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Treatment Services for Adolescent Substance Abusers

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Chapter 3

An Overview of Selected Adolescent Substance Abuse Treatment Programs

Stanley Kusnetz

An estimated 1 out of 16 high school seniors uses marijuana on a daily or regular basis in this country. Approximately two-thirds (64 percent) of American youth experiment with an illicit drug before finishing high school (NIDA 1983). Parents who discover that their youngsters use drugs are generally in a quandary, not knowing how to respond to the child nor where to turn for help. In an emotionally charged family situation of this type, parents frequently overreact or react inappropriately. Even trained professionals (i.e., doctors, teachers, clergy) often have difficulty counseling these families and steering them to someone who can give them guidance.

Among the reasons for these predicaments is that the problem is apt to be more complex than it seems on the surface, involving the entire family. The young drug user is likely to be confused, at odds with his or her family, and not likely to see drug use as a serious problem. The youngster will probably not be motivated to seek help with what others perceive to be a drug problem. To complicate matters, most community service agencies are reluctant or unable to respond to the family crisis in a timely way. Most counselors view adolescent substance abusers as extremely difficult to treat and do not have the resources required to work with the family.

Little information is available about the effectiveness of programs that treat adolescent substance abusers. Unlike the evaluation of products or other services, no absolute standards are available by which to judge a local program. Adolescent treatment programs tend to operate independently and rarely have the resources or inclination to evaluate how effective they are in treating adolescents (Smith et al. 1979). Even more disconcerting is that these programs generally fail to follow up on clients, particularly early dropouts, in an effort to determine which client benefits most and which client benefits least from the services provided. As a result, referral sources often operate in the dark, basing their decisions primarily on hearsay.

In this chapter, we will examine nine existing adolescent drug treatment programs that are known to be of high quality in an effort to fill this void. In the last section, we discuss the differences and similarities between these programs, in terms of who they serve, how they function, and where they get their support.

Types of Treatment and Intervention Programs

Many different types of adolescent drug treatment resources can be used in the United States. These include such settings as therapeutic communities, halfway houses, outpatient programs, and specialized counseling programs in family services units, often associated with city- or county-run clinics.

Hotlines

Hotlines are emergency telephone services that usually operate 24 hours a day. Trained volunteers or paid staff answer calls and make appropriate referrals. All major cities have hotlines, and many small cities and towns also have this type of service.

Hospital Emergency Units

More and more urban hospitals and those serving smaller areas now have units designed to serve emergency needs of persons who have had a serious reaction to a drug or have overdosed on drugs. Hospitalization may be only for a period of a few days or may be for several weeks. This service is generally succeeded by followup coun-

seling or a referral to other modes of treatment for continued care and counseling.

Therapeutic Community

Therapeutic Communities (TCs) are highly structured residential treatment programs that are generally designed to serve some substance abusers. There are about 125 TCs in the United States, but only a small number specialize in treating adolescents. The therapeutic community is *not* the approach to treatment for everyone. Less than 15 percent of all TC admissions graduate from treatment, and over half leave treatment before 90 days (De Leon 1984). Most TCs are highly structured, nonpermissive, drug-free residential settings. The daily regimen of the TC is an intensive one that generally includes encounter groups, group therapy, and/or counseling, tutorial learning sessions, remedial and formal education classes, residential job functions (e.g., cooking, cleaning, painting, repairs), and, in the last stages of treatment, regular occupations for clients who may then live outside of the TC. Length of stay in the TCs may vary from 6 months to 18 months and is often based on client needs and progress. In chapter 14, George De Leon and David Deitch describe how adolescent substance abusers are treated in residential facilities.

Outpatient Programs

Outpatient programs range from completely unstructured drop-in or teen rap centers located in store fronts to highly structured programs offering individual, group, and family therapy. It is not surprising that most adolescent substance abusers (82.5 percent) are treated in outpatient programs (NIDA 1981). Outpatient programs generally provide basic individual counseling and require that patients be self-motivated. The programs are usually small in size (on the average, serve between 20 to 30 clients) and serve youngsters with different types of "presenting" problems (drug abuse, alcohol abuse, antisocial behavior, etc.).

Host Treatment Services

The host-oriented approach is founded on the principle of peer pressure. When a youngster enters the program, he or she is usually away from home for a minimum of 14 days, placed in the home of a peer who is further along in the rehabilitation process. The youngster attends programs at the agency during the day and goes to the host home at night to sleep. After the new client progresses in the rehabilitation program, his or her home may then become a host home, and the youngster will be allowed to return to it while continuing to attend the program during the day. The average stay in these host-type programs is approximately 1 year.

Halfway House

Many communities support a halfway house as an alternative for those who may need to be housed in a location (with strict supervision) that is away from their own homes. Adolescents may attend school or work during the day or part of the day and return to the halfway house during the afternoon and evening. They will have meals and sleep there. These houses usually have small capacities—15–25 people at the most—and, while the length of stay will vary, the average time in this setting is from 1 month to 4 months. The halfway house is often used as a transition from a therapeutic community to the outside community, or in conjunction with outpatient therapy.

Inpatient Programs

Inpatient programs for adolescent drug abusers have been growing but are still small in number. Few States have more than one or two inpatient programs serving adolescent substance abusers. These programs provide more intensive services for adolescents who require a controlled setting. Unlike other drug treatment settings, inpatient programs have lock-up wards. Patients cannot leave. Services provided in inpatient facilities generally include diagnostic testing and evaluation, psychotherapy, group therapy, and counseling for parents. Inpatient treatment is generally very costly, averaging from $10,000 to $15,000 per month to maintain a youngster in an inpatient facility. For this reason, inpatient treatment is usually short term—no more than 2 months. Most inpatient programs will attempt to refer youngsters to residential or outpatient programs upon completion of the inpatient phase.

Selected Programs

Preliminary figures from a nationwide study of treatment facilities indicate the existence of approximately 400 adolescent programs treating drug abusers as of December 31, 1984. The number of adolescent drug treatment programs varies widely from State to State, however. It was surprising to find that no such programs were available in some States. Most adolescent treatment programs tend to serve small numbers of clients, usually in the range of 10 to 29 youngsters at any one time (capacity) (Friedman and Kusnetz 1985). As Blum and Richards (1979) point out, most treatment in the drug field is for

older drug abusers who are clearly dependent or debilitated.

In choosing the programs to be discussed in this chapter, the following criteria were applied:

- Programs must treat primarily adolescents.
- The major treatment modalities—residential, day care, and drug-free outpatient—would be represented.
- Programs would be located in different areas of the country in order to get some geographic representation.
- A mix of urban, suburban, and rural programs would be included. Programs chosen would be either widely known or of excellent reputation. The programs were recommended for inclusion by their respective single State agencies and/or reputable persons in the field of drug abuse treatment.

Descriptions of the programs cover their philosophical orientations, demographic characteristics, and fee structures.* Included also is information about the types of clients with which each program believes it has the most success and the least success.

Information was gathered by means of a structured telephone interview. Prior to the interview, letters outlining the interview subject areas were sent to each of the programs, so that they could select the appropriate person to be interviewed and have sufficient time for the preparation of demographic and other materials.

The information collected for this chapter is based primarily on self-report. Since these, like most adolescent drug treatment programs, have not been evaluated formally, it is not possible to determine their effectiveness in treating particular types of clients. Therefore, we can get only a general view of the programs, who they serve, how they serve, who they feel are served best, and who they have difficulty serving or believe they serve least adequately.

Palmer Drug Abuse Program

The Palmer Drug Abuse Program located in Houston, Tex., can best be described as an outpatient counseling program with day care capability. Satellite centers provide drop-in locations for clients to gather and meet other people in the program. Palmer Drug Abuse Programs can be found in Texas, New Mexico, Arizona, California, Colorado, and Oklahoma, and new treatment facilities are planned for Detroit, St. Louis, and Pittsburgh. Although distinctive in its own right, much of the Palmer Drug Abuse Program is patterned after Alcoholics Anonymous.

Youngsters ages 12 to 16 comprise 54 percent of the clients in the Palmer Drug Abuse Program in Houston. During any given week, an average of 300 youngsters in this age range participate in the program. In the 12–16 age group, the male/female ratio is approximately 50/50. Racially, 80 percent of participants are Caucasian, 15 percent Mexican American, and 5 percent black or other ethnic background.

Drug Abuse Patterns

Eighty percent of the 12–16 age group in this program are classified as multiple drug abusers, generally combining alcohol with marijuana. Ten percent primarily abuse alcohol. The other 10 percent abuse a variety of other substances. Many of the multiple drug abusers reportedly use Mandrax, a form of methaqualone. Most of the other multiple drug abusers combine alcohol with marijuana and amphetamines. Hallucinogens have been increasing in popularity during the past year, and it is estimated that at least 25 percent of the clients used hallucinogens occasionally. The use of cocaine is also increasing in popularity. Of the multiple drug abusers, at least 20 percent have used cocaine.

Service Area/Referral Sources

Approximately 95 percent of the clients reside in the city of Houston and its surrounding county. Youngsters from outside this area can be accepted, providing that suitable living arrangements are made privately by the client. Three to four percent of the clients are from other areas of Texas and elsewhere in the United States. A few come from outside of the United States. Most clients are self-referred or referred by family and friends, and a small percentage are referred by various social agencies and the juvenile justice system. Only "the desire to live a chemical-free life" is required for entry to the Palmer Drug Abuse Program.

Fee Structure/Funding

The Palmer Drug Abuse Program does not charge fees for any of its services to clients, their families, or referral agencies. The program is supported by private donations. Corporate donations supply 20 percent of the budget, and foundations furnish 30 percent. Various fundraising events held in the community account for an additional 30 percent, with the remaining 20 percent provided by churches and civic organi-

*The fees cited were current at the time this chapter was written. Some fees may have since increased.

zations such as the Rotary Club and Kiwanis. The Palmer Drug Abuse Program receives no government funding, United Way funding, or third-party payments.

Program Philosophy

The Palmer Drug Abuse Program considers itself a nonsectarian fellowship structured around 12 phases or steps drawn from Alcoholics Anonymous. The program can be classified as a self-help program that is built upon client participation and interaction. Included in the program goals are to motivate and encourage teenagers and help them rebuild and replace lost confidence and thus increase self-esteem.

The Palmer Drug Abuse Program is careful in protecting the confidentiality of the youngsters served. Records are maintained only when the client is referred through an agency. The program director notes that some of the Palmer Drug Abuse Programs are beginning to establish recordkeeping systems, with the understanding that the records are confidential and for internal use only. Of course!!!

The major difference between the Palmer Drug Abuse Program and other self-help programs is that individual counseling is provided in Palmer along with the group counseling. Most counselors in the drug abuse program are former drug abusers who have recovered through either Palmer or some other 12-step rehabilitation program. The Palmer Drug Abuse Program requires that counselors be at least 18 years of age, high school graduates, and go through a training program in Palmer Program methodology. Approximately half of the counselors in the program are certified by the State of Texas as drug and alcohol abuse counselors.

Program Description

In the initial interview, the counselor tries to determine the client's level of motivation for change. The client is encouraged to participate in a series of weekly meetings and counseling sessions.

In the first session as well as subsequent sessions, the counselor evaluates the client in order to ascertain whether he or she is appropriate for the program or has needs that the program is not equipped to handle. Should the counselor feel that the latter is the case, an attempt will be made to refer the youngster elsewhere. It is estimated that approximately 5 percent to 10 percent of the clients treated at Palmer have not abused substances but are in need of the services because of problems similar to those of substance-abusing clients. Typically, however, a Palmer Drug Abuse client in this age group has been involved with drugs for 2 to 4 years.

The program is open ended and can be described as a continuing, ongoing treatment program. The length and depth of an individual's participation are based upon that individual's needs and desires. Most clients stay involved for at least 1 year. A small percentage of clients have been involved for more than 1 year.

The Palmer Drug Abuse Program also maintains parents groups. Many of the parents of the youngsters in the program also have substance abuse problems. It is estimated that some 15 percent of the parents, for example, use marijuana.

Parents usually do not participate directly with their children, although under certain circumstances a group counseling session will be held with parents and child. Parent meetings usually take place at the same time as teenager meetings. As with the teenager meetings, parent meetings are voluntary and anonymous. Parents also can avail themselves of individual counseling sessions.

Who Benefits

The type of client who does best is the one who recognizes that he or she has a problem and is motivated to change. Older youngsters often do better than younger teenagers because they have had more time to experience the negative consequences of drug abuse. The client who does the worst is the one who is just not ready for help. Included among the clients who do poorly are those who are severely depressed and those who are unable to handle any structured situation or are unwilling to take direction. Males and females appear to do equally well in this program.

Because this is a voluntary program, a youngster can stop treatment at any time. Youngsters whose families will not cooperate in treatment generally do not do well. It is the feeling of staff at the Palmer Drug Abuse Program that inhalant abusers generally do poorly because they often have more serious psychological problems and need more psychiatric care than the Palmer Program is equipped to provide.

(2)

Bridgeback

Bridgeback is an outpatient program in Los Angeles, CA, physically located in a juvenile justice center but accepting referrals from other sources. At the time of interview, 29 youngsters were enrolled in Bridgeback, all between the ages of 11 and 18. Fourteen percent were female, 86 percent male. Racially, 42 percent of the clients are Hispanic, and 58 percent are black.

Drug Abuse Patterns

Marijuana is the primary drug of abuse for 49 percent of the clients. A surprisingly high percentage of the clients (24 percent) reported that Phencyclidine (PCP) was the primary drug of abuse. Seven percent of the clients primarily abused alcohol while cocaine accounted for 3 percent, and inhalants comprised an additional 7 percent. Multiple drug users comprise the final 10 percent. Although these figures are based on the primary drugs of abuse as reported by the clients, Bridgeback staff believe that most of the youngsters in the program are multiple drug abusers.

Service Area/Referral Sources

Clients come to Bridgeback from a variety of referral sources, approximately 80 percent through court order. The clients all reside in nearby areas of Los Angeles. Referrals are accepted on a space-available basis, except for those who are diagnosed as psychotic, more than mildly retarded, or in immediate need of detoxification services. In these latter cases, appropriate referrals are made.

Fee Structure/Funding

Although Bridgeback has a sliding fee scale, clients who cannot afford to pay are not charged or charged a token fee. Most of the support for the program comes from the county. The referral agency is not charged, nor are third-party payments received.

Program Philosophy

According to the Bridgeback director, "One learns from those with whom he or she identifies. The program provides role models—individuals who have acquired the emotional resources that allow them to respond constructively to the everyday pressures of life. The program attempts to guide clients by helping them search for and examine basic beliefs, attitudes, and habits."

Program Description

Client visits are scheduled on an average of twice a week, during which time the youngster participates in either group or individual counseling. A parent awareness group provides parents with an opportunity to speak openly about their problems, including those that they feel are related to their youngsters. The goal of the parents groups is to help them learn how to best communicate with their children. Although parental participation is encouraged, it is not required. The staff consists of a supervisor, intake worker, and two counselors. Ex-addicts are not used as counselors. Although a counseling degree is not essential, Bridgeback staff must have extensive experience in counseling.

Who Benefits

The youngster who does best is one who really wants to change. Bridgeback staff do not feel that age, sex, or race have any bearing upon how well a person does in this program, although older clients seem to do better because of their relatively greater life experience. The clients who do the worst are those with histories of violence, extensive drug usage, gang affiliation, and deep immersion in the drug culture.

(3) Northwest Youth Outreach

Northwest Youth Outreach, a project of the YMCA in Metropolitan Chicago, started in 1959 as a social program to work with youth in the northwest side of Chicago. Because of changing needs, the program evolved into one that focused on adolescent drug and alcohol abuse. This outreach and outpatient program provides a variety of services to youth and their families in an area of approximately 60 square miles with a population of 1.5 million.

At the time of interview, the Northwest Youth Outreach program had 340 formal outpatient clients and 12,000 informal clients (those worked with through the outreach effort in schools and communities). For purposes of this chapter, we will focus on the 340 outpatient clients, who range in age from 13 to 19. Of the 340 clients, 250 are considered to have substance abuse problems. Fifty-three percent are male, 47 percent female. Racially, 75 percent are Caucasian, 15 percent Hispanic, and 10 percent black.

Drug Abuse Patterns

Northwest Outreach staff report that alcohol and marijuana in combination are the primary drugs of abuse of 75 percent of the clients. Other popular drugs include hallucinogens and look-alike amphetamines. The abuse of alcohol alone accounts for approximately 10 percent to 12 percent of the population, and the remainder are considered multiple abusers. The Northwest Outreach program generally will not work with heroin abusers. Very little PCP abuse is seen. Recently, there has been an increase in the use of look-alike amphetamines, especially among the female clients.

Service Area/Referral Sources

Clients of the Northwest Youth Outreach program are recruited from the surrounding neighborhood and communities. None of the clients are from out of State. The primary service area is Northwest Chicago and its surrounding suburbs, including two large adjoining townships that are outside the Chicago city limits. This is a very diverse service area—one of the suburban communities is a white upper middle-class community, while the other is predominantly a blue-collar, lower middle-class black community. In the area within the Chicago city limits, approximately half would be characterized as middle-class and white, while the other half comprises a mixture of Hispanic, black, and Asian.

The major source of entry to the program is through an outreach effort conducted in the community, which brings in 45 percent of the client population. Northwest Outreach has two teams, each comprised of five or six members, who spend a portion of their day in the community at places where youngsters hang out, such as the school yard, cafeterias, snack shops, parks, and street corners. When an outreach worker recognizes that a particular youngster appears to have a drug problem, he or she will try to form a relationship with that youngster and work toward moving the youngster into the formal treatment structure.

A second way of entering the program is by referral through community agencies—the police, criminal justice system, mental health agencies, and the schools. The Northwest Youth Outreach Program accepts youngsters before and/or after court adjudication.

Fee Structure/Funding

The Northwest Outreach program is supported primarily by public funds, 80 percent from the State and 10 percent from the municipality. An additional 10 percent of the budget is supplied by private sources such as United Way.

No fees are charged for participation in the program. Participating families are asked for donations, however, which are strictly voluntary.

Program Philosophy

Northwest Youth Outreach considers itself a community-based treatment program reaching out and attracting youngsters in need of service without stigmatizing or labeling them. Chemical dependency is seen as a primary problem. The program believes that youngsters should be treated in their community so that services also can be provided to their friends and families, as well as to the systems that affect them, such as schools and police. A goal is to assist the youngster in moving forward in his or her development toward adulthood. Youngsters are given opportunities for recreational activities as well as for participating in leadership training exercises. The programs are oriented to develop self-awareness, social, coping, and problem-solving skills.

Program Description

Outreach, the key service provided by Northwest Outreach, provides casefinding as well as direct treatment. What takes place in the informal setting is the same type of activity that takes place during individual counseling. Some of the best "individual counseling" takes place during outreach, which is used as an introduction into more formal activities such as group and individual counseling. As the youngster enters the formalized treatment program, the preferred treatment choice is group therapy. Approximately 70 percent of the youngsters in the treatment program participate in groups in one form or another.

Family therapy also is recommended for all clients. The family of a youngster seen through an agency referral must, according to program policy, participate in an assessment process for at least one session. At any one time, 20 percent of the client population are involved in family therapy. Additionally, all youngsters are required to participate in individual counseling and 70 percent participate in recreational activities. Typically, a youngster spends 30–36 weeks in the formal program, with an additional 4–6 months of aftercare.

Upon entry into the formal treatment program, youngsters receive 5 consecutive weeks of education covering pharmacological aspects of substance abuse, disease concepts, and family issues, as well as an introduction to self-help. The treatment regime has four levels. In the first level ("discovery phase") youngsters become aware of their alcohol and drug use through education and through individual meetings with a counselor. This is also the time when the youngster becomes more familiar with the program and involved with other program activities. During this period, which lasts from 6 to 12 weeks, a comprehensive assessment is completed to determine if chemical dependency is the primary problem, or if it is symptomatic of other adolescent adjustment problems. Upon completion of Level 1, the youngster moves to the second level—the abstinence phase. During this time, the youngster is encouraged to participate in self-help groups, including Alcoholics Anonymous and Narcotics Anonymous. Abstinence is a goal. The youngster comes to realize that relapse is likely to happen and makes plans for

dealing with it, if and when it does. Parents become more heavily involved in their own support groups. Northwest Outreach runs two parent group programs, one modeled after Tough Love, the other after Families Anonymous.

In Level 3, the program focuses on other life skills that need to be developed. The youngster participates actively in a self-help group, as the staff works on decreasing the youngster's dependence on the program. If the adolescent is involved in social and recreational activities, it is now as a leader, helping other youngsters who are at a lower level of treatment. At the end of Level 3, the youngster and members of his or her family or significant others participate in an achievement banquet. Level 4 is the aftercare phase. At any time during the program, if a youngster should backslide or drop out and later want to reenter the program, he or she may, but most likely at a lower level.

The program's outreach staff need not be professionally trained nor have college degrees. However, outreach staff must be certified as either alcohol or drug abuse counselors. Those staff who participate in the more formalized part of the treatment program generally have a minimum of 2 to 3 years' experience. Some are professionally trained social workers or persons with master's degrees in other related fields.

Who Benefits

The Northwest Outreach staff feel that the youngster who is a chronic user and is invested in the drug culture is easier to work with than one who is not. "It is much easier for them to see the consequences of their use." Youngsters who do worst generally have had prior treatment involvements and are "treatment wise." Some have been in and out of different outpatient and residential programs. "These are the type of kids who know the therapeutic talk, who know how to act in a therapeutic setting. They will frequently attempt to sabotage their own treatment or the treatment of others." Northwest Outreach staff recognize and expect that a good percentage of youngsters will drop out of the program for a period of time. Sometimes a youngster will enter and reenter a program three or four times until he or she is ready to seriously confront the issues. Data compiled by the program show that 35 percent to 40 percent of those who begin the program are terminated successfully.

4 Corner House

Corner House is an outpatient program located in Princeton, NJ, a university town that is home to numerous corporate headquarters as well. Most Corner House clients fall within the 13- to 18-year age range. The client population is 55 percent female, 45 percent male. Racially, 90 percent of the clients are Caucasian, 10 percent black.

Drug Abuse Patterns

The primary substances of abuse for 60 percent of the Corner House clients are alcohol combined with marijuana. Fifteen percent primarily abuse alcohol, 8 percent are considered multiple drug abusers, 5 percent primarily abuse amphetamines, 5 percent cocaine, 4 percent hallucinogens, and 3 percent heroin. The use of cocaine has been increasing during the past few years.

Service Area/Referral Sources

The primary service area of Corner House is Mercer County, where it is located, which generates 92 percent of all clients. The remaining 8 percent come from outside of the county but within the State. The largest number of clients are self-referred or referred by family. Corner House also accepts clients from community agencies, and through the juvenile justice system, which refers youngsters who are on parole or probation.

Fee Structure/Funding

As a municipal agency, Corner House occupies space in the municipal building of the Township of Princeton. Clients are charged a sliding fee of between $1 and $50 per counseling hour. The fee charged depends on income and the number of children in a family. Corner House also will charge back to third-party insurance plans when appropriate.

State and Federal contributions total 44 percent of the overall budget, 15 percent is provided by the Township and Borough of Princeton, and the county contributes an additional 11 percent. Fees comprise 12 percent of the budget, and the remaining 18 percent is raised through private donations. Private donations are received through the nonprofit Corner House Foundation, a group of private citizens who raise funds for Corner House through annual mailings to the general public and solicitations to private corporations.

Program Philosophy

The goal of Corner House is to provide caring and professional individual, family, and group counseling to adolescents and young adults. Drugs and alcohol are seen essentially as the symptom of a larger problem often buried deeply within the family. One of the first goals of staff

is to establish a basis of trust in which the youngster can see that a problem exists and that something can be done about it. Much of the counseling concerns personal responsibility, values, and decisionmaking. The counselor strives to establish a feeling of trust and, on that trust, motivation for treatment.

Program Description

Corner House is essentially an outpatient counseling program. All counselors are certified social workers, and a psychiatrist is on the Corner House staff. Clients participate in individual as well as group counseling, and families are strongly encouraged to participate in family counseling sessions. Indeed, in cases where the staff considers it vital, family participation is a requirement of treatment. Typically, a client remains in the program for a period of 3 to 8 months, although some clients remain as long as 2 to 3 years. A client with a serious psychiatric problem such as depression, after a diagnostic session with the staff psychiatrist, may be referred to a more appropriate facility for treatment. Corner House does not accept clients who require detoxification. Referral services are considered an essential part of the program.

It is not an absolute requirement that a client be drug free at time of discharge from the program. The counselors at Corner House look for improvement over a period of time in the clients' ability to make responsible decisions for themselves, including decisions about using drugs or alcohol. It is recognized that some clients will backslide into drug usage, and, in that case, they can be readmitted into the program.

Who Benefits

Corner House prefers to begin working with clients before they are heavily involved in drug usage. Motivation for change is recognized as the key to success. Since a large number of clients are self-referred, Corner House gets more highly motivated clients than other programs. The youngster who may be depressed because of family and/or school pressures may begin to drink or use drugs but is essentially concerned about working out the personal problem and recognizes its existence. Clients referred by parents and schools tend to be poorly motivated, while those sent by the juvenile justice system are usually the least motivated and represent the greatest challenge.

Corner House does not find any significant difference in the rate of success between male and female clients. Interestingly, Corner House staff also find that the type of drug a client uses is not as important in predicting success as the length of time that the youngster has been using drugs in general and the client's overall investment in the drug culture.

(5) Woodbridge Action for Youth

The Woodbridge Action for Youth program in Woodbridge, NJ, contains an outpatient unit, a prevention unit, and an adolescent unit (our focus here). The program is located in a blue-collar town that is undergoing change. The adolescents seen at this program come essentially from the older neighborhoods.

On a typical day, the Woodbridge Action for Youth day care program treats 15 adolescents between the ages of 14 and 18. At any one time, 75 percent of those treated are male. On the average, 98 percent of the client population are Caucasian and 2 percent various minorities.

Drug Abuse Patterns

Eighty-five percent of the clients treated in this program are considered multiple drug abusers, with the primary combinations being amphetamines, alcohol, and marijuana. Fifteen percent of the clients report themselves to be primary barbiturate users. The use of opiates and PCP has not been prominent.

Service Area/Referral Sources

The director of this program attributes the high percentage of males in the treatment population to her feeling that the juvenile justice system in that part of the State treats females somewhat more leniently than males, and that males are more likely to be referred by the school system. Fifty percent of those treated are from the township and 50 percent from elsewhere in the county and other areas of New Jersey within commuting distance.

Fee Structure/Funding

The day care program charges are on a sliding scale ranging from $1 to $100 a week. Approximately 85 percent of all clients pay less than $15 a week for care. Under certain circumstances, the fee can be waived entirely. Forty-five percent of the Woodbridge operating budget is received from State and Federal funds, and fundraising and fees account for another 10 percent. The remainder comes from the local township government.

Program Philosophy

Woodbridge Action for Youth focuses on drug-related problems, i.e., interference with school, family, social lives, and the law. Absti-

nence is not required as a criterion for being in the program. Program staff accept the fact that, at some point in their lives, clients may be able to drink recreationally. Because they can see clients only 5 hours a day, they are not so strict in terms of abstinence as other programs. Staff work toward abstinence, but it is not a requirement to stay in the program.

Program Description

Clients come to the program for a total of 5 hours each day, during which they are exposed to a combination of counseling, socialization, remedial education, and other activities. Several criteria determine entry into this program. Prospective clients must agree not to be under the influence of drugs during the 5 hours of the program. They must agree to participate in all phases of the program, and their parents or guardians must agree to participate in the parents group. Adolescents with a history of violent acting-out behavior or severe psychiatric pathology are not accepted into the day care program. If detoxification is required, the youngster must complete such a program before he or she is accepted for treatment.

The first 30 days of the program are considered a probationary time during which clients are expected to demonstrate the motivation needed to participate in the program. If, at the end of 30 days, a youngster still is not adequately motivated, a meeting is held with the parents, the child, and other referral agency personnel. During this meeting, a recommendation may be made to transfer the youngster to another program, back to the school, courts, or to simply say that the youngster is not yet ready and suggest ways that he or she might be made ready to fully participate in the Woodbridge program.

Family participation is required. In those cases where a youngster is self-referred and does not want his or her family to be involved in treatment, the program will comply for a "reasonable" period of time until the client agrees to family counseling. Staff feels that the minimum amount of time that an adolescent should stay in the program is between 6 and 9 months, with an additional 6 months of family counseling. The maximum amount of time a person can stay in program is 2 years, although this is rare.

Who Benefits

The youngster who does best has some kind of active parental support. Youngsters over the age of 16 generally do significantly better than those who are younger, because they are starting to feel the consequences of their own actions. In addition, parents are beginning to force them to take responsibility.

Another important factor in predicting treatment outcome is the length of time the youngster has been using drugs, and how invested he or she is in the drug culture. The longer a youngster has been using drugs, the harder he is to treat. Another significant indicator is whether the youngster's family is abusing drugs or alcohol. Adolescents cannot understand why parents can smoke marijuana, work, and appear to be happy, but they cannot. The Woodbridge program estimates that at least 40 percent of all youngsters in the program have at least one parent who abuses alcohol, marijuana, or other drugs. Youngsters referred by the criminal justice system do less well than those who come through other referral sources.

Genesis House

Genesis House, located in Pampa, TX, is a residential treatment center, with male and female clients housed separately in two buildings located several blocks apart. A distinguishing feature of Genesis House is its extensive use of community facilities. All of the residents attend the local public schools and regularly participate in community athletic and recreational activities. Pampa, an old established town of approximately 25,000 people, is located in the panhandle section of Texas. Pampa residents, mostly farmers and industrial workers, believe in "taking care of their own" and have historically been supportive of Genesis House. A large number of volunteers participate in the program by providing transportation, instruction to the clients, and numerous other services.

Genesis maintains a census of 14 youngsters, 7 in each residence, ranging in age from 13 to 17 years. At the time of interview, approximately 40 percent of the clients were Hispanic, 10 percent black, and 50 percent Caucasian.

Drug Abuse Patterns

All of the clients at Genesis House are considered to be multiple drug abusers. Most use marijuana regularly, and many combine their marijuana usage with amphetamines and alcohol. Barbiturates are also popular, as is inhalant use. Though limited by its high cost, the use of cocaine is growing in popularity. No resident of Genesis House is a primary abuser of heroin, other opiates, or PCP.

Service Area/Referral Sources

In admitting clients to treatment, priority is given to those who reside in the local area and surrounding counties, who generally account for 50 percent of the client population. Remaining

space is used for referrals from other areas in the State. Between 50 percent and 75 percent of clients are referred by the Texas Youth Commission, a part of the juvenile justice system. Genesis House will accept referrals from other agencies, school officials, and parents. However, the program will not accept clients in need of detoxification. Clients with mild degrees of retardation or psychiatric disturbances may be accepted. The major criterion for acceptance into this program is that a client must be able to function in a public school.

Fee Structure/Funding

Fees are on a sliding scale with a maximum of $26 per day. The referring agency will often pay the entire fee; otherwise, the client's family is charged according to the ability to pay. A client would not be turned down if his or her family is unable or unwilling to support him or her in the program. The average family pays from $2.50 to $10 a month.

Approximately one-third of the budget of Genesis House is generated from agency fees, another third by local contributions, and somewhat less than a third by other grants. The remainder of the budget is made up by special projects and fees collected from clients and client families. Third-party insurance payments have not been used.

Program Philosophy

The Genesis House program is designed to change the adolescent's destructive behavior and substance abuse lifestyle through a highly structured residential program. Youngsters are given an opportunity to set achievable goals that will lead to growth in self-esteem.

Program Description

This program provides a home-style residential atmosphere with a great deal of community involvement and interaction. All clients attend the local high school and are required to complete at least one semester successfully as a condition of discharge. The high school offers a variety of educational programs, and an appropriate course of work is chosen in consultation between the high school guidance counselor, Genesis House staff, and the client. Genesis House provides a work readiness program in which clients are taught how to relate to employers, dress for work, make job applications, behave in an interview, and present themselves and their skills in the best possible manner. Participation in summer job programs is offered as well. Clients participate in a home skills program, which includes landscaping, clothing care, decorating, and building maintenance such as painting and plumbing.

All clients are involved in both a regular in-house group and individual counseling. After the first month in program, group counseling sessions take place at a minimum of twice a month and individual counseling once a month. Family counseling is provided when the family is able and willing to attend sessions, which approximately 5 percent of the families do. When a client is referred by the juvenile justice system, the probation officer will maintain contact with both the client and the client's family.

Residents of Genesis House undergo screening for drugs only when the house supervisors suspect that drugs are being used. The average stay in Genesis House is from 6 to 9 months, with 6 months being considered a minimum. A number of residents have stayed longer than 9 months when this is dictated by treatment needs and untenable family situations. Clients cannot stay in the program past their 18th birthday.

Who Benefits

The client who does best at Genesis House is a person older than 15 years with an average IQ who is able to express himself or herself and state personal feelings clearly. Genesis House finds that the most difficult clients to work with are passive youngsters and those who are retarded. Additional problems are presented by the youngster whose parents abuse drugs and/or alcohol. It is estimated that upwards of 60 percent of the clients have smoked marijuana in the presence of or together with their parents.

The Bridge

The Therapeutic Center at Fox Chase, better known as The Bridge, is a residential treatment program located in Philadelphia, PA. At the time of interview, The Bridge was serving 58 residential clients—72 percent Caucasian, 25 percent black, and 3 percent Hispanic. The facility has a capacity of 60 to 65 residents. Typically, 65 percent are male, 35 percent female.

Drug Abuse Patterns

Fifteen percent of The Bridge clients primarily abuse alcohol, 20 percent used alcohol in combination with marijuana, 30 percent were considered multiple drug abusers, 20 percent abused amphetamines, and 15 percent had PCP as their primary drug of abuse.

Service Area/Referral Sources

Clients come to The Bridge through self-referral and referral by family, schools, other

community agencies, and the criminal justice system. Approximately 40 percent to 50 percent of the clients are court referred.

Eighty-five percent of the residents are from the city of Philadelphia and surrounding communities. Fifteen percent are from New Jersey and from elsewhere in Pennsylvania. Occasionally, some clients come from outside the States of Pennsylvania and New Jersey.

Fee Structure/Funding

The per diem of $56.41 charged to those in the residential program is usually paid by the referring agency or court. For those referred by self or family, a sliding scale applies. No one is turned away for lack of funds. Third-party insurance is also accepted when appropriate.

Program budget is based 70 percent upon public funds. Donations from individuals, corporations, foundations, and the United Way account for another 10 percent. Client fees constitute 15 percent of the budget, while third-party payments make up the remaining 5 percent.

Program Philosophy

The program is founded on the belief that drug/alcohol-dependent adolescents can be helped to gain the internal motivation, the skills, and the external supports necessary for sober, independent, and responsible living. It is believed that the substance abuse problem is intimately connected to other problems of youth. Substance abuse is one way that residents try to cope with or react to other problematic situations—low self-esteem, social/emotional disturbance, marginal family structure, minimal academic achievement, inability to find or sustain employment, and negative peer relationships. Staff of The Bridge believe that adolescent substance abusers can be motivated to change and to learn skills that will help them develop an appreciation of their personal worth, learn how to make decisions, set goals and accept consequences, learn how to cope, behave responsibly in difficult situations, communicate more effectively with their families, and develop honest, positive, and supportive friends.

Program Description

The primary criterion for entry to The Bridge program is that the resident have alcohol and/or drug abuse problems. The program will not accept persons with severe physical handicaps because of facility limitations. It will not accept applicants with serious psychological problems, suicidal tendencies, or a history of arson or other problems suggesting that the youngster is a danger to self and/or others. Detoxification for potential residents is provided off site. Upon entry, all residents receive complete physical, dental, psychological, and educational assessments. The program is concentrated in five major areas.

- Residents receive a minimum of 10 hours of group therapy weekly and as much individual therapy as staff feel is needed. Emphasis is on realistic thinking and upon gaining awareness skills and strengths needed for responsible living.

- A formal plan of family therapy is offered.

- An education program provides residents a minimum of 27½ hours of classroom experience per week, including vocational guidance and development as well as job placement service. The Bridge school is licensed as a private academic high school in the States of Pennsylvania and New Jersey; residents therefore complete credits for a high school diploma on the premises. Both regular and special education programs are offered.

- The Bridge also offers a life skills development program, which provides residents exposure to, and instruction in, a wide spectrum of cultural, social, survival, athletic, and recreational skills. The purpose of the life skills development program is to help them learn how to organize free time and to become aware of alternatives to their present lifestyle.

- Additionally, a full range of medical, dental, psychiatric, and psychological services are included.

A new resident moves through the program in six phases. In the initial 4 weeks, called the investment level, the resident identifies personal strengths and gains self-confidence; identifies weaknesses/problems and begins to learn how to change them; and gains the motivation, trust, and support needed to change or to cope. A "big brother" or "sister" helps the new resident during this period of transition. The resident learns how addiction and drug abuse have had an effect on life, family, friends, school, and work and to appreciate how a new attitude and behavior will affect the same. Level 2 is a period of 2 to 3 months during which the resident assumes a role of leadership within the community. He or she will begin to share personal growth with younger residents and continue to help them address situations by offering support and confrontation in an appropriate manner. During this time, family therapy is intensified. The goal of Level 2

is for the resident to attain understanding of his or her responsibility and be able to enumerate areas that need to be addressed with some or all family members.

During the 2 to 4 months that comprise Level 3, the resident begins to test new attitudes and behaviors. The goal of Level 3 is to help the resident gain motivation and a new value system, as well as develop an external support system that will enable him or her to cope with problems and life situations in a more appropriate manner. The final 6- to 8-week period is considered the senior level, during which the resident finalizes educational and vocational goals, as well as the development of needed support systems. Following the senior level is graduation, symbolizing the formal completion of the program. An outpatient aftercare program, generally lasting 6 months, is available at The Bridge and is recommended for all graduates.

Staff at The Bridge are trained, experienced, licensed, and/or certified in their specific areas of expertise.

Who Benefits

Residents 16 years of age and older generally do better than younger clients. This is thought to be due to the fact that the older client will have experienced more of the negative effects of drug abuse and is more likely to have hit rock bottom. Younger clients are less likely to consider their drug use or problems serious.

8 Psychiatric Institute of Montgomery County

The Closed Adolescent Unit of the Psychiatric Institute of Montgomery County is located in Rockville, MD, a suburb of Washington, DC. This unit is designed to provide an intensive evaluation and treatment program for disturbed adolescents, particularly those whose psychiatric illness is complicated by alcohol and/or drug abuse.

The Psychiatric Institute program has a capacity of 20 youths between the ages of 13 and 18. Of these, one-third are female and two-thirds are male. Eighty-six percent of the clients are Caucasian, 12 percent black, and 2 percent Hispanic or other.

Drug Abuse Patterns

Nearly all of the clients at the closed adolescent unit consistently use marijuana and alcohol. In addition, 2 percent are cocaine abusers, 2 percent abuse heroin, and the remainder are considered to be multiple drug abusers.

Service Area/Referral Sources

The Psychiatric Institute reports that 77 percent of its clients come from the city of Rockville and surrounding counties. Four percent come from the city of Annapolis, 5 percent from Baltimore, 3 percent from the District of Columbia, and 11 percent from the State of Virginia. Because of the nature of the program, most clients are referred by parents, other family members, or physicians. Referrals are also occasionally received through community agencies and the courts.

Fee Structure/Funding

Clients are charged $418 a day in the closed (secure) unit or $365 a day in the open unit, plus additional professional charges, which average $700 a week, for a total of $3,626 (closed) or $3,255 (open) per week. The above charges do not include any prescribed medication or laboratory tests. Although the program has no sliding scale, nearly all of the clients are covered by third-party insurance. The fee structure is adjusted on an individual basis in cases where families cannot afford the insurance copayment, or insurance has run out.

Program Philosophy

The Psychiatric Institute program focuses on adolescents who suffer from the concurrent problems of psychiatric illness and substance abuse or dependency. According to the program director, "For these adolescents, one cannot assume that the treatment of a psychiatric illness alone or substance abuse problem alone will bring about recovery. Attention needs to be paid to both problems simultaneously. The goal is to prepare the adolescent for continuing growth in a less restricted environment as quickly as possible. Our main goal is to help youngsters to the point where they see that a problem exists, that something can be done about it, and that something can be learned about how to get there. We don't see ourselves as being able to cure what is a very serious chronic illness in a couple of months but rather, through therapy, to help the family and the youngster understand problems and be in a better position to resolve them. We then refer the youngster to an outpatient or residential program depending on his or her best interests."

Program Description

Detoxification may be required prior to or during the early part of the evaluation phase, depending on the type of drug problem. Upon

admission to the adolescent unit, the youngster and his or her family participate in an evaluation phase lasting approximately 2 weeks. This phase involves continued diagnostic assessment, e.g., a medical history, physical examination and assessment of daily living skills, and a social worker's evaluation of the adolescent's history and family relationships. The evaluation phase also includes psychiatric assessment of the nature and severity of the emotional disorders and evaluation of the youngster's ability and potential for self-expression, including his or her use of leisure time and social skills. Also accomplished during this period are a detailed drug and alcohol use history and appraisal of the youngster's educational level and potential for learning. Other psychological testing is performed as appropriate.

During the evaluation phase, efforts are initiated to break through the problems of denial. Should the evaluation phase show that the youngster can be helped by the treatment phase of the program, it will follow immediately. If not, an appropriate referral will be made.

An individual treatment program is designed according to the needs of the youngster and family and is based on the evaluation. Treatment is comprised primarily of one-to-one counseling, traditional group, and confrontational group therapy.

As part of psychiatric treatment, the therapist educates the adolescent about his or her psychiatric problems and about types of therapies and/or medications required for treatment. The patient learns to cope with his or her particular disorder and specialized psychopharmacology strategies are recommended. Therapies that encourage expression, such as art, music, and drama, are used as appropriate. A behavior modification program is used to help prepare the adolescent for learning ways to earn privileges and to feel rewarded for his or her efforts.

Youngsters also learn about the nature of their drug or alcohol problem and about the recovery process. The treatment program has been built around the recovery principles of such self-help organizations as Alcoholics Anonymous and Narcotics Anonymous, whose meetings patients attend as appropriate during the treatment phase. While a drug-free lifestyle is encouraged on the inpatient unit, it is the viewpoint of the Psychiatric Institute that medications can be useful for treating patients. The family is involved in an intensive orientation program while the adolescent is in the hospital. Individual family therapy takes place once a week, as do multifamily groups, which meet weekly while the patient is in the adolescent unit. Alanon meetings, lectures on drug and alcohol abuse, and parent peer groups are emphasized during this phase. The youngster is also enrolled in the developmental school, which is a nonprofit special education junior/senior high school located within the hospital.

The average client spends 55 days in the closed unit, after which he or she is referred to either inpatient or outpatient treatment as appropriate to his or her individual needs.

Who Benefits

The youngster who does best in this program is one who has an actively involved and supportive family group who are willing to listen and to work constructively with program staff. Youngsters who need a great deal of one-on-one therapy and who are unable to participate in group therapy programs do not do as well and are usually referred elsewhere after the evaluation period. It should be noted that the intensive evaluation period of this program helps to ensure that only those youngsters who can benefit from the therapeutic services offered are accepted into the program, and that others are referred to programs that would be more appropriate.

Rural Adolescent Model

The Rural Adolescent Model (RAM), located in a rural area of central Minnesota, combines residential and day care programs. It is structured to meet the needs of rural communities and serves an area within a radius of approximately 60 miles that is characterized by marginal employment, marginal farming, and very high unemployment. The residential program begins with a period of assessment, followed by a period of residential treatment. A day program is offered to those completing the residential treatment program, as well as to those for whom a residential treatment program is not appropriate, or who have been evaluated and/or received primary treatment services elsewhere. The residential and day care programs are combined, the only difference being that those in the day care program return home to sleep. The residential and outpatient programs will be considered here as one total program in that, for most clients, treatment begins in the residential setting and continues in the day program.

The Rural Adolescent Model can serve up to a maximum of 14 clients in an age range of 12 to 19. At time of interview, 37 percent of the clients were male and 63 percent female. Staff at RAM attributes this ratio to prevailing attitudes in the area, which hold that "drinking and carousing" are normal behaviors for male adolescents but signs of needing help for females. Racially, the typical client census is 3 percent black, 7 percent Native American, and 90 percent Caucasian.

Drug Abuse Patterns

Program records show that alcohol combined with marijuana comprise the primary drugs of abuse for 70 percent of RAM clients. Twenty percent are considered multiple drug abusers, while 10 percent of the clients report that alcohol is the primary drug of abuse.

Service Area/Referral Sources

All clients are from within the State of Minnesota, and 29 percent reside in the agency's home county. RAM serves nine counties, each having a population of 20,000 to 30,000 people. The program generally limits acceptance to those youngsters living within a 60-mile radius of the program in order to better involve their families in the rehabilitation process.

Liaison is maintained with the local school systems, from which half of the client population is derived. The major criterion for entry into the program is evidence chat a youngster has been harmfully involved with alcohol and/or other drugs. The Adolescent Alcohol Involvement Scale is routinely used in making this determination. RAM ties in with the local schools, seeking out behavior that would indicate drug and alcohol involvement. The consequences of chemical abuse show up in school problems, whereas parents generally don't know the extent of their children's drug involvement.

Fee Structure/Funding

RAM charges $135 a day in the residential program and $80 a day for the day care segment of the program. Third-party insurance covers part or all of the fees for approximately 40 percent of the families involved in the program, while the remainder of the fees are generally paid to the program through a State block grant.

Program Philosophy

RAM views chemical abuse as resulting from a variety of environmental factors and behavioral and psychological problems. RAM staff believe that chemical abuse adversely affects the entire family, and the entire family therefore should be involved in the treatment process. Since, in the rural community, families are usually geographically spread out, the agency makes an effort to provide family services in the family's community. The family is encouraged to become involved in community activities, including religious groups, which can offer a positive approach to their problems. Clients also are encouraged to participate in, and make use of, the self-help principles of Alcoholics Anonymous.

A somewhat different approach is used in working with members of the American Indian community, in that a larger community/family group is involved in the rehabilitation process, and local tribal leaders cooperate in obtaining community support.

Program Description

Typically, a client will spend 45 to 50 days in the Rural Adolescent Model program—28 days in the residential segment and 20 days in the day program. Some clients simply come for a 10- to 14-day evaluation in order to determine the potential treatment benefits of the program. If a youngster who has been referred for treatment completes an evaluation period, and it is felt by RAM staff that the particular youngster does not need full treatment services, the youngster would be sent home with a contract, establishing criteria that will enforce the belief that formal treatment is not needed. Such criteria would include regular school attendance, weekly meetings with parents, possibly a counselor involved in the case from the family's community, and attendance at Alcoholics Anonymous meetings when appropriate. Compliance with this contract is monitored through contact with the parents and other involved helping professionals.

Treatment services include two daily group counseling sessions, with individual counseling taking place at a minimum of every other day. Two types of family counseling sessions are available, one involving the client and his or her own family, the other involving a group of families together. During the course of treatment, the family will meet with the youngster and RAM staff a minimum of 10 times. If a family is reluctant to participate, the parents are confronted with the belief that the youngster will not improve without their involvement. The youngster is encouraged to call, write, or otherwise encourage his or her family to become involved. Because of the potentially long distances that may have to be covered by families, effort is made to go into individual communities in order to hold multifamily meetings. These meetings are generally held at a church, a school, or some other neutral nonstigmatizing site.

RAM provides a small one-room school, so that youngsters may keep up with their peers in the community school systems. The program also provides recreational opportunities and numerous educational seminars on drug abuse, alcohol abuse, sexuality, spirituality, and other topics of interest to an adolescent. Support groups including Alcoholics Anonymous are also provided at the facility.

Who Benefits

Clients who acknowledge the consequences of using drugs or alcohol do best in the program.

The client who succeeds will have a supportive family that acknowledges they have been affected and will do their part toward helping the situation. Since the goal of this program is not only for a youngster to do well in the program, but to continue to do well after leaving the program, it is felt that the key is high-quality family involvement and followup beyond treatment. The older adolescent appears to do somewhat better than the younger adolescent.

The youngsters who are most difficult to work with "come from families that expect the program to work miracles. Youngsters who are immersed in the drug culture are often not sufficiently motivated, although every effort is made to get them to take a good look at their behavior and to become motivated to participate. A youngster is asked to leave unless he or she is making progress and is actively participating in the rehabilitation process." The decision to drop a client is made mutually between the youngster, his or her parent, and the referral agency. Occasionally, youngsters may leave the program without permission, but they generally come back on their own in a short period of time and, usually but not always, are accepted back into the program. This decision is made in the best interests of the clients. Adolescents who present the most serious challenge are those who have multiple problems in addition to chemical abuse, such as sexual abuse, physical abuse, anorexia, and other psychiatric problems. Youngsters with these problems are accepted if the initial 10- to 14-day evaluation shows that they can benefit from the program offered.

Differences also are noted between those clients referred by the school and those referred by the criminal justice system. School-referred adolescents are more likely to be aware of the consequences of their abuse and to acknowledge that a problem exists. Clients referred through court order often are not as ready to acknowledge the consequences of chemical abuse, even though they have seen themselves in court because of it. They have been there before, and they know how to play the game.

Program Comparisons

Although diverse in many ways, these programs share much in common. As seen in table 1, with two exceptions, the adolescent programs are small, half serving 30 or fewer youngsters. With one exception, the ages of clients range from 11 to 19—The Bridge having a small percentage of clients over 19. The male proportions of the populations of these programs were at a mean of 59 percent, with a range of 37 to 86 percent. The female proportions comprised a mean of 41 percent, from a low of 14 percent to a high of 63 percent. Seventy-nine percent were Caucasian, ranging from 0 percent to 98 percent; the remainder were black and Hispanic, with a small percentage of Native Americans in the Rural Adolescent Model. These percentages are in the same range as found in the national sample of adolescents in treatment for drug abuse (NIDA 1983).

Drug Abuse Patterns

The vast majority of the clients seen in these programs are multiple drug abusers, with alcohol and marijuana being prime substances of abuse. The program directors report that amphetamines and amphetamine look-alikes continue to be used widely among the adolescents and that cocaine is growing in popularity. With the exception of one program, barbiturates are rarely seen as primary drugs of abuse, nor are opiates. Two programs reported PCP as a primary drug of abuse for large percentages of their clients (15 percent and 24 percent, respectively). While most program directors reported that hallucinogens were used occasionally by many of their clients, they were rarely seen as a primary drug of abuse. Such was the case also with inhalants.

Service Area/Referral Sources

With the exception of The Palmer Drug Abuse Program, the adolescent programs serve their local areas (towns, cities, counties) primarily. Clients are at times self-referred or referred by family; however, the two most common referral sources are the juvenile justice corrections system and the schools.

Few of the programs accept clients with serious psychiatric disturbances. With the exception of the Psychiatric Institute, which is hospital based, none of the programs surveyed accept clients who are in need of detoxification.

Fee Structure/Funding

Although fees charged vary considerably (ranging from $0 to more than $800 per week), all programs are structured so their services are affordable to clients, through the use of a sliding fee scale based on need, third-party insurance payments, or a combination of both (see table 2). Each program that charged a fee claimed that special arrangements could be made to treat indigent clients. With the exception of Palmer House and the Psychiatric Institute, all programs are supported by a combination of municipal and other governmental grants. Of the nine programs surveyed, only four make any use of third-party payments, with such payments forming a significant portion of the budget of only the Rural

Table 1. Demographics of nine adolescent substance abuse programs

Program	Number of clients	Age range	Percentage					
			Male	Female	White	Black	Hispanic	Other
The Bridge	60	13–21	65	35	62	35	3	–
Palmer	300	*	50	50	80	5	15	–
Woodbridge								
Outpatient	35	12+ (50% <20)	75	25	98	<———	2	———>
Daycare	15	14–18						
Genesis	14	13–17	50	50	50	20	30	–
RAM	13		37	63	90	3	–	7
Northwest Outreach	250	13–19	53	47	75	10	15	–
Corner House	–	13–28 (16–18)	45	55	90	10	–	–
Psychiatric Institute	30†	13–18	66	34	86	12	2	–
Bridgeback	20	11–18	86	14	0	58	42	–

*Three groups: Group I (12–16)—54 percent; group II (17–24)—34 percent; group III (25+)—12 percent.
†Projected capacity.

Adolescent Model and the Psychiatric Institute. The budget of Palmer House is heavily dependent on private foundation donations.

Who Benefits

Most adolescent programs are in basic agreement regarding the types of clients who do best and worst in treatment. The more successful clients recognize that they have a problem and are motivated to participate in program activities. According to the director of the Psychiatric Institute, the youngster with the best prognosis has an actively involved and supportive family group and is willing to listen and work constructively with program staff. In the words of the director of the Rural Adolescent Model, the client who does best is the one who acknowledges the consequences of using drugs and/or alcohol. He or she will have a supportive family with knowledge that they are directly involved and will do their part toward helping the situation. All of the programs are in agreement that the older adolescent generally does better than the younger one, because of their greater degree of life experience and the fact that they have had more time to experience the negative consequences of substance abuse. According to the director of Corner House, the older teenager tends to be more mature, more motivated, and have more life experiences to use in problem solving. In the words of the director of The Bridge, "the younger client has more denial and is less likely to consider his or her problem serious."

None of the program directors see any difference in terms of treatment success between male and female clients, nor is race felt to be a significant factor. Interestingly, the type of drug used does not appear to be a factor in predicting treatment success among this population of adolescent clients, with the exception of primary inhalant abusers, who are less likely to succeed in treatment. Inhalant abusers tend to be younger than other types of adolescent drug abusers (NIDA 1981).

Without exception, all of the programs believe that the adolescent who was referred through the criminal justice system is less apt to have a successful treatment outcome than one who is referred by other sources. According to the director of Corner House, the clients referred by the juvenile corrections system are usually the least motivated and pose the greatest challenge. Another negative indicator of treatment success are those youngsters who have had numerous prior treatment experiences. In the words of the director of Northwest Outreach, they are treatment wise, know the therapeutic language, how to act in a therapeutic setting, and can more easily "con" a counselor. They often sabotage their own treatment and the treatment of

Table 2. Fees/support structure of nine adolescent substance abuse programs

Program	*Client charges	Percentage						
		Municipal	Other gov't	Third party	Foundation	Donation	Other	Client fees
The Bridge	$0–$56.41 p/d slide	<——70——>		5		10		15
Palmer	None	0	0	0	30	<——70——>		
Woodbridge								
Outpatient	$1–$45/hr	45	45				2	8
Daycare	$1–$100 p/d							
Genesis	$10–$250 slide	<——66†——>				33	1	
RAM	$135 p/d res	47.6	40				10.1	2.3
Northwest Outreach	None	<——85–90——>				<——10–15‡——>		
Corner House	$1–$50/hr slide	15	55	12	<——18——>			
Psychiatric Institute	$3,255–$3,526/wk			100§				
Bridgeback	NA	<——100——>						

* May be paid by third-party insurance.
† Includes per diem paid by referring agency.
‡ Includes United Way.
§ Client copayment, if any, varies according to the client's insurance coverage.

others. Additionally, clients with histories of violence, extensive drug use, and gang affiliation tend to do less well than those without these attributes.

All of the program directors note that those adolescents coming from a family in which the parents abuse alcohol or drugs do more poorly than adolescents with parents who do not abuse substances. According to the director of Woodbridge Action for Youth, the adolescent whose parents are substance abusers is extremely difficult to work with because he or she is unable to see why the parents can use drugs and, in the adolescent's perception, still appear to be successful in their lives, while he or she is unable to do so. The directors of programs agree that in many of the families of clients, marijuana has assumed a status similar to that of alcohol and is used casually. According to Friedman et al. (1980), examples set by parents and siblings often influence decisions of teenagers to use or not to use drugs. In addition, parents, particularly the mother, exert a powerful modeling influence for their children, either encouraging or discouraging drug use. Studies also show that parents of adolescents who use illicit drugs are more likely to use illicit drugs themselves than parents of those youngsters who do not use these drugs.

Program Descriptions

Although there are many differences in the services offered by the programs surveyed, there are also many similarities. All programs make extensive use of group counseling. All programs also provide individual therapy or counseling. To some extent, all programs require parental and/or familial involvement in the counseling/therapy process and attempt to provide family counseling and/or therapy insofar as is logistically possible. Adolescent drug abusers coming to treatment present a multiplicity of problems that extend beyond drug use per se. All of the programs surveyed attempt to understand and address these underlying problems, which often are rooted in the family milieu.

Of the programs surveyed, many make use of such self-help programs as Alcoholics Anonymous and Narcotics Anonymous. The self-help

groups may meet at the program location, or the adolescent may be encouraged to attend AA or NA meetings in their neighborhoods.

Conclusion

Although adolescent drug abuse is acknowledged to be a major national problem, the substance abuse treatment programs that exist in the United States are far too few to meet the burgeoning need. Most of these programs are small and accept youngsters only from their local communities. Indeed, the decision as to which program is chosen to treat a youngster often is dictated by geographic factors. Outside of major urban areas, precious few programs are available from which to choose. Unless a residential treatment program is clearly called for, parents and counselors alike are often put into the position of having to make do with whatever services may be available and accessible.

Not all programs are suitable for particular youngsters. In attempting to locate an appropriate program, one must first consider the type of problems the youngster is experiencing, how long he or she has been using drugs, the youngster's personality traits, and, to some extent, the type of drugs being abused. It is best to determine all of the types of programs available in an area, and to visit more than one, in order to obtain a clearer picture of the alternative programs available. Whatever treatment program a youngster enters, parents will most likely be expected to attend counseling sessions. As seen in the descriptions of programs, parental participation is a hallmark of nearly all of those programs judged to be of high quality. If a common thread can be found that ties these programs together, it is that they require active participation on the part of all involved. The youngster cannot do it alone. The family cannot do it alone. Similarly, the treatment program cannot make the difference alone. In the words of the director of the Rural Adolescent Model:

> We are not here to fix families that just want to send their children here and have us fix them. We cannot do that. Both youngsters and their families must assume responsibility for the problem. We use all the skills possible to motivate the youngsters and the family to see, understand, and begin to change dysfunctional behavior.

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