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ABSTRACT

This guide looks at drug abuse in the context of adolescent development and provides a framework for understanding what has been learned about effective adolescent drug treatment over the last decade. The guide, which underscores the need to address developmental issues when treating adolescents, provides concrete ways to assess treatment programs, including the key elements of effective adolescent drug treatment and questions to ask of treatment providers. Provided is current information on 144 adolescent drug programs across the country, and an in-depth look is provided for seven promising programs that reflect a variety of treatment approaches. It includes hotline numbers and website addresses for finding treatment in each state and definitions of frequently used treatment terms. The guide also provides information about teen drug treatment in the juvenile justice system, and discusses the treatment of substance abuse and mental health problems, which co-occur in two-thirds of adolescents in drug treatment. (Contains 55 references.) (GCP)

Treating Teens:

A Guide to Adolescent Drug Programs

Treating Teens: A Guide to Adolescent Drug Programs was made possible by a grant from the Robert Wood Johnson Foundation. This project is guided by Drug Strategies' Board of Directors as well as by a distinguished panel of researchers, policymakers and practitioners (see inside back cover for names). We are grateful for their help and their wisdom.

Treating Teens reflects the judgement of Drug Strategies alone, not necessarily the views of our advisors or funders. The treatment programs described in this guide were identified by a number of expert sources, listed in Methodology. Drug Strategies does not endorse or take responsibility for any of the treatment programs included in this guide.

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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 leamed 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 adolescents. 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 psychiatric 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 problems, 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-

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.

Programs:

Northeast

Program	Address	Date Established	Accreditation	Services	Length of Stay	Capacity
Bridge Over Troubled Waters, Inc.	47 West Street Boston, MA 02111 (617) 423-9575 www.bridgeovertroubledwater.org	1970		Twelve Step model & psycho-education. Halfway house & outpatient: co-ed, ages 13-24 (geared toward runaway or homeless teens & young adults).	residential: 9-12 months outpatient: 17 visits	residential: 15 outpatient: 85
Caron Adolescent Treatment Center	Galen Hall Road PO Box 150 Wernersville, PA 19565 (800) 678-2332 www.caron.org	1980	JCAHO	Twelve Step model. Detoxification & short-term residential: co-ed, ages 12-19 halfway house: males, ages 13-19; females, ages 16-23.	residential: 28 days halfway house: 90 days	residential: 30 halfway house: 16 males, 13 females
Center Point	81 West Canal Street Winooski, VT 05404 (802) 654-7711	1992	CARF	Cognitive behavioral, multidimensional family & narrative therapies. Day & outpatient: co-ed, ages 12-18.	6-10 weeks	day: 10 individual outpatient: 20 group outpatient: 8
The Children's Center of Hamden, Inc.	1400 Whitney Avenue Hamden, CT 06517 (203) 248-2116 www.childrenscenterhamden.org	1997	JCAHO	Twelve Step model, cognitive behavioral & reality therapies. Short-term residential: co-ed, ages 12-16 outpatient: co-ed, ages 12-18.	residential: 45 days outpatient: 3-6 months	residential: 14 outpatient: 23
CODAC III	93 Thames Street Newport, RI 02840 (401) 846-4150	1997	JCAHO	Cognitive behavioral therapy. Intensive outpatient & outpatient: co-ed, ages 13-19.	12-16 weeks	35 clients
Community Solutions, Inc.	1095 Blue Hills Avenue Bloomfield, CT 06002 (860) 242-7544 www.csi-online.org	1999		Multisystemic therapy. Outpatient (with in-home sessions): co-ed, ages 12-17 (continuing care program for youths leaving juvenile justice or other residential programs).	6 months	30 clients

Program	Address	Date Established	Accreditation	Services	Length of Stay	Capacity
Conifer Park	79 Glenridge Road Glenville, NY 12302 (518) 399-6446 www.libertymgt.com	1984	JCAHO	Twelve Step model, cognitive behavioral, motivational enhancement & multidimensional family therapies. Short-term residential & outpatient: co-ed, ages 12-17.	residential: 15-21 days outpatient: 4 months	residential: 24 outpatient: 180
Cornell Abraxas I	Blue Jay Village, Box 59 Forest Road Marienville, PA 16239 (800) 352-3402 www.cornellcompanies.com	1973	JCAHO	Cognitive behavioral & reality therapies. Long-term residential: males only, ages 14-18.	10 months	248 (males only)
Cornell Abraxas Center for Adolescent Females	306 Penn Avenue Pittsburgh, PA 15221 (412) 244-3710 www.cornellcompanies.com	1988		Cognitive behavioral therapy. Long-term residential: adjudicated females only, ages 13-18.	9 months	104 (females only)
Credo Community Center for the Treatment of Addictions	24180 County Route 16 Evans Mills, NY 13637 (315) 629-4441 www.credocommunitycenter.com	1973		Twelve Step model. Long-term residential: males only, ages 16-30.	7-10 months	18-20 adolescent males 6-8 adult males
Day One Residential Treatment Center	PO Box 41 Bar Mills, ME 04004 (207) 929-5166 www.day-one.org	1973		Twelve Step model, cognitive behavioral & motivational enhancement therapies. Long-term residential, outpatient & continuing care: co-ed, ages 16-20.	residential: 6 months outpatient: 8 weeks continuing care: 13 weeks	residential: 12 outpatient: 80 continuing care: 90
Day One Substance Abuse Services	University of Vermont Treatment Research Center 54-56 West Twin Oaks Terrace South Burlington, VT 05403 (802) 847-3333	2001	JCAHO	Cognitive behavioral & motivational enhancement therapies. Outpatient: co-ed, ages 12-18.	1 month (4 sessions) 3 months (14 sessions)	14 clients

Programs:

Northeast

Program	Address	Date Established	Accreditation	Services	Length of Stay	Capacity
Dynamic Youth Community, Inc.	1830 Coney Island Avenue Brooklyn, NY 11230 (718) 376-7923	1970		Therapeutic community. Long-term residential, outpatient & continuing care: co-ed, ages 13-21.	1 year in each of the 3 phases	residential: 76 outpatient: 35 continuing care: 20
Hartford Behavioral Health	Cole Treatment Center 2550 Main Street Hartford, CT 06120 (860) 548-0101 www.hartfordbehavioralhealth.org	1983		Multisystemic therapy. Outpatient (with in-home sessions): co-ed, ages 9-17.	4-6 months	17 clients
KidsPeace	RR3 Box 3406 Saylorsburg, PA 18353-9632 (610) 381-3400 www.kidspeace.org	1996	JCAHO	Therapeutic community & reality therapy. Residential: co-ed, ages 13-18.	70 days	19 clients
Living in Freedom Early (LIFE) Program	St. Joseph's Villa of Rochester 3300 Dewey Avenue Rochester, NY 14616-3795 (716) 865-1550	1987	JCAHO	Twelve Step model. Long-term residential: males only, ages 13-18.	6 months	14 (males only)
McLean Hospital Adolescent Dual Diagnosis Program	115 Mill Street, EH2 Belmont, MA 02478 (617) 855-2000 www.mcleanhospital.org/Child/	1990	JCAHO	Multisystemic therapy. Short-term residential & day: co-ed, ages 13-18.	2-4 weeks	12 clients
Newark Renaissance House, Inc.	74-8 Norfolk Street Newark, NJ 07103 (973) 623-3386 www.nrh.org	1975		Twelve Step model & therapeutic community. Long-term residential: males only, ages 14-19 day: co-ed, ages 14-19.	residential: 9-18 months day: 6 months	residential: 53 (males only) day: 15

Program	Address	Date Established	Accreditation	Services	Length of Stay	Capacity
The Outreach Project	400 Crooked Hill Road Brentwood, NY 11717 (631) 231-3232 www.outreach-project.org/adolesce.htm	1984		Therapeutic community. Long-term residential: co-ed, ages 12-17.	9-12 months	54 clients
Phoenix Academy at Wallum Lake	2090 Wallum Lake Road Pascoag, RI 02859 (401) 568-1770 www.phoenixhouse.org	1990	CARF	Therapeutic community. Long-term residential: males only, ages 13-18 ½.	6 months	16 clients
Phoenix Academy of Westchester	3151 Stoney Street Shrub Oak, NY 10588 (914) 962-2491 www.phoenixhouse.org	1982		Therapeutic community & cognitive behavioral therapy. Long-term residential & transitional care: co-ed, ages 15-21.	18-24 months	160 clients
Providence Community Action	662 Hartford Avenue Providence, RI 02909 (401) 272-0660	1982		Twelve Step model & cognitive behavioral therapy. Intensive outpatient: co-ed, ages 13-17.	4 months	100 clients
Renaissance Campus	920 Harlem Road West Seneca, NY 14224 (716) 821-0391	1990		Twelve Step model, motivational enhancement, multidimensional family & reality therapies. Long-term residential: co-ed, ages 12-18 transitional living: co-ed, ages 13-20.	residential: 6-8 months transitional: 6-10 months	residential: 30 males, 10 females transitional: 16 males, 6 females
Rose Hill Chemical Dependency Program for Youth	County Route 43 PO Box 100 Massena, NY 13662 (315) 764-9700 www.rosehillrehab.org	1988		Twelve Step model & cognitive behavioral therapy. Short-term residential: co-ed, ages 12-18.	42 days	30 clients

Programs:

Northeast

Program	Address	Date Established	Accreditation	Services	Length of Stay	Capacity
Sameem Associates, Inc.	34 Lincoln Street Newton, MA 02461 (617) 964-1060 www.sosdrugs.org	1986		Twelve Step model. Outpatient detoxification & outpatient: co-ed, ages 13-19.	9-16 months	56 clients
Smithers Comprehensive Addictions Program for Adolescents	St. Luke's-Roosevelt Hospital Center 411 West 114th Street Suite 3C New York, NY 10025 (212) 523-7157	1993	JCAHO	Twelve Step model, cognitive behavioral & motivational enhancement therapies. Day, intensive outpatient & outpatient: co-ed, ages 14-19.	1 year	24 clients
Stonington Institute	75 Swantown Hill Road North Stonington, CT 06359 (860) 535-1010 www.stoningtoninstitute.com	1999	JCAHO	Twelve Step model & therapeutic community. Detoxification & residential: co-ed, ages 12-18.	residential: 3-6 months day: 3 weeks	residential: 22 day: 40
Tri-County Substance Abuse Services	79 Coventry Street, Suite 4 Newport, VT 05855 (802) 334-5246 www.nkhs.org/subabuse.html	1999		Cognitive behavioral & motivational enhancement therapies. Outpatient: co-ed, ages 12-17.	3 months	50 clients
Washington County Youth Service Bureau – Boys & Girls Club	38 Elm Street PO Box 627 Montpelier, VT 05601 (802) 229-9151	1974		Twelve Step model & cognitive behavioral therapy. Outpatient & early intervention: co-ed, ages 12-22.	12 weeks	30 clients
The Youth Council	112 West Pearl Street Nashua, NH 03060 (603) 889-1090 www.theyouthcouncil.org	1974		Twelve Step model, cognitive behavioral, motivational enhancement & art therapies. Outpatient & early intervention: co-ed, ages 13-18.	3-6 months	60 clients

Depth Look:

Phoenix Academy of Westchester

3151 Stoney Street
Shrub Oak, NY 10588
(914) 962-2491
www.phoenixhouse.org

Phoenix Academy of Westchester, a therapeutic community (TC) established in 1982, offers a highly structured program of group therapy and cognitive behavioral therapy for clients with severe behavioral and drug problems. The Academy serves 160 adolescent clients, 15 to 21 years of age, primarily from New York City, 60 miles away. Additionally, there is a program for 100 adult clients at the site. The New York City Board of Education maintains an alternate school at Phoenix Academy; adolescents must remain in the program until they earn a high school diploma, which typically takes two or more years. The Academy is housed in a former Jesuit seminary situated on a campus of several hundred wooded acres, affording camping, athletics, farming and other outdoor activities that build responsibility and self-esteem.

Assessment and Matching
Initial assessments, conducted at a Manhattan office, include surveys such as the Mental Health Screening Form III, an easy-to-use, 18-item instrument to identify co-occurring psychiatric disorders. A psychiatrist also does an evaluation. Although Academy students are referred from many different sources, a significant number come into treatment from the criminal justice system; the courts will place certain non-violent, first time felony offenders at the school. Once admitted, adolescent males are assigned to the Induction Unit for one month to learn the rules of living in a therapeutic community. Adolescent females go directly to the female wing. Staff collect additional information on family, legal and mental health histories. During this period, a teacher from the alternative high school assesses the educational level of clients.

Comprehensive, Integrated Approach
Clients are assigned to one of eleven "clans," separated by gender but not by age, each with its own counselor. From 4:00 p.m. until 10:00 p.m., clients participate in seminars on drug-related topics and in discussions where residents can confront each other on behavior and attitudes. Specific job duties, house meetings and study time also take place during this period. The Academy maintains close links with the juvenile justice system and regularly reports clients' progress to probation officers and judges. Phoenix Academy also maintains a full-time medical staff and clinic. Upon entering treatment, all clients receive physical and dental exams, with follow-up dental exams every three months and physical exams monthly.

The New York City Board of Education employs two administrators and 18 teachers assigned to the alternative high school. Class size is small to deal with students with varying levels of education. The academic track is accelerated so students can earn enough credits to graduate in two years. From 8:00 a.m. until 3:00 p.m., clients attend seven 45-minute classes which include math, science, English, graphic arts, music and computers. To graduate, clients must pass state-regulated standardized tests. Teachers often donate time outside classes to help clients prepare for these tests. Twice a year, teachers meet with clinical staff to discuss clients' progress. Teachers also travel to New York City to meet with the parents of clients.

Family Involvement
Phoenix Academy regards the family as an important component of the therapeutic process and conducts a two-phase family program. The first phase consists of Parent Education Seminars (P.E.S.)—three educational sessions that take place in New York City. These seminars are led by family therapists from the Academy who cover the therapeutic process, family dynamics and substance abuse. Recent graduates of the program discuss the importance of family participation. After P.E.S., parents attend the second phase—six multi-group family therapy sessions over a twelve week period—held at the Westchester facility. Transportation from New York City is provided. After the group session, parents can

visit with their children for half an hour. About 75 percent of families attend these sessions. Family therapists also conduct a weekly session for clients to discuss issues that arise in the family group. After the second phase, clinical staff maintain monthly family contact by telephone. When necessary, family counseling and therapy are provided to help establish stable and supportive home environments for students to return to.

Developmentally Appropriate

Phoenix Academy uses materials developed specifically for adolescents, along with a variety of interactive techniques for its educational seminars. For example, the HIV coordinator, at monthly seminars on HIV, sexually transmitted diseases and reproductive health, engages adolescents with role plays, open forums or discussions of topics that students pick out of a "grab bag" and explain to the group. Phoenix Academy has tailored the therapeutic community model for adolescents. Group leaders use simple language, even tones of voice and careful listening while avoiding confrontation, raised voices and techniques to "break down" the client, the approach usually taken with adults.

Engage and Retain

To engage adolescents, there are twice weekly seminars to help clients understand the importance of treatment, covering a variety of educational topics related to substance abuse and recovery. As clients move through the four phases of the program (induction, transition, primary treatment and re-entry), they earn privileges. These privileges can be withheld due to poor or uncooperative behavior. The TC environment encourages students to explore their potential and to become valued and respected members of a community. It prepares them for greater independence and responsibility. Earning a high school diploma is also a motivating factor. Many clients want their families to be proud of them; a diploma is a highly regarded symbol of achievement. Clients who drop out of the program often have their sentences increased by the courts.

Qualified Staff

Staff may have therapeutic community experience or academic training. Phoenix Academy provides staff training, including 82 hours that can be credited towards a CASAC certificate (Credentialed Alcohol and Substance Abuse Counselor). About 60 percent of counselors have a CASAC license. Staff includes family therapists and a consulting psychiatrist. High school teachers typically do not have formal chemical dependency training but do receive training at Phoenix Academy on therapeutic communities.

Gender and Cultural Competence

There are approximately seven males to one female in residential treatment. During the week, clients attend three groups: two gender separate and one co-ed. Topics for females include dress, grooming, relationships and strategies to avoid sexually predatory situations. Males and females live on separate floors. Females are always assigned to female counselors. Safety is a high priority.

Continuing Care

Continuing care typically lasts for 6-12 months. When adolescents leave Phoenix Academy, they may return home or may enter one of two co-ed re-entry facilities. The facilities, located in New York City, house both adolescents and adults. As a facility resident, an adolescent is still considered in treatment, and is thus eligible for New York Vocational Educational Services for Individuals with Disabilities (VESID) funding for training. The adolescent attends vocational training for six months before taking a job. While working, clients are required to put money in a savings account; the goal is to save between $5,000-$6,000. At the facility, they must submit weekly itineraries to the staff and observe a curfew. Clients also attend weekly group meetings which cover re-entering the community, socialization, engaging in positive activities, and making friends with non-substance abusing individuals. For adolescents who return home, they must attend the same weekly group meetings at the re-entry facilities for 6 to 12 months. Adolescents who live at home are expected to be involved in some vocational or academic training.

Outcomes

Phoenix Academy of Westchester has no outcome data. However, beginning in 2002, clients are being asked to sign release forms that will allow Phoenix to obtain outcome data in the future.

Cost

Typically patients qualify for Medicaid, so there is no cost to the patient. Costs to Medicaid vary based on services required. Costs per day per client, exclusive of medical and educational services, range from $56 to $201 at nine Phoenix Academies.

Programs: Midwest

Program	Address	Date Established	Accreditation	Services	Length of Stay	Capacity
Adolescent Center for Treatment (ACT)	Johnson County Mental Health Center 301 North Monroe Street Olathe, KS 66061 (913) 782-0283	1985		Twelve Step model & cognitive behavioral therapy. Short-term residential & outpatient: co-ed, ages 12-18.	residential: 24 days outpatient: 6 weeks	residential: 20 outpatient: 40
Area Substance Abuse Council	3601 16th Avenue SW Cedar Rapids, IA 52404 (319) 390-4611	1996		Twelve Step model & cognitive behavioral therapy. Residential, intensive outpatient & outpatient: co-ed, ages 13-18.	residential: 60-90 days intensive outpatient: 8-10 weeks outpatient: 10-15 weeks	residential: 20 intensive outpatient: 12 outpatient: 135
Associated Youth Services	1620 South 37th Street Kansas City, KS 66106 (913) 831-2820 www.childally.org/projects/ays.html	1986		Cognitive behavioral & motivational enhancement therapies. Outpatient & continuing care: co-ed, ages 12-18.	outpatient: 8 weeks continuing care: 8 sessions	24 clients
Bassett House	100 Hospital Drive Athens, OH 45701 (800) 645-8287	1980		Twelve Step model, cognitive behavioral, multisystemic, rational emotive behavior & reality therapies. Short-term residential & outpatient: co-ed, ages 13-18.	residential: 35 days outpatient: 1-3 months	residential: 24 outpatient: 12
Catholic Charities Services of Cuyahoga County	3135 Euclid Avenue Cleveland, OH 44115 (216) 631-3499 www.clevelandcatholiccharities.org	1982	JCAHO	Twelve Step model. Intensive outpatient & outpatient: co-ed, ages 11-21.	2-4 months	70 clients
The Center for Alcohol & Drug Services	4869 Forest Grove Bettendorf, IA 52722 (563) 332-9080	1982	CARF	Twelve Step model & cognitive behavioral therapy. Residential, day & outpatient: co-ed, ages 12-18.	6-8 weeks	32-38 clients

Programs:

Midwest

Program	Address	Date Established	Accreditation	Services	Length of Stay	Capacity
Central East Alcoholism & Drug Council	635 Division Street Charleston, IL 61920 (217) 348-8108	1972	CARF	Twelve Step model, cognitive behavioral & multisystemic therapies. Residential & outpatient: co-ed, ages 10-20 recovery home (halfway house): males only, ages 10-20.	residential: 90 days, recovery home: 1 year outpatient: 6-9 months, juvenile court outpatient: 3 or 6 months	residential: 16 recovery home: 9 (males only) outpatient: 20 juvenile court outpatient: 20
Chestnut Health Systems	1003 Martin Luther King Drive Bloomington, IL 61701 (309) 827-6026 www.chestnut.org	1985	JCAHO	Twelve Step model, cognitive behavioral, motivational enhancement, reality & Rogerian therapies. Short-term residential, outpatient & early intervention: co-ed, ages 12-18.	residential: 40-60 days outpatient: 2-4 months	residential: 48 outpatient: 60
Cornell Abraxas of Ohio	2775 State Route 39 Shelby, OH 44875 (800) 680-5747 www.cornellcompanies.com	1973		Twelve Step model, cognitive behavioral therapy & therapeutic community. Long-term residential: males only, ages 12-18.	7 months	108 (males only)
Drake Counseling Services	1202 23rd Street South Fargo, ND 58103 (701) 293-5429 www.drakecounselingservices.com	1992		Twelve Step model, cognitive behavioral, multisystemic & brief therapies. Intensive outpatient: co-ed, ages 13-18.	9 weeks	18 clients
Egyptian Public & Mental Health Department	1412 U.S. 45 North Eldorado, IL 62930 (618) 273-3326 www.egyptian.org	1992	COA	Cognitive behavioral therapy. Outpatient: co-ed, ages 12-18.	3-6 months	45-50 clients
Elm Acres Youth & Family Services, Inc.	1002 East Madison Pittsburgh, KS 66762 (620) 231-9840	1985		Twelve Step model & cognitive behavioral therapy. Short-term residential: co-ed, ages 13-18 outpatient: females only, ages 13-18.	residential: 28 days outpatient: 60 days	residential: 18 outpatient: 25 (females only)

Assessment and Matching | Comprehensive, Integrated Approach | Family Involvement | Developmentally Appropriate | Engage and Retain | Qualified Staff | Gender and Cultural Competence | Continuing Care | Outcomes

Program	Address	Date Established	Accreditation	Services	Length of Stay	Capacity
Fairbanks	8102 Clearvista Parkway Indianapolis, IN 46256 (317) 849-8222	1982	JCAHO	Twelve Step model, cognitive behavioral & reality therapies. Detoxification, residential, halfway house, day & intensive outpatient: co-ed, ages 12-18.	residential: 10-14 weeks halfway house: 90 days day:10-14 wks intensive out-patient:6-10 wks	22 clients
Hazelden Center for Youth & Families	11505 36th Avenue North Plymouth, MN 55441-2398 (800) 833-4497 www.hazelden.org	1981	JCAHO & CARF	Twelve Step model. Detoxification, residential & day: co-ed, ages 14-25; extended care: males only, ages 16-25.	residential / day: 3-4 wks halfway house: 60-90 days	residential / day: 50 halfway house: 20 (males only)
Lake County Health Department – Youth Services Program	3004 Grand Avenue Waukegan, IL 60085 (847) 360-6770	1980	JCAHO	Twelve Step model, cognitive behavioral & multisystemic therapies. Outpatient (school-based): co-ed, ages 12-17.	12-14 months	180 clients
Lawrence Center – Waukesha Memorial Hospital	3011 Saylesville Road Waukesha, WI 53189 (262) 928-4036 www.waukeshamemorial.org	1984	JCAHO	Twelve Step model & cognitive behavioral therapy. Detoxification, short-term residential, day, intensive outpatient & outpatient: co-ed, ages 12-17.	residential: 8 days day: 5-8 days intensive outpatient & outpatient: 90 days	residential: 10 day: 24 intensive outpatient: 36 outpatient: 100
Meridian Services, Inc.	527 North Meridian Road Youngstown, OH 44509 (330) 652-1470	2001	CARF	Cognitive behavioral therapy. Residential, intensive outpatient & outpatient: males only, ages 13-18.	residential: 90 days outpatient: 12 weeks	residential: 24 (males only) outpatient: 40
Omni Youth Services	1111 West Lake Cook Road Buffalo Grove, IL 60089 (847) 353-1500 www.omniyouth.org	1972		Cognitive behavioral & multisystemic therapies. Outpatient: co-ed, ages 12-18.	7 months	180 clients

Programs:

Midwest

Program	Address	Date Established	Accreditation	Services	Length of Stay	Capacity
Options Youth Services	1642 West Douglas Wichita, KS 67203 (316) 265-8561 www.dccca.org	1997		Strength perspective. Short-term residential & outpatient: co-ed, ages 12-19.	residential: 21-28 days outpatient: 5 months	residential: 23 outpatient: 100-120
Pathway Family Center	6408 Castleplace Drive Indianapolis, IN 46250 (317) 585-6953 www.pfcenter.org	1993	COA	Twelve Step model, cognitive behavioral & multidimensional family therapies. Day, outpatient & continuing care: co-ed, ages 12-18 (in first phase, clients live in home of another client who is more advanced in the program).	12 months	35 clients (Indianapolis, IN) 50 clients (Southfield, MI)
LE Philips-Libertas Center	St. Joseph's Hospital 2601 Highway 1 Chippewa Falls, WI 54729 (715) 723-5585	1977	JCAHO	Twelve Step model, cognitive behavioral & rational emotive behavior therapies. Detoxification, inpatient, intensive outpatient & outpatient: co-ed, ages 12-18.	inpatient: 14-17 days intensive outpatient: 5-8 wks outpatient: 4 months	inpatient: 6 intensive outpatient: 8 outpatient: 50
Rediscovery Drug & Alcohol Treatment Center	334 Third Street SW Huron, SD 57350 (605) 353-1025 www.ourhomeinc.org	1986		Twelve Step model & positive peer culture. Inpatient & short-term residential: co-ed, ages 12-18.	47 days	24 clients
Rosecrance Adolescent Services	1505 North Alpine Road Rockford, IL 61107 (815) 399-5351 www.rosecrance.org	1982	JCAHO	Twelve Step model, cognitive behavioral & multidimensional family therapies. Residential & halfway house: females only, ages 15-18 day & outpatient: co-ed, ages 12-18.	residential: 25 days halfway house: up to 2 years outpatient: 8 weeks	residential: 45 outpatient: 80
Sobriety High School	5250 West 73rd Street Minneapolis, MN 55439 (952) 831-7138	1989		Twelve Step model. School for teens who have completed treatment & are in recovery: co-ed, grades 9-12.	2 years	60 students

Program	Address	Date Established	Accreditation	Services	Length of Stay	Capacity
Transitus House	1830 Wheaton Street Chippewa Falls, WI 54729 (715) 723-1155	1976		Twelve Step model & cognitive behavioral therapy. Residential: females only, ages 15 & older (program considers intergenerational communication valuable to the therapeutic process for adolescents & adults alike).	30-90 days	5 adolescent females 15 adult females
Volunteers of America – Heisler Adolescent Treatment Program	1401 West 51st Street Sioux Falls, SD 57109 (800) 365-8336 www.voa-dakotas.org	1992	JCAHO	Twelve Step model & social learning theory. Inpatient, day & intensive outpatient: co-ed, ages 11-19 residential: pregnant females only, ages 12-17.	inpatient, day & intensive outpatient: 45 days residential: 9 months	inpatient: 22 residential: 10 (pregnant females only) day: 22 intensive outpatient: 13
West Central Human Service Center	600 South Second Street, Suite 5 Bismarck, ND 58504 (701) 328-8888	1991		Twelve Step model & cognitive behavioral therapy. Intensive outpatient, outpatient & continuing care: co-ed, ages 13-18.	16 weeks	intensive outpatient: 12 outpatient: 12 continuing care: 12
White Oaks Companies – Youth & Community Services	5113 North Executive Drive Peoria, IL 61614 (309) 589-4864	1975	JCAHO	Twelve Step model, cognitive behavioral, motivational enhancement, multidimensional family & multisystemic therapies. Intensive outpatient & outpatient: co-ed, ages 12-18.	intensive outpatient: 3 mos. outpatient: 10-12 mos.	intensive outpatient: 25 outpatient: 25
Woodlands Treatment Center	4715 Sullivan Slough Road Burlington, IA 52601 (319) 753-0700	1986		Twelve Step model. Long-term residential: co-ed, court-ordered, ages 13-17.	6-9 months	24 clients
Youth & Shelter Services, Inc.	511 Duff Avenue, Suite 301 PO Box 1628 Ames, IA 50010 (515) 233-3141 www.yss.ames.ia.us	1976		Twelve Step model, multidimensional family & multisystemic therapies. Short-term residential, halfway house, intensive outpatient & outpatient: co-ed, ages 12-18.	residential: 4 wks halfway house: 4 mos. intensive outpatient: 4 wks outpatient: 6 wks	residential, halfway house & intensive outpatient: 40 outpatient: 100

In-Depth Look:

Chestnut Health Systems

1003 Martin Luther King Drive
Bloomington, IL 61701
(309) 827-6026
www.chestnut.org

Chestnut Health Systems provides residential (30 to 180 days), day treatment, intensive outpatient, outpatient, early intervention and aftercare services for adolescents aged 12 to 18. Located in a university town (Illinois State University) two hours south of Chicago, Chestnut uses a combination of modalities. These include Rogerian therapy, which emphasizes unconditional positive regard for clients; motivational enhancement therapy; cognitive behavioral therapy; reality therapy and the Twelve Step model. This program has developed an extensive manual that permits replication elsewhere.

Assessment and Matching
Case managers and therapists use the Global Appraisal of Individual Needs (GAIN) to evaluate prospective clients. GAIN includes in-depth questions for documenting substance use disorders, environmental issues, and other co-occurring behavioral and mental health disorders. Information is obtained from parents and other relevant sources during the assessment process. Placement recommendations and individualized treatment plans are developed by staff based on American Society of Addiction Medicine criteria. Clients are assigned to specific groups where attendance and participation are closely monitored. This information is reviewed every seven to ten days to determine modifications to the treatment plan.

Comprehensive, Integrated Approach
In addition to a wide range of treatment modalities, Chestnut reaches out to many sectors in the community. Staff members are assigned to 30 schools in the county to provide Student Assistance Programs (SAPs). SAP staff provide a variety of mental health and substance abuse services to schools such as referring a student for treatment and facilitating a variety of skills-building groups (i.e., resisting peer pressure). Chestnut has an on-site alternative school staffed by two teachers and two aides provided by the local school district. A case manager helps the residential client's transition back to their home school by transporting them for a visit prior to their discharge from residential treatment. Chestnut conducts assessments and provides treatment at selected juvenile justice facilities and has created a specialized treatment unit to deal with youths who have had extensive involvement with the criminal justice system. The program's psychiatrist conducts evaluations of those who demonstrate psychiatric disorders and may prescribe medication.

Family Involvement
Chestnut has a family night program that meets one night a week. The first hour is an educational group. Each week a different topic is discussed such as adolescent development, parenting issues, substance abuse and recovery. The second hour is a multi-family therapy group. Chestnut also offers individual family therapy sessions. Families are encouraged to take part in the treatment plan development and discharge planning for their child. Chestnut requires staff to have weekly contact with parents.

Developmentally Appropriate
Treatment is based on developmental level (i.e., emotional maturity) rather than chronological age. Chestnut's curriculum, developed by a Licensed Clinical Counselor with a doctorate in education, allows clients to proceed at their own pace. One skill must be learned before the next skill development begins. The curriculum, adjusted for younger clients, employs many hands-on activities and exercises to which adolescents can relate.

Engage and Retain
To engage youths in the treatment process, Chestnut utilizes motivational enhancement therapy, which emphasizes internal motivation in the recovery process. Chestnut offers various group therapy and skill build-

ssions for clients. Skill building sessions, such as communication, anger and stress management, decision making, healthy relationships and recovery process, are interactive. Art therapy and group counseling are provided several times per week with the topics to be addressed identified by the clients. Clients receive a score for their participation level and behavior in groups. The scores earn them privileges and demonstrate progress in treatment. Clients are actively involved in their treatment planning.

Qualified Staff

Since Chestnut promotes from within, there is very low staff turnover among managers and therapists. Supervisors are constantly mentoring subordinates to help improve their skills and prepare them for advancement in the organization. An ongoing training program plus an hour of individual supervision per week is provided to each staff member. State certification or license is required for clinical staff. The majority of therapists have master's degrees.

Gender and Cultural Competence

Chestnut believes it is important to create a supportive therapeutic environment where males and females can learn to have productive interactions. Chestnut found that males, when totally separated, became more aggressive. Some activities are co-ed, such as selected group therapy sessions and some skill building lessons. However, gender counseling groups are provided weekly. Chestnut offers several groups and activities that address diversity and cultural competence. Approximately half of Chestnut's residential staff is African-American. A Latino Youth Interventionist works with Latino youth and families. Typically, sexual orientation issues are addressed in individual counseling sessions.

Continuing Care

Chestnut's research on aftercare indicates that the first three months after discharge are critically important. However, in Illinois only a third of adolescents who completed treatment in 1999 received continuing care services. Therefore, Chestnut is actively involved in making sure the client is connected with an agency/program for continuing care needs. When clients return to schools which have SAP counselors, they receive services for at least 90 days. Prior to discharge, clients are required to identify activities and contacts they will undertake in their communities. They are also linked to Twelve Step meetings.

Outcomes

Residential Treatment: Approximately 12 months after intake to Chestnut's residential treatment programs, adolescents reduced their substance use by 54 percent and their substance-related problems by 60 percent. Nearly one year after intake, 60 per cent had abstained from alcohol and other drugs for the past 30 days. These results compare favorably to a national study of residential treatment. Chestnut also did as well or better than the national average in terms of other 12 month outcomes, including reduced family problems (47 percent reduction in the national sample vs. 57 percent reduction in the Chestnut sample), no fighting (39 percent vs. 50 percent reduction in the Chestnut sample), vocationally engaged in school or work (98 percent vs. 95 percent) and no past month arrests, detention or jail time (70 percent vs. 73 percent).

Outpatient Treatment: Approximately 12 months after intake to Chestnut's outpatient program, 74 percent of adolescents were abstinent for the previous month and in recovery compared to 71 percent of the national sample. Both the national sample and the Chestnut sample experienced a 38 percent reduction in substance-related problems. Chestnut exceeded the national average on the following 12-month outcomes: reduced arguments and fighting (34 percent reduction for national sample vs. 45 percent reduction among Chestnut sample), and achieved a greater reduction in participants arrested in the past month (54 percent reduction for the national sample vs. 100 percent reduction for the Chestnut sample).

Cost

Residential treatment costs $495 per day; day treatment costs $350 per day; intensive counseling costs $210 per day; individual/family counseling sessions are billed at $115 per hour and group counseling at $90 per session. Private insurance and Medicaid are accepted. Some services are financed through state grants and parents are offered a sliding scale.

Hazelden Center for Youth and Families

11505 36th Avenue North
Plymouth, MN 55441-2398
(800) 833-4497
www.hazelden.org

Hazelden, long a leader in alcohol and other drug treatment, operates the Hazelden Center for Youth and Families (HCYF) for young people ages 14 to 25 and their families. Services, which are based on the Twelve Step model, include comprehensive screening and assessment; co-ed residential or outpatient chemical dependency treatment or a combination of the two; residential extended care (males only); parent education programs; and outpatient mental health and family counseling services. The treatment facility, located in a suburban community of Minneapolis, is situated on 15 wooded acres overlooking a large lake, which offers opportunities for outdoor activities and for quiet reflection.

Assessment and Matching
HCYF's licensed drug and alcohol intake counselors conduct a comprehensive assessment that begins with initial screening of both the parents and the adolescent, often by telephone. The counselor contacts other agencies that may be involved for relevant information. Once admitted, the client goes through three days of extensive assessment, including the Personal Experience Inventory (PEI) which measures drug problem severity, psychosocial risk and protective factors, eating disorders, suicide potential, physical and sexual abuse and parental history of drug abuse. In addition, the Minnesota Multiphasic Personality Inventory I and II and other assessment instruments are used. There is also a medical review by a psychiatrist and a nurse. In a two-hour examination, the nurse assesses vital signs, vision and hearing. Additional tests are available upon request. If the client has a medical condition, a treatment plan is developed. During this time, the client is introduced to peers in the program while staff observe how they interact. Hazelden will extend the assessment period for another 4-7 days to collect further data when necessary.

Comprehensive, Integrated Approach
HCYF is an abstinence-based program that utilizes the Twelve Steps of Alcoholics Anonymous throughout treatment. Each client receives an individualized treatment plan; treatment length varies according to individual needs. Group and individual therapy sessions address relapse prevention, stress management, mental health disorders such as depression and post-traumatic stress disorder. HCYF operates its own school component where clients spend two hours per day in class during the academic school year. A teacher from the local school district coordinates assignments with the client's home school. Several times a week, clients participate in local recreational activities and local AA meetings. Recreational activities offer exercise and other drug-free activities. HCYF works with several colleges to provide "sober" dorms where, if appropriate, clients can continue with their recovery in college.

Family Involvement
HCYF offers a Parent Program that runs weekly from Sunday afternoon to Wednesday afternoon. Parents usually attend during the adolescent's third week in treatment. The objective of the program is to teach parents that substance abuse is a no-fault disease. The parent curriculum is designed to educate the parent on substance abuse; to provide an open forum to discuss the difficulty of having a chemically dependent teen; and to teach new skills for more effective communication and how to establish boundaries. This is accomplished through lectures, videos, small-group discussions, role playing and special activities that teach effective parenting skills. The cost of the parent com-

is $405 per person. HCYF parent involvement in the program is very high; over 85 percent participate. Approximately 80 percent of the clients do not live near HCYF, so much of the parent involvement prior to and after the four-day program is via telephone. HCYF's Parent Program is open to all parents, including those whose children have never been enrolled in its program.

Developmentally Appropriate

Hazelden has produced a wide range of educational materials for all ages, including adolescents, which are used by many programs across the country. HCYF accepts young people ages 14-25 because the program believes that their development has been arrested by chemical abuse, so older youths are closer in maturity level to adolescents than to adults. The Twelve Step program has been tailored to youths. For example, to explain the step of powerlessness, the therapist reviews everyday occurrences to explore what youths can control and what they cannot.

Engage and Retain

Adolescents are motivated by activities and interaction with their peers in recovery. Twelve Step lessons are taught through activities that build confidence and trust in peers. Recreational activities also help to engage clients in the program. There are strong efforts to build a therapeutic alliance between counselors and clients.

Qualified Staff

HCYF staff, a multidisciplinary professional team, includes chemical dependency counselors and technicians, nurses, family counselors, psychologists, spiritual care professionals and recreation specialists, as well as consulting doctors and psychiatrists. Hazelden has created a 40-hour continuing education course on adolescent development for its licensed counselors which is open to outside professionals. The organization also brings in experts to train staff on new issues in the field.

Gender and Cultural Competence

The primary unit is co-ed; the extended care unit is all male. Male and female clients are assigned separate sleeping accommodations but share the dining and recreation rooms as well as group activities. Hazelden offers gender separate groups where males and females can work on gender specific issues, such as rites of passage for males (taking responsibility for one's actions), and relationships and self-esteem for females.

Continuing Care

A new program, Recover Care, sends information to clients and families at regular intervals (30, 60, 90 days, six months and one year) after discharge to help them understand what to expect at different stages of recovery. Topics for youths include refusal skills; how to handle leisure time; and managing their mental health. For parents, topics address letting go; setting boundaries; and how to parent a youth in recovery.

Outcomes

Hazelden has developed its own quality assurance and outcome measurement systems. The quality assurance system provides monthly and quarterly reports on indicators for key clinical process (pre-entry; access to care; admissions; assessment and care planning; care; and ongoing recovery). These indicators are a mix of client and parent satisfaction questions and clinical data. A quality assurance committee meets quarterly to review the data and suggest changes in the clinical process to improve problem areas. Outcome indicators measure not only abstinence but also AA attendance, independence, employment status, education and community involvement. Between 1988 and 1993, 1,291 adolescents were surveyed one year post-treatment. Results showed that 42 percent of program completers reported total abstinence, compared with 17 percent of non-completers. Hazelden is currently undertaking a Youth Typology Study to capture current outcomes more extensively.

Cost

The fee for the residential program is $545 per day; for the outpatient treatment, it is $360 per day. Payment is usually provided by private insurance, private pay or self pay. Scholarships to pay for treatment may be available, based on a needs assessment.

Programs:

South

Program	Address	Date Established	Accreditation	Services	Length of Stay	Capacity
The Adolescent Center	1525 Fullilove Drive Bossier City, LA 71112 (318) 747-1211	1989		Twelve Step model. Halfway house: co-ed, ages 12-17.	8 months	28 clients
Allegany County Health Department – Lois E. Jackson Unit	Thomas B. Finan Center Country Club Road Cumberland, MD 21502 (301) 777-2290 www.alleganyhealthdept.com	1980		Twelve Step model, cognitive behavioral & multisystemic therapies. Detoxification & short-term residential: co-ed, ages 12-18.	60 days	33 clients
The ARK	PO Box 1078 Jackson, MS 39215-1078 (601) 355-0077 www.mchsfsa.org.theark.cfm	1984	JCAHO	Twelve Step model & cognitive behavioral therapy. Residential, intensive outpatient & outpatient: co-ed, ages 13-18.	residential: 8 months outpatient: 3-4 months	residential: 10 males, 10 females outpatient: 10
The Bridge	2346 Two Notch Road Columbia, SC 29204 (803) 253-6351	1994	CARF	Twelve Step model & multisystemic therapy. Intensive outpatient, outpatient & intensive case management: co-ed, ages 12-17 (sometimes 18), (transitional program for youths leaving juvenile justice or other residential programs).	14 months	270-320 clients
The Bridge, Inc.	3232 Lay Springs Road Gadsden, AL 35904 (256) 546-6324	1974		Twelve Step model, cognitive behavioral therapy & wilderness experience. Residential, group home (halfway house) & intensive outpatient: co-ed, ages 13-18.	residential: 28-90 days group home: 3-6 mos intensive out-patient: 4-6 mos	residential: 201 group home: 24 intensive outpatient: 450
Brief Strategic Family Therapy (BSFT)	University of Miami Spanish Family Guidance Center 1425 NW Tenth Avenue, Suite 309 Miami, FL 33136 (305) 243-4592	1974		Brief strategic family therapy. Outpatient (with in-home sessions): co-ed, ages 8-13 & 14-19 (early intervention program to reduce substance abuse risk factors & strengthen families).	13-16 weeks	12-15 families per BSFT facilitator

Assessment and Matching | Comprehensive, Integrated Approach | Family Involvement | Developmentally Appropriate | Engage and Retain | Qualified Staff | Gender and Cultural Competence | Continuing Care | Outcomes

Program	Address	Date Established	Accreditation	Services	Length of Stay	Capacity
Brighter Day	Edgecombe-Nash Mental Health Services 500 Nash Medical Arts Mall Rocky Mount, NC 27804 (252) 937-8141	1996	COA	Twelve Step model & cognitive behavioral therapy. Outpatient: pregnant females only, ages 17 & younger.	up to 1 year postpartum	12-15 (pregnant females only)
CART House	302 North Jackson Street Starkville, MS 39760 (662) 324-9612	1992		Twelve Step model, cognitive behavioral & motivational enhancement therapies. Long-term residential: males only, ages 12-18.	4½-7 months	12 (males only)
Centerstone	Highland Rim Mental Health Center 1830 North Jackson Street Tullahoma, TN 37388 (931) 461-1300 www.centerstone.org	1994		Twelve Step model, multisystemic therapy & psycho-education. Day: co-ed, ages 12-19.	12 weeks	12 clients
Chilton-Shelby Mental Health Center	3156 Pelham Parkway, Suite 4 Pelham, AL 35124 (205) 685-9535	1994		Twelve Step model, cognitive behavioral therapy & corrective thinking. Intensive outpatient, outpatient & continuing care: co-ed, ages 12-19.	outpatient: 3 mos continuing care: 3 mos	outpatient: 24 continuing care: 16-20
Community Adolescent Rehabilitation Effort (CARE)	3621 North Kelley Avenue Suite 100 Oklahoma, OK 73111 (405) 524-5525	1974	COA	Cognitive behavioral, motivational enhancement & reality therapies. Intensive outpatient & outpatient: co-ed, ages 12-18.	6 months	25 clients
Comprehensive Community Services	6145 Temple Star Road Kingsport, TN 37660 (423) 349-4070	1988	CARF	Twelve Step model. Long-term residential: co-ed, ages 13-18.	4 months	49 clients

Programs:

South

Program	Address	Date Established	Accreditation	Services	Length of Stay	Capacity
Deep Run Lodge	13259 Blackwells Mill Road Goldvein, VA 22720 (540) 752-4619 www.vanguardservices.org	1990	CARF	Twelve Step model & therapeutic community. Residential: co-ed, ages 13-19.	3 months	20 males, 8 females
Drug Abuse Treatment Association (DATA)	1720 East Tiffany Drive Suite 102 Mangonia Park, FL 33407 (561) 844-3556	1980	CARF	Twelve Step model, motivational enhancement, multidimensional family & multisystemic therapies. Residential & outpatient: co-ed, ages 13-18.	residential: 4-6 months outpatient: 3-6 mos continuing care: 3-6 mos	residential: 39 outpatient: 100-120 continuing care: 30
Family Effectiveness Training (FET)	Center for Family Studies University of Miami School of Medicine 1425 NW Tenth Avenue Miami, FL 33136 (305) 243-8217	1980		Family effectiveness training. Outpatient (with in-home sessions): co-ed, ages 6-13 (early intervention program targets family factors that place children at risk as they transition to adolescence).	13 weeks	15-20 families per FET facilitator
First Step	10400 Ridgeland Road Cockeysville, MD 21030 (410) 628-6120	1971		Twelve Step model & cognitive behavioral therapy. Outpatient: co-ed, ages 11-18.	4 months	75 clients
Foundation House of New Orleans	3942 Laurel Street New Orleans, LA 70115 (504) 899-1468	1990		Twelve Step model & self-empowerment. Residential & halfway house: co-ed, ages 12-17.	6 months	15 clients
Gateway Adolescent Treatment Center	PO Box 4582 Pineville, LA 71361 (318) 484-6802	1989		Cognitive behavioral therapy. Short-term residential: co-ed, ages 12-18.	40-45 days	25 clients

Program	Address	Date Established	Accreditation	Services	Length of Stay	Capacity
Hillcrest Hall	2479 Grassy Lick Road Sterling, KY 40353 (859) 498-6574	1991		Twelve Step model & family systems therapy. Detoxification, residential & outpatient: males only, ages 13-18.	7-9 months	16 clients
Horizon Adolescent Chemical Dependency Treatment Center	3113 South 70th Street Fort Smith, AR 72903 (501) 478-6664	1990	CARF	Twelve Step model & multisystemic therapy. Detoxification, residential & outpatient: co-ed, ages 13-18.	residential: 52 days outpatient: 6 months	residential: 24 outpatient: 80
House of Life Adolescent Treatment Center	505 North Broadway Arcadia, OK 73007 (405) 396-2921	1983		Twelve Step model, cognitive behavioral therapy & therapeutic community. Long-term residential: co-ed, ages 13-18.	6-9 months	30 clients
Inova Kellar Center	10396 Democracy Lane Fairfax, VA 22030-2522 (703) 218-8500 www.inova.org/ifhc/kellar.html	1991	JCAHO	Twelve Step model, cognitive behavioral & family systems therapies. Intensive outpatient & outpatient: co-ed, ages 13-19.	4-6 months	22 clients
Lighthouse	1935 Bluegrass Avenue Louisville, KY 40215 (502) 366-0705	1994	JCAHO	Twelve Step model, cognitive behavioral & multisystemic therapies. Residential & intensive outpatient: co-ed, ages 12-18.	residential: 5.5 months outpatient: 7 weeks	residential: 16 outpatient: 16
Lincoln Trail Behavioral Health System	3909 South Wilson Road Radcliff, KY 40160 (270) 351-9444 www.lincolnbehavioral.com	1986	JCAHO	Twelve Step model & cognitive behavioral therapy. Inpatient: co-ed, ages 12-18.	28-30 days	6-8 clients

Programs:

South

Program	Address	Date Established	Accreditation	Services	Length of Stay	Capacity
William J. McCord Adolescent Treatment Facility	910 Cook Road PO Box 1166 Orangeburg, SC 29118 (803) 534-2328 www.mccordcenter.com	1993	CARF	Twelve Step model, cognitive behavioral & reality therapies. Detoxification & inpatient: co-ed, ages 13-18 intensive outpatient & outpatient: co-ed, ages 10-18.	inpatient: 5-7 weeks outpatient: 1 year	inpatient: 8 males, 7 females outpatient: 125
Memphis Recovery Centers, Inc.	219 North Montgomery Ave. Memphis, TN 38104 (901) 272-7751 www.memphisrecovery.com	1986	CARF	Twelve Step model. Long-term residential: males only, ages 13-18 residential: co-ed, ages 13-18.	long-term residential: 6-9 months residential: 3-6 months	long-term residential: 13 (males only) residential: 12
Morning Star Adolescent Treatment Unit	PO Box 500 Marietta, OK 73448 (580) 276-5443	1987		Twelve Step model. Long-term residential: females only, ages 13-18.	1 year	16 (females only)
The Morton Center	1028 Barret Avenue Louisville, KY 40202 (502) 451-1221	1985		Twelve Step model, family systems and art & expression therapies. Intensive outpatient & outpatient: co-ed, ages 13-19.	6 months	20-25 clients
Mountain Manor Treatment Center	3800 Frederick Avenue Baltimore, MD 21229 (410) 233-1400	1989	JCAHO	Twelve Step model. Detoxification, residential, day, intensive outpatient & outpatient: co-ed, ages 12-20.	residential: 45 days day: 8 days intensive outpatient: 6-10 weeks outpatient: 6 months	residential: 69 day: 10-15 intensive outpatient/ outpatient: 100
Multidimensional Family Therapy (MDFT)	Center for Treatment Research on Adolescent Drug Abuse Univ. of Miami School of Medicine 1400 NW Tenth Avenue Dominion Tower, Suite 1108 Miami, FL 33136 (305) 243-6434	1986		Multidimensional family therapy. Outpatient: co-ed, ages 12-18.	4-8 months (MDFT programs at 16 sites, each with between 3-10 counselors)	6-10 clients per MDFT counselor

Assessment and Matching | Comprehensive, Integrated Approach | Family Involvement | Developmentally Appropriate | Engage and Retain | Qualified Staff | Gender and Cultural Competence | Continuing Care | Outcomes

Program	Address	Date Established	Accreditation	Services	Length of Stay	Capacity
Multisystemic Therapy (MST)	MST Services 710 Johnny Dodds Boulevard Mt. Pleasant, SC 29464 (843) 856-8226 www.musc.edu/fsrc	1978	JCAHO & CARF	Multisystemic therapy. Outpatient (with in-home sessions): co-ed, ages 10-17.	4 months	typical MST program serves approx. 50 families per year (MST programs are in 27 states)
Olympic Center	PO Box 158 Kingwood, WV 26537 (304) 329-2400	1986	JCAHO	Twelve Step model, cognitive behavioral, motivational enhancement & reality therapies. Short-term residential: co-ed, ages 12-18.	45 days	12 males, 8 females
Operation PAR, Inc.	6655 66th Street North Pinellas Park, FL 33781 (727) 545-7564	1970	JCAHO	Therapeutic community, cognitive behavioral & motivational enhancement therapies. Detoxification, residential & outpatient: co-ed, ages 12-18.	residential: 4-6 months outpatient: 3-4 months	residential: 30 outpatient: 120
Pathway House	1202 SW A Avenue Lawton, OK 73501 (580) 357-8114	1989		Twelve Step model. Halfway house: co-ed, ages 13-17.	6-9 months	18 clients
Providing Opportunities for Recovering Teens (PORT) Program	116 Health Drive Greenville, NC 27834 (919) 413-1950	1988	COA	Twelve Step model, cognitive behavioral, multidimensional family & multisystemic therapies. Residential III, residential II (less intensive), & outpatient: co-ed, ages 13-18.	residential III: 90-100 days residential II: 30-45 days outpatient: 1 year	residential III: 10 residential II: 4 outpatient: 50-100
John G. Richards Therapeutic Community	4900 Broad River Road Columbia, SC 29210 (803) 896-9103	2000		Therapeutic community. Long-term residential: male juvenile offenders only, ages 12-18.	6-12 months	96 (male juvenile offenders only)

Programs:

South

Program	Address	Date Established	Accreditation	Services	Length of Stay	Capacity
Second Chance	325 South Washita, Suite B Wetumka, OK 74883 (405) 452-3276	1985	JCAHO	Twelve Step model. Residential & halfway house: co-ed, ages 13-18.	4-6 months	30 clients
Spartanburg Alcohol & Drug Abuse Commission	187 West Broad Street PO Box 1252 Spartanburg, SC 29304-1252 (864) 582-7588	1990	CARF	Twelve Step model & cognitive behavioral therapy. Intensive outpatient: co-ed, ages 12-17.	2-3 months	8-10 clients
The Springs of Recovery Adolescent Program	23260 Greenwell Springs Rd. Greenwell Springs, LA 70739 (225) 262-3586	1998		Twelve Step model. Short-term residential: co-ed, ages 12-18.	45-60 days	30 clients
Stewart-Marchman Center for Chemical Independence	3875 Tiger Bay Road Daytona Beach, FL 32124 (386) 947-1300 www.stewartmarchman.org	1970	CARF	Cognitive behavioral & motivational enhancement therapies & community reinforcement. Residential, day & outpatient: co-ed, ages 13-18.	residential: 4-6 mos day: 3-4 mos outpatient: 6-16 weeks	residential: 23 residential (juvenile court): 40 males, 54 females day: 23 outpatient: 160
Street School	1135 South Yale Tulsa, OK 74112 (918) 833-9800	1974		Twelve Step model, rational emotive behavior & reality therapies. Outpatient: co-ed, ages 15-18, (alternative high school for substance-involved teens).	2 years	90 clients
Sunflower Landing	Highway 49 South PO Box 145 Dublin, MS 38739 (662) 627-7267 www.regionone.org	1993		Twelve Step model. Detoxification & long-term residential: co-ed, ages 13-18.	8 months	24 clients

Program	Address	Date Established	Accreditation	Services	Length of Stay	Capacity
Teen Primary Outpatient Program (Teen POP)	Bluegrass East Comprehensive Care Center 1500 Leestown Road, Suite 120 Lexington, KY 40511 (859) 381-1077	1987	JCAHO	Twelve Step model, cognitive behavioral & family systems therapies. Intensive outpatient & outpatient: co-ed, ages 13-17.	3 months	10 clients
Treatment Resources for Youth, Inc.	2517 North Charles Street Baltimore, MD 21218 (410) 366-2123	1973		Cognitive behavioral & motivational enhancement therapies. Outpatient & early intervention: co-ed, ages 12-18.	167 days	95 clients
Turn About, Inc.	2771 Miccosukee Road Tallahassee, FL 32308 (850) 671-1920	1981		Twelve Step model, cognitive behavioral, motivational enhancement, multidimensional family & multisystemic therapies. Intensive outpatient & outpatient: co-ed, ages 11-18.	intensive outpatient: middle sch, 12-15 weeks high sch, 21-30 weeks outpatient: 16-24 weeks	intensive outpatient: 10 middle sch, 15 high sch outpatient: 50
Valley HealthCare System	301 Scott Avenue Morgantown, WV 26505 (304) 366-7174 www.valleyhealthcare.org	1990	CARF	Twelve Step model, cognitive behavioral, multidimensional family & experiential therapies. Outpatient: co-ed, ages 13-18 (up to 21 if still in school).	intensive outpatient: 8 wks outpatient: less than 90 days	intensive outpatient: 12 outpatient: 120
The Village	3180 Biscayne Boulevard Miami, FL 33137 (305) 573-3784	1973	JCAHO	Cognitive behavioral, motivational enhancement & multidimensional family therapies. Detoxification, long-term residential & outpatient (with in-home sessions): co-ed, ages 12-18.	8-10 months	residential: 50-60 outpatient: 125-150
Worcester Addiction Cooperative Service	11827 Ocean Gateway Ocean City, MD 21842 (410) 213-0202	1988	JCAHO	Motivational enhancement & multisystemic therapies. Intensive outpatient, outpatient & outpatient (school-based): co-ed, ages 12-19.	intensive outpatient: 6 wks outpatient: 6-9 months school-based outpatient: 6 months	intensive outpatient: 20 outpatient: 40 school-based outpatient: 75

In-Depth Look:

Multidimensional Family Therapy

Center for Treatment Research on Adolescent Drug Abuse
School of Medicine
University of Miami
Dominion Tower, Suite 1108
1400 NW 10th Avenue
Miami, Florida 33136
(305) 243-6434
www.miami.edu/ctrada

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 Luhman) 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

scent 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 complete 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 percent 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.

In-Depth Look:

Multisystemic Therapy

MST Services
710 Johnny Dodds Boulevard
Mt. Pleasant, SC 29464
(843) 856-8226
www.mstservices.com
www.musc.edu/fsrc

Multisystemic Therapy (MST) targets adolescents at highest risk for incarceration or foster care. An intensive four-month home-based intervention, MST addresses the specific problems of individual families in the context of home, school and community. Parents set the agenda; therapists assist them in identifying and reaching their goals. The therapists carry low caseloads and are available around the clock in order to maximize interaction with the family. Parents are taught skills that will preserve the intervention after the therapist withdraws. Located at the Medical University of South Carolina in Charleston, MST continues to conduct randomized trials to assess the program's effectiveness with new and diverse populations. In addition, MST Services has trained staff and has licensed agencies in 27 states and seven countries. These agencies annually treat more than 7,000 youths and their families.

Assessment and Matching
MST uses a process it terms "functional analysis" to determine the root causes of the family's and youth's dysfunction and to design an individualized treatment plan. The analysis, conducted at the beginning of the intervention and used throughout the course of treatment, identifies situations creating specific problems. For example, to analyze the problem of fighting in school, the therapist identifies the frequency, duration and intensity of the fighting, as well as the antecedents to the behavior. Setting events could include the adolescent having Attention Deficit Hyperactivity Disorder (ADHD) and not taking his/her medication or experiencing conflict at home. The therapist initiates strategies to break the sequence of events leading to bad behavior: e.g., monitoring recess, buying a pill box, setting up fixed consequences for bad behavior. MST believes that relieving these problems and helping parents be more effective will stabilize the adolescent and develop more constructive attitudes and behavior.

Comprehensive, Integrated Approach
MST provides comprehensive mental health and substance abuse services. Parents and caregivers are viewed as the key to achieving favorable outcomes. Therapists empower parents and caregivers to disengage youths from deviant peers and to support positive peer activities, such as sports and church youth groups. Educational activities are stressed and parents are taught how to work with school personnel to promote gains. For provider agencies elsewhere who want to replicate the program, MST Services conducts extensive site reviews to ensure that all necessary services are available and that an agency's key administrators and supervisors are eager to participate in the intervention. Approximately one-third of the agencies that apply to replicate the MST program are accepted. MST Services closely monitors them to ensure that the program is carried out with fidelity to MST standards.

Family Involvement
Guided by MST therapists, family members establish goals, such as reducing the adolescent's substance use and reducing strife between the adolescent and a stepfather. The program focuses on developing skills of the parent/guardian to accomplish the goals. If the family is not making progress, the therapist regards that as a failure of MST, not the family. Clinical resources are devoted to identifying and overcoming barriers to progress. This process often re-engages the family with MST. Families usually cooperate with the

counselors because they are finding solutions to long-standing problems. Treatment is terminated when the goals have been reached, generally four months after intervention begins.

Developmentally Appropriate

MST treatment is developmentally appropriate because the goals and interventions are specifically tailored to the individual adolescent. The counselor recommends steps for parents based on the maturity and skill level of the adolescent.

Engage and Retain

MST is attractive to families because it addresses individual needs which the families have identified. This family involvement, combined with around the clock availability of therapists, usually defuses a crisis situation, strengthening family commitment to the program. The skills which families learn in the process also encourage them to continue. The intensity of MST, along with a highly qualified staff, builds a strong therapeutic alliance between the therapist and the client.

Qualified Staff

MST has established an elaborate system for training, supervising and monitoring staff. A detailed training manual has been developed. After a five-day orientation, therapists are supervised on a daily basis. MST has three staff levels: a consultant (a Ph.D. with extensive MST experience) oversees a clinical supervisor (a Ph.D. with less MST experience) who oversees a master's level counselor. To measure fidelity, MST developed an adherence report that each member in the chain completes, beginning with the family rating the therapist's performance. Supervisors give therapists concrete suggestions on how to deal with particular family situations. MST has developed a culture of accountability. Staff members know exactly what is expected of them and they have objective measures to ensure adherence to MST principles.

Gender and Cultural Competence

Gender and cultural issues are addressed in the context of the individualized treatment plan. Where possible, therapists have the same ethnic background as the family.

Continuing Care

MST generally does not provide continuing care. After the four-month treatment period, adolescents may be referred to community services. MST is currently involved in a clinical study in Philadelphia that is creating a continuum of care for juvenile offenders with severe mental health problems. The continuum includes inpatient hospital care, foster care, aftercare, and outpatient services

Outcomes

Several randomized clinical trials indicate that MST reduces recidivism, improves family relations and decreases behavior problems. In 1998, Washington State Institute for Public Policy rated MST as the most cost-effective of 16 major crime-cutting programs. The cost of MST was approximately $4,500 per youth (1996 dollars). In a 1998 study, 118 juvenile offenders meeting DSM III-R criteria for substance abuse were randomly assigned to MST or to the usual community services, which included weekly group meetings based on the Twelve Step model as well as mental health services, school-based intervention and family preservation. The study found that MST reduced self-reported alcohol and drug use. At six months follow-up, total days of out-of-home placements for MST graduates were 50 percent less than for those who had received traditional treatment services. At four year follow-up, MST youths had committed significantly fewer violent offenses and were less drug involved.

Cost

There is no cost to the client. MST Programs charge the juvenile justice system approximately $5,000 per family. MST program support and training cost $15,000-$18,000 per MST team (2-4 clinicians and a clinical supervisor).

Programs:

West

Program	Address	Date Established	Accreditation	Services	Length of Stay	Capacity
Aspen Achievement Academy	98 South Main Street Loa, UT 84747 (435) 836-2472 www.aspenacademy.com	1990	COA	Cognitive behavioral & experiential therapies & wilderness experience. Short-term residential: co-ed, ages 13-17.	7 weeks	40-60 clients (8 clients per group, which can be co-ed or single-sex)
The Bobby Benson Center	56-660 Kamehameha Highway Kahuku, HI 96731 (808) 293-7555 www.bobbybenson.org	1990	CARF	Twelve Step model, cognitive behavioral therapy & therapeutic community. Residential: co-ed, ages 13-17.	3-6 months	16 males, 8 females
La Cañada	160 West Fort Lowell Tucson, AZ 85705 (520) 318-3266	1997	CARF	No particular approach emphasized; depends on each patient. Short-term residential, intensive outpatient & outpatient: co-ed, ages 12-17.	5 months in 3 phases residential:1mo intensive outpatient and outpatient: 2 mos each	residential: 6 males, 3 females intensive outpatient & outpatient: 30-40
Center for Family Development	1258 High Street Eugene, OR 97401 (541) 342-8437	1998		Multisystemic therapy. Outpatient: co-ed, ages 10-18.	4-6 months	30 clients
Childrens Hospital Los Angeles	Division of Adolescent Medicine 4650 Sunset Boulevard, #2 Los Angeles, CA 90027-6062 (323) 669-2463 www.childrenshospitalla.org/adolescent.cfm	1989	JCAHO	Cognitive behavioral, motivational enhancement & family systems therapies. Outpatient: co-ed, ages 10-24.	4-5 months	120 clients
Columbia Community Mental Health	31 Cowlitz Street PO Box 1234 St. Helens, OR 97051 (503) 366-5989	2000		Twelve Step model, cognitive behavioral, motivational enhancement & strength-based therapies. Day & outpatient: co-ed, ages 13-18.	4 months	20 clients

Program	Address	Date Established	Accreditation	Services	Length of Stay	Capacity
Cottonwood de Tucson	4110 West Sweetwater Drive Tucson, AZ 85745 (800) 877-4520	1993	JCAHO	Twelve Step model, cognitive behavioral therapy & psychotherapy. Detoxification, short-term residential & day: females only, ages 13-18.	45 days	12 (females only)
Court House, Inc.	333 West Hampden Avenue Suite 305 Englewood, CO 80110 (303) 761-6756 www.courthouseinc.org	1970		Cognitive behavioral therapy. Short-term & long-term residential & continuing care (with in-home sessions): co-ed, ages 12-18.	short-term residential: 2-3 months long-term residential: 6-9 months continuing care: 3-6 mos	residential: 18 males, 36 females continuing care: 3-10
Day Break	11707 East Sprague Spokane, WA 99207 (509) 927-1991	1978		Twelve Step model, cognitive behavioral & structural family therapies. Short-term residential & outpatient: co-ed, ages 12-17.	residential: 45 days outpatient: 6 months	residential: 56 outpatient: 150
EMPACT-SPC Teen Substance Abuse Treatment Program	1232 E. Broadway Road #120 Tempe, AZ 85282 (480) 784-1514 www.empact-spc.com	1989	CARF	Cognitive behavioral, motivational enhancement & multisystemic therapies. Intensive outpatient & outpatient (with in-home sessions): co-ed, ages 12-18.	3 months	24 clients
Four Corners Regional Adolescent Treatment Center	PO Box 3529 Shiprock, NM 87420 (505) 368-4712	1989	JCAHO	Multisystemic cultural model (blends cognitive behavioral therapy with Native American values & cultural practices). Residential: co-ed, Native Americans only, ages 12-19.	50 days	24 clients (Native Americans only)
Catherine Freer Wilderness Therapy Expeditions	420 SW Third Avenue PO Box 1064 Albany, OR 97321 (541) 926-7252 www.cfreer.com	1988	JCAHO	Twelve Step model, multidimensional family & wilderness therapies. Short-term residential: co-ed, ages 13-18 (summer sessions) & ages 14-18 (winter sessions).	21 days	28 clients

Programs:

West

Program	Address	Date Established	Accreditation	Services	Length of Stay	Capacity
Gray Wolf Ranch	PO Box 102 Port Townsend, WA 98368 (360) 385-5505 www.graywolfranch.com	1995	CARF	Twelve Step model, cognitive behavioral & multisystemic therapies. Halfway house & intensive outpatient: males only, ages 14-25.	5 months	26 (males only)
Hina Mauka – Teen CARE	45-845 Po'okela Street Kaneohe, HI 96744 (808) 236-2600 www.hinamauka.org	1976	CARF	Twelve Step model, cognitive behavioral & motivational enhancement therapies. Outpatient (school-based): co-ed, ages 11-20.	4 months	595 clients
Island Grove Regional Treatment Center	1140 M Street Greeley, CO 80631 (970) 356-6664	1974	CARF	Cognitive behavioral, motivational enhancement, strength-based & brief therapies. Detoxification & outpatient: co-ed, ages 13-18.	detoxification: 5 days outpatient: 4-6 months	36 clients
Jacob Center	729 Remington Street Fort Collins, CO 81501 (970) 484-8427	1988		Twelve Step model & motivational enhancement therapy. Long-term residential & outpatient: co-ed, ages 11-21.	6-12 months	12 clients
Kalihi YMCA Outreach Services	1335 Kalihi Street Honolulu, HI 98619 (808) 848-2494	1982		Cognitive behavioral therapy. Outpatient: co-ed, ages 12-18.	school-based: 4 months court-ordered: 1 year incarcerated: 9 months	school-based: 510 court-ordered: 145 incarcerated: 50
Lakeside-Milam Recovery Centers	Burien Adolescent Unit 12845 Ambaum Boulevard SW Seattle, WA 98148 (800) 544-1211	1983	CARF	Twelve Step model & cognitive behavioral therapy. Detoxification, short-term residential, intensive outpatient & outpatient: co-ed, ages 13-18.	35-45 days	45 clients

Program	Address	Date Established	Accreditation	Services	Length of Stay	Capacity
Lost & Found, Inc.	9189 South Turkey Creek Rd. Morrison, CO 80465 (877) 818-1816 www.lostandfoundinc.org	1973		Therapeutic community. Long-term residential: males only, ages 12-18 independent living (in supervised apartments): males only, ages 17-20 outpatient: co-ed, ages 12-18.	residential: 6 mos independent living: 9 mos outpatient: 6 mos	residential: 18 (males only) independent living: 50 outpatient: 160
Matrix Institute	12304 Santa Monica Blvd. Suite 200 West Los Angeles, CA 90025 (310) 207-4322 www.matrixcenter.com	1986	CARF	Matrix model, cognitive behavioral & multidimensional family therapies. Outpatient: co-ed, ages 14-18.	13 weeks	20-40 clients
MK Place	735 North Main Street Pocatello, ID 83240 (208) 234-4722 www.byfhome.com/programs.html	1999		Therapeutic community. Residential & outpatient: co-ed, ages 12-17.	residential: 45-90 days outpatient: 6-12 months	residential: 8 outpatient: 50
Morrison Center – Breakthrough	830 NE Holladay, Suite 125 Portland, OR 97232 (503) 233-4356 www.morrisoncenter.org	1986	COA	Twelve Step model, cognitive behavioral, motivational enhancement & multisystemic therapies. Day & outpatient: co-ed, ages 14-18.	5-6 months	20 clients
New Directions	1514 East 12th Street Suite 101 Casper, WY 82604 (307) 237-6033	1988		Twelve Step model, cognitive behavioral & multidimensional family therapies. Short-term residential: co-ed, ages 12-17.	45-60 days	8 clients
Odyssey House	607 East 200 South Salt Lake City, UT 84102 (801) 363-0203 www.odysseyhouse.org	1981		Therapeutic community, cognitive behavioral & family therapies. Long-term & short-term residential: co-ed, ages 13-18.	long-term residential: 6-12 months short-term residential: 60 days	32 clients

Programs:

West

Program	Address	Date Established	Accreditation	Services	Length of Stay	Capacity
Ohlhoff Outpatient Programs	2418 Clement Street San Francisco, CA 94121 (415) 221-3354 www.ohlhoff.org	1976		Twelve Step model, cognitive behavioral & multidimensional family therapies. Outpatient: co-ed, ages 13-18.	13 weeks	60 clients
Phoenix Academy of Los Angeles	11600 Eldridge Avenue Lake View Terrace, CA 91342 (818) 896-1121 www.phoenixhouse.org	1987		Therapeutic community. Long-term residential: co-ed, ages 12-18.	6 months	140 clients
Ryther Child Center	2400 NE 95th Street Seattle, WA 98115 (206) 525-5050 www.ryther.org	1983	COA	Twelve Step model, cognitive behavioral & multidimensional family therapies. Short-term residential: co-ed, ages 12-17 outpatient: co-ed, ages 12-20.	residential: 50-60 days outpatient: 3 months	residential: 10 males, 10 females outpatient: 50-100
Savio House	325 King Street Denver, CO 80219 (303) 922-5576 www.saviohouse.org	1996	COA	Cognitive behavioral, motivational enhancement, multisystemic & reality therapies. Long-term residential: males only, ages 12-18; day: co-ed, ages 10-18.	residential: 5 months day: 6 months	residential: 8 (males only) day: 10
Sea Mar / Visions	1603 East Illinois Bellingham, WA 98226 (360) 647-4266	1997	JCAHO	No particular approach emphasized; depends on each patient. Residential & halfway house: females only, ages 14-17.	residential: 3-4 mos halfway house: 3 mos	residential: 20 (females only) halfway house: 6 (females only)
Sundown M Ranch	PO Box 217 Selah, WA 98942 (800) 326-7444 www.sundown.org	1993	CARF	Twelve Step model. Detoxification, short-term residential, halfway house & continuing care: co-ed, ages 12-18.	residential: 24 days halfway house: 45 days continuing care: 3 months	residential: 56 halfway house: 4 continuing care: 10

Assessment and Matching | Comprehensive, Integrated Approach | Family Involvement | Developmentally Appropriate | Engage and Retain | Qualified Staff | Gender and Cultural Competence | Continuing Care | Outcomes

Program	Address	Date Established	Accreditation	Services	Length of Stay	Capacity
Synergy Adolescent Treatment Services	3738 West Princeton Circle Denver, CO 80236 (303) 781-7875	1978		Therapeutic community & multisystemic therapy. Long-term residential: males only, ages 14-18 day & outpatient: co-ed, ages 13-18.	residential: 5 mos day: 4-6 mos outpatient: 4-6 mos	residential: 52 (males only) day: 56 outpatient: 40
Thunder Road Adolescent Treatment Centers, Inc.	390 40th Street Oakland, CA 94609 (510) 653-5040 www.thunder-road.org	1987	CARF	Twelve Step model & therapeutic community. Inpatient, residential & intensive outpatient: co-ed, ages 13-19.	inpatient: 1-3 months residential: 1 year intensive outpatient: 10-12 weeks	inpatient and residential: 50 intensive outpatient: 12-20
Touchstones	PO Box 849 Orange, CA 92856 (714) 639-5542	1992		Twelve Step model. Residential: co-ed, ages 12-17.	4 months	23 clients
Valley Mental Health ARTEC	3809 West 6200 South Kearns, UT 84118 (801) 963-4211 www.vmh.com	1975		Twelve Step model, cognitive behavioral, multisystemic & multidimensional family therapies. Residential & day: co-ed, ages 12-18.	residential: 6-8 months day: 9-12 months	residential: 23 day: 70
Wilderness Treatment Center	200 Hubbart Dam Road Marion, MT 59925 (406) 854-2832 www.wildernessaltschool.com	1983		Twelve Step model & wilderness experience. Residential: males only, ages 14-24.	60 days	35 (males only)
Yes House	404 NW 23rd Street Corvallis, OR 97330 (541) 753-7801	1990		No particular approach emphasized; depends on each patient. Short-term residential & outpatient: co-ed, ages 12-18.	3 weeks - 3 months	residential: 36 outpatient: 25

In-Depth Look:

Catherine Freer Wilderness Therapy Expeditions

420 SW Third Avenue
PO Box 1064
Albany, OR 97321
(541) 926-7252
info@cfreer.com
www.cfreer.com

Licensed by the state of Oregon as both a substance abuse and mental health treatment program, Catherine Freer offers intensive residential therapy through 21-day wilderness treks in the Pacific Northwest. The trek, which teaches teens to camp, cook, backpack and rely on themselves in the outdoors, is designed to promote self-exploration and build self-confidence. The trek includes daily individual and group therapy sessions as well as educational activities, including a modified Twelve Step approach. Family involvement in the program is mandatory. Before and after the trek, adolescents and their families participate in all-day, multi-family therapy sessions conducted by a clinical supervisor.

Assessment and Matching

Most adolescents are assessed elsewhere prior to coming to Catherine Freer. The family completes a 26-page admissions application, which provides information on the physical, developmental, academic, social, substance abuse and mental health status of the youth. Clinical counselors review applications and conduct telephone screenings before teens are enrolled. Using American Society of Addiction Medicine criteria, a Psych-social Assessment is developed for each client and then refined during an all-day multi-family session held prior to the trek. Treatment plans are designed to meet the specific needs of each client, such as substance abuse problems, other behavioral problems, mental health issues or eating disorders. Clients also undergo a full physical examination to be sure they can meet the physical requirements of the program.

Comprehensive, Integrated Approach

Each day on the trek, adolescents engage in four to five hours of formal individual, group, and educational therapy, conducted by a therapist (M.A., M.S.W. or Ph.D.) who is also trained in chemical dependency treatment, and/or a Certified Alcohol and Drug Counselor trained in mental health treatment. Informally, teens spend several hours a day in therapeutic discussions with trek staff while hiking and in camp, and in completing assigned journal work. Adolescents are encouraged to reflect on their concerns and their values. During the trek, the first five steps of the Twelve Step approach are covered with a strong focus on spirituality; nature provides an inspiring background for these discussions.

Family Involvement

Parents or guardians are required to attend a multi-family all-day meeting before the trek, where they receive education on addiction, relapse and family dynamics. Stepparents, siblings, extended family members and close family friends are encouraged to attend these meetings; usually at least three or four family members are present with each client. Parents and siblings are asked about their substance use and emotional problems. Family members are urged to discontinue alcohol and other drug use and where appropriate, to consider treatment or Twelve Step groups for themselves. During the trek, the family meeting facilitator, who is also the trek's clinical supervisor, conveys messages between field staff and families and works with parents by phone on family issues and aftercare provision. At the end of the trek, another all-day multi-family meeting gives clients a chance to disclose the full extent of their drug abuse and other negative behaviors, and to work with their families and the facilitator to complete continuing care plans.

Developmentally Appropriate

Program materials are designed to meet the needs of adolescent clients, including Twelve Step workbooks, educational reading, notebooks to maintain journals, and art therapy materials. Strong emphasis is placed on observing nature. Lessons are taught in a hands-on fashion. Each client is taught to camp alone to increase self-confidence. Adolescents learn that they must ask for help if they want it, and also learn the consequences of their actions. For example, if they do not choose to start a fire, they cannot cook.

Engage and Retain

Although a majority of entering clients are reluctant to undergo treatment, 97 percent complete treatment because there is no way to "drop out" (aside from serious injury or illness) in the wilderness. The program offers sessions that address adolescent issues, including depression management, anger management, relapse prevention and sexuality. The program establishes strong therapeutic alliances with most participants by having the same three field staff live with the teens throughout the three weeks of a trek. The staff set clear, firm rules and boundaries and offer emotional support. This approach, along with age-appropriate outdoor activities, moves most clients from resistance to open acknowledgment of their problems within the first week of a trek.

Qualified Staff

On each trek, there are three staff for every seven clients. One is a wilderness guide who is certified as an emergency medical technician or wilderness first responder and may also be a certified alcohol and drug counselor (CADC). Another is the lead therapist, usually a master's or doctorate level counselor, who may also be a certified addiction drug counselor. The third is either a therapist or a wilderness guide. Clinical supervisors at the base facility have master's or doctorate training in psychology, or are second level CADCs. Trek staff call in once or twice a week for clinical supervision. Field staff receive approximately 12 hours of clinical, wilderness and first aid training before and after each trek. They typically work seven treks a year. Those who are not already certified alcohol and drug counselors are required to complete 150 hours of CADC-qualifying training within two years after joining the program. Most of that is offered in-house at weekly all-day training sessions, which cover substance abuse, psychological and family therapy. Staff also receive five to ten paid days annually for outside training.

Gender and Cultural Competence

Adolescent males and females receive the same treatment, but there is a strict protocol for separating the sexes during treks. About 40 percent of clients are female. Half the staff, including many of the wildemess guides, are female. The program selects physically strong, self-confident female staff and emotionally open male staff to promote good gender role modeling. More than 30 percent of the clients are members of ethnic minorities, particularly Native American, and many staff are, too. At staff training sessions, cultural issues are often covered; for example, being sensitive to issues of emotional privacy with Native American parents during family sessions.

Continuing Care

Clinical supervisors begin coordinating aftercare with parents and teens at the initial family meeting. Via telephone, they work with parents during the trek to get an appropriate continuing care program in place before the trek ends. A majority of the children return home; more than 90 percent of these clients attend outpatient treatment. Most families are involved in follow-up treatment as well. However, a substantial minority of clients with more severe problems or family issues go on to residential treatment facilities, halfway houses or transitional homes.

Outcomes

Since 1993, Catherine Freer has completed six follow-up outcome studies and is currently engaged in two large-scale studies. Two of the outcome studies, conducted by the University of Idaho, found that the program is highly effective in treating mental health and family problems, and at least as effective as non-wilderness residential programs in treating substance abuse.

Cost

The program costs $367 per day. There is a sliding fee scale. Private insurance and public assistance are accepted. The program also arranges set rates for clients from individual tribes.

In-Depth Look:

Thunder Road Adolescent Treatment Centers

390 40th Street
Oakland, CA 94609
(510) 653-5040
www.thunder-road.org

Thunder Road offers three treatment options: long-term (6-12 months) residential; short-term (3 months or less) inpatient; and intensive outpatient. Most of the clients in the long-term program are referred from the juvenile justice or social services systems. All treatment modalities provide a structured environment for youths with serious substance abuse problems. For adolescents with stable living circumstances, the intensive outpatient program facilitates 9 hours of counseling services per week. Each program has a strong family component that includes individual and group therapy sessions for adolescents and caregivers. Education and addiction awareness topics include anger management and relapse prevention. Clients are encouraged to utilize Twelve Step meetings for support. Clients participate in continuing care support groups for the balance of one year, designed to assist them in maintaining recovery skills gained during treatment.

Assessment and Matching
Thunder Road provides drug, alcohol and nicotine screening assessments. An initial 90-minute multidimensional assessment involves the youth and families in decisions about the level of care recommendations. Thunder Road uses the American Society of Addiction Medicine's patient placement criteria guidelines to place clients in appropriate levels of care. Clients who need services not available at Thunder Road are referred to other programs. Upon admission to treatment at Thunder Road, a preliminary treatment plan is developed based on identified priorities, problems and strengths within the family.

Comprehensive, Integrated Approach
Thunder Road's treatment design features approaches from a variety of disciplines. Elements from the therapeutic community model and medical model programs are interwoven with the Twelve Step approach. Thunder Road's therapeutic community creates an environment where peers support each other in the recovery process by learning to appropriately challenge the negative behavior of others. Medical staff provide clients with ongoing clinical services and supervise weekly multidisciplinary treatment planning meetings. The Twelve Step self-help framework serves as the basis for ongoing recovery support, with meetings held both inside and outside the program. Nicotine abuse treatment is a critical program component and smoking cessation is offered for clients, parents, and staff. Since 1999, Thunder Road has provided enhanced and coordinated mental health services for youths referred from local juvenile justice systems. The program offers comprehensive day treatment for dually diagnosed clients, with each client having access to a full range of mental health services. The Alameda County Office of Education operates an onsite school for youths at the inpatient or residential levels of care. School credits earned at Thunder Road are transferable to the client's home school district. Teachers also participate in weekly treatment planning meetings. In recent years, Thunder Road has become a major provider of substance abuse treatment services for youths in Alameda County's juvenile hall and correctional camp program.

Family Involvement
Thunder Road considers addiction a family disease and requires extensive family involvement, including twice weekly meetings. One meeting covers educational topics such as the nature of addiction, what to expect from an adolescent in treatment and parenting techniques for parents. A second meeting consists of multi-family group work, which explores family dynamics, enabling behavior, relapse prevention, and other problems of the participating families. Youths and family members also attend treatment planning confer-

as active participants in formulating goals and treatment objectives. In cases where involving immediate family members is not appropriate, extended family members participate in the treatment process. Youth recovery environments are important and the dynamics of the family are carefully weighed when considering where the youth will reside after discharge. Thunder Road asks all families to remove alcohol and narcotics from the home and for the home to be smoke-free prior to the client's discharge. These points and behavioral expectations are covered in the Continuing Care Contract that is initially negotiated by staff between clients and their caregivers.

Developmentally Appropriate

Written treatment assignments in each phase of treatment are adjusted to maximize youths' assimilation of materials, with Twelve Step recovery language modified into small manageable pieces as necessary. The smoking cessation program includes writing and drawing assignments geared to the developmental level of early adolescents. Confrontation, a mainstay of adult therapeutic communities, has been adjusted for adolescents so that confrontation groups are more positively balanced to support youth with emotional, behavioral or cognitive impairments. Treatment assignments are matched to the maturity and intellectual ability of the clients and are carefully assessed in the treatment planning sessions.

Engage and Retain

A client government council helps engage new clients in the treatment process. This appointed body, the Committee of Trusted Servants, is composed of model clients who have the authority to confront negative behavior in others, delegate chores and assist in assigning weekly treatment learning experiences for their peers. Thunder Road also offers activities such as art and drama therapy, a culinary arts vocational program and therapeutic wilderness treks.

Qualified Staff

Thunder Road staff is experienced in working with dually diagnosed clients; it is estimated that 80 to 90 percent of their clients have co-existing disorders. The multidisciplinary clinical staff includes psychiatrists, psychologists, pediatricians, social workers, nurses, family therapists and recovery counselors. The nursing staff and many of the counselors have degrees in behavioral sciences or are certified as drug and alcohol counselors.

Gender and Cultural Competence

Gender and cultural issues are assessed periodically to assure continued relevancy to treatment plans. Gender-specific groups address sensitive issues such as physical maturation, sexual abuse and family planning. Clear expectations and limits support youth in focusing on treatment, the development of a positive self-image, and pro-social character traits. Strict rules govern behavior to prevent dating. Males and females also live in separate quarters.

Continuing Care

Prior to discharge from treatment, youths and caregivers attend two workshops on the continuing care process before negotiating a Continuing Care Contract. Thunder Road advises families that their most challenging work begins after discharge and this contract is one of the primary tools in their recovery plans. After discharge, clients and families are encouraged to attend continuing care support sessions twice weekly for up to one year after discharge from primary treatment.

Outcomes

Thunder Road is part of the national Adolescent Treatment Model Study, currently being conducted by the Public Health Institute and funded by the Federal Substance Abuse and Mental Health Services Administration. Extensive outcome evaluation is nearing completion and will be available in 2003.

Cost

For the short-term inpatient program, the maximum private pay rate is $450 per day. The program has a sliding fee scale; full scholarship funding for treatment may be available. The program has negotiated contracts with more than 50 managed care companies throughout northern California. Contracts with juvenile justice and social service departments provide funding for the long-term program. For intensive outpatient services, the maximum fee is $170 a day.

Treatment in the Juvenile Justice System

The Numbers:

Substance abuse is a pervasive problem among youths charged with delinquent or criminal behavior. An estimated two-thirds of the 1.2 million youths charged with delinquency offenses each year are substance abusers. Many of them also have mental and physical health problems, learning disabilities and dysfunctional families. Without effective treatment, the majority of them will not be able to break the cycle of delinquency and drugs.

Although arrests of juveniles for violent and property crimes have declined in recent years, the number of youths entering the juvenile justice system on drug-related charges has dramatically increased. According to the U.S. Department of Justice, juvenile arrests and juvenile court cases involving drug law violations more than doubled over the past decade. Yet adolescent drug treatment is even more scarce inside juvenile detention centers than it is in the community.

The juvenile justice system is now the largest single source of youth referrals to treatment. Almost half of all adolescents currently in treatment have been mandated to programs by the juvenile justice system, or in the case of older teens, by the adult criminal courts. The rate of mental disorders among juveniles is also very high. Recent studies indicate that three-quarters of the juveniles in public and private juvenile facilities reported mental health problems during screening. In addition, more than half reported that they had previously received treatment of some kind for mental health problems.

There is currently no requirement for screening for substance abuse or mental disorders in the juvenile justice system. Furthermore, the availability of screening, assessment and substance abuse treatment as well as mental health services is uneven nationally, exacerbating the current crisis in the capacity to address these problems. Only one in three juvenile correctional facilities offers onsite treatment for substance abuse. Yet incarceration remains far more expensive than treatment. Putting a juvenile in jail costs about $40,000 annually, compared to $13,000 for residential treatment and $3,000 for outpatient care.

The Challenge:

Juvenile justice professionals need to establish a youth intake process—whether in detention or in other community contexts—that screens and assesses for substance abuse and related problems no matter how and why youths enter the juvenile justice system. In order to make a good referral "match" to treatment, a continuum of treatment slots must be developed to meet the unique needs of youth offenders and their families. Some services must be available in detention and other locked settings as well as among community providers knowledgeable about the drugs/delinquency cycle.

Many staff do not have adequate knowledge of current best practices. Without regular infusions of quality training on new approaches, administrators and staff may well use outdated models that attempt to "scare" youth "straight," and push them to adopt a disease model that does not reflect adolescent perspectives or does not support prosocial skill building and substance-free identity development. Structuring ways to remain current regarding innovations in both substance abuse treatment and juvenile justice is critical to staff ability to provide quality services.

Unfortunately, community services often occur within what have become known as funding and professional "silos" which operate separately from each other without collaboration or regular communication. In order to meet the complex needs of youths and their families, service providers must learn to work across systems as well as within them. A comprehensive, integrated approach requires dynamic case management to support youths and their families through the particular legal complexities of juvenile justice, substance abuse treatment and other services.

Recent Federal studies show that effective drug and alcohol treatment for adolescents requires a system of care that provides help with the transition back into the community from juvenile detention centers, jails or prisons. Treatment must be extended beyond the brief, active intervention phase to provide continuing care as a youth puts new identity building skills to work in the community. This can be particularly challenging once a youth leaves a locked setting or periodic monitoring by a probation officer. This system of care should offer a range of services that includes prevention, intervention and treatment for at least a year or longer.

During the last fifteen years, the juvenile justice system has worked to develop a variety of approaches to encourage and improve interaction with both public health and substance abuse treatment systems. Best practices are beginning to guide the way for future reforms. These include community assessment centers, juvenile drug courts, and integrated treatment networks as well as innovative strategies such as restorative justice, graduated sanctions, integrated case management, strength-based approaches and efforts to reduce disproportionate confinement of minority youth. One new strategy is Adolescent Portable Therapy (APT), developed by the Vera Institute of Justice and the New York City Department of Juvenile Justice. APT identifies youths with substance use problems early and provides a system for bringing treatment to the youth as they are processed through the justice system. The goal is to provide comprehensive, uninterrupted treatment to juveniles who otherwise would be unlikely to receive the help they need. (To learn more about APT, see www.vera.org).

The Denver Juvenile Justice Integrated Treatment Network, started in 1995 with funding from SAMSHA, is an excellent example of local efforts to adopt best practices related to substance-abusing juvenile offenders. The goal of the Network is to provide customized treatment that offers a comprehensive array of services drawn from more than 40 programs and agencies. In addition, the Network works with providers to develop common policies and to incorporate best practices in their programs. A specialized management information system allows providers and agencies to access information from each other's databases while still respecting confidentiality concerns. Network services include screening, assessment, referral, case management, treatment, family advocacy and health services for offenders ages 10 to 21. An independent evaluation in 1999 found that an overwhelming majority of participating agencies reported that the Network improved services to juveniles (84 percent) and facilitated information sharing (95 percent). (A fuller description of the Denver Network is available at www.drugstrategies.org).

Building on the success of the Denver Network, the Robert Wood Johnson Foundation has funded Reclaiming Futures, a major five-year initiative in eleven different communities to reinvent the way courts, police, detention facilities and communities address the needs of juvenile offenders with substance abuse problems. The goal is to structure a system of comprehensive community care that supports youths as they come back to the community after incarceration or other court involvement; to open productive avenues for youths as they work to strengthen themselves; and to foster the development of skills for positive social interaction through organizations, jobs and community participation. To learn more about this important initiative, please visit www.reclaimingfutures.org.

A more detailed discussion of substance abuse treatment within the juvenile justice system by Dr. Laura Burney Nissen, Director of Reclaiming Futures, is available at www.drugstrategies.org

Substance Abuse and Mental Health

Dual diagnosis of both substance abuse and mental health problems is one of the most important challenges in treating adolescents. More than two-thirds of adolescents in drug treatment programs also have mental health problems that are sufficiently serious to meet psychiatric diagnostic criteria (DSM IV-Axis I). These include depression, anxiety, post-traumatic stress and conduct disorders. However, accurate diagnosis is often difficult and many youths go untreated.

Assessment of mental health disorders among youths in drug treatment programs varies widely. Written questionnaires are most frequently used, including those completed by the adolescent, such as the Personal Experiences Screening Questionnaire (PESQ), or by the parent, such as the Child Behavior Checklist (CBCL). Formal diagnoses require the use of well-standardized interview instruments, such as the Diagnostic Interview Schedule for Children (DISC), Schedule for Affective Disorders and Schizophrenia for School Age Children (K-SADS) or Composite International Diagnostic Interview (CIDI). Urinalysis is critical in the diagnostic process. The adolescent may have taken drugs which cause serious mental health symptoms, such as hallucinations, or which exacerbate existing symptoms, such as depression.

Substance abuse and psychiatric disorders share common biological, behavioral and environmental risks and may be precipitated or exacerbated by each other. For example, an adolescent may have a mood disorder which was induced by substance abuse or a conduct disorder which resulted in a substance use disorder. Youths diagnosed with conduct disorders have problems with aggression, impulsiveness, and irritability.

Dually diagnosed youths who receive both mental health and drug treatment show improvement. However, research indicates that total abstinence from alcohol and other drugs is rare and mental health problems decrease but do not disappear. Nonetheless, integrated treatment of the co-occurring problems appears critical. For example, integrated treatment for youths with both conduct disorders and substance abuse problems has been shown to increase engagement and retention in treatment, which is a key factor in treatment success. Similarly, family involvement increases the likelihood that the adolescent will stay in treatment, which also improves outcomes.

Parents and other concerned adults should ask the following questions when assessing the suitability of a treatment program:

- Are mental health problems routinely assessed?
- Are nationally recognized assessment instruments used to make a diagnosis?
- Is withdrawal from alcohol and other drugs taken into account before a mental health disorder diagnosis is made?
- Is corroborative information, such as urinalysis, used to determine if a disorder has been induced by drug use?
- Are mental health disorders considered in the treatment plan?
- Are mental health disorders reevaluated after periods of sustained abstinence?
- Are psychiatrists and psychologists available for formal assessments, integrated treatment planning and interventions?
- Are special efforts made to engage and retain dually diagnosed youths, including aggressive aftercare plans?

Further information about substance abuse and mental health, prepared by Dr. Sandra A. Brown, Professor, Department of Psychology and Psychiatry, University of California, San Diego, can be found at www.drugstrategies.org

Ten Important Questions to Ask A Treatment Program

1. How does your program address the needs of adolescents?
Most treatment programs are designed for adults, not adolescents. Although adolescent treatment capacity has recently begun to expand, relatively few teens can get help for substance abuse in programs that specifically address the unique challenges of adolescence. Experts agree that adolescent treatment cannot just be adult treatment modified for kids. The program should be developmentally appropriate for adolescents. It should also actively engage the family, which is the primary provider of financial support and the dominant force in the adolescent's life. In addition, the program should address the many different contexts which shape the teen's environment, such as school, health care, recreation, peer groups and where necessary, juvenile court and probation. For residential treatment programs, it is important to know how teens continue their education. Do they attend school in the local community, or does the program include regular onsite classes approved by the local school district with credits that can be transferred to the student's home school? The nine key elements of effectiveness discussed in *Treating Teens* provides a framework for assessing how well a treatment program addresses the needs of adolescents.

2. What kind of assessment does the program conduct of the adolescent's problems?
When a parent or other concerned adult contacts a program—often in response to an immediate crisis—program staff will ask a brief set of screening questions to explore the severity of the youth's problems and to determine whether a more thorough assessment is required. Screening helps sort out what the teen needs, the severity of the problem, and whether the parent or other referring adult should contact a different kind of program.

Assessment provides a road map for developing an effective treatment plan tailored to the adolescent's specific needs. Most programs do not use standardized, scientifically-sound screening and assessment instruments. Rather they rely on questionnaires they develop in-house that may have questionable reliability. If the program does not have the necessary services indicated by the assessment, such as intensive psychiatric or medical care, the teen may either be referred to a different program or retained in the original program but sent elsewhere for these services.

3. How often does the program review and update the treatment plan in light of the adolescent's progress?
The treatment plan, which the program develops after an initial comprehensive assessment of the adolescent and his family, provides a guide to recovery that is tailored to the adolescent's specific needs. These needs will change as the adolescent progresses through the treatment process. Experts suggest that the treatment plan should be reviewed within the first thirty days and again after sixty and ninety days. In addition, the plan should be reviewed in light of significant developments, such as urinalysis tests that show drug use. As the adolescent nears completion of treatment, the plan should be modified to include continuing care and relapse prevention strategies. Follow-up after the teen leaves the program is also important in improving the likelihood that gains made in treatment will not be lost.

4. How is the family involved in the treatment process?
Family involvement in the adolescent's treatment is critically important for treatment success. Engaging parents—or in the absence of 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. Programs should encourage parents to participate in counseling, group meetings, drug education and other activities offered by the program. Some programs involve intensive interventions with teens and their families not only at the program, but also at home, school, juvenile facility, probation office and workplace. Occasional telephone calls from program staff to parents are not enough. The more the family is involved, the better the treatment outcomes will be.

5. How do you engage adolescents so that they stay in treatment?
Both the length and the intensity of treatment vary widely depending on the adolescent's specific needs. Keeping adolescents in treatment is critically important since completion of treatment is closely related to better outcomes. Retention rates are an important measure of program success. How many clients drop out? How long do they stay in treatment? How many actually complete treatment?

The initial assessment process can engage the teen in treatment by helping him or her recognize that he or she does have substance abuse and other problems. Motivational interviewing and feedback also help engage the teen, particularly if he or she sees that treatment can address some of the pressing issues in his or her life, including school performance and family relationships. Creative program content targeted to adolescents in terms of examples and developmental appropriateness can make treatment more relevant. The key is to address the everyday concerns of the adolescent so that he or she will be motivated to make the necessary effort to change fundamental behavior patterns.

Practical assistance, such as transportation to the program and other service providers, also helps keep teens in treatment. So, too, do recreational activities, sports events, mentors, after-school tutoring and reward systems, such as vouchers for drug-free urine tests.

6. What are the qualifications of program staff and what kind of clinical supervision is provided?
Qualified staff are critically important to treatment effectiveness. The relationship between the teen and his or her counselor greatly influences the extent to which the program will be able to motivate change and to retain the teen in treatment. In addition to training in substance abuse treatment, staff should be trained to recognize psychiatric problems, understand adolescent development and to work with families. They should also have practical experience in dealing with adolescents and be responsive to the way young people think.

Staff to client ratio is also important: experts suggest that one counselor should treat no more than 20-25 adolescents in outpatient programs, 10-15 clients in intensive outpatient, and 4-8 clients in residential programs. In addition, programs should provide regular clinical supervision several times a week by more experienced staff to provide guidance for counselors as well as to monitor progress in staff-client interactions.

7. Does the program offer separate single sex groups as well as male and female counselors for girls and boys?
Recent research points to significant differences between male and female adolescent drug users. Girls with drug abuse problems are more likely to have serious mental health problems, particularly depression, anxiety and post-traumatic stress disorder. They are also more likely to be the victims of sexual and physical abuse, often by family members or older friends. Boys more often have conduct disorders, including aggressive, disruptive and even violent behavior, and they, too, may have been victims of sexual abuse.

Single sex group sessions provide the opportunity to focus on issues that might be difficult to discuss in co-ed groups. Teenage girls often strive for approval from males rather than focusing on their own problems. In addition, they may be reluctant to talk freely in front of males about their experiences, which many regard as shameful. Working with women counselors and with other girls in group therapy provides girls a psychologically safe haven to explore problems related to their substance abuse. Boys, too, can benefit from single sex group focus on disruptive behaviors, date rape, HIV risks, and understanding the responsibilities of becoming an adult. They can also learn new behaviors and attitudes from male counselors who provide positive role models.

8. How does the program follow up with the adolescent and provide continuing care after treatment is completed?
The period following treatment is vitally important in consolidating the gains made in treatment. Most

adolescents relapse in the first three months after treatment. However, effective continuing care services substantially increase the teen's chances of successful, sustained recovery. These services include relapse prevention training, follow-up plans and referrals to community resources. In addition, the program should schedule periodic check-ups with the adolescent at one month, three months and one year after completing treatment. Wherever possible, more frequent contact is preferable, both to monitor the teen's progress and to make sure the teen and his or her family are receiving the necessary services in the community.

Most programs provide referrals to community resources, including Twelve Step meetings and group therapy, where available. Some programs offer continuing services, such as counseling and education, after the period of formal treatment is completed. Less frequently, programs develop a comprehensive continuing care plan while the teen is still in treatment so that the transition back into the community is as seamless as possible.

9. What evidence do you have that your program is effective?
Very few programs have formal, scientific outcome evaluations that measure treatment success. However, in the absence of such evaluations, other information can shed light on the effectiveness of a program. For example, completing treatment is closely related to positive outcomes.

Retention rate is an important indicator of effectiveness. How many teens drop out? How long do they stay? How many actually complete treatment? Even without formal evaluations, programs should be able to provide accurate information on client retention and completion. Programs should also be able to demonstrate how they measure the individual teen's progress through treatment. Does the program routinely report on key indicators of behavioral change? Do urine tests come back clean? Is school performance improving? Is aggressive behavior diminishing? Are family relationships getting stronger? In short, can the program show that the trajectory of the teen's life has changed for the better?

10. What is the cost of the program?
The cost of drug treatment varies widely, depending on the program, its location and the type of care offered. Residential programs are generally the most expensive option, since they provide live-in facilities and around the clock supervision by trained counselors. For example, the rates charged by three of the programs described in this guide, Chestnut Health, Hazelden and Thunder Road, are about $500 a day. Outpatient treatment is much less expensive, since the adolescent lives at home. For example, MDFT (Multidimensional Family Therapy), which is described in this guide, costs $164 per week. An intensive version of MDFT is more expensive ($384 per week) because of the additional services provided.

Health plans do not generally offer full coverage for substance abuse treatment, although six states now require health insurance companies to cover substance abuse treatment at the same level as any other illness. Some states offer free assessments, while others charge for assessments according to a sliding scale based on ability to pay.

Medicaid coverage for substance abuse treatment varies by state. Some states, like Massachusetts, provide Medicaid coverage for a full range of treatment options, while others, like Mississippi, cover only inpatient detoxification. Costs for participation in certain programs, such as MST (Multisystemic Therapy) in South Carolina, are covered by the juvenile justice system, while Catherine Freer, a wilderness therapy program in Oregon which treats a significant number of Native American adolescents, arranges set rates for clients from individual tribes. Many programs receive federal and/or state grant funds that allow them to subsidize in whole or in part the cost of treatment for low income clients.

How Do I Find Help?

State	Hotline	Website	What website provides	Cost of assessment
Alabama	800-SOBER-90	www.mh.state.al.us/services/sa/sa-main.html	Links to SAMHSA treatment locator	Most programs use a sliding scale
Alaska	907-463-3755	www.alaskaprevention.org	Searchable database of treatment programs	Most programs use a sliding scale
Arizona	602-381-8999	www.hs.state.az.us/bhs/bhsguide.htm	Information on substance abuse programs	Depends on eligibility requirements
Arkansas	501-280-4500	www.healthyarkansas.com/healthyyou/healthyyou.html	Contact information for hotline	Free assessments are available
California	800-662-HELP	www.calcarenet.ca.gov/alcohol_drug_treatment.asp	Searchable database of treatment programs	Free assessments are available
Colorado	303-866-7480	www.cdhs.state.co.us/ohr/adad/index.html	Searchable database of treatment programs	Most programs use a sliding scale
Connecticut	800-842-2288	www.dmhas.state.ct.us	Searchable database of treatment programs	Most programs use a sliding scale
Delaware	302-633-2571	www.state.de.us/kids/cmhhome.htm	Contact information for hotline	Free assessments are available
District of Columbia	888-294-3572	dchealth.dc.gov/services/administration_offices/apr/services.shtm	Information on substance abuse programs	Free assessments are available
Florida	850-487-2920	www5.myflorida.com/cf_web/myflorida2/healthhuman/substanceabusementalhealth	Searchable database of treatment programs	Depends on district
Georgia	800-338-6745	www2.state.ga.us/departments/dhr/mhmrsa/index.html	Information on regional offices	Most programs use a sliding scale
Hawaii	808-692-7506	www.state.hi.us/doh/resource/drug_abuse.html	Information on substance abuse programs	Most programs use a sliding scale
Idaho	800-926-2588	www2.state.id.us/dhw/mentalhealth/index.htm	Information on substance abuse programs	Free assessments are available
Illinois	312-814-2300	www.state.il.us/agency/dhs/indexasanp.html	Contact information for hotline	Most programs use a sliding scale
Indiana	None	www.in.gov/fssa/shape/providers.asp	Searchable database of treatment programs	Most programs use a sliding scale
Iowa	866-242-4111	www.drugfreeinfo.org	Searchable database of treatment programs	Most programs use a sliding scale
Kansas	800-586-3690	www.srskansas.org/hcp/mhsatr/SATRradac.htm	Information on regional offices	Most programs use a sliding scale
Kentucky	502-564-2880	dmhmrs.chr.state.ky.us/sa	Contact information for hotline	Free assessments are available
Louisiana	225-342-6717	www.dhh.state.la.us/oada/prevention_services.htm	Information on substance abuse programs	Free assessments are available
Maine	207-287-8900	www.maineosa.org	Searchable database of treatment programs	Free assessments are available
Maryland	410-402-8632	www.dhmh.state.md.us/adaa/html/trtindex.htm	Searchable database of treatment programs	Most programs use a sliding scale
Massachusetts	800-327-5050	www.helpline-online.com	Searchable database of treatment programs	Free assessments are available
Michigan	888-736-0253	www.michigan.gov/mdch/0,1607,7-132-2941_4871_4877---,00.html	Links to SAMHSA treatment locator	Most programs use a sliding scale
Minnesota	651-582-1832	www.dhs.state.mn.us/Contcare/chhome.htm	Information on substance abuse programs	Most programs use a sliding scale
Mississippi	877-210-8513	www.dmh.state.ms.us/alcohol_and_drug_abuse_services.htm	Information on regional offices	Depends on program

State	Hotline	Website	What website provides	Cost of assessment
Missouri	800-575-7480	www.modmh.state.mo.us/ada/treatment.htm	Information on regional offices	Depends on district
Montana	800-457-2327	www.prevention.state.mt.us/resources/directory/directory.htm	Information on regional offices	Most programs use a sliding scale
Nebraska	800-648-4444	www.hhs.state.ne.us/sua/beh_sua.htm	Information on regional offices	Free assessments are available
Nevada	775-825-4537	health2k.state.nv.us/bada	Contact information for hotline	Most programs have a flat rate
New Hampshire	800-852-3388	www.dhhs.state.nh.us/DHHS/SUBABUSESRVC	Information on substance abuse programs	Most programs use a sliding scale
New Jersey	800-225-0196	www.state.nj.us/health/as/directory	Searchable database of treatment programs	Depends on program
New Mexico	505-827-8018	www.health.state.nm.us/satc/satcweb.html	Information on substance abuse programs	Depends on program
New York	800-522-5353	www.oasas.state.ny.us	Information on substance abuse programs	Depends on eligibility requirements
North Carolina	800-662-7030	www.dhhs.state.nc.us/mhddsas/public/sap.htm	Information on substance abuse programs	Most programs use a sliding scale
North Dakota	800-755-2719	Inotes.state.nd.us/dhs/dhsweb.nsf/ServicePages/MentalHealthandSubstanceAbuseServices	Information on regional offices	Public centers are sliding scale; private ones are not
Ohio	614-466-3445	www.state.oh.us/ada/odada.htm	Searchable database of treatment programs	Free assessments are available
Oklahoma	800-522-9054	www.odmhsas.org/subab.htm	Information on substance abuse programs	Free assessments are available
Oregon	800-621-1646	www.oadap.hr.state.or.us/direct.html	Links to SAMHSA treatment locator	Most programs use a sliding scale
Pennsylvania	717-783-8200	www.health.state.pa.us/php/SCA/default.htm	Information on regional offices	Most programs use a sliding scale
Rhode Island	866-ALC-DRUG	www.healthri.org/family/adolescent/home.htm	Contact information for hotline	Most programs use a sliding scale
South Carolina	800-942-DIAL	www.daodas.state.sc.us/web	Searchable database of treatment programs	Most programs use a sliding scale
South Dakota	605-773-3123	www.state.sd.us/dhs/ada	Information on substance abuse programs	Most programs use a sliding scale
Tennessee	800-889-9789	www2.state.tn.us/health/A&D/index.htm	Contact information for hotline	Depends on program
Texas	877-9-NO-DRUG	www.tcada.state.tx.us/findingtreatment	Searchable database of treatment programs	Most programs use a sliding scale
Utah	866-633-HOPE	www.hsdsa.state.ut.us	Information on substance abuse programs	Most programs use a sliding scale
Vermont	800-639-6095	www.state.vt.us/adap	Information on substance abuse programs	Free assessments are available
Virginia	804-786-3906	www.gosap.state.va.us/	Links to SAMHSA treatment locator	Most programs use a sliding scale
Washington	800-562-1240	www1.dshs.wa.gov/dasa/index.htm	Contact information for hotline	Most programs use a sliding scale
West Virginia	304-558-2276	www.wvdhhr.org/bhhf	Information on substance abuse programs	Most programs use a sliding scale
Wisconsin	608-266-2717	www.dhfs.state.wi.us/SubstAbuse	Links to SAMHSA treatment locator	Depends on district
Wyoming	800-535-4006	sad.state.wy.us	Contact information for hotline	Most programs use a sliding scale

Teen Treatment Terms

Art and Expression Therapies
Emphasize creative and performing arts such as painting, music and movement to express feelings in non-verbal ways.

Brief Therapy
Relies on systematic client assessment, engagement and rapid implementation of behavioral strategies to change attitudes and address the problems underlying substance abuse.

Brief Strategic Family Therapy
Provides an intensive, short-term, problem-focused intervention with youths and families, generally lasting three months.

Case Management
Addresses individual healthcare, treatment and other needs and efficiently utilizes resources to achieve optimum results.

Cognitive Behavioral Therapy
Teaches positive behavioral alternatives to alcohol and other drug use, including refusal skills, anger management, problem-solving, and effective communication.

Community Reinforcement
Encourages abstinence by giving clients points exchangeable for retail items, which they earn by remaining in treatment.

Co-Occuring Disorder; Comorbidity
See dual diagnosis.

Day Treatment
Offers treatment services on a daily, non-residential basis, which is similar in intensity to inpatient care, but less costly.

Detoxification
Monitors and assists, with appropriate medications, an individual who is undergoing physical withdrawal from addictive drugs.

Dual Diagnosis
Refers to a client diagnosed with both substance abuse and mental health problems.

Early Intervention
Aims to prevent individuals who are experimental or occasional users from further alcohol and other drug use.

Experiential Therapy
Uses activities shared by both the therapist and the client, such as horseback riding, animal care and outdoor adventure programs, to achieve behavior change.

Family Effectiveness Training
Provides didactic lessons and participatory activities to help parents master family management skills, and offers planned discussions in which the therapist intervenes to improve communication among family members.

Family-based Treatment; Family Systems Therapy
Focuses on family interactions and dynamics, pinpoints problems and helps improve family relationships by clarifying family roles and reshaping dysfunctional behaviors.

Halfway House
Provides food, shelter, and vocational, recreational and social services in a supportive, sober residential environment.

Inpatient Treatment; Hospital Inpatient Treatment
Provides residential medical care in a hospital facility in conjunction with substance abuse services.

Intensive Outpatient Treatment
Provides treatment services on a non-residential basis at least two hours a day, three or more days a week.

Matrix Model
Provides clients with information on addiction and relapse, encourages them to participate in self-help programs, conducts family and group sessions and monitors clients for drug use.

Minnesota Model
Provides short residential treatment (4-6 weeks), which includes individual counseling, family and group therapy, schooling and recreation, with emphasis on Twelve Step approach.

Motivational Enhancement Therapy
Helps clients quickly develop strong motivation to curtail substance abuse

through therapy consisting of an initial assessment session followed by two to four individual treatment sessions.

Multidimensional Family Therapy
Addresses adolescent substance abuse in the context of the family, community, peers and other social systems by working intensively with the adolescent and his or her family in a number of settings.

Multisystemic Therapy
Addresses comprehensively the multiple determinants of youth and family problems through individualized case management and therapeutic services in the client's home environment.

Narrative Therapy
Emphasizes writing and storytelling in order to increase self-understanding and encourage behavioral change.

Outpatient Treatment
Provides wide range of non-residential treatment services.

Positive Peer Culture
Encourages adolescents to develop new friendships and to become involved in new activities in order to create a positive peer culture which supports sobriety.

Psycho-education
Teaches psychological concepts of individual and group dynamics in order to provide the client with greater self-awareness.

Psychotherapy
Treats mental and emotional problems by helping patients learn about themselves, develop new insights into relationships and change patterns of behavior.

Rational Emotive Behavior Therapy
Helps clients recognize irrational thinking and adopt more rational thinking and behavior.

Reality Therapy
Teaches clients how to choose more effectively positive behaviors that do not involve substance abuse.

Residential Treatment
Provides round-the-clock supportive living arrangements for clients undergoing treatment for substance abuse.

Rogerian Therapy
Emphasizes empathy, sincerity and unconditional positive regard for the client rather than negative judgments of the client's behavior.

Self-Empowerment Training
Teaches clients to assert personal control in order to make changes in their lives.

Social Learning Theory
Emphasizes the importance of observing and modeling the behaviors, attitudes and emotional reactions of others.

Strength-based Therapy, Strength Perspective
Builds on the strengths of the individual and family to show how problems can be resolved.

Structural Family Therapy; Systems Therapy
Teaches families appropriate interaction through the assignment by a therapist of tasks requiring cooperation and consensus.

Twelve Step Approach
Builds on Alcoholics Anonymous Twelve Steps to recovery, which views alcohol and other drug abuse as a disease that requires long-term management with abstinence as the goal; widely used in treating adolescents, particularly in connection with relapse prevention and continuing care.

Therapeutic Alliance
Builds a climate of trust between therapist and client which facilitates behavior change.

Therapeutic Community
Provides highly structured residential treatment for adolescents with severe substance abuse and other problems for periods ranging from six months to two years.

Wilderness Therapy
Provides adolescents who have substance abuse and other problems clinically supervised therapeutic activities in outdoor settings.

Sources

Federal Government

U.S. Department of Health and Human Services

Center for Substance Abuse Treatment (CSAT). *Adolescents and Young Adults in the National Treatment Improvement Evaluation Study.* 1999.

——. *Screening and Assessing Adolescents for Substance Use Disorders.* Treatment Improvement Protocol (TIP) #31, 1999.

——. *Strategies for Integrating Substance Abuse Treatment in the Juvenile Justice System: A Practice Guide.* 1999.

——. *Treatment of Adolescents with Substance Abuse Disorders.* Treatment Improvement Protocol (TIP) #32, 1999.

National Institute on Alcohol Abuse and Alcoholism (NIAAA). "Treatment of adolescent alcohol problems: Research review and appraisal." *NIAAA Extramural Scientific Advisory Board: Treatment.* 1999.

National Institute on Drug Abuse (NIDA). *Adolescent Drug Abuse: Clinical Assessment and Therapeutic Interventions.* 1995.

——. *Current Issues and Future Needs in the Assessment of Adolescent Drug Abuse.* 1995.

——. *Monitoring the Future: National Survey Results on Drug Use, 1975-2001: Volume I, Secondary School Students.* 2002.

——. *Therapeutic Community: Advances in Research and Application.* 1994.

Substance Abuse and Mental Health Services Administration (SAMHSA). *Results from the 2001 National Household Survey on Drug Abuse: Volume I. Summary of National Findings.* 2002.

——. *Substance Abuse Treatment in Adult and Juvenile Correctional Facilities: Findings from the Uniform Facilities Data Set 1997 Survey of Correctional Facilities.* 2000.

U.S. Department of Justice

National Institute of Justice (NIJ). *1999 Annual Report on Drug Use Among Adult and Juvenile Arrestees.* 2000.

——. *Breaking the Juvenile Drug-Crime Cycle: A Guide for Practitioners and Policymakers.* 2001.

Office of Juvenile Justice and Delinquency Prevention (OJJDP). *Drug Offense Cases in Juvenile Courts, 1989-1998.* OJJDP Fact Sheet #36, 2001.

——. *Juvenile Offenders and Victims: 1999 National Report.* 1999.

General

A.M. Abrantes & S.A. Brown. "Psychiatric comorbidity among substance abusing adolescents: Assessment issues in clinical research." *Clinical Psychology Review* (in press).

G.S. Alford et al. "Alcoholics Anonymous-Narcotics Anonymous model inpatient treatment of chemically dependent adolescents: A 2-year outcome study." *Journal of Studies on Alcohol,* 52:118-126, 1991.

American Academy of Child and Adolescent Psychiatry (AACAP). "Being prepared: Know when to seek help for your child." *Facts for Families #24.* Washington, DC: AACAP, 1999.

——. "Substance abuse treatment for children and adolescents: Questions to ask." *Facts for Families #41.* Washington, DC: AACAP, 2000.

American Society of Addiction Medicine (ASAM). *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, 2nd Edition, Revised.* Chevy Chase, MD: ASAM, 2001.

N.H. Azrin et al. "Youth drug abuse treatment: A controlled outcome study." *Journal of Chiid and Adolescent Substance Abuse,* 3:1-16, 1994.

G. Bazemore & L. Nissen. "Mobilizing social support and building relationships: Broadening correctional and rehabilitative agendas." *Corrections Management Quarterly,* 4(4):12-21, 2000.

S.A. Brown et al. "Correlates of success following treatment for adolescent substance use." *Applied and Preventive Psychology,* 3:61-73, 1994.

S.A. Brown et al. "Four-year outcomes from adolescent alcohol and drug treatment." *Journal of Studies on Alcohol,* 62:381-388, 2001.

J.J. Cocozza & K. Skowyra. "Youth with mental health disorders: Issues and emerging responses." *Juvenile Justice,* 7(1), April 2000.

S.S. Covington. "Creating Gender-Specific Treatment for Substance-Abusing Women and Girls in Community Correctional Settings". Paper prepared for the 6th Annual Research Conference of the International Community Corrections Association. Arlington, VA: 1998.

G.A. Dakof et al. "Predictors of engagement in adolescent drug abuse treatment." *Journal of the American Academy of Child and Adolescent Psychiatry,* 40:274-281, 2001.

D. Deas & S.E. Thomas. "An overview of controlled studies of adolescent substance abuse treatment." *American Journal on Addictions,* 10:178-189, 2001.

G. DeLeon (ed). *Community as Method: Therapeutic Communities for Special Populations and Special Settings.* Westport, CT: Praeger Publishers/Greenwood Pubilshing Group, 1997.

R. Dembo. "Problems among youths entering the juvenile justice system, their service needs and innovative approaches to address them." *Substance Use and Misuse,* 31(1):81-94, 1996.

M.L. Dennis et al. "Main findings of the Cannabis Youth Treatment (CYT) randomized field experiment." *Archives of General Psychiatry* (under review).

M.L. Dennis et al. "The need for developing adolescent treatment models," in S.J. Stevens & A.R. Morral (eds), *Adolescent Substance Abuse Treatment in the United States: Exemplary Models from a National Evaluation Study.* Birmingham, NY: Hawthorn Press (in press).

C. Grella et al. "Drug treatment outcomes for adolescents with comorbid mental and substance use disorders." *Journal of Nervous and Mental Disease,* 189(6):384-392, 2001.

S.W. Henggeler et al. "Multisystemic treatment of substance abusing and dependent delinquents: Outcomes, treatment fidelity, and transportability." *Mental Health Services Research,* 1:171-184, 1999.

Y. Hser et al. "An evaluation of drug treatments for adolescents in 4 U.S. cities." *Archives of General Psychiatry,* 58(7):689-695, 2001.

N. Jainchill et al. "Adolescents in therapeutic communities: One-year post-treatment outcomes." *Journal of Psychoactive Drugs,* 32(1):81-94, 2000.

Y. Kaminer & J.A. Burleson. "Psychotherapies for adolescent substance abusers: 15-month follow-up of a pilot study." *American Journal on Addictions,* 8:114-119, 1999.

P.C. Kendall & J.F. Clarkin. "Introduction to special section: Comorbidity and treatment implications." *Journal of Affective Disorder,* 8:153-157, 1992.

G.L. Klerman. "Approaches to phenomena of comorbidity," in J.D. Maser & C.R. Cloninger (eds), *Comorbidity of Mood and Anxiety Disorders.* Washington, DC: American Psychiatric Press, 1990.

H.A. Liddle et al. "Multidimensional family therapy for adolescent drug abuse: Results of a randomized clinical trial." *American Journal of Drug and Alcohol Abuse,* 27(4):651-687, 2001.

C.S. Martin & K.C. Winters. "Diagnosis and assessment of alcohol use disorders among adolescents." *Alcohol Health and Research World,* 22(2):95-105, 1998.

D. Mendel. "A family affair." *AdvoCasey,* 4(1):13-19, Spring 2002.

K.T. Meuser et al. "Dual diagnosis: A review of etiological theories." *Addictive Behaviors,* 23(6): 717-734, 1998.

R. Muck et al. "An Overview of the effectiveness of adolescent substance abuse treatment models." *Youth and Society,* 33(2):143-168, 2001.

T.J. Ozechowski & H.A. Liddle. "Family-based therapy for adolescent drug abuse: Knowns and unknowns." *Clinical Child and Family Psychology Review,* 3(4):269-298, 2000.

S. Perrin & C.G. Last. "Dealing with comorbidity," in A.R. Eisen et al. (eds), *Clinical Handbook of Anxiety Disorders in Children and Adolescents.* Northvale, NJ: Jason Aronson, Inc., 1995.

Physician Leadership on National Drug Policy (PLNDP). *Adolescent Substance Abuse: A Public Health Priority.* Providence, RI: PLNDP, 2002.

M.A. Schuckit et al. "The history of anxiety symptoms among 171 primary alcoholics." *Journal of Studies on Alcohol,* 51(1):34-41, 1990.

C. Spooner et al. "Outcomes of a comprehensive treatment program for adolescents with a substance-use disorder." *Journal of Substance Abuse Treatment,* 20:205-213, 2001.

J. Szapocznik & R.A. Williams. "Brief Strategic Family Therapy: Twenty-five years of interplay among theory, research and practice in adolescent behavior problems and drug abuse." *Clinical Child and Family Psychology Review,* 3(2):117-134, 2000.

J.C. Titus & M.D. Godley. "What Research Tells Us About the Treatment of Adolescent Substance Abuse Disorders." Briefing Report prepared for the Governor's Conference on Substance Abuse Prevention, Intervention, and Treatment for Youth. Chicago, IL: 1999.

E.F. Wagner & H.B. Waldron. *Innovations in Adolescent Substance Abuse Interventions.* New York, NY: Pergamon, 2001.

H.B. Waldron et al. "Treatment outcomes for adolescent substance abuse at 4 and 7 month assessment." *Journal of Consulting and Clinical Psychology,* 69(5):802-812, 2001.

R.J. Williams et al. "A comprehensive and comparative review of adolescent substance abuse treatment outcome." *Clinical Psychology: Science and Practice,* 7(2):138-166, 2000.

K.C. Winters. "Treating adolescents with substance abuse disorders: An overview of practice issues and treatment outcome." *Substance Abuse,* 20(4):203-225, 1999.

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