Adolescent Portable Therapy (APT) for the Juvenile Justice System

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Executive Summary

Among all adolescents, those involved in the juvenile justice system are most likely to use and abuse drugs. The best available research on these troubled teenagers suggests they could occupy nearly half the beds in urban detention centers across the country. That study assessed more than 1,800 adolescents detained in Chicago. Forty-six percent met clinical criteria for substance abuse or dependence. When Vera asked these researchers to adjust their data to reflect the demographic characteristics of New York City's juvenile detention population, they estimated that 49 percent of teenagers detained here would meet the same clinical criteria. More alarming, nearly one out of every five adolescents detained here could be described as a heavy user, someone who takes drugs at least thirty times within a thirty-day period. While nearly all of these teenagers are abusing alcohol and marijuana, some take cocaine, heroin, and psychedelics.

Heavy drug use can be very harmful in the short-term and over time. It can cause or exacerbate serious physical, emotional, neurological, and developmental problems. Regardless of age, gender, or ethnicity, the more teenagers abuse drugs, the more likely they are to commit delinquent or criminal acts. Treatment can help heavy drug users change their behavior. Unfortunately, where adolescent drug abuse is most concentrated—in the juvenile justice system—there is no effective way to provide treatment. Most cities, New York included, lack a reliable way to identify heavy drug users, enough services to treat them, and the ability to sustain treatment as these adolescents move through the system and resettle in their communities.

To address flaws in the system, the Vera Institute of Justice and the New York City Department of Juvenile Justice have developed a model of portable drug treatment designed to begin treating the most serious drug abusers as soon as they enter detention and provide care without interruption. By identifying heavy users and giving detention authorities a new treatment option, Vera hopes to overcome obstacles to starting treatment at the earliest possible moment. And by creating a treatment provider with authority to follow adolescents from agency to agency and into the community, we hope to eliminate the breaks in treatment that usually coincide with these transitions.

The model combines elements of the most promising cognitive-behavioral and family-centered therapies—approaches shown to be effective with young drug abusers. Vera will test this approach in a three-year demonstration program serving approximately 130 juveniles each year. We hope to demonstrate significant reductions in substance abuse; prevent delinquent and criminal behavior; and improve the physical, mental, social, and educational well being of the adolescents we serve. Research suggests that appropriate drug treatment provided without interruption should have a positive impact on the most serious drug abusers in the juvenile justice system. Vera aims to demonstrate how that promise can be made real.

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I. The Problem and Current Responses

Drug Use Among Juveniles in the Justice System

Teenagers are more likely to experiment with drugs than they were a decade ago.[1] In a recent national survey, 22 percent of 14- and 15-year-olds admitted to using an illicit drug at least once.[2] But among all adolescents, those in the juvenile justice system are most likely to use and abuse drugs. Information collected annually on boys arrested or detained in 12 U.S. cities reveals a high rate of drug abuse among them.[3] In eight of the cities last year, approximately 60 to 70 percent of these boys tested positive for an illicit drug, usually marijuana, when they were arrested—a sizable increase over rates reported in previous years. In 1993, for example, just five of these cities reported positive test rates topping forty percent, and in only one city did it reach sixty.

New York City appears to be following the national trend. According to one recent study, 74 percent of male arrestees aged 15 to 20 tested positive for an illicit substance, usually marijuana.[4] And in another report, nearly half the 12- to 17-year-old boys and girls in state custody were found to need substance abuse services.[5]

Researchers at Northwestern University have provided the best information available about the rate and severity of drug use among juveniles in the justice system. Dr. Linda Teplin and her colleagues have assessed more than 1,800 adolescents detained in Chicago—making their study the largest to date.[6] Based on formal interviews using the Diagnostic Interview Schedule for Children and urine analysis, they determined that nearly half these young people—46 percent—met clinical criteria for substance abuse and dependence.[7]

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[1] Increases in adolescent substance use are attributed mostly to the rise in marijuana use, which from 1992 to 1997 increased 146 percent for eighth graders and 76 percent for twelfth graders. Johnston, O'Malley & Bachman, *National Survey Results on Drug Use from the Monitoring the Future Study* (Rockville, MD: National Institute on Drug Abuse, 1997).

[2] The National Household Survey on Drug Abuse, conducted annually since 1971 by the Substance Abuse and Mental Health Services Administration, is the primary source of information on the prevalence of illicit drug, alcohol, and tobacco use. The survey is based on a nationally representative sample of people 12 years and older. Substance Abuse and Mental Health Services Administration, *1998 National Household Survey on Drug Abuse.* On-line. 20 March 2000. http://www.samhsa.gov.

[3] National Institutes of Health, National Institute on Drug Abuse, *1997 Drug Use Forecasting Annual Report on Adult and Juvenile Arrestees* (Washington, D.C.: U.S. Department of Health and Human Services, 1998).

[4] National Institute of Justice, Arrestee Drug Abuse Monitoring Program (ADAM), *1998 Annual Report on Drug Use Among Adult and Juvenile Arrestees* (Washington, D.C.: U.S. Department of Justice, 1999), 56.

[5] New York State Office of Children and Family Services, *1997 Annual Report, Division of Rehabilitative Services* (Resselaer, New York: Office of Strategic Planning and Policy Development; Albany, New York: Bureau of Management Information and Evaluation Services, 1998).

[6] Linda Teplin, Ph.D., "Study of Detained Juveniles in Cook County, IL," (Preliminary results of unpublished study, Northwestern University, 1999).

[7] The American Psychiatric Association defines substance abuse as "a maladaptive pattern of substance use leading to clinically significant impairment or distress," manifested over a twelve month period by one or more of the following: (1) recurrent use resulting in failure to fulfill major obligations; (2) recurrent use in physically hazardous situations; (3) recurrent substance-related legal problems; and (4) persistent use despite continuing problems exacerbated by the effects of the substance. A diagnosis of dependence is appropriate where three or more of the following are manifested over a twelve month period: (1) increased tolerance; (2) withdrawal; (3) taking a substance in larger amounts or over a

Some kids experiment with drugs with few long-term consequences. But for teens that use regularly, drug abuse can be very harmful in the short-term and over time. It can cause or exacerbate serious emotional, physical, neurological, and developmental problems, and adolescents who use more often are likely to suffer greater damage and inflict more harm.[8] Dr. Teplin's research team found that 60 percent of the clinically diagnosed drug abusers in their study also suffered from an affective, anxiety, or disruptive behavior disorder.[9] According to the U. S. Department of Education, drug abuse can lead to withdrawal: students who use drugs are likely to view school in a negative light, neglect their homework, and avoid playing sports or volunteering in their communities.[10] They are also more likely to behave violently in school and participate in gang activity. Regardless of age, gender, or ethnicity, the more teenagers abuse drugs, the more likely they are to commit delinquent or criminal acts.[11] And kids who take drugs are more likely to use harder drugs later in life.[12]

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longer period than intended; (4) having a persistent desire or making unsuccessful efforts to cut down; (5) spending a great deal of time obtaining, using, or recovering from use; (6) giving up or reducing important activities as a result of substance use; and (7) continuing to use despite knowing the problems it causes. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition, (Washington, D.C.: American Psychiatric Association, 1994).

[8] Center for Substance Abuse Treatment, *Treatment of Adolescents With Substance Use Disorders,* Treatment Improvement Protocol (TIP) Series Number 32, DHHS Publication No. (SMA) 99-3283 (Washington, D.C.: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services, 1999), 2-5.

[9] Affective Disorders (also referred to as Mood Disorders) are characterized by a disturbance of mood that is not due to any other physical or mental disorder. Examples include mania and major depression.
Anxiety disorders are characterized by persistent anxiety and avoidance behaviors. Examples include generalized anxiety disorder, panic disorder, and obsessive-compulsive disorder. Disruptive behavior disorders involve a pattern of socially disruptive behaviors such as hostility, defiance, hyperactivity, and impulsiveness. Examples include attention deficit hyperactivity disorder, oppositional defiant disorder, and conduct disorder. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders,*Third Edition, (Washington, D.C.: American Psychiatric Association, 1994). Note: The data referenced here was collected using DSM IIIR criteria. In DSM-IIIR Disruptive Behavior disorders are a subclass of developmental disorders (disorders usually first evident in infancy, childhood, or adolescence). In DSM-IV, the class of disorders are referred to as Attention-Deficit and Disruptive Behavior Disorder. The subcategories are attention-deficit/hyperactivity disorder not otherwise specified, conduct disorder, and oppositional defiant disorder.

[10] E. Suyapa Silvia and Judy Thorne, *School-Based Drug Prevention Programs: A Longitudinal Study in Selected School Districts,* prepared for the U.S. Department of Education, Planning and Evaluation Service (Washington D.C.: U.S. Department of Education, 1997).

[11] David Huizinga, Rolf Loeber, and Terence P. Thornberry, *Urban Delinquency and Substance Abuse: Initial Findings,* research summary prepared for the U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention (Washington, D.C., 1994), 11.

[12] Sung-Yeon Kang, Stephen Magura, and Janet L. Shapiro, "Correlates of Cocaine/Crack Use among Inner-City Incarcerated Adolescents," *American Journal of Drug and Alcohol Abuse* 20, no. 4 (1994): 419. *See also* A recent door-to-door survey in Brooklyn, New York found that among inner-city youth, drug use and peer acceptance of drug use at age 15 is a very accurate predictor for later use of illicit drugs in adulthood. Peter L. Flom et al., "Adolescent Peer Norms towards Drug Use and Subsequent Drug Use in Young Adulthood in a Low-Income, Minority Urban Neighborhood" (unpublished study conducted at The National Development and Research Institutes, New York City, 1999), 14.

Although drug treatment for adolescents is a relatively new field, there is evidence that early intervention can reduce the frequency of drug use and related behaviors, and can reverse many of its negative consequences.[13] There are four main approaches to treating adolescents: twelve-step programs, cognitive behavioral therapies, family-based interventions, and therapeutic communities.[14] Each works to some degree. Regardless of the approach, teens who receive treatment do better than those who do not.[15] Research has yet to reveal, however, which methods are most effective in the long run.

Twelve-step programs modeled on Alcoholics Anonymous are the most widely used treatments for adolescents, but the effectiveness of this approach has not been adequately demonstrated.[16] Such programs view addiction as a disease that must be controlled through abstinence. An established series of steps and goals helps teenagers maintain abstinence with greater ease. Cognitive behavioral therapies view substance abuse as a learned behavior with underlying causes and cues.[17] Through individual or group counseling sessions, adolescents investigate what motivates their drug use, learn how to cope with stressful situations, and acquire new behaviors over time. Perhaps the most promising approach views family dynamics as both a cause of and a solution to the problem of adolescent drug abuse.[18] Treatment focuses on improving how family members communicate and interact.

Therapeutic communities (TCs) differ greatly from the other treatment approaches. Highly structured, long-term residential facilities, therapeutic communities traditionally ask addicts to sever all ties to their old lives—the people, places, and things associated with drug abuse—and to build new lives and personalities among their peers in treatment. Residents typically run the treatment facility; those who are further along in treatment serve as models for newer members. TCs have changed over the years and have been modified substantially to serve young drug abusers. Compared with therapeutic communities for adults, TCs for adolescents tend to be shorter and rely less on peer modeling. Even with these changes, TCs may not work for very young teens and those who are immature for their age.[19]

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[13] CSAT, *Treatment of Adolescents With Substance Use Disorders*, 2-3, 5; Center for Substance Abuse Treatment (CSAT), *Strategies for Integrating substance Abuse Treatment and the Juvenile Justice System: A Practice Guide* (Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 1999), 2-3.

[14] Janet C. Titus and Mark D.Godley, "What Research Tells Us About the Treatment of Adolescent Substance Use Disorders"(report prepared for the Governor's Conference on Substance Abuse Prevention, Intervention , and Treatment of Youth, Chicago, August 1999), 5-7.

[15] Ibid., 7.

[16] McBride, Duane C. et al., *Breaking the Cycle of Drug Use Among Juvenile Offenders*, (Washington, D.C.: U.S. Department of Justice, National Institute of Justice, 1999), 46. While youth who attend 12-step meetings after completing inpatient treatment do have higher abstinence rates than those who do not attend meetings, that may simply mean that more motivated youth are attending meetings.

[17] Titus and Godley, "What Research Tells Us About the Treatment of Adolescent Substance Use Disorders," 5-6.

[18] Ibid.,6.

[19] Ibid., 6-7; McBride et al., *Breaking the Cycle of Drug Use Among Juvenile Offenders*, 47. *See also* CSAT, *Treatment of Adolescents With Substance Use Disorders*, 10-11.

Like TCs, the other treatment approaches were developed for adult drug abusers and have been modified to meet the needs of juveniles. For example, the concept of "powerlessness" does not resonate with most teenagers, so 12-step programs for kids downplay this idea. Similarly, cognitive behavioral therapists take a more concrete and directive approach with very young or developmentally delayed adolescents. While professionals in this field understand the importance of gearing treatment to the client's developmental stage, meeting this standard is not easy.[20] People who treat teens say many concepts are still too abstract to be effective.[21] And demands for less intellectual interventions have only become more acute as younger and developmentally delayed kids enter the juvenile justice system in greater numbers.

Insufficient and Fragmented Responses by the Juvenile Justice System

Given the concentration of juvenile drug abusers in detention, these facilities are a convenient place to initiate treatment services. Unfortunately, kids who abuse drugs are rarely identified while they are detained, and few of them are treated. Beyond the mammoth tasks of assessing everyone entering detention and creating enough treatment services lies the challenge of sustaining treatment as teenagers move through the system. Too often treatment ends when juveniles are transferred to another facility or released on probation. Even if these kids enroll in another drug treatment program later on, there would be little or no continuity between that program and the treatment they received previously.

To achieve continuity requires at minimum coordinating the activities of many different agencies. In cities across the county, juveniles interact with police, prosecutors, legal aid attorneys, detention staff, judges, probation officers, and corrections officials, following different pathways through the system.[22] Representatives of foster care, mental health, welfare, and homeless agencies are also frequently involved. Because they move quickly from the custody of one agency to another, each agency's role is naturally limited, and each lacks the incentive to ensure that relevant information is collected, transferred, and acted upon. A probation officer might detect signs of substance abuse while interviewing a juvenile under arrest. But with a backlog of kids to interview and little or no information about appropriate and available treatment services, that officer cannot guarantee the problem will be addressed by a prosecutor or a judge later on. The same is true for people who staff detention centers. Moreover, if these professionals lack faith in the system's ability to respond to the problem of juvenile substance abuse, they will have little incentive even to pass on relevant information to their colleagues in other agencies.

[20] CSAT, Treatment of Adolescents With Substance Use Disorders, 10-11.
[21] Based on conversations with treatment providers working around the country.
[22] See Joseph Cocozza, Responding to the Mental Health Needs of Youth in the Juvenile Justice System (Seattle, WA: The National Coalition for the Mentally Ill in the Criminal Justice System, 1992).

Continuity is most critical—and perhaps most difficult to achieve—as kids leave secure facilities and return to the community.[23] Difficult because this move in particular nearly always triggers the transfer of control from one juvenile justice agency to another. Smoothing this transition and providing support during the crucial weeks and months after release are important for all juvenile offenders. For those who receive drug treatment in custody, these services are essential. Any gains made tend to be lost quickly without follow-up treatment services designed to continue the process begun during confinement.[24]

Attempts to Provide Continuous Care

Juvenile justice officials in some cities are attempting to address the needs of young drug abusers by changing their systems. The city of Jacksonville, Florida, collaborated with the University of Florida to develop a standardized assessment tool, which includes a section on substance abuse. Today every adolescent detained in Jacksonville receives this assessment. As a result, the city identifies substance abusers and places many of them, particularly kids with serious drug abuse problems, in treatment programs. Prior to developing the assessment tool, judges had little or no reliable information on which to base decisions about whether or not to mandate treatment.

To expand treatment and ensure continuity of care, some cities have created networks that aim to assess and treat every drug abuser who passes through the juvenile justice system. Officials in Denver, Colorado, are pioneers in this area. In 1994, the city combined its social services, youth corrections, and mental health departments to form a single agency with a central assessment center.

Using their own standardized assessment tool, they refer every adolescent with a substance abuse problem to a local treatment program. Although judges can require treatment, officials in Denver aim to direct the most severe users to the most intensive programs regardless of judicial mandate. While treatment is provided by a variety of independent programs, there are elements common among them. Each program conducts regular drug tests and submits the results of these tests, as well as periodic progress reports, to the kid's probation officer and to the court.

By consolidating government agencies, officials in Denver created a system that naturally provides continuous care as long as the teenager remains in the juvenile justice system. Kids have juvenile justice caseworkers that follow their movements through the system and their progress until they complete treatment.

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[23] CSAT, Strategies for Integrating Substance Abuse Treatment and the Juvenile Justice System: A Practice Guide, 46.
[24] David Altschuler, Troy L. Armstrong, and Doris Layton MacKenzie, "Reintegration, Supervised Release, and Intensive Aftercare," *Juvenile Justice Bulletin* (Washington, D.C.: U.S. Department of Justice, Office Justice Programs, Office of Juvenile Justice and Delinquency Prevention, July 1999), 2.

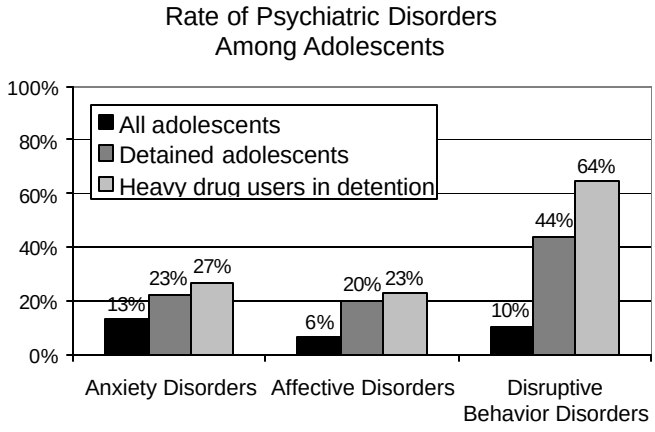
Each year approximately 5,000 kids are detained with the Department of Juvenile Justice in New York City, yet a large-scale study like the one in Chicago has never been done in New York. To get a better picture of adolescent drug abuse here, Vera asked the researchers in Chicago to adjust their data to match the age, gender, and racial make-up of New York City's juvenile detention population. According to their calculations, 49 percent of kids detained in New York City would meet clinical criteria for substance abuse or dependence. Vera also asked the researchers to count the number of very heavy drug abusers—adolescents who not only meet clinical criteria for substance abuse but who would report taking drugs thirty or more times within a thirty-day period. Based on their calculations, about 20 percent of the city's entire detention population, or 1,000 kids, are daily or very heavy users. When the Chicago researchers looked at their own data to identify heavy users, they found an incident rate similar to New York City's: 22 percent. Research on this subject suggests that the rate of heavy drug use in Chicago and New York are similar to rates in other U.S. cities.[25]

Who are the heavy users? We asked the researchers in Chicago to describe New York City's population of heavy users in detention. In terms of their gender, race, and age, heavy drug users resemble the city's overall juvenile detention population. The vast majority—more than eighty percent—are male and fifteen or younger. African-Americans make up just under two-thirds of all kids in detention and Hispanics just under a third. The information below shows the demographic breakdown of both groups.

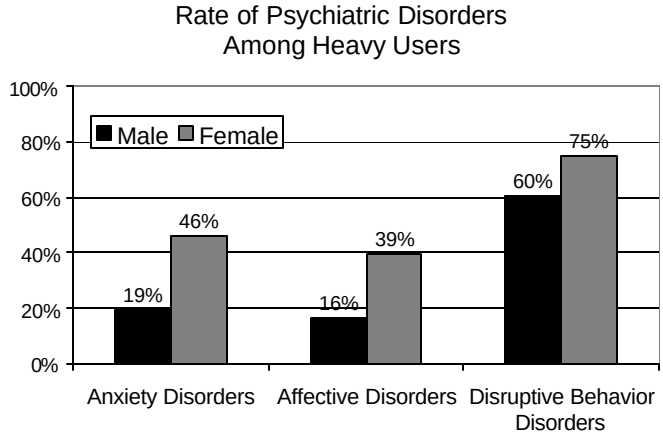
~~Heavy Users in Detention~~		~~All Detained Youth~~	
Gender		*Gender*	
Male	82%	Male	83%
Female	18%	Female	17%
Race/Ethnicity		*Race/Ethnicity*	
Black	64%	Black	63%
Hispanic	31%	Hispanic	31%
White	5%	White	4%
Other	0%	Other	2%
Ages		*Ages*	
Twelve	2%	Twelve	3%
Thirteen	8%	Thirteen	8%
Fourteen	20%	Fourteen	24%
Fifteen	50%	Fifteen	42%
Sixteen	14%	Sixteen	19%
Seventeen	6%	Seventeen	3%

While the two groups are similar in basic ways, there are a few important differences. Heavy drug users have somewhat higher rates of psychiatric disorders and are more likely to use drugs other than alcohol or marijuana. More important, among heavy users, mental health disorders and drug use patterns differ by race and gender. Those differences illustrate the range of needs among this population.

About a quarter of heavy users suffer from depression and other affective disorders. Anxiety-related mental illnesses are somewhat more common. And over half these teenagers have a history of disruptive behavior extreme enough to meet the clinical criteria for a psychiatric disorder. These rates are particularly alarming when compared to rates among the general population of adolescents, which range from six percent for affective disorders to 13 percent for anxiety disorders.

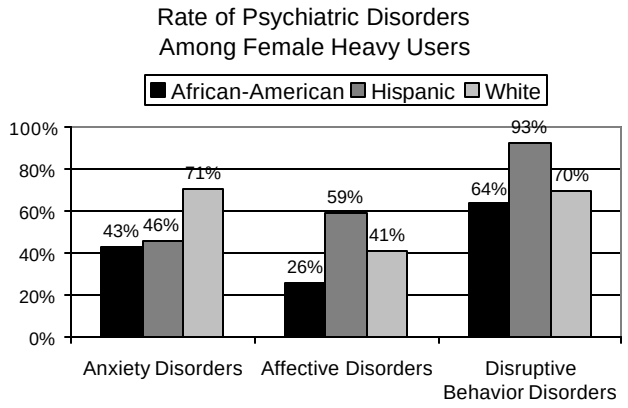


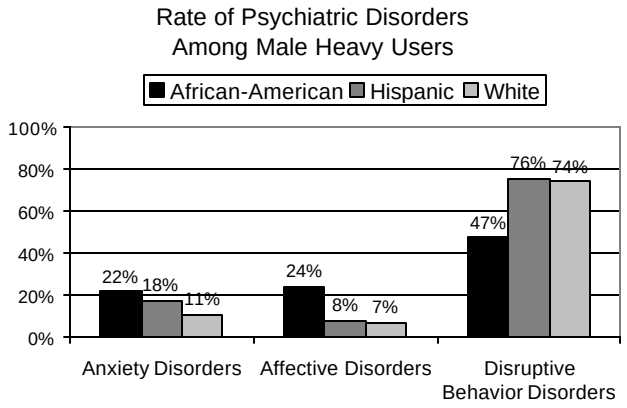
Although girls make up only 18 percent of heavy users, they are more likely than boys who use heavily to also suffer from one of the three types of mental health disorders. Seventy-five percent meet criteria for a disruptive behavior disorder, about half for an anxiety disorder, and just over a third for an affective disorder.



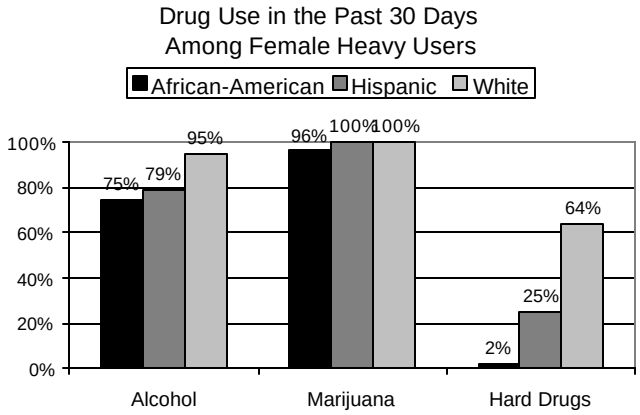
[25] *See* ADAM, *1998 Annual Report on Drug Use Among Adult and Juvenile Arrestees.* See also, Substance Abuse and Mental Health Services Administration, *1998 National Household Survey on Drug Abuse.*

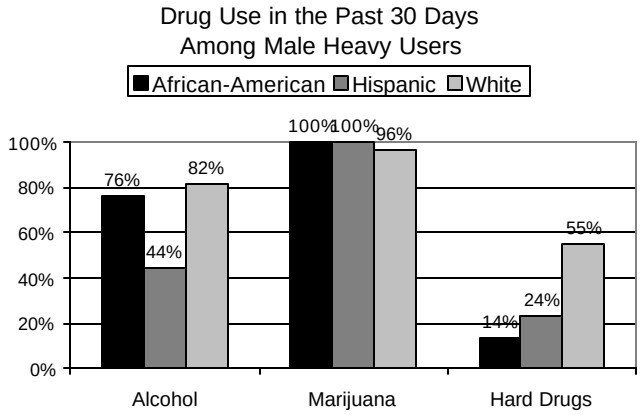
Hispanic girls are especially hard hit. Ninety-three percent meet the criteria for a disruptive behavior disorder, and just over half suffer from an affective disorder. Among boys, African-Americans have the highest rates of anxiety and affective disorders, 22 and 24 percent respectively. Hispanic and white boys, on the other hand, have very high rates of behavior disorders.





According to self-reports, use of marijuana and alcohol is very high among all heavy users, but consumption of hard drugs differs by gender and race.





More specifically, white and Hispanic kids are more likely than African-Americans to have used hard drugs such as powder cocaine, heroin, and psychedelics in the thirty days prior to their arrest, while use of crack cocaine is much higher among African-American kids.[26] Gender also plays a role. White and Hispanic girls are more likely than their male counterparts to take powder cocaine and psychedelics, but heroin use is much more common among the boys. Among African-Americans, boys are much more likely to use crack cocaine.

[26] New York City's detention population contains very few white detainees, but the Chicago data used a "weighting" method, which allowed use of a larger sample for the purpose of this analysis. Other studies, including one by the New York State Office of Alcoholism and Substance Abuse Services (cited below) confirm this trend. *See* Teplin, "Study of Detained Juveniles in Cook County, IL."

We recently supplemented the Chicago data with a small study of adolescents confined at Bridges, the intake center for juveniles entering detention in New York City. We interviewed 27 teens, using the *Global Appraisal of Individual Needs (GAIN)* and informal conversations to identify kids who use drugs and explore this behavior in the context of other mental health problems and related life experiences.[27] All but five of the kids were 15 or 16 years old at the time of the interview. Most, eighty percent, are male. Slightly more than a half are African-American, and about a fifth are Hispanic. While ours is not a representative sample and the findings are not statistically significant, the results are interesting given the scarcity of substance abuse and mental health information about kids in detention.

Of the 27 kids we interviewed, 14 met clinical criteria for substance abuse or dependence, and six of them were heavy users, kids who reported consuming alcohol or drugs at least thirty times during the month prior to their arrest, a finding which supports our prediction, based on the Chicago data, that about twenty percent of kids detained in New York City are heavy users. All six of these juveniles are boys who were fifteen at the time of the interview. Only one of them identified as white. All the heavy users said that marijuana was their favorite drug, but most of them said they had also taken other drugs, typically LSD and other hallucinogens, although never crack cocaine. “Kids don’t use crack,” one boy said, and added, “They’re scared of it.” Five of them said they had been in treatment at least once. “I want to be in treatment,” the sixth boy told us. “I’ve been trying to stop using for two years. But I want treatment with kids my own age. I don’t want to sit around a talk to a bunch of old crack heads…

Five of the six heavy users scored high on a questionnaire designed to identify physical problems, depression, suicidal and homicidal thoughts, and anxiety.[28] Two showed signs of serious Axis II psychiatric problems, such as mental retardation, paranoia, schizophrenia, borderline personality, and antisocial, histrionic, narcissistic, avoidant, dependent, and obsessive-compulsive behavior disorders. Four met clinical criteria for conduct disorder and two for attention deficit hyperactivity disorder (ADHD).[29]

How does New York City’s juvenile justice system respond to kids who abuse drugs?
Like so many cities with large juvenile justice systems, adolescents move through New York City’s system quickly, along several routes. The city has no standard procedures to identify substance abusers and not nearly enough services to treat even heavy users. The city’s detention centers function as pit stops for many kids, a home for a few days before

[27] Prior to conducting each interview we obtained consent from the juvenile and his or her parents. Most of the kids we interviewed said they felt no need to lie and believed their peers would also answer our questions honestly. We feel we generally got truthful and thoughtful answers, and that most kids enjoyed talking with us.

[28] General Mental Distress Index, part of the *Global Appraisal of Individual Needs* (GAIN).

[29] The actual rates of conduct disorder and ADHD may be higher. Some of the kids we interviewed did not have an opportunity to answer specific questions about conduct disorder and ADHD since they responded negatively to the question designed to trigger more specific questions.

they are released.[30] The impermanence of the placement has been viewed as reason not to begin treatment in detention. Unfortunately, the situation outside these holding facilities is no more advanced. The city's juvenile probation department does not routinely conduct substance abuse assessments. Even if it did, there are not enough programs to treat teens that need help. Kids who are adjudicated delinquent and placed with the New York State Office of Children and Family Services—about forty percent of all juveniles detained in New York City—receive the most comprehensive substance abuse and mental health assessments. But since the state also lacks enough treatment programs, many adolescents with serious drug abuse problems never receive treatment while they are confined. There is no process to sustain treatment for the few kids who receive it as they move from one agency to the next.

[30] The New York City Department of Juvenile Justice is responsible for initially housing juveniles accused of committing crimes while they are 15 or younger.

II. The Innovation: Early and Portable Treatment for Juveniles In the Justice System

Because juveniles in the justice system move among many agencies, the ideal drug treatment program would serve them no matter where they are in the system. In partnership with the New York City Department of Juvenile Justice, the Vera Institute has developed a model of portable care designed to begin treating the heaviest drug abusers as soon as they enter detention and provide treatment without interruption. The treatment provider will identify, track, and treat these kids as they move through the system and eventually return to the community. In particular, treatment will focus on smoothing the final transition, from custody to community, by establishing whatever longer-term supports these teens need to maintain what they achieve during treatment.

The Vera Institute will test the model in a three-year demonstration program, designed to serve approximately 130 juveniles per year. By giving detention authorities a new drug treatment option, the information they need to identify eligible participants and incentives to use the program, we hope to overcome the usual obstacles to starting treatment at the earliest possible moment. And by giving the treatment provider authority to follow kids as they move from agency to agency through the system, we hope to eliminate the breaks in treatment that usually coincide with these transitions.

Treatment will combine elements of cognitive-behavioral and family-centered therapies—both shown to help teenagers move toward drug-free lifestyles. In particular, research suggests that improving family dynamics is one of the best ways to change a kid's behavior. By building on the inherent strengths of families and communities, the program will try to gradually decrease the teen's drug use and other destructive behaviors, and move the entire family toward establishing healthier communication patterns and interactions. We will standardize and document our methods so that others can use them in the future.

We hope that portable treatment will demonstrate significant reductions in substance abuse and recidivism, and improve the physical, mental, social, and educational well being of the kids and families we serve. Research and current wisdom suggest that appropriate drug treatment provided without interruption should have a positive impact on the most serious drug abusers in the juvenile justice system.[31] We aim to demonstrate how that promise can be made real.

[31] Titus and Godley, "What Research Tells Us About the Treatment of Adolescent Substance Use Disorders," 7. *See also*, Altschuler, Armstrong, and MacKenzie, "Reintegration, Supervised Release, and Intensive Aftercare," 2.

III. Design of the Demonstration

We plan to operate and evaluate a short-term, intensive drug treatment program, one that provides uninterrupted care as kids move through the juvenile justice system. The program will use a two-step process to identify heavy users. We will screen juveniles within hours after they enter a New York City detention facility, and those who show signs of substance abuse will receive a more comprehensive assessment within a few days. Kids who meet the program's criteria of heavy drug abuse and agree to participate in treatment will be randomly assigned to the program or to a control group. We expect to complete the process of screening, assessing, and enrolling eligible adolescents within a week after they enter detention.

Kids who enter the program will receive treatment in three phases. The first phase will occur while they are in custody, either in a city detention facility or in a state-run institution for juveniles. The second phase, which features intensive individual and family counseling, will begin immediately before kids are released from custody and will continue for several months after they return home. The final phase will conclude the treatment process and establish any long-term community support necessary to maintain the gains made in treatment.

Identifying and Enrolling Adolescents

The initial screen. In New York City, as in most juvenile justice systems, kids entering detention go through a series of interviews. Staff of the detention facility record basic information, and a nurse conducts a brief medical exam. If the teen remains at the facility beyond a day, detention staff will conduct a more in-depth assessment. The initial screening for participation in the program will occur during the medical exam. The nurse will ask each adolescent a few brief questions extrapolated from the Global Appraisal of Individual Needs (GAIN).[32] This quick interview will enable us to begin identifying heavy users at the earliest moment possible but without disrupting detention intake procedures. The screen will have a relatively low threshold: we believe it will flag about half the juveniles entering detention. The results of the screening will be confidential and, therefore, will not be shared with juvenile prosecutors or with police.

An assessment of severity. During the first year of the demonstration, detention staff will provide the program with a daily list of everyone who passes the initial screen. Eventually, we will be able to access this information electronically. Program staff will then interview as many of these kids as possible within three days. That time frame is important because, according to the New York City Department of Juvenile Justice, about a third of the juveniles they detain are released within three days. The questionnaire used

[32] The GAIN is a standardized psychosocial assessment designed to detect substance abuse and to track changes in substance use over time. Michael L Dennis, *Overview of the Global Appraisal of Individual Needs,* (Bloomington, IL: Chestnut Health Systems, 2000).

to measure severity also will be adapted from the GAIN, changed to meet the needs of the program. The GAIN contains sections on mental health, substance abuse, family issues, school, peers, and physical health. It asks detailed questions about drug use patterns and symptoms of drug abuse and dependency. Each interview will take approximately an hour. At that time, we will also review the detention intake file and attempt to verify contact information for the teenager's parent or guardian.

Enrolling kids in the program. Detained juveniles who are identified as heavy substance abusers are eligible to participate if they agree and their parents or guardians provide written consent. We may also enroll kids who are required by judges to complete a treatment program. While we are not designing an alternative to incarceration, judges may be more inclined to release participants headed for an intensive treatment program, and a judicial mandate would ensure the participation of less willing adolescents. We will work with the New York City Family Court to make use of this option without being pushed to enroll kids who do not meet the program's eligibility criteria.

Although about 1,000 detained juveniles would qualify for the program each year, some of them will be released before we have an opportunity to identify them through the assessment process. And we expect to lose other eligible participants within the first week or so if we cannot secure parental consent prior to their release. We anticipate being left with a pool of approximately 300 detained juveniles, from which we will randomly select about 130 participants.

Eligible kids who are not selected for the program will form a control group used to evaluate the demonstration. Since city and state juvenile justice agencies provide very few drug treatment services, we expect few people in the control group to receive any treatment at all. If the number of eligible participants is not large enough to support a control group, we will compare participants with juveniles who did not agree to participate in the program or whose parents did not provide consent, accounting for this difference in our evaluation.

Our conversations with juveniles detained at Bridges suggest that the treatment program will interest many kids. Generally, these kids told us that they desperately want productive ways to spend their free time: "Kids need something to do. There's nowhere to go. There's one park, but it's all beat up. There's no jobs." "Kids are bored. I wish I could be in Job Corps or something. Maybe a basketball league." And many of the kids who say they use drugs recognize the problems it causes and the benefits of treatment: "Most of the time when I'm doing crimes, I'm high. [Treatment] would stop me from smoking weed or help me cut down." "Treatment helps me think positive about myself." And the kids we met typically were eager to share their life experiences, feelings, and opinions with the adults who were interviewing them.

Obtaining parental consent will be a challenge. Parents are often difficult to contact, either because they lack phone service or because their contact information is missing from detention files. Once we reach them, they are likely to be upset and confused about their child's legal status, whereabouts, and what they should do. While intake staff and

counselors must understand their distress and reassure them that ours is a voluntary, beneficial program, not a punishment, our conversations with parents of detained juveniles suggest that the program will appeal to many of them precisely because they often feel powerless to respond adequately and have so few options. James has been raising Jamal and his younger siblings for five years, and caring for them alone since his wife died. When we met James, he was overwhelmed by an inability to help his 14-year-old grandson quit using drugs and to respond to the immediate crisis of Jamal's detention. James does not know where the detention center is and, even if he did, says no one is available to watch over Jamal's younger siblings in his absence.

The Treatment Model

Treatment for this group of heavy drug users will incorporate elements of the most promising interventions operating today—approaches that feature cognitive behavioral therapies and a focus on family dynamics. Counselors will help these kids identify situations, particularly within their peer groups and families, that prompt substance abuse. Once teens have a better understanding of what triggers their drug use, the counselors can help them develop healthier ways of coping with and responding to these situations.

When negative family dynamics contribute to a pattern of substance abuse, changing these interactions should be part of solving the problem. Treatment providers and researchers agree that involving family members in drug treatment for kids is valuable.[33] Several treatment models, including multidimensional therapy, brief strategic/structural family therapy, and multisystemic therapy, focus on the web of relationships that defines a family and on building strength within families to reduce drug abuse.[34] Among these models, multisystemic therapy (MST) has been most rigorously evaluated and has shown some success in treating substance abuse.[35] Developed to address anti-social and violent behavior among kids, MST is delivered primarily in the home. Family members collaborate with each other and with the therapist to design a treatment plan, which usually involves drawing some support from school and community resources. The ultimate goal is to help the family create a home environment that promotes the healthy development of the child.[36]

While we will not adopt MST as our treatment approach, we will use a strengths-based approach with families and in individual therapy. We also will use culturally

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[33] CSAT, *Treatment of Adolescents With Substance Use Disorders*, 55-56. *See also*, CSAT, *Strategies for Integrating Substance Abuse Treatment and the Juvenile Justice System: A Practice Guide, 9. See also*, McBride et al., *Breaking the Cycle of Drug Use Among Juvenile Offender*, 50-51, 65.

[34] McBride et al., *Breaking the Cycle of Drug Use Among Juvenile Offenders*, 51-52. *See also*, Howard Liddle and Cynthia Rowe, "Multidimensional Family Therapy for Adolescent Drug Abuse," in *Addictions Newsletter*, American Psychological Association, Division 50, Special Issue: Diversity in Addiction Treatment, Volume 7, No. 2, (Spring 2000). *See also*, Michael S. Robbins and Jose Szapocznik, Office of Juvenile Justice and Delinquency Prevention, Juvenile Justice Bulletin, *Brief Strategic Family Therapy*, (Justice Department, April 2000). *See also*, Henggeler et al., Center for the Study and Prevention of Violence, *Blueprints for Violence Prevention: Book Six Multisystemic Therapy*.

[35] McBride et al., *Breaking the Cycle of Drug Use Among Juvenile Offenders*, 51-52.

[36] Henggeler et al., Center for the Study and Prevention of Violence, *Blueprints for Violence Prevention: Book Six Multisystemic Therapy*, 7-8.

sensitive interventions to engage these families. Tailoring treatment to the client's culture facilitates the treatment process and, ultimately, makes success more likely.[37] About a third of the adolescents in our program will be Hispanic. Their language and the cultural norms of their families will influence how we provide treatment.

We will assess each child individually and develop a treatment plan based on his or her strengths and needs. Each plan will address the four life areas that influence substance abuse: family, peers, school, and community support.[38] In addition, we will look for and address any mental health problems that may be causing or exacerbating substance abuse. Many of the kids in the program will have at least one mental health disorder in addition to a diagnosis of substance abuse and dependence. Different disorders will demand different approaches: a 14-year-old girl with a history of physical abuse who suffers from post-traumatic stress disorder, for example, will need a different treatment plan than a 13-year-old boy with attention deficit disorder.

While these therapeutic methods will be familiar to the treatment community, our core innovation lies in delivering continuous care, treating kids wherever they are—in detention, in a juvenile corrections facility, at home, or in the program's offices. Treatment will begin while kids are detained and will continue for four to five months after they return home—until they are fully resettled in their communities. (A diagram showing how kids will progress through both New York City's juvenile justice system and the program is attached as an Appendix.)

Providing Continuous Care in Phases

To effectively serve kids as they move through the justice system, the program will deliver treatment in three phases. Within each phase, the program will increase or reduce contact depending on the juvenile's progress.[39]

Phase One (Duration: Up to One Year)

As soon as kids agree to participate in the program—and their parents provide written consent—they will be assigned a counselor who will meet with them within two days. The counselor will have six priorities:

Build trust with the adolescent. The counselor will begin to gain the adolescent's trust by demonstrating an interest in his or her well-being, getting to know him or her through individual therapy sessions, reliably providing information about substance abuse and other concerns, and demonstrating an understanding of the issues the adolescent faces. This will not happen quickly but gradually, over time.

Establish a relationship with the adolescent's family or caretaker. The counselor will work with the adolescent to decide which family members to engage in the treatment

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[37] CSAT, *Strategies for Integrating Substance Abuse Treatment and the Juvenile Justice System: A Practice Guide,* 23.

[38] Adolescents who have friends that abuse drugs are more likely to use and abuse drugs themselves. *See* Flom et. al., 2, 14-16. *See also* Silvia and Thorne, *School-Based Drug Prevention Programs: A Longitudinal Study in Selected School Districts,* 16.

[39] American Society of Addiction Medicine (ASAM) guidelines require that programs provide care along a continuum and that treatment be no more intensive than is necessary.

process. If there are no appropriate family members to involve, the counselor will work with the participant to identify another supportive adult, such as a family friend or a foster parent. The adult does not need to live in the same household as the child but should be willing to commit a significant amount of time to the treatment process and serve as a positive role model. As soon as possible, the counselor will arrange a meeting with this adult to explore the family's strengths and weaknesses and schedule a family session at the detention facility. If no adult is available and willing to fulfill this role, the counselor will engage in more intensive cognitive behavioral therapy with the adolescent.

Gather relevant information. Counselors will gather information about the adolescent's living situation and family composition; social network, including any gang membership; medical and psychiatric history; school attendance and performance; any recent traumas, such as the death of a family member or divorce; and involvement with any other government agencies.

Identify urgent needs. The assessment required for entry into the program will identify most major medical and mental health conditions that could impede treatment, including traumatic stress disorder, attention deficit disorder, conduct disorders, and chronic pain-related diseases.[40] But the counselor will also work closely with detention center staff to quickly identify needs that were overlooked during the assessment. These on-site counselors spend a great deal of time with kids and should be able to help us identify their many problems and needs. In addition, we will engage a psychiatrist affiliated with a local medical center to help assess and find appropriate treatment for adolescents who have more serious mental health disorders.

Begin educating adolescents about substance abuse. Individually and in groups, counselors will discuss the physiological effects of drugs, the long-term consequences of drug abuse, and strategies for coping with peers who use drugs. Providing such information in a group setting will also facilitate future group therapy sessions.

Start formulating a treatment plan and begin treatment sessions. Assuming that the adolescent remains in detention more than a few days, therapy will begin during phase one. The counselor will begin forming a treatment plan based on information he or she has collected. While adolescents are in custody, program counselors will see them about twice a week, depending on each adolescent's needs. Some of these sessions may occur in groups, and family members will participate occasionally.

Phase one will continue as long as the adolescent remains in custody—it could last a little as a few days or as long as a year. If the adolescent is released quickly, the counselor will complete any tasks remaining from phase one in the second phase. Because of the brief duration of the demonstration project, we will not continue to treat kids who are placed in state-run juvenile facilities for longer than a year. We will inform

[40] CSAT, *Treatment of Adolescents With Substance Use Disorders*, 69. Addressing physical and mental health issues will be critical to the success of an intervention. In our site visits to adolescent treatment programs around the country this was a common theme. Treatment providers emphasized that physical health problems as simple as painful dental problems are often ignored in substance abuse treatment settings although they can have a profound impact on the behavior of the client.

staff of the Pyramid Reception Center, who assess teens headed for state institutions, that these kids have an acute need for drug treatment.

In addition, adolescents who remain in city detention centers for more than thirty days will receive less intensive treatment services. This is a logical move and the right moment to make it since kids who are detained in New York City for thirty days are much more likely to spend months or even years in confinement. Since much of the activity in phase one is focused on developing a treatment plan based on the teenager's life in the community, it makes sense to step down treatment services until release is imminent.

Phase Two (Duration: Four - Five Months)

If we know the release date in advance, this phase will begin one to two weeks before the adolescent leaves the facility. Otherwise, it will begin as soon as the juvenile returns home. The focus of the second phase is on smoothing the transition from custody to community. Treatment will be most intensive during this phase because the months following release are critical ones—both for continuing progress made while the teen was in custody and for ensuring long-term recovery and stability in the community.[41] The counselor will have three priorities:

Engage the adolescent and his or her family in intensive counseling. In preparation for release and until the adolescent is stabilized at home and in the community, he or she will have daily contact with a counselor. The counselor will schedule two to three formal therapy sessions per week, some involving family members, and will have less formal contact with the adolescent in between sessions—perhaps dropping by the home or meeting briefly at the program's offices.

Unless the adolescent is released from detention very quickly, the counselor will have developed a treatment plan based on what he or she learned about the teen and his or her family during phase one. Counselors will use cognitive behavioral techniques, particularly during individual sessions with the adolescent. If the teenager has episodes of volatile behavior or impulsiveness, for example, the counselor will help the adolescent explore what triggers those incidents, and how to better manage his or her responses. Not all kids, particularly younger ones and those who are developmentally delayed, will be naturally introspective and able to analyze and adjust their behavior. Counselors will tailor treatment to the developmental level of the juvenile; using more concrete language and providing more direction for those who need it.[42] As therapy delves deeper into problem areas, counselors will use role-playing techniques to offer opportunities for the adolescent and family members to test new behaviors and ways of interacting. Role-playing, with feedback from the counselor, is an especially effective way to improve family dynamics—a key to resolving substance abuse problems.

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[41] Altschuler, Armstrong, and MacKenzie, "Reintegration, Supervised Release, and Intensive Aftercare," 2.

[42] Henggeler, Scott W. et al., *Multisystemic Treatment of Antisocial Behavior in Children and Adolescents* (New York: Guilford Press, 1998), 37-38. *See also* CSAT, *Strategies for Integrating Substance Abuse Treatment and the Juvenile Justice System: A Practice Guide,* 20-21.

Address urgent needs identified during phase one. Many adolescents will have urgent needs beyond the scope of what the program can provide. In addition to beginning treatment, counselors will help these kids locate and access appropriate services in their communities. For example, counselors will help teens with serious mental health problems find the therapeutic care they need—care that will complement, not replace, drug treatment.

Build a community network. In the weeks before and after the adolescent leaves custody, the level of contact between the counselor, teen, and the agencies involved in discharge planning and reintegration will be intense. In particular, the counselor will establish close contact with point people in the department of probation, in schools, and, in some cases, in the city child welfare agency. Together, they will develop plans to successfully resettle the adolescent in the community.

Many kids in the program will be on probation at some point during treatment. We plan to establish procedures for maintaining regular contact with each teenager's probation officer. While we cannot share privileged information gathered during treatment, we will try to explain whatever efforts the adolescent is making to change his or her behavior, and we hope the probation officer will share his or her views about the teen's problems and needs. Through regular communication we hope to maximize each other's impact without duplicating services.

Getting kids back in school will be a priority. The counselor will help the adolescent and family determine whether it is possible and desirable for the teenager to return to the same school. If not, the counselor will help the family find another school willing to enroll the adolescent. In either case, the counselor will meet with school administrators and review the participant's educational records in order to develop a plan designed to keep the teenager advancing in school. The counselor will continue to communicate regularly with school officials to monitor the student's progress and help resolve any problems that may arise. The return to school is a crucial and stressful transition, one that will be particularly difficult and time consuming to negotiate successfully for teens who have been absent from school for long periods or who have performed very poorly in school. In such cases, counselors may need to arrange for the adolescent to receive remedial services.

If a participant is in foster care, the counselor will maintain regular contact with caseworkers at the New York City Administration for Children's Services, with staff of any private agency responsible for the adolescent, and with any foster parents. Essentially, the counselor will help the adolescent prepare either to return to the same placement or move to a new home. Both carry stresses that will affect treatment and thus need to be addressed.

Phase Three (Duration: One – Two Months)

This phase begins the discharge process, in which treatment is completed and kids are settled in the community with the ongoing support they need to use skills acquired in treatment. Counselors will have two priorities:

Solidify gains made in treatment. At this point the adolescent should be in school full-time and be drug free. The goal is to affirm the teenager's and the entire family's strengths and discuss how they can maintain what they have gained during treatment and continue improving their lives. Solidifying family support is crucial as the counselor prepares to terminate treatment.

Ensure connections with community social service agencies. Connecting kids and families to permanent community services that can help them maintain stability is a vital part of concluding treatment and ensuring the adolescent's and family's success over time.[43] The program will work with the adolescent and family to ensure that appropriate support services, such as mental health counseling, educational assistance, and mentoring, are in place before treatment ends and that the family is committed to using these services. Where there are barriers to accessing needed services, the counselor will help the family remove these blocks or seek alternative services. Counselors will aim to connect every participant to at least one community agency, so that kids leave the program with at least one source of support beyond their families and the government agencies responsible for their care and supervision.

Challenges to Providing Continuous Care

Providing drug treatment to kids as they move through the juvenile justice system is the primary goal of our program. Just keeping track of these movements will be a challenge. Even before kids leave the custody of the New York City Department of Juvenile Justice, for example, they are often moved among its detention facilities. Program staff will stay in close contact with officials at the department in order to know where participants are on a given day.

Beyond tracking lies the separate challenge of delivering quality drug treatment to teenagers living in detention centers. Gaining entry to and maneuvering around a secure facility can be a time-consuming and frustrating experience. Access is strictly controlled at all times. In this environment, it also will be difficult for counselors to forge trusting relationships with kids. Overcoming these challenges will require close working relationships between the program's counselors and detention staff.

Most kids return home when they leave detention, but many others are transferred to state-run juvenile facilities. These institutional settings present some of the same barriers to effective treatment as the city's detention centers. And the remote locations of many of them make it even more difficult for counselors to provide consistent treatment while the juvenile is confined. Although we will not continue to treat kids who are placed in state-run facilities for more than a year, it will be important to forge strong relationships with kids who will be released so they will want to continue receiving treatment in the community.

Release creates another set of challenges. Participants will be even more difficult to track once they return to the community, and scheduling appointments will be more

[43] Altschuler, Armstrong, and MacKenzie, *Reintegration, Supervised Release, and Intensive Aftercare,* 2, 11.

complicated. Program staff will need to be flexible and persistent in their efforts to maintain contact and continue treatment in a variety of natural settings.

Because we aim to serve kids as they pass through various agencies, public and private, it will be critical to reach out to all of them. City and state juvenile justice agencies are our natural partners, but we will also enlist the support of other organizations affected by our program. Most kids in the program will have a Legal Aid attorney, who must understand the purpose and benefits of the program and feel assured that we respect the rights of their clients. Similarly, we must reach out to juvenile prosecutors assigned to these cases. Working with the Administration for Children's Services and the Board of Education will be just as important. Finally, we will involve community agencies that can provide crucial services to these adolescents and families while they are in treatment and after treatment ends. If the program's offices are located in a residential area, it will also be important to gain the support of community and local authorities. Only by creating such alliances will the program be able to fulfill its mission.

Staffing and Siting the Demonstration

The program director will oversee all substantive and administrative functions and will manage relationships with the program's partners inside government and throughout the community. An intake supervisor will conduct many of the assessments at the city's detention centers. A clinical director will head the counseling staff. A senior clinical supervisor will help oversee the other six counselors. Trained, experienced, masters-level counselors will fill each of the counseling positions. Support staff will perform administrative tasks. In addition, we will engage a psychiatrist affiliated with a New York City medical center as a consultant to help us assess and find appropriate treatment for adolescents who have serious mental health problems. We are currently developing an electronic application of the assessment instrument and case management software—tools that will help program staff track information about participants, making their work more efficient and organizing the data needed to evaluate the program.

The planning of this program has been guided by a national advisory board made up of researchers, public policy experts, and drug treatment providers, as well as representatives from federal, state, and local government agencies with an interest in the program. The board will be expanded once the demonstration is fully funded. The board and program staff will meet twice a year to discuss major operational issues, and staff will consult with individual board members throughout the year.

The program will have offices in at least one location in New York City, equipped with private rooms where counselors can meet with kids as well as office space for staff. Since counselors will also treat adolescents while they are detained, the program will have small offices or some type of designated space in each of the city's detention centers and in each state-run facility. Treatment will also take place in peoples' homes and perhaps in schools and community centers, and it will occur during normal business hours as well as in the evening and on weekends.

IV. Evaluating the Demonstration

Members of the Vera Institute's research department will evaluate the Portable Drug Treatment Program. Their evaluation will have two components. The first is an implementation study, gauging to what extent the program remains faithful to the original design, documenting any design changes, and exploring obstacles that impede the functioning and full implementation of the program. The second is an impact study, assessing the program's effects on juvenile substance use, antisocial behavior, and mental health.

The Implementation Evaluation

The implementation evaluation will focus on recruitment, retention, and service delivery, answering the following questions:

Did the program recruit, enroll, and retain as many teens as expected? Recruitment and retention data provide important information about the program's long-term feasibility. The research will document whether the program achieves its intake and retention goals, and obstacles to meeting those numbers and expanding them in the future. Relying mainly on information collected during the screening process, the study will determine if kids in the program are representative of all heavy users detained in New York City—documenting any age, race, gender, drug use, and mental health differences between kids who enroll and remain in the program and those who do not participate or drop out. The researchers will also look for groups who are underrepresented and try to explain why the program is not reaching and retaining these kids. If Hispanic teens were underrepresented, for example, the researchers would investigate whether the program lacks the language and other cultural skills needed to work with them and their families.

Because the program treats teens over time, the researchers will calculate several retention rates. The most important is the percentage of kids who complete treatment. A series of interim rates will identify phases of the treatment process associated with particularly high and low attrition rates. The researchers will also collect and analyze any available information about the reasons kids drop out, so that program staff can improve retention rates in the future.

There are many reasons for low or unrepresentative recruitment and retention that can not be explained merely by looking at data on participants. Information contained in case notes and administrative records and conversations with staff, government officials, and kids will help the researchers understand the dynamics underlying the program's recruitment and retention rates. Additionally, during the program's start-up phases, program staff, researchers, and juvenile justice officials will identify some likely barriers to full recruitment and retention—such as insufficient access to records or trouble remaining in contact with families—and develop plans to overcome them.

Did the program deliver services as planned and successfully treat kids without interruption as they moved through the juvenile justice system and into the community? Relying mainly on information stored in the program's computerized case management system, the researchers will document the services kids receive and how often they receive services—comparing what the program actually provides with the treatment model outlined in this document and with the program's more detailed treatment manual. Counselors will record in the case management system every attempt, successful and not, to contact kids and their parents. Immediately after each counseling session or meeting, they will use an electronic checklist to record the services they provided, including an explanation whenever they fail to provide a required service. They will also enter information describing the nature of the contact. Senior staff periodically will review these electronic logs and case notes for completeness and accuracy.

The researchers will also collect and analyze data stored in the project's administrative records, particularly information about staff. Because the program aims to provide intensive counseling, adequate staffing is a priority. The implementation study will document the number of counselors hired and their educational and professional credentials, staff-to-participant ratios, participation in staff training sessions, and how long people remain employed by the program.

Senior researcher and program staff will collaborate closely to ensure that the data collection and analysis supports both the implementation study and internal efforts to manage the program. In periodic reports, the researchers will compare current findings with previous data to monitor changes in recruitment, retention, and service delivery and give staff an opportunity to adapt practices as needed.

The Impact Evaluation

The impact evaluation will measure the program's effectiveness, guided by a different set of questions:

- *Does the program reduce substance abuse and recidivism among kids who participate? Does it improve their mental and physical health, school attendance and performance, social functioning, and family dynamics?*
- *Do all kids and families benefit equally, and in the same ways, or does the program affect adolescents differently?*
- *When kids do improve, do they improve steadily or in spurts at specific moments during treatment? Are there benefits that emerge only after treatment ends?*
- *Does the program have lasting effects?*
- *How can the results of this experiment guide other programs aiming to improve the lives of juveniles with serious substance abuse problems?*

We hope to employ an experimental design to answer these questions. Eligible adolescents would be randomly assigned to either the program or a control group. We

expect to have access to three hundred kids each year and to serve roughly half this number. This will allow the researchers to create a control group of about the same size to test the treatment program. Kids in the control group will not necessarily be denied drug treatment. Rather, they will receive whatever assistance the juvenile justice system normally would offer.[44] Realistically, that often will mean no treatment, particularly while kids are in custody.

If we are not able to recruit at least 260 kids per year, an experimental design will not be feasible. In that case, the researchers will identify a comparison group, most likely detained juveniles who meet our criteria but are released before we get consent. Even without a control or comparison group, we will be able to gauge the impact of the program by monitoring changes over time in the kids who participate. Regular assessments are an integral part of the program, making this assessment strategy more feasible and powerful than simple pre-post comparisons.

If the number of eligible kids allows it, the researchers will over sample girls. The ability to make meaningful comparisons between boys and girls is important because their needs and experiences differ markedly. Patterns of drug use vary according to gender, and girls are more likely than boys to suffer from mental health problems, especially anxiety and affective disorders. Moreover, some studies suggest that antisocial behavior among girls is becoming more common, adding urgency to understanding their problems, needs, and responses to interventions. We hope to recruit enough girls to make up a third of the total sample. Girls make up only 18 percent of heavy drug users in detention. Without over sampling, there would be only 94 girls—distributed evenly among the treatment and control groups—among the 520 adolescents we expect to recruit in the first two years, a number is too small to support reliable statistical comparisons.

The principal source of data for the impact study will be kids' responses to the *Global Appraisal of Individual Needs* (GAIN), supplemented by interviews with parents, other caregivers, and program staff, as well as review of case notes. The GAIN covers past and current substance use in great detail and provides equally comprehensive inquiries into other life areas of concern to the program. Additionally, the GAIN provides information on potentially stressful situations that can affect treatment, such as family members' substance use and criminal activity, housing, family income, physical disabilities, and pregnancy.

There are two versions of the GAIN—the GAIN-Initial (GAIN-I) and the GAIN-Monitoring 90 Days (GAIN-M90). As previously discussed, we will use the GAIN-I, the full assessment, to screen potential participants, and this information will generate baseline data for the impact analysis. Certified counselors who are thoroughly trained in the proper administration of the GAIN will conduct these interviews. Researchers who are trained in the administration of the GAIN-M90, and ideally have some experience working with substance-abusing adolescents, will conduct follow-up interviews every 90

[44] Kids in both the treatment and control groups will receive written information (available in English and Spanish) describing resources in New York City for adolescents with substance use problems. This information will be provided after the first full administration of the GAIN.

days during treatment and every six months for one year after treatment ends. As an incentive to continue participating in the evaluation, and to convey our appreciation for their time, kids in both the treatment and control groups who have been released from detention will receive 25 dollars for each completed GAIN.[45]

The researchers will validate kids' reports of substance use and other problems by interviewing their families, perhaps using the Collateral Assessment Form for Intake (CAF-I) and the CAF-F for follow-up, both sister instruments of the GAIN. Additionally, we will work with juvenile justice officials to develop a plan to integrate drug testing into the program and research process.

Using the Circumplex Model of Marital and Family Systems (also known as FACES) developed by David H. Olson and colleagues to interview kids and parents, the researchers will learn whether these families are becoming more cohesive and adaptable, and whether their communications and interactions have improved. School administrative records will supplement self- and parental reports on school attendance and performance. Finally, the researchers will track information about subsequent arrests and detention using data from the New York City Department of Juvenile Justice and the New York State Division of Criminal Justice Services.

The researchers will score kids' changes in substance abuse and related life areas: positive scores indicating improvement; negative ones signaling changes for the worse; and scores of zero denoting no change. Using data gathered from kids before they enter treatment or the control group, the researchers will identify any significant baseline differences between kids who receive treatment and those who do not, as well as differences among kids treated. Using multiple regression analyses, the researchers will determine to what extent specific improvements are the result of taking part in the program. At the same time, they will examine other factors that might mediate the program's impact—in particular, age, ethnicity, and gender. They will also look at the influence of less obvious factors, such as a family member's substance abuse. Additionally, the researchers will measure how outcomes vary according to the amount of time kids spend in the program and will use interim scores to assess patterns of improvement or decline during treatment.

Staff

The principal investigator has a doctorate in social welfare and a master's in public health, and more than ten years of related experience. She will assume full responsibility for directing the research, ensuring its timely completion, and supervising all other research staff. We will hire a research associate—either a Ph.D. candidate with some training and experience in research methods or a new Ph.D.—to oversee data collection and quality control and generate statistical measures under the supervision of the principal investigator. We will also hire two full-time research assistants to schedule and help conduct the GAIN interviews and to maintain the database.

[45] The New York City Department of Juvenile Justice prohibits making payments to kids who are in detention.

Reports

The research staff will submit progress reports every six months. The second report, to be submitted at the end of the first year, will include an initial assessment of the program's implementation and the first information on outcomes. Both second-year progress reports will include additional information about implementation and outcomes.

Starting in the third year, the progress reports will include findings from the impact study. The final report, to be submitted at the end of the third year, will describe the evaluation in full, incorporating findings from both the implementation and impact studies. This report will also describe the research procedures and data analysis and discuss implications of the findings for this program and others.