DASA Adolescent Substance Abuse Treatment Statewide Coordination Project

Treatment Improvement Survey Findings

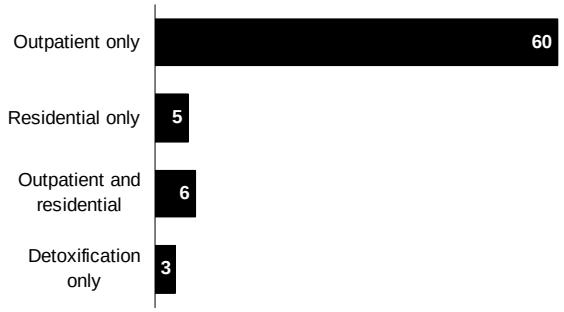
INTRODUCTION

To assess Washington's statewide adolescent substance abuse treatment system, DASA conducted a treatment improvement survey in spring and summer 2006 to appraise adolescent treatment providers' use of established best practices.

A total of 74 providers responded to the survey. This first treatment improvement survey conducted by DASA serves as a baseline measure of best practices currently in use by adolescent treatment providers throughout the state. A version of the treatment improvement survey may be readministered in subsequent years to track changes over time in providers' use of best practices and to guide decision making regarding the commitment of resources and technical support to providers progressing toward increased implementation of best practices.

The survey consisted of four topical areas: evidence-based practices currently in use, evidence-based practice implementation issues, co-occurring disorder services currently provided, and agency demographics. In the analysis and presentation of findings, adolescent treatment providers are divided into four provider service categories: agencies that provide outpatient services only; agencies that provide residential services only; agencies that provide both outpatient and residential services; and agencies that provide detoxification services only.

Survey respondents by provider service category



- An introductory letter distributed to all DASA-funded adolescent treatment providers via mail asked providers to participate in the survey effort. The survey was developed as an Internet-based application. The introductory letter included the survey's URL (electronic address) and furnished each provider with a unique user name and password to use to access and complete an agency-specific survey. In addition, each introductory letter included a $3 coffee card incentive for completing the survey. In response to the 105 introductory letters distributed, 74 surveys were completed.
- Detoxification-only providers are included in the presentation of findings selectively due to their extremely small numbers.
- See Appendix A for a complete listing of the survey items.

DISCLAIMER: The tables and graphs in this report are presented for descriptive purposes only. Comparisons among percentages of residential-only, outpatient and residential, and detoxification-only providers are discouraged due to the very small numbers of providers in each of these categories.

DASA Adolescent Substance Abuse Treatment Statewide Coordination Project

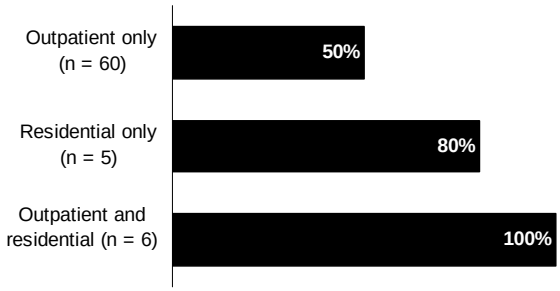
Treatment Improvement Survey Findings

SUMMARY

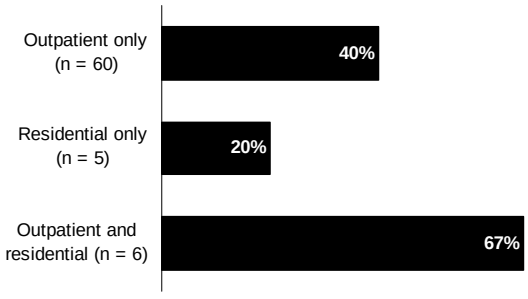
Most providers reported current use of at least one evidence-based practice and generally rated their implementation of evidence-based practices as "successful." Relatively small numbers of providers reported experiencing barriers when implementing evidence-based practices and most reported "high" or "moderate" interest in implementing new evidence-based practices.

FINDING: Over 70 percent of providers in each service category reported using a minimum of one evidence-based practice.

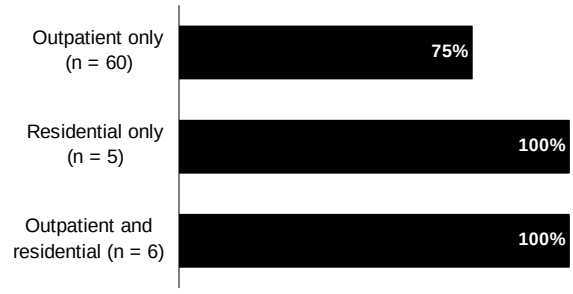
FINDING: At least half of providers in each service category rated their implementation of evidence-based practices as "successful."



FINDING: Agencies that provide both outpatient and residential services were the most likely to report barriers to implementing evidence-based practices.

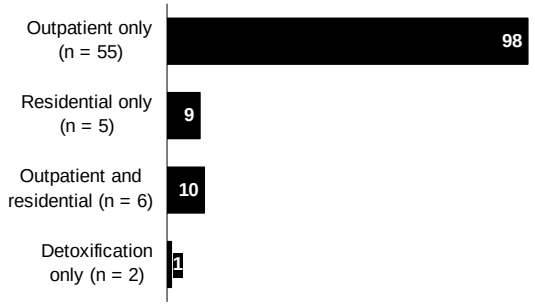


FINDING: At least three quarters of providers in each service category reported having a "high" or "moderate" interest in implementing new evidence-based practices.

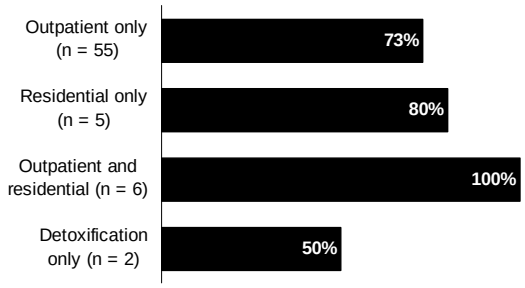


EVIDENCE-BASED PRACTICES IN USE: OVERVIEW

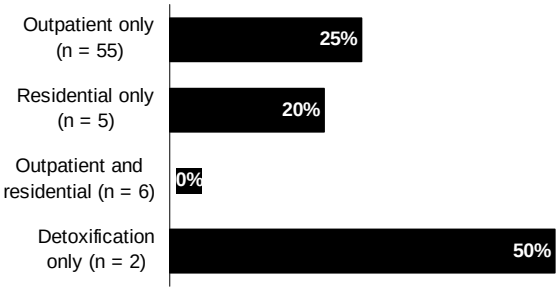
FINDING: Providers across all service categories reported current use of a total of 118 evidence-based practices.



FINDING: Other than detoxification-only providers, over 70 percent of providers reported using a minimum of one evidence-based practice.



FINDING: Other than detoxification-only providers, no more than one quarter of providers reported "no current use" of an evidence-based practice.



- The providers that responded to the evidence-based practice items on the survey included 55 outpatient-only, 5 residential-only, 6 outpatient and residential, and 2 detoxification-only.
- Each respondent selected from a list of 35 recognized evidence-based practices the best practice interventions their agency was using to treat adolescent clients. Listed in addition to the 35 evidence-based practices were the response options "other" and "not currently using an evidence-based practice."
- The evidence-based practices selected for inclusion on the list of 35 were drawn from the following sources: Chestnut Health Systems' Lighthouse Institute, National Institute of Drug Abuse, National Registry of Effective Programs and Practices, Northwest Frontier Addiction Technology Transfer Center, Oregon's Addictions and Mental Health Division, University of Washington's Alcohol and Drug Abuse Institute, and the Western Center for the Application of Prevention Technology. See Appendix B for a more detailed description of each evidence-based practice.

EVIDENCE-BASED PRACTICES IN USE: OVERVIEW

	Outpatient-Only Providers
Evidence-Based Practices:	
Group-Based Outpatient Treatment for Adolescent Substance Abuse	24%
Aggression Replacement Training (ART)	16%
Relapse Prevention Therapy (manualized)	15%
Functional Family Therapy (FFT)	13%
Behavioral Therapy for Adolescents	11%
Dialectical Behavioral Therapy for Substance Abuse (DBT-S)	11%
Matrix Intensive Outpatient Program (IOP) for the Treatment of Stimulant Abuse	11%
MET/CBT 5 (Motivational Enhancement Therapy and Cognitive Behavioral Therapy: 5 sessions)	11%
Adolescent Community Reinforcement Approach	7%
Multisystemic Therapy (MST)	5%
Seven Challenges (manualized)	5%
Cognitive Behavioral Therapy for Depression–Adolescents	4%
Contingency Management: Using Motivational Incentives to Improve Drug Abuse Treatment	4%
Family Support Network	4%
MET/CBT 7 (Motivational Enhancement Therapy and Cognitive Behavioral Therapy: 7 sessions)	4%
Assertive Continuing Care Protocol: A Case Manager's Manual	2%
Brief Intervention (manualized)	2%
Chestnut Health Systems Treatment Manual—OP and IOP Treatment Model	2%
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)® Manual	2%
Multidimensional Family Therapy (MDFT)	2%
Node-Link Mapping: Mapping New Roads to Recovery: Cognitive Enhancements to Counseling	2%
Solution-Focused Brief Therapy (manualized)	2%
Walking in Beauty on the Red Road: A Holistic Cultural Treatment Model for AI/AN Adolescents and Families	2%
Other evidence-based practice	20%

- Outpatient-only providers (*n* = 55) reported using 24 evidence-based practices.

EVIDENCE-BASED PRACTICES IN USE: OVERVIEW

Residential-Only Providers

Evidence-Based Practices:	
Dialectical Behavioral Therapy for Substance Abuse (DBT-S)	60%
Adolescent Community Reinforcement Approach	20%
Behavioral Therapy for Adolescents	20%
Cognitive Behavioral Therapy for Depression–Adolescents	20%
Group-Based Outpatient Treatment for Adolescent Substance Abuse	20%
MET/CBT 5 (Motivational Enhancement Therapy and Cognitive Behavioral Therapy: 5 sessions)	20%
Relapse Prevention Therapy (manualized)	20%

- Residential-only providers (*n* = 5) reported using 7 evidence-based practices

Outpatient and Residential Providers

Evidence-Based Practices:	
Dialectical Behavioral Therapy for Substance Abuse (DBT-S)	83%
Behavioral Therapy for Adolescents	17%
Cognitive Behavioral Therapy for Depression–Adolescents	17%
Seven Challenges (manualized)	17%
Other evidence-based practice	17%

- Outpatient and Residential providers (*n* = 6) reported using 5 evidence-based practices

Detoxification-Only Providers

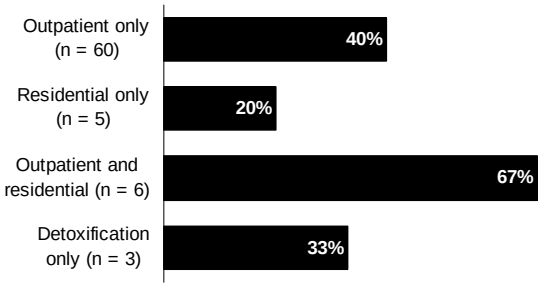
Evidence-Based Practices:	
Brief Intervention (manualized)	50%

- Detoxification-only providers (*n* = 2) reported using 1 evidence-based practice:

EVIDENCE-BASED PRACTICES IN USE: BARRIERS

Each provider respondent was asked to report the barriers to the implementation of evidence-based practices they had experienced.

FINDING: Between one fifth and two thirds of providers across all service categories reported experiencing barriers to the implementation of evidence-based practices.



Outpatient-Only Providers

Barriers:	
Lack of resources	58%
Needing to adjust staff schedules	29%
Staff resistance	29%
Lack of sufficient preparation time	21%
Needing to adjust policy manuals	21%
Needing to adjust forms and paperwork	17%
Needing to adjust outcome measures	17%
Needing to adjust program schedules	17%
Needing to adjust reporting requirements	17%
Not being able to make modifications to fit local needs	17%
Gaining facility certification	13%
Lack of coaching from a knowledgeable supervisor	13%
Lack of fidelity monitoring	8%
Lack of administrative support	4%
Other barrier	33%

- Outpatient-only providers (*n* = 24) reported experiencing 15 implementation barriers.

EVIDENCE-BASED PRACTICES IN USE: BARRIERS

Residential-Only Providers

Barriers:	
Lack of coaching from a knowledgeable supervisor	100%
Lack of sufficient preparation time	100%

- Residential-only providers (*n* = 1) reported experiencing 2 implementation barriers.

Outpatient and Residential Providers

Barriers:	
Lack of administrative support	50%
Lack of coaching from a knowledgeable supervisor	50%
Lack of resources	50%
Gaining facility certification	25%
Lack of fidelity monitoring	25%

- Outpatient and residential providers (*n* = 4) reported experiencing 5 implementation barriers.

Detoxification-Only Providers

Barriers:	
Lack of sufficient preparation time	100%
Needing to adjust forms and paperwork	100%
Needing to adjust staff schedules	100%
Staff resistance	100%

- Detoxification-only providers (*n* = 1) reported experiencing 4 implementation barriers.

EVIDENCE-BASED PRACTICES IN USE: ASSISTANCE NEEDED

Providers that reported experiencing implementation barriers were asked to identify types of assistance most needed to facilitate implementation of evidence-based practices from a list of potential implementation technical supports.

Outpatient-Only Providers

Assistance Needed:	
Training	63%
Identifying and selecting appropriate evidence-based practices	54%
Building organizational capacity to implement program changes	50%
Ongoing coaching	46%
Making acceptable modifications to evidence-based practices to meet local needs	42%
Monitoring and tracking implementation fidelity	33%
Other implementation technical assistance	38%

- Outpatient-only providers (*n* = 24) reported 7 types of assistance needed.

Residential-Only Providers

Assistance Needed:	
Training	100%
Ongoing coaching	100%

- Residential-only providers (*n* = 1) reported needing 2 types of assistance.

Outpatient and Residential Providers

Assistance Needed:	
Training	75%
Ongoing coaching	75%
Making acceptable modifications to evidence-based practices to meet local needs	50%
Monitoring and tracking implementation fidelity	25%

- Outpatient and residential providers (*n* = 4) reported needing 4 types of assistance.

Detoxification-Only Providers

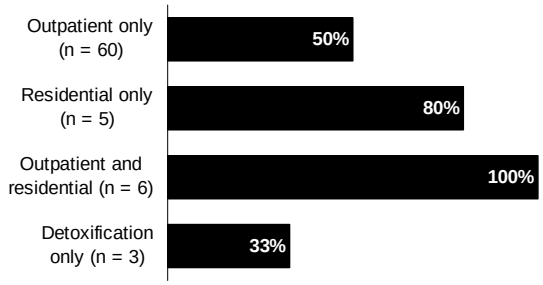
Assistance Needed:	
Building organizational capacity to implement program changes	100%
Identifying and selecting appropriate evidence-based practices	100%
Ongoing coaching	100%
Monitoring and tracking implementation fidelity	100%

- Detoxification-only providers (*n* = 1) reported needing 4 types of assistance.

EVIDENCE-BASED PRACTICES IN USE: SUCCESS

Provider respondents were asked to rate the success of their current evidence-based practice implementation efforts. Providers that rated their implementation of evidence-based practices as successful were also asked to identify what facilitated their implementation success from a list of potential implementation catalysts.

> **FINDING:** Although nearly two fifths of providers across all service categories reported experiencing implementation barriers, at least half of providers in most service categories rated current implementation of best practices as successful.



Outpatient-Only Providers

Catalysts:

Staff having the appropriate skills to implement the evidence-based practice	63%
Support from administration	57%
Staff motivation to try new practices	53%
Staff buy-in to the evidence-based practice	47%
Ongoing coaching from a knowledgeable supervisor	43%
Expert trainers	40%
Client outcome data collection	27%
Receiving guidance from national or local trainers on making acceptable modifications to meet local needs	27%
Receiving expert assistance in building organizational capacity to implement program changes	10%
Receiving expert assistance in monitoring and tracking implementation fidelity	10%
Other catalyst	17%

- Outpatient-only providers (*n* = 30) reported 11 catalysts.

Residential-Only Providers

Catalysts:	
Ongoing coaching from a knowledgeable supervisor	75%
Receiving guidance from national or local trainers on making acceptable modifications to meet local needs	75%
Staff buy-in to the evidence-based practice	75%
Staff motivation to try new practices	75%
Expert trainers	50%
Staff having the appropriate skills to implement the evidence-based practice	50%
Support from administration	50%
Client outcome data collection	25%
Receiving expert assistance in monitoring and tracking implementation fidelity	25%

- Residential-only providers (*n* = 4) reported 9 catalysts.

Outpatient and Residential Providers

Catalysts:	
Expert trainers	67%
Ongoing coaching from a knowledgeable supervisor	67%
Staff buy-in to the evidence-based practice	67%
Staff motivation to try new practices	67%
Staff having the appropriate skills to implement the evidence-based practice	50%
Support from administration	50%
Receiving guidance from national or local trainers on making acceptable modifications to meet local needs	17%

- Outpatient and residential providers (*n* = 6) reported 7 catalysts.

Detoxification-Only Providers

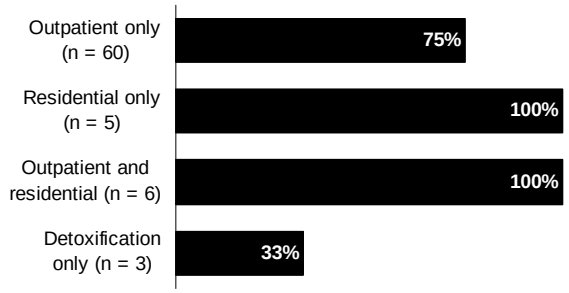
Assistance Needed:	
Ongoing coaching from a knowledgeable supervisor	100%
Staff having the appropriate skills to implement the evidence-based practice	100%

- Detoxification-only providers (*n* = 1) reported 2 catalysts.

EVIDENCE-BASED PRACTICES IN USE: INTEREST

Providers also rated their interest in implementing new evidence-based programs into their treatment programs as high, moderate, low, or none.

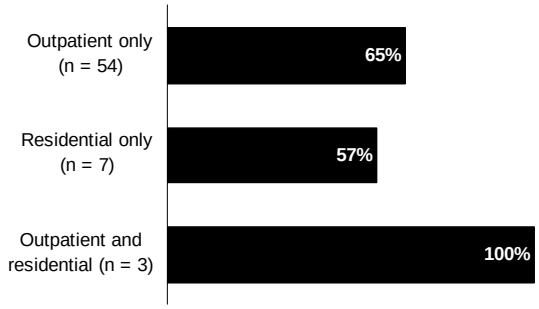
> **FINDING:** At least three quarters of providers in most service categories reported a high or moderate interest in implementing new evidence-based practices.



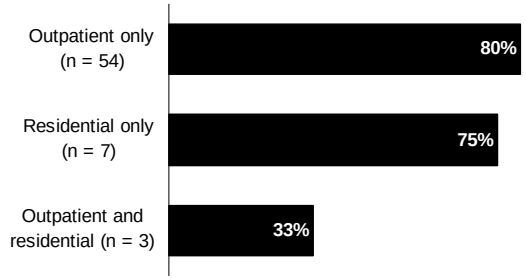
IMPLEMENTATION FIDELITY: TRAINING

For each evidence-based practice identified as currently in use, providers were asked to designate the practice as a major (provided to more than half of clients) or minor (provided to less than half of clients) component of their overall treatment program. Regarding only evidence-based practices designated as major, providers answered subsequent questions about the training delivered to staff, monitoring of implementation, and modifications or adaptations made to the evidence-based practice.

FINDING: Staff were trained in over half of the evidence-based practices implemented by providers in each service category.



FINDING: In most service categories, at least three quarters of the evidence-based practices were implemented with over 60 percent of clinical staff trained.

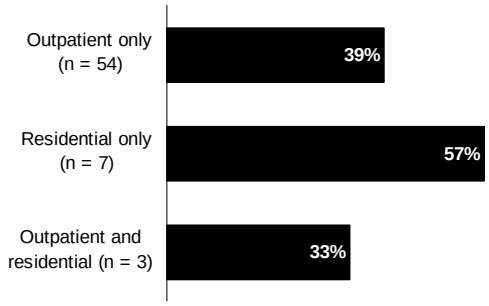


FINDING: At least two thirds of evidence-based practices implemented by providers in each service category included some level of follow-up training.

- Respondents that designated evidence-based practices as major components of their overall treatment programs included 53 percent of outpatient-only, 60 percent of residential-only, and 33 percent of outpatient and residential providers and represent 55 percent, 78 percent, and 30 percent, respectively, of evidence-based practices implemented by the providers. The sole detoxification-only provider that designated an evidence-based practice as a major component was omitted from the implementation fidelity findings.

IMPLEMENTATION FIDELITY: MONITORING

FINDING: Less than three fifths of evidence-based practices implemented by providers in each service category were monitored for implementation fidelity.



	Outpatient-Only Providers
Staff Positions Monitoring Fidelity:	
Clinical supervisor	33%
Agency director	9%
Program manager	9%
Assigned clinician	6%
Other staff	4%
Fidelity Monitoring Method:	
Clinical supervision	46%
Direct observation	26%
Audio or video tapping clinical sessions	11%
Checklist	11%
Other method	6%

- Among the providers that reported implementation monitoring, outpatient-only providers (*n* = 18) reported using 5 staff positions to monitor fidelity and 5 monitoring methods.

Residential-Only Providers	
Staff Positions Monitoring Fidelity:	
Assigned clinician	100%
Clinical supervisor	100%
Evaluator	100%
Program manager	100%
Fidelity Monitoring Method:	
Checklist	100%
Clinical supervision	100%
Direct observation	100%

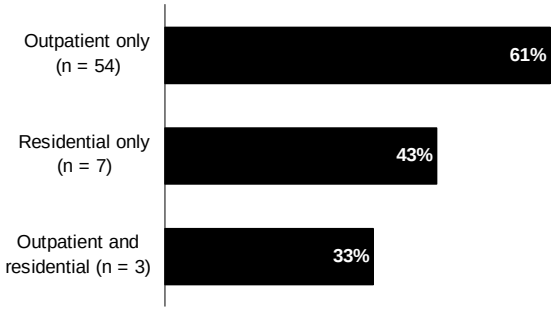
- Among the providers that reported implementation monitoring, residential-only providers (*n* = 1) reported using 4 staff positions to monitor fidelity and 3 monitoring methods.

Outpatient and Residential Providers	
Staff Positions Monitoring Fidelity:	
Assigned director	100%
Clinical supervisor	100%
Fidelity Monitoring Method:	
Clinical supervision	100%

- Among the providers that reported implementation monitoring, outpatient and residential providers (*n* = 1) reported using 2 staff positions to monitor fidelity and 1 monitoring method.

IMPLEMENTATION FIDELITY: MODIFICATIONS OR ADAPTATIONS

FINDING: Less than two thirds of evidence-based practices implemented by providers in each service category were modified or adapted to meet local needs.



Outpatient-Only Providers

Modification or Adaptations:	
With guidance from experts/trainers	42%
With guidance from experts/trainers on *how* to make the modifications/adaptations	33%

- Among the outpatient-only providers that reported modifications or adaptations to evidence-based practices (*n* = 33), two fifths of these practices were modified or adapted with guidance from experts or trainers and one third of the providers received specific guidance on how to make the modifications or adaptations.

Implementation Fidelity: Modifications or Adaptations

Residential-Only Providers

Modification or Adaptations:	
With guidance from experts/trainers	67%
With guidance from experts/trainers on *how* to make the modifications/adaptations	33%

- Among the residential-only providers that reported modifications or adaptations to evidence-based practices (*n* = 3), two thirds of these practices were modified or adapted with guidance from experts or trainers and one third of the providers received specific guidance on how to make the modifications or adaptations.

Outpatient and Residential Provider

Modification or Adaptations:	
With guidance from experts/trainers	100%
With guidance from experts/trainers on *how* to make the modifications/adaptations	100%

- The single outpatient and residential provider that reported modifications or adaptations to an evidence-based practice indicated that the practice was modified or adapted with guidance from experts or trainers and the provider received specific guidance on how to make the modifications or adaptations.

SCREENING AND ASSESSMENT TOOLS IN USE: OVERVIEW

Each provider respondent was asked to select from a list of 6 standard screening tools and 6 standard assessment tools the tools their agency was using with adolescent clients. (The list of tools was drawn from 2 sources: Northwest Frontier Addiction Technology Transfer Center and University of Washington's Alcohol and Drug Abuse Institute.) Listed in addition to the 12 standard screening and assessment tools was the response option "other."

> **FINDING:** Providers across all service categories reported currently using 5 of the listed screening tools and 5 of the listed assessment tools, and two fifths of all providers also reported using other screening and assessment tools not listed.

	Outpatient-Only Providers
Standard Screening Tools:	
Substance Abuse Subtle Screening Inventory (SASSI)	47%
Global Assessment of Individual Needs Short Screener (GAIN-SS)	13%
Massachusetts Youth Screening Inventory (MAYSI)	2%
Problem Oriented Screening Instrument for Teenagers (POSIT)	2%
Standard Assessment Tools:	
Global Assessment of Individual Needs (GAIN)	23%
Teen Addiction Severity Index (T-ASI)	5%
Adolescent Diagnosis Interview (ADI)	2%
Adolescent Drug Abuse Diagnosis (ADAD)	2%
Other assessment tool	35%

- Outpatient-only providers (*n* = 60) reported using 4 screening tools and 5 assessment tools.

	Residential-Only Providers
Standard Screening Tools:	
None	
Standard Assessment Tools:	
Teen Addiction Severity Index (T-ASI)	20%
Other assessment tool	100%

- Residential-only providers (*n* = 5) reported no use of screening tools but did report use of 2 assessment tools.

SCREENING AND ASSESSMENT TOOLS IN USE: OVERVIEW

Outpatient and Residential Providers

Standard Screening Tools:	
Substance Abuse Subtle Screening Inventory (SASSI)	33%
Standard assessment tools:	
Teen Addiction Severity Index (T-ASI)	33%
Other assessment tool	50%

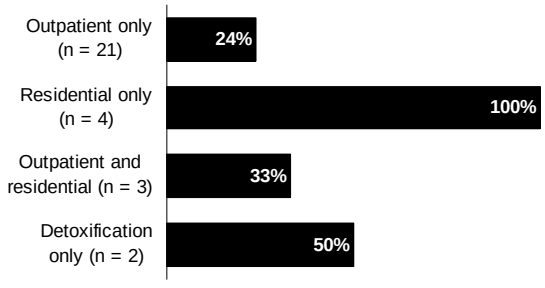
- Outpatient and residential providers (*n* = 6) reported using 1 screening tool and 2 assessment tools.

Detoxification-Only Providers

Standard Screening Tools:	
Drug Use Screening Inventory (DUSI-R)	67%
Problem Oriented Screening Instrument for Teenagers (POSIT)	33%
Substance Abuse Subtle Screening Inventory (SASSI)	33%
Standard Assessment Tools:	
Personal Experience Inventory (PEI)	33%
Other assessment tool	67%

- Detoxification-only providers (*n* = 3) reported using 3 screening tools and 2 assessment tools.

FINDING: Across service categories, at least a quarter of the providers that reported using tools other than those listed indicated using these other tools only.

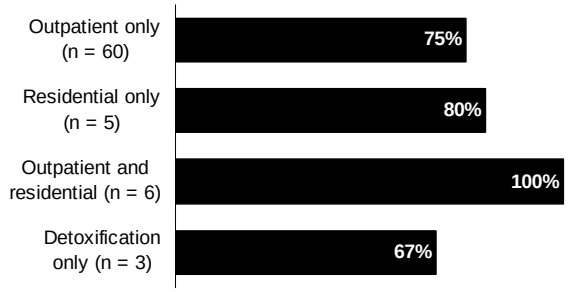


- The following definitions for screening and assessment are from the Center for Substance Abuse Treatment's *Treatment Improvement Protocol 7*: "Screening is a gathering and sorting of information used to determine if an individual has a problem with alcohol or other drug abuse, and if so, whether a detailed clinical assessment is appropriate; and assessment is the collection of detailed information concerning the client's alcohol or other drug abuse, emotional and physical health, social roles, and other relevant areas."

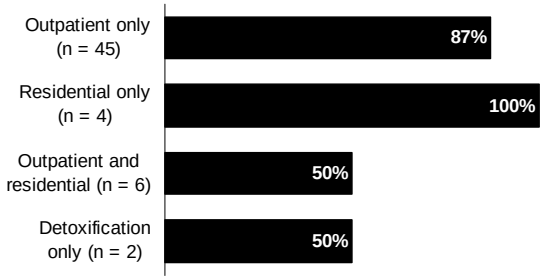
CO-OCCURRING DISORDER SERVICES IN USE: OVERVIEW

Respondents were asked if their agency treats youth with co-occurring substance abuse and mental health disorders. Providers that responded "yes" were asked about screening and assessment for mental health disorders, the timeframe for screening and assessing for mental health disorders, the services provided to co-occurring disorder clients, and the provision of any co-occurring disorder specific treatment interventions.

FINDING: At least two thirds of providers in each service category reported treating youth with co-occurring disorders.



FINDING: Among the providers that reported treating youth with co-occurring disorders, at least half in each service category reported screening or assessing clients for mental health disorders.



Co-Occurring Disorder Services in Use: Screening Clients

Providers that reported screening or assessing clients for mental health disorders were also asked to identify from a list of 11 tools commonly used to screen or assess clients for mental health disorders the tools they used. (The list of tools was drawn from 2 sources: the Division of Alcohol and Substance Abuse and Northwest Frontier Addiction Technology Transfer Center.) Listed in addition to the 11 tools was the response option "other."

	Outpatient-Only Providers
Mental Health Disorder Screening Tools:	
Structured Clinical Interview for DSM IV	38%
Global Assessment of Individual Needs (GAIN)	36%
Youth Self Report (YSR)	23%
Comprehensive Addiction Severity Index for Adolescents (CASI-A)	5%
Coping Behaviors Inventory	5%
Diagnostic Interview for Children and Adolescents (DICA)	5%
Personality Assessment Inventory	5%
Ways of Coping	5%
Other	49%

- Outpatient-only providers (*n* = 39) reported using 9 tools to screen or assess for mental health disorders.

	Residential-Only Providers
Mental Health Disorder Screening Tools:	
Structured Clinical Interview for DSM IV	75%
Youth Self Report (YSR)	50%
Diagnostic Interview for Children and Adolescents (DICA)	25%
Global Assessment of Individual Needs (GAIN)	25%
Other	50%

- Residential-only providers (*n* = 4) reported using 5 tools to screen or assess for mental health disorders.

Outpatient and Residential Providers

Mental Health Disorder Screening Tools:	
Structured Clinical Interview for DSM IV	33%
Other	33%

- Outpatient and residential providers (*n* = 3) reported using 2 tools. *(Data were missing for one provider.)*

Detoxification-Only Providers

Mental Health Disorder Screening Tools:	
Other	100%

- Detoxification-only providers (*n* = 1) reported using 1 tool to screen or assess for mental health disorders.

In addition, these providers were asked to identify the timeframe during which they screen or assess for mental health disorders using the following response options: "intake," "after stabilization," or "both at intake and after stabilization."

FINDING: Over three quarters of providers in each service category, other than detoxification-only, screened or assessed clients for mental health disorders at both intake and after stabilization.

	Timeframe for Screening for Mental Health Disorders		
Provider	**Intake**	**After Stabilization**	**Both**
Outpatient-only	15%	3%	79%
Residential-only	0%	0%	100%
Outpatient and residential	0%	0%	100%
Detoxification-only	100%	0%	0%

Note. There were missing data for one outpatient-only provider.

CO-OCCURRING DISORDER SERVICES IN USE: SERVICES AND TREATMENT INTERVENTIONS

Providers that reported treating youth with co-occurring disorders were asked to identify from a list of 4 possible services provided to co-occurring disorder clients and a list of 5 co-occurring-disorder-specific treatment interventions the services and interventions their agency was providing to adolescent clients. (The list of services was drawn from 2 sources: Division of Alcohol and Substance Abuse and Northwest Frontier Addiction Technology Transfer Center.) "Other" and "none" were also response options.

	Outpatient-Only Providers
COD Services:	
Referral to mental health treatment	69%
Concurrent substance abuse and mental health treatment	62%
Medication management	31%
COD-specific treatment	22%
Other	7%
COD Interventions:	
Cognitive Behavioral Therapy for Depression–Adolescents	18%
Dialectical Behavioral Therapy for Substance Abuse (DBT-S)	16%
Multidimensional Family Therapy (MDFT)	7%
Other	24%

- Outpatient-only providers (*n* = 45) reported providing 5 services and 4 interventions to co-occurring disorder clients.

	Residential-Only Providers
COD Services:	
Concurrent substance abuse/mental health treatment	100%
Medication management	100%
Referral to mental health treatment	50%
COD-specific treatment	25%
Other	25%
COD Interventions:	
Cognitive Behavioral Therapy for Depression–Adolescents	50%
Dialectical Behavioral Therapy for Substance Abuse (DBT-S)	50%
Cognitive Behavioral Therapy for Child Sexual Abuse (CBT-CSA)	25%
Other	25%

- Residential-only providers (*n* = 4) reported providing 5 services and 4 interventions to co-occurring disorder clients.

Co-Occurring Disorder Services in Use: Services and Treatment Interventions

Outpatient and Residential Providers

COD Services:	
Medication management	100%
Concurrent substance abuse/mental health treatment	83%
Referral to mental health treatment	83%
COD-specific treatment	50%
COD Interventions:	
Dialectical Behavioral Therapy for Substance Abuse (DBT-S)	83%
Cognitive Behavioral Therapy for Child Sexual Abuse (CBT-CSA)	17%
Cognitive Behavioral Therapy for Depression–Adolescents	17%
Other COD-specific treatment intervention	17%

- Outpatient and residential providers (*n* = 6) reported providing 4 services and 4 interventions to co-occurring disorder clients.

Detoxification-Only Providers

COD Services:	
Referral to mental health treatment	100%
Medication management	50%
COD Interventions:	
Other COD-specific treatment intervention	50%
None	50%

- Detoxification-only providers (*n* = 2) reported providing 2 services and 1 treatment intervention to co-occurring disorder clients.

Adolescent treatment providers were divided into four provider service categories: (a) agencies that provide outpatient services only, (b) agencies that provide residential services only, (c) agencies that provide both outpatient and residential services, and (d) agencies that provide detoxification services only.

The overall survey response rate was 70%. Agencies that provide both outpatient and residential services and agencies that provide detoxification services only had the highest response rate (100%), whereas the largest service category—agencies that provide outpatient services only—had the lowest response rate (67%).

Survey Response Rate

Respondents	Number Surveyed	Number Responses	Response Rate
Outpatient-only	89	60	67%
Residential-only	7	5	71%
Outpatient and residential	6	6	100%
Detoxification-only	3	3	100%

	Treatment Population Served	
Provider	**Youth Only**	**Youth and Adults**
Outpatient-only (*n* = 60)	25%	68%
Residential-only (*n* = 5)	80%	20%
Outpatient and residential (*n* = 6)	67%	33%
Detoxification-only (*n* = 3)	0%	100%

Note. Data for 4 outpatient-only providers (7%) were incomplete.

	Population of Geographic Service Area			
Provider	**5,000 or less**	**5,001–50,000**	**50,001–500,000**	**500,001 or more**
Outpatient only (*n* = 60)	8%	35%	32%	20%
Residential only (*n* = 5)	0%	80%	20%	0%
Outpatient and residential (*n* = 6)	0%	33%	50%	17%
Detoxification only (*n* = 3)	33%	0%	67%	0%

Note. Data for 3 outpatient-only providers (5%) were incomplete.

Section 1: Evidence-Based Practices

1. Is your agency currently using any of the following youth-specific evidence-based practices? (Select all that apply.)

   Response options: A list of 35 recognized evidence-based practices and the response options "Other" and "Not currently using an evidence-based practice."

   The evidence-based practices selected for inclusion on the list of 35 were drawn from the following sources: Chestnut Health Systems' Lighthouse Institute, National Institute of Drug Abuse, National Registry of Effective Programs and Practices, Northwest Frontier Addiction Technology Transfer Center, Oregon's Addictions and Mental Health Division, University of Washington's Alcohol and Drug Abuse Institute, and the Western Center for the Application of Prevention Technology. See Appendix B for a description of each evidence-based practice.

2. Is this practice a major or minor component of your agency's overall treatment program?

   Response options: Minor (defined as "provided to less than half of your clients") or Major (defined as "provided to more than half of your clients."). The rest of the items in this section pertained only to evidence-based practices reported as major components of the providers' overall treatment program.)

3. Did staff at your agency receive training from certified trainers in these evidence-based practices?

   Response options: Yes/No/Don't Know

   3.1. *If yes:* What percentage of your management staff (i.e., clinical supervisors, program managers, agency directors) received this training?

   Response options: 0–20%, 21–40%, 41–60%, 61–80%, 81–100%

   3.2. What percentage of your clinical staff received this training?

   Response options: 0–20%, 21–40%, 41–60%, 61–80%, 81–100%

   3.3. What percentage of your nonclinical staff received this training?

   Response options: 0–20%, 21–40%, 41–60%, 61–80%, 81–100%

   3.4. Does your agency employ mental health clinicians?

   Response options: Yes/No

   3.4.1. *If yes:* How many?

   Numeric response

   3.4.2. How many of these mental health clinicians are also licensed as chemical dependency professionals?

   Numeric response

   3.4.3. Were your mental health clinicians trained in this evidence-based practice?

   Response options: Yes/No/Don't Know

   3.5. Did staff at your agency receive follow-up booster training and/or coaching in this evidence-based practice from national experts, local experts, or from in-house clinical supervisors with expert knowledge?

   Response options: Yes/No/Don't Know

3.6. *If yes:* How much follow-up booster training and/or coaching did staff at your agency receive?
Response options: Half day, One day, More than one day.

4. Is your agency monitoring implementation of this evidence-based practice to ensure fidelity (i.e., the practice is being implemented as intended following the established guidelines and manuals)?
Response options: Yes/No/Don't Know

4.1. If yes, how does your agency monitor and track fidelity of this evidence-based practice? (Select all that apply.)
Response options: a list of fidelity monitoring tools including Checklists, Direct observation, Audio- or videotaping sessions, Clinical supervision, and others.

4.2. Who is monitoring and tracking fidelity?
Response options: Clinical Supervisor, Program Manager/Agency Director, Assigned Clinician, Evaluator, Other.

5. Did your agency modify or make any adaptations to the evidence-based practice to meet local needs or to better fit your client population?
Response options: Yes/No/Don't Know

5.1. *If yes:* Did your agency receive any guidance from trainers or experts in making these modifications or adaptations?
Response options: Yes/No/Don't Know

5.1.1. *If yes:* Did your agency receive any guidance from trainers or experts on *how* to make these modifications or adaptations?
Response options: Yes/No/Don't Know

Section 2: Implementation of Evidence-Based Practices

1. Has your agency experienced any barriers to adopting, implementing, and monitoring evidence-based practices?
Response options: Yes/No/Don't Know

1.1. *If yes:* What type of barriers has your agency experienced? (Select all that apply.)
Response options: a list of potential barriers including Lack of resources, Lack of fidelity Monitoring, and others.

1.2. What type of assistance is most needed by your agency to help facilitate the adoption and implementation of evidence-based practices? (Select all that apply.)
Response options: a list of technical assistance options including Training, Ongoing coaching, and others.

1.3. Does your agency serve populations or address specific client needs for which there are no known or available evidence-based practices?
Response options: Yes/No

1.4. If yes, what are these populations or client needs?
Narrative response

2. Would you rate the implementation of these practices as successful?
Response options: Yes/No/Don't Know

2.1. *If yes:* What facilitated your agency's ability to successfully implement these practices? (Select all that apply.)
Response options: a list of facilitator options including Expert training, Ongoing coaching from a knowledgeable supervisor, and others.

3. Is your agency currently using any of the following standardized screening and assessment instruments? (Select all that apply.)
Response options: a list of instruments.

4. What is your agency's interest in implementing evidence-based practices into your treatment program?
Response options: High, Moderate, Low, None

Section 3: Co-Occurring Disorder-Specific Clients & Services

1. Does your agency treat youth with co-occurring disorders (substance abuse and mental health)?
Response options: Yes/No/Don't Know

1.1. *If yes:* Are clients specifically screened/assessed for mental health disorders?
Response options: Yes/No/Don't Know

1.1.1. *If yes:* How does your agency assess mental health disorders? (Select all that apply.)
Response options: a list of instruments.

1.1.2. Does your agency screen/assess for mental health disorders at intake or after the client has stabilized in substance abuse treatment?
Response options: Intake, After Stabilization, Both

2. What services does your agency provide to these co-occurring disorder–assessed clients? (Select all that apply.)
Response options: a list of treatment options including COD specific treatment, Concurrent substance abuse and mental health treatment, Medication management, Referral to mental health treatment, Other.

3. Does your agency provide any of the following COD-specific treatment interventions? (Select all that apply.)
Response options: a list of COD-specific treatment interventions.

Section 4: Agency and Respondent Demographics

1. Agency demographic questions:
   - 1.1. Population of geographic area of agency setting
     Response options: < 5000; 5001–50,000; 50,001–500,000; > 500,000
   - 1.2. Treatment population
     Response options: Youth Only, Youth and Adult
   - 1.3. Estimated number of youth currently receiving treatment/services
     Numeric response
   - 1.4. Total client capacity
     Numeric response
   - 1.5. Type of agency
     Response options: Outpatient, Residential, Both
   - 1.6. Number of chemical dependency professionals on staff
     Numeric response
   - 1.7. Number of chemical dependency professional trainees on staff
     Numeric response
2. Respondent demographics questions:
   - 2.1. Name
   - 2.2. Position/Title
   - 2.3. Address
   - 2.4. Telephone Number
   - 2.5. Email Address
   - 2.6. Would you mind if we followed-up with you to get more detailed information about these issues?
     Response options: Yes/No
3. Please use the following space to provide any suggestions for or comments regarding DASA's Adolescent Substance Abuse Treatment Coordination Grant.

   Narrative response

APPENDIX B: ADOLESCENT EVIDENCE-BASED PRACTICES

This appendix provides brief descriptions of the 35 recognized evidence-based practices listed on the survey. The list was accumulated from the following sources: Chestnut Health Systems' Lighthouse Institute, National Institute of Drug Abuse, National Registry of Effective Programs and Practices, Northwest Frontier Addiction Technology Transfer Center, Oregon's Addictions and Mental Health Division, University of Washington's Alcohol and Drug Abuse Institute, and the Western Center for the Application of Prevention Technology.

Adolescent Community Reinforcement Approach (ACRA)—individual, group, and family outpatient therapy that is composed of 10 individual sessions with the adolescent and 4 sessions with caregivers. The focus is on rearranging environmental contingencies so that abstinence is more rewarding than using behavior. ACRA teaches participants how to build on their reinforcers, how to use existing community resources that support positive change, and how to develop a positive support system within the family.

Adolescent Portable Therapy (APT): A Practical Guide for Service Providers—an intensive family- and community-based intervention for adolescents who are heavy substance abusers. APT was created to serve juvenile justice-involved adolescents and their families as young people move through the justice system and reenter the community. The APT model is flexible enough to be adapted to other environments and other client populations for which a home-based family therapy intervention is indicated.

Aggression Replacement Training (ART)—a 10-week, 30-hour intervention administered to groups of 8 to 12 juvenile offenders three times per week. ART can be implemented by court probation staff or private contractors after they receive formal training. A juvenile offender is eligible for ART if the youth has a moderate to high risk for reoffense and has a problem with aggression or lacks skills in prosocial functioning. Using repetitive learning techniques, offenders develop skills to control anger and use more appropriate behaviors. In addition, guided group discussion is used to correct antisocial thinking.

Assertive Continuing Care Protocol: A Case Manager's Manual—seeks to minimize the time between discharge from treatment and the first continuing care appointment by engaging clients in home visits and telephone support. This approach requires the case manager to assume responsibility for completing continuing care appointments. The manual describes procedures and techniques for initiating and providing community-based services to adolescents with substance use disorders.

Behavioral Therapy for Adolescents—an individual, behavioral, and abstinence-based therapy that incorporates the principle that unwanted behavior can be changed by clear demonstration of the desired behavior and consistent reward of incremental steps toward achieving it. Therapeutic activities include fulfilling specific assignments, rehearsing desired behaviors, recording and reviewing progress, and providing praise and privileges for meeting assigned goals. Urine samples are collected regularly to monitor drug use. The therapy aims to equip the patient to gain three types of control: stimulus, urge, and social.

Brief Intervention (manualized)—individual, behavioral intervention targeted at people drinking excessively but not yet experiencing major problems from their consumption. The intervention aims to convince the drinkers that they are drinking at levels that could be harmful to their health and

encourage them to reduce consumption to sensible limits to reduce the risk of future health problems. The intervention is generally restricted to four or fewer sessions, each lasting from a few minutes to an hour. Key components of the brief intervention are summarized by the acronym FRAMES: feedback, responsibility, advice, menu of strategies, empathy, and self-efficacy.

Brief Strategic Family Therapy (BSFT)—family behavior therapy that is used to treat adolescent drug use that occurs in concert with other problem behaviors. These co-occurring problem behaviors include conduct problems at home and at school, oppositional behavior, delinquency, associating with antisocial peers, aggressive and violent behavior, and risky sexual behavior. BSFT targets family interactions that are thought to maintain or exacerbate adolescent drug abuse and other behavioral problems. BSFT typically involves 12 to 24 sessions, each lasting about 90 minutes, over the course of 4 months plus up to 8 booster sessions (the number of sessions depends on the severity of the problem).

Chestnut Health Systems (CHS) Treatment Manual for Bloomington's Outpatient and Intensive Outpatient Treatment Model—an eclectic treatment approach that draws from Rogerian, behavioral, cognitive, and reality therapies and incorporates 12-step concepts and approaches. The approach has been highlighted by Drug Strategies in *Treating Teens: A Guide to Adolescent Drug Programs*. A quasi-experimental evaluation, which compared the CHS outpatient approach to research-based outpatient interventions, showed that adolescents in both groups reported decreased frequency of use, substance problems, emotional problems, illegal activities, school problems, and family problems. Adolescents receiving the CHS intervention showed greater improvement in their recovery environment, self-help attendance, and emotional problems, whereas adolescents participating in the research-based interventions had greater reductions in substance use.

Cognitive Behavioral Intervention for Trauma in Schools (CBITS)® Manual—a skills-based, group intervention that is aimed at relieving symptoms of posttraumatic stress disorder (PTSD), depression, and general anxiety among children exposed to trauma. The CBITS program has been used most commonly for children in Grades 6–9 (ages 10–15) who have experienced events such as witnessing or being a victim of violence, being in a natural or manmade disaster, being in an accident or house fire, or physical abuse or injury and suffer from moderate to severe levels of PTSD symptoms. Children learn skills in relaxation, challenging upsetting thoughts, and social problem solving, and children work on processing traumatic memories and grief. These cognitive-behavioral skills are learned through the use of drawings and through talking in both individual and group settings. The program consists of 10 1-hour group sessions (including 6–8 children) usually conducted once a week in a school, mental health, or other office settings.

Cognitive Behavioral Therapy for Child Sexual Abuse (CBT-CSA)—a treatment approach designed to help children and adolescents who have suffered sexual abuse to overcome posttraumatic stress disorder (PTSD), depression, and other behavioral and emotional difficulties. The program helps children learn about both child sexual abuse and healthy sexuality; therapeutically process traumatic memories; overcome problematic thoughts, feelings, and behaviors; and develop effective coping and body safety skills. The approach emphasizes the support and involvement of nonoffending parents or primary caretakers and encourages effective parent-child communication. Cognitive behavioral methods are used to help parents learn to cope with their own distress and respond effectively to their children’s behavioral difficulties. This CBT approach is suitable for all clinical and community-based

mental health settings and its effectiveness has been documented for both individual and group therapy formats.

Cognitive Behavioral Therapy for Depression–Adolescents—aims to monitor moods, improve social skills, increase pleasant activities, decrease anxiety, reduce depressogenic cognitions, and improve communication and conflict resolution. The material is presented in workbook format that includes brief readings, short quizzes, and homework assignments. There is also a workbook for parents of adolescents enrolled in the Adolescent Coping With Depression Course. The workbooks are used in the group therapy courses that span 8 weeks, 2 hours twice a week for teens, and one 2-hour session a week for 8 weeks for parents.

Contingency Management: Using Motivational Incentives to Improve Drug Abuse Treatment—individual and behavioral approach that uses positive reinforcement to encourage abstinence from drugs.

Dialectical Behavioral Therapy for Substance Abuse (DBT-S)—a modification of cognitive behavioral therapy (CBT) that was originally developed for people with Borderline Personality Disorder. DBT uses traditional CBT tools and techniques but also integrates Eastern concepts of mindfulness.

Dynamic Youth Community, Inc.: A Therapeutic Community for Adolescents and Young Adults–Treatment Manual—a 3-year multistage, modified therapeutic community that serves adolescents and young adults aged 13 to 21 with severe substance use problems (often related to cocaine and heroin use). Adolescents begin the program at a residential center in upstate New York and transition after one year to a day treatment center in New York City, where they complete the program's Day Treatment, Re-Entry, and Phase-Ambulatory program stages. Because adolescent drug use affects the entire family, parents or guardians are required to participate in the parent program, which meets weekly for the duration of the adolescent's tenure in treatment.

EMPACT: Teen Substance Abuse Treatment Program–Treatment Manual—for use by clinicians, administrators, evaluators, and other treatment providers in communities to provide treatment for adolescents with co-occurring mental illness and substance-related disorders. This step-down model offers 3 months of intensive outpatient services beginning with an average of 15 hour of counseling a week and decreasing to an average of 11 hours, depending on client and family needs. Services include, but are not limited to, group, individual, and family counseling; urinalysis testing; and transportation. Psychiatric and 24-hour crisis services are available when needed. Treatment modalities include cognitive-behavioral therapy and motivational enhancement therapy from a solution-focused, family systems perspective.

Family Support Network—individual, group, and family outpatient therapy that includes the MET/CBT12 group therapy plus additional engagement-type case management, family support groups, and aftercare. This treatment was designed to wrap several additional low-cost services around the MET/CBT12 group therapy. Family Support Network addresses family issues and services in line with CSAT TIPS recommendations.

Functional Family Therapy (FFT)—a multisystemic prevention program that focuses on multiple domains and systems in which adolescents and their families live. The primary focus of prevention is the family and the approach reflects an understanding of the positive and negative behaviors that are both influenced by and influence relational systems within the family. FFT focuses on the treatment system, family and individual functioning, and the therapist as major components.

Group-Based Outpatient Treatment for Adolescent Substance Abuse—a moderate-intensity, group-based approach to adolescent outpatient substance abuse treatment. The program combines a 20-week group counseling intervention including individual and family therapy and addresses the issues and problems adolescent substance abusers (aged 14 to 18) commonly face. The program's foundations are in social learning theory and conditioning theory, which when integrated help explain how substance use behaviors are learned and subsequently unlearned.

La Cañada: Adolescent Substance Abuse Step-Down Treatment Model—a residential and outpatient treatment model that offers adolescent treatment providers an innovative program model, which begins with a 30-day residential component, continues with a 60-day intensive outpatient phase, and concludes with a 60-day nonintensive outpatient phase. The La Cañada program uses an integrated treatment model that combines traditional psychiatric and milieu approaches with systems theory and interventions.

Matrix Intensive Outpatient Program (IOP) for the Treatment of Stimulant Abuse—individual and group abstinence-based, cognitive behavioral treatment in which patients learn about issues critical to addiction and relapse, receive direction and support from a trained therapist, become familiar with self-help programs, and are monitored for drug use by urine testing. The program includes education for family members affected by the addiction. The regular 4-month Matrix treatment protocol consists primarily of group sessions. Also available are the Intensive Individualized Treatment Program and the 6-week Early Intervention program, which is an individual session-only program designed for people at the earliest stages of readiness for treatment.

MET/CBT 5 (Motivational Enhancement Therapy and Cognitive Behavioral Therapy: 5 sessions)—individual, group, and family outpatient therapy that is composed of 2 individual sessions of Motivational Enhancement Therapy (MET) and 3 weekly group sessions of Cognitive-Behavioral Therapy (CBT). The MET sessions focus on factors that motivate participants who abuse substances to change, and the CBT sessions teach participants skills to cope with problems and meet needs in ways that do not involve turning to marijuana or alcohol. This treatment is designed to be inexpensive and in line with what many parents and insurers are seeking as a basic intervention.

MET/CBT 7 (Motivational Enhancement Therapy and Cognitive Behavioral Therapy: 7 sessions)—individual, group, and family outpatient therapy that extends MET/CBT 5 with 7 additional CBT sessions.

Mountain Manor Treatment Center–Baltimore: Manual for a Short-Term Residential Treatment Program for Adolescent Substance Use Disorders—utilizes a strategy of centralized linkage, linking core treatment components with several key adjunctive interventions (including psychiatric services, primary medical care, educational assessment and onsite school, family therapy, and conduct/legal remediation) to address impairment in multiple psychosocial domains. The manual provides treatment professionals with a model for short-term residential care that has shown promise in treating high-severity adolescent substance abusers with multiple comorbidities.

Multidimensional Family Therapy (MDFT)—individual and family behavioral therapy that is meant to treat polydrug-abusing adolescents by targeting the individual adolescent, the parent(s), the relationship between children and parents, and other systems (school, peers, juvenile justice, etc.). MDFT is an integrative therapeutic philosophy and clinical approach. Interventions work within the multiple ecologies of adolescent development, and they target the processes known to produce or maintain

drug taking and related problem behaviors. MDFT typically involves 14–16 weekly sessions, ranging from 60 to 90 minutes each, and incorporates both individual and family formats.

Multidimensional Treatment Foster Care (MTFC)—a foster care program for delinquent youth or youth in need of out-of-home care that provides close supervision, fair and consistent limits, predictable consequences for rule breaking, a supportive relationship with at least one mentoring adult, and reduced exposure to delinquent peers. Goals are to decrease delinquent behavior and increase participation in developmentally appropriate prosocial activities.

Multisystemic Therapy (MST)—family behavioral and cognitive behavioral therapy that addresses the factors associated with serious antisocial behavior in children and adolescents who abuse drugs. These factors include characteristics of the adolescent (for example, favorable attitudes toward drug use), the family (poor discipline, family conflict, parental drug abuse), peers (positive attitudes toward drug use), school (dropout, poor performance), and neighborhood (criminal subculture). By participating in intense treatment in natural environments (homes, schools, and neighborhood settings) most youths and families complete a full course of treatment. MST is a pragmatic and goal-oriented treatment and uses cognitive behavioral, behavioral, and the pragmatic family therapies.

Node-Link Mapping: Mapping New Roads to Recovery: Cognitive Enhancements to Counseling (manualized)—individual and group cognitive behavioral therapy that involves the counselor and client in the development of visual representations (maps) of issues that emerge in substance abuse treatment. Drawing a map or diagram can help clients see and understand relationships between their actions and consequences and can help them express complex relationships and parallel ideas that are difficult to verbalize. Maps can also be used as communication aids for group and individual discussions. The counselor leads the client through the first mapping process by asking a series of questions and then drawing the answers in the form of a schematic or map. Clients can also do parts or all of their own maps once they understand the process.

Phoenix Academy Clinical Manual—a modified therapeutic community treatment model for adolescent substance abusers. This treatment approach is used in California, New York, Florida, Texas, and many other states, making it one of the most widely available residential youth treatments in the United States. The approach is also one of the few shown to be effective with substance abusing adolescents. A recent independent evaluation of a Phoenix Academy by RAND, a nonprofit research organization, found that Phoenix Academy treatment, in comparison to other types of residential care, is associated with better drug use and psychological functioning outcomes for treated youths.

Relapse Prevention Therapy (manualized)—individual and group behavioral and cognitive behavioral therapy in which individuals learn to identify and correct problematic behaviors. Relapse Prevention Therapy encompasses several cognitive-behavioral strategies that facilitate abstinence and provide help for people who experience relapse.

Seeking Safety: A Psychotherapy for Trauma/PTSD and Substance Abuse (manualized)—individual and group cognitive behavioral therapy that is a present-focused therapy to help people attain safety from co-occurring PTSD and substance abuse. The treatment is available as a book, providing both client handouts and guidance for clinicians. The treatment was designed for flexible use and has been conducted in group and individual format; for women, men, and mixed gender; using all or fewer topics; in a variety of settings (e.g., outpatient, inpatient, residential); and for both substance abuse

and dependence. The approach has also been used with people who have a trauma history but do not meet criteria for PTSD.

Seven Challenges (manualized)—designed to help adolescent substance abusing and substance dependent individuals motivate to make a commitment to change and to help young people prepare, and ultimately succeed, in implementing the desired changes. This program starts where youth "are at," usually in the early stages of change. In addition to using motivational approaches and other strategies designed to increase awareness of harm from drug use without increasing defensiveness, the program provides a framework for respectfully challenging youth to engage in self-evaluation and a decision-making process. Through counseling sessions, supported by readings and nine interactive journals, young people are assisted in evaluating their lives; the needs they are attempting to satisfy by using drugs; and the risks, harm, and potential harm from their drug use. Concurrently, clients address life skill deficits and co-occurring problems, empowering them to cope in positive ways and thrive without drugs. In this program youth make informed, internally motivated, and committed decisions to change. They are taught the skills needed to succeed in overcoming drug abuse and drug dependency problems and then are supported in following through.

Solution-Focused Brief Therapy (manualized)—an approach to psychotherapy based on solution-building rather than problem-solving. This approach explores current resources and future hopes rather than present problems and past causes and typically involves only three to five sessions. It has great value as a preliminary and often sufficient intervention and can be used safely as an adjunct to other treatments.

Thunder Road Treatment Manual: A Hybrid Therapeutic Community Treatment Model—a hybrid model that integrates aspects of three treatment philosophies: social model/therapeutic community, medical/psychiatric models, and 12-step programs. Thunder Road serves high-severity adolescents with substance use and co-occurring psychiatric disorders through short-term (30–50 days) and long-term (6–12 months) residential treatment tracks with a step-down outpatient continuing care phase. The program's therapeutic milieu incorporates psychiatric and pediatric services; individual, group and family therapy; an onsite school; multidisciplinary assessments; and treatment planning provided by a multidisciplinary staff.

Walking in Beauty on the Red Road: A Holistic Cultural Treatment Model for American Indian and Alaska Native Adolescents and Families—provides a foundation for substance abuse treatment programs to develop and replicate alcohol and other drug treatment for American Indian and Alaska Native adolescents and families. This model was formulated for rural programs that can adapt it to fit local needs. This treatment manual provides insight into how to interweave indigenous cultural beliefs and healing ceremonies with Westernized treatment approaches (e.g. cognitive behavioral therapy, motivational interviewing, and crisis debriefing techniques).