationwide to assure high quality service delivery and consistent standards of care. Half of the programs included in the guide (72 of 144) are accredited by one or more of the following national organizations: the Council on Accreditation (COA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the Rehabilitation Accreditation Commission (CARF). For more information on accreditation, please visit www.drugstrategies.org

Services Offered

The services offered by each program are described in terms of the treatment model or approach emphasized (e.g., Twelve Step model); the treatment setting (e.g., residential); whether services are co-ed or single-

sex only; and the age range of youths served.

Predominant Treatment Approaches:

Among the 144 programs described, 101 (70 percent) offer services based on a combination of treatment approaches. By far the most widely used approaches are the Twelve Step model (66 percent of all programs) and cognitive behavioral therapy (58 percent). Four other approaches are featured by more than a dozen of the 144 programs: motivational enhancement therapy (19 percent); multisystemic therapy (19 percent); multidimensional family therapy (13 percent); and therapeutic community (13 percent).

Most Common Treatment Settings:

The majority of the programs (87 of 144) provide services in more than one treatment setting. Outpatient (offered by 63 percent of all programs) and residential (60 percent) are the two most common settings. Other major settings include day treatment (14 percent); detoxification (13 percent); halfway house or transitional living (13 percent); and inpatient (4 percent). Among the 57 programs

that offer a single treatment setting, residential (28 programs) and outpatient (24 programs) predominate.

Co-ed and Single-Sex Programs:

Nearly 90 percent of the programs (127 of 144) are co-ed. Of the 17 programs that are not co-ed, eleven are for males only and six for females only.

Length of Stay

The expected length of treatment at each program is presented in terms of days, weeks, months or years. For programs offering services in more than one setting, such as residential or outpatient, lengths of stay are typically presented for each setting. Where programs use their different settings as sequential phases through which each client is intended to progress, only one length of stay is presented.

Capacity

The capacity figures represent the maximum number of clients who can be served by a program at any given moment in time. Where applicable, capacity figures are indicated for each of the different treatment settings offered by the program.

Multidimensional Family Therapy



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Multidimensional Family Therapy (MDFT) is an outpatient family-based program to treat adolescents with drug abuse and behavioral problems. The program works intensely at the same time with the individual adolescent; the family apart from the adolescent; the family and teen together; and social systems that affect both, such as schools, courts, peer groups and the community. MDFT has a strong theoretical structure based on developmental psychological principles. The program, housed in a research center at the University of Miami, has conducted several randomized clinical trials which have demonstrated the effectiveness of different versions of the approach. Detailed treatment and supervisor

manuals allow replication of the program, which has been implemented in 16 other sites across the country.



Assessment and Matching

Therapists assess each adolescent's risk factors such as school failure, parental drug abuse, connection with drug using peers, and family conflict as well as protective factors, including strong bonds to family, school and religious organizations and clear, consistent parental discipline. Observation and clinical interviews are used to determine individual and family functioning. The approach is applied at various levels of intensity depending on individual needs. Because the teen's and family's functioning in their everyday environment is so important to positive development, therapists help families get referrals to other services.



Comprehensive, Integrated Approach

Individual and family counseling sessions usually take place in a clinic but can be conducted elsewhere. A family sees a therapist one to four times a week for four to eight months,

depending on the intensity of the intervention being used. MDFT views any interaction between the therapist and the client/family as an opportunity to provide treatment. Therapists and client/family members attend school meetings, wait in court rooms, ride in elevators or sit in parks. The interaction and insights provided in these informal settings are critical for increasing trust between therapists and clients and for improving family dynamics. MDFT incorporates multiple social systems into its therapeutic work. Its operations involve family, peer groups, courts, schools, psychiatric and other community services. Therapists are in constant contact with all these institutions to help coordinate services and to assess treatment progress. For example, therapists work with schools to obtain tutoring, arrange transfers to better schools or transfers into different classrooms. Staff utilize *Special Education Advocacy* (edited by Joseph Luman) which describes Federal regulations outlining the rights of students and how to obtain the educational activities needed for these students.



Family Involvement

Since MDFT seeks to improve the parent/child relationship, therapists work diligently to involve parents in the treatment. MDFT understands how a good parent/child relationship is a powerful protective factor against substance abuse. Therapists work on resolving parents' personal mental health and substance use issues, teaching parenting skills, and addressing the family environment as a whole. Therapists have frequent telephone contact with families to follow up on issues raised in counseling and to monitor the home environment.



Developmentally Appropriate

MDFT strives to foster the adolescent's functioning in multiple domains at the appropriate stage of development that was derailed by substance abuse. Treatment is geared to emotional and developmental maturity rather than chronological age. Therapists teach parents how to parent for that particular age and how to change parenting as the teen matures. Individual sessions with the

adolescent focus on important developmental tasks such as identity formation, peer relations and coping with the demands of school.



Engage and Retain

MDFT's record of success is a significant factor in recruiting new clients. To engage these clients, therapists work intensively with adolescents to identify their treatment goals: what they want to see changed in themselves, their families and their environment. Therapists explain how the program can help meet these goals. In order to gain parental cooperation, therapists acknowledge parents' past efforts and encourage them to express their frustrations with their children's drug use and behavioral problems. To engage parents, therapists may use a family photo album to help parents recall when family life was better. Earlier hopes and dreams of parents for their children are discussed, which often motivate parents to try once more.



Qualified Staff

MDFT therapists are required to have at least a master's degree, with two years of post-master's experience in family-based intervention. Therapists are then required to com-

plete 100 hours of model-based training (didactic seminar, review of videotapes with a supervisor, completion of several pilot cases.) In Miami, all MDFT therapy sessions are videotaped. Families voice no objection and the camera is quickly forgotten. Once a week, all therapists have a two-to-three hour session to review these videotapes and to discuss ways to improve their clinical skills. In the intensive version of MDFT, Therapist Assistants are responsible for many case management services, such as filling in forms for school transfers, acquiring food stamps, tracking down employment opportunities for clients and arranging housing, medical information or medical care.



Gender and Cultural Competence

The program addresses gender and cultural issues on an individual basis. The staff in the Miami clinic reflect a variety of cultures and nationalities (Haitian, Venezuelan, Cuban, African-American) and relate to Miami's ethnic diversity. Sometimes an adolescent feels estranged from the culture from which his or her parents came. Here cultural interventions include the use of media or print materials, such as PBS videos and relevant publications from consulates and libraries,

as informational aids to the therapy process, which focuses on bridging the family's cultural divides.



Continuing Care

The intensity and length of aftercare services depend on the agency implementing MDFT. Services can include booster family sessions or referral to a less intensive program. Adolescents are linked to Twelve Step meetings during treatment that continue after treatment ends. Adolescents and families work on relapse prevention issues during treatment.



Outcomes

The program has extensive research data from four randomized clinical trials and several therapy process studies that demonstrate the effectiveness of the program. Positive outcomes in MDFT are observed in symptom reduction and in the promotion of protective factors such as school performance and family functioning. In one randomized study, MDFT was compared to two alternative treatments—adolescent group therapy and family education, workshops and discussions. Outcome measures were taken at 6 and 12 months post-treatment with abstinence confirmed through urinalysis. At one year post-treatment, 45 per-

cent of youths who had received MDFT reported clinically significant reductions in drug use, compared to 32 percent and 26 percent of adolescents in the other two groups. Grade point average (GPA) improved significantly. At intake, 20 percent of the MDFT population had a grade point average of 2.0 or better. At one year follow-up, the percentage increased to 76 percent.

Another study compared MDFT to individual cognitive-behavioral therapy (CBT) for adolescent drug abuse. Participants in the study were 224 drug-using adolescents and their families. Self-reported adolescent drug use and adolescent-reported and parent-reported externalizing and internalizing symptomatology were assessed at intake, termination, and again at 6 and 12 months following treatment termination. Although both approaches produced a significant decrease in drug use and other problems during treatment, only MDFT adolescents continued to improve in the year following treatment.



Cost

MDFT's standard program costs \$164 per adolescent per week; the intensive version costs \$384 per week.