Bridging the Gap:
A Guide to Drug Treatment in the Juvenile Justice System
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More than two million youth are charged with delinquency offenses each year. Most of them are age 15 or younger and have serious problems with drugs and alcohol. Many also have mental and physical health problems, dysfunctional families, learning disabilities and school failure. Without effective treatment, the majority of these juveniles will not be able to break the cycle of delinquency and substance abuse.

Recent research on adolescent brain development has particular relevance in the context of treatment delivery. Adolescence is a period of rapid change involving major behavioral and cognitive transitions as well as important physiological developments. Exposure to alcohol and other drugs may alter critical ongoing processes of brain development. The developing adolescent brain may also be particularly vulnerable to alcohol and other drugs. Clinical evidence shows that stress is more strongly associated with drinking in adolescents and that adolescents are more likely to engage in higher rates of binge drinking than adults. Adolescents may also be at higher risk of relapse after treatment.

Drug treatment is scarce for adolescents in this country. The National Survey on Drug Use and Health reports that 1.1 million youths ages 12-17 needed treatment for an illicit drug problem in 2003, but only one in ten actually received help. Treatment is even less available for adolescents in the juvenile justice system. A 2004 study by the National Center on Addiction and Substance Abuse estimated that fewer than three percent of juveniles arrested who have substance abuse problems receive treatment.

Why is drug treatment so scarce for juvenile offenders when the need is so great? The fundamental reality is that youth with substance abuse problems have generally been overlooked. Relatively few drug treatment programs are designed specifically for adolescents. In the juvenile justice system, drug treatment is often not available despite the fact that three in four juveniles arrested annually are substance abusers.

**Bridging the Gap: A Guide to Drug Treatment in the Juvenile Justice System** provides a framework for understanding what we have learned about drug treatment for adolescents in the juvenile justice system. Drug Strategies was guided by a distinguished advisory panel of nationally recognized experts, whose names are listed on the inside back cover. The panel included leading academics, clinical researchers, treatment providers and juvenile justice experts. We are grateful for the time they have given to this important effort as well as for their insights and their wisdom.

Working closely with the panel, Drug Strategies undertook a comprehensive review of program elements that research and practice suggest are critically important in treating juvenile offenders. Lengthy structured interviews with panel members helped identify key elements and examined central issues related to drug treatment in the juvenile justice system. The Expert Advisory Panel met in Washington, D.C., on October 27, 2004 to discuss the content of **Bridging the Gap** and the selection of key elements. After extensive further communication, consensus was reached on eleven key elements that the panel believes contribute to effective treatment of youthful offenders. **Bridging the Gap** discusses each of these elements and describes various programs and approaches that illustrate how the elements apply in practice.

This report builds on Drug Strategies’ earlier work in **Treating Teens: A Guide to Adolescent Drug Programs** (2003) that identifies nine key elements of effective adolescent drug treatment. In the juvenile justice system, these nine elements still apply. In addition, the panel identified two new elements of particular importance: first, the recognition that juvenile offenders are much more likely than other youth to have co-occurring disorders and multiple problems that must be addressed; and second, the need to integrate the many different agencies and systems involved in providing treatment to juveniles and to improve collaboration between juvenile justice officials and treatment providers.

A complete list of sources and additional materials are available on the Drug Strategies website at www.drugstrategies.org
By 1945, separate juvenile courts existed in every state and the District of Columbia. Today there are 51 different juvenile court systems and no common standards of practice or accountability nationwide. During much of the 20th century, juvenile justice systems acted to protect and rehabilitate young offenders and juvenile court judges had ultimate discretion. The constitutional guarantees of the adult criminal system, such as the right to counsel and trial by jury, were not formally available to juveniles. Although the original intent of the juvenile court concept was to provide guidance and treatment, punishments of juveniles could be as harsh as adult sentences. In the 1960s, concern about potential abuses arising from the informality of juvenile proceedings led to a series of U.S. Supreme Court decisions that extended many of the due process safeguards to juvenile offenders already available to adults. These included the right to counsel, questioning of witnesses, protection against self-incrimination, a transcript of the proceedings, and appellate review. In 2005, the U.S. Supreme Court ruled that it was unconstitutional to sentence juvenile offenders to death, which includes adults who committed their crimes before the age of 18.

During the 1980s and 1990s, most states moved away from the early rehabilitative goals of the juvenile court to focus more on punishment. An increase in juvenile arrests for violent offenses and drug law violations as well as greater media attention to juvenile crime may have contributed to this shift. Many states have lowered the age for juvenile court jurisdiction and enacted tougher laws to hold violent, serious, and chronic offenders more accountable for their actions. These laws have made it easier for juveniles to be tried as adults, narrowed the age range of those classified as juveniles, and set mandatory minimum sentences for certain juvenile offenders.

Still, in recent years, new efforts to improve the ability of the juvenile justice system to address the many complex problems of juvenile offenders have led to the development of innovative strategies and programs. These efforts include community assessment centers, juvenile drug courts, graduated sanctions and integrated case management.

CURRENT REALITIES
■ 2.4 million juveniles (under the age of 18) were arrested in the year 2000
■ 54% of those arrested tested positive for drugs (not including alcohol) at time of arrest
■ 62.5% of those arrested reported substance abuse problems
■ 75% of arrested juveniles reported mental health problems in 1999
■ Black juveniles were more than 1 1/2 times likelier then white juveniles to be arrested for drug crimes
■ In the last decade, the juvenile arrest rate for drug law violations increased by 105% compared to a 12.9% decrease in arrests for all juvenile offenses
■ Between 1991 and 2000, the number of drug law cases handled in juvenile court increased by 197 percent, the largest increase of all major offenses

2 Ibid: estimate based on NIJ Arrestee Drug Abuse Monitoring (2000), drawn from testing 2,106 juvenile male detainees at 9 sites across country.
Overview of the Juvenile Justice System

This chart presents a general overview of key stages in the juvenile justice system. It is important to note that each state has somewhat different procedures and disposition alternatives.

**Delinquent Act:** An act committed by a juvenile, which if committed by an adult, would be a criminal act. Delinquent acts include crimes against persons, crimes against property, drug offenses, and crimes against public order.

**Petition:** A document filed in juvenile court alleging that a juvenile is a delinquent and asking that the court assume jurisdiction over the juvenile or that the juvenile be transferred to criminal court for prosecution as an adult.

**Adjudication:** Judicial determination that a juvenile is responsible for an offense, similar to a conviction in adult criminal court.

**Disposition:** Court-ordered handling of adjudicated juvenile. Dispositions can include:

- **Dismissed/Released:** Dismissal or release with no further sanction or consequence.
- **Probation:** Voluntary or court-ordered supervision of juvenile in the community. Violation of probation conditions can result in stricter sanctions or incarceration in juvenile correctional facility.
- **Placement:** Mandating placement of juvenile in a residential drug treatment program, correctional facility, or other out of home placement.
- **Waiver:** Process by which jurisdiction over juvenile (usually 14 or older) is transferred to adult criminal court.
- **Other Dispositions:** Wide range of alternatives, including fines, restitution, community service, referrals for services.

**Parole:** Conditional release from incarceration after serving part of sentence, generally under supervision of a parole officer. Violation of parole terms can result in juvenile being sent back to correctional facility.
Although we often refer to the “juvenile justice system” as if it were a single, internally coherent system for dealing with juvenile offenders, in fact, it involves many different agencies with diverse missions, philosophies and concerns. The responsibilities of these distinct agencies, including juvenile courts, probation, police departments, schools, family welfare, mental health, drug treatment and other service organizations, intersect as each endeavors to protect public health and safety through the care and supervision of juvenile offenders.

The goals of agencies working within the juvenile justice system may be dissimilar and even conflict with each other. The goal of juvenile justice as articulated in most state statutes is to protect public safety, reduce recidivism and serve the “best interests” of the child. Those involved most directly with juvenile justice, such as corrections staff, often have differing priorities from treatment providers who typically view recovery and rehabilitation as paramount. These goals are not necessarily mutually exclusive: juveniles who are no longer abusing drugs and alcohol are much less likely to be rearrested or present a threat to the community. However, in practice, philosophical differences often shape the context in which decisions are made and how treatment is structured. In particular, juvenile justice agencies and personnel may stress safety first whereas more clinically oriented agencies and individuals stress treatment. Juvenile justice dispositions may appear punitive, without regard to treatment needs, in order to maintain control and ensure that the juvenile is held accountable for his offense, while more treatment focused strategies may be perceived as not carefully considering safety issues. Greater collaboration and systems integration are essential if efforts to improve treatment outcomes are to succeed.

In addition to obstacles arising from mission differences, effective integration of services among vari-

### Key Elements of Effectiveness

Both treatment research and clinical practice suggest that certain elements are critically important in providing effective drug treatment to adolescents in the juvenile justice system. Drug Strategies, guided by an expert advisory panel, has identified the following eleven key elements:

- **Systems Integration**
- **Assessment and Treatment Matching**
- **Recognition of Co-Occurring Disorders**
- **Comprehensive Treatment Approach**
- **Qualified Staff**
- **Developmentally Appropriate Program**
- **Family Involvement in Treatment**
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- **Treatment Outcomes**

### Systems Integration

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Assessment and Treatment Matching

Screening and assessment are among the most critical services youth with substance abuse problems need in navigating the juvenile justice system. Yet there is currently no requirement for screening for substance abuse or mental disorders in most juvenile justice systems. Moreover, the availability of screening, assessment, and mental health and drug treatment services is uneven nationally, exacerbating the current crisis in the capacity to address these problems effectively.

Screening is the first step in identifying whether a youth is involved with drugs and alcohol; assessment explores more deeply the nature of the youth’s substance abuse and other problems. Assessment can help distinguish between problem drug users and those who are already drug dependent. The assessment should include a thorough psychiatric and medical examination to determine whether physical, biomedical, and psychiatric conditions may relate to the adolescent’s substance abuse.

Assessment provides a basis for developing a comprehensive treatment plan to address the individual’s needs and for determining the appropriate level of treatment intensity. For example, a youth in the early stages of substance abuse who does not have other major behavioral problems should not in most cases be placed in treatment with seriously addicted adolescents whose problems may be far more severe. The assessment should be reviewed periodically and revised throughout treatment in light of the youth’s progress.

Many adolescent drug treatment programs do not use standard, nationally recognized screening and assessment instruments and rely instead on questionnaires they develop in-house. Treatment experts agree that programs should use standard screening instruments that have been rigorously evaluated for reliability and validity, such as the Substance Abuse Subtle Screening Inventory (SASSI) and Personal Experience Screening Questionnaire (PESQ). After the initial screening, a comprehensive assessment may be needed to explore in depth the teen’s substance use, risk behaviors, mental health problems, learning disorders, peer and family relationships. Two standard assessment instruments that have been independently

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tested are the Comprehensive Addiction Severity Index for Adolescents (CASI-A) and the Global Assessment of Individual needs (GAIN).

Many persistent serious delinquents face additional problems that need to be addressed, according to the Office of Juvenile Justice and Delinquency Prevention’s long-term Research on the Causes and Correlates of Delinquency. Careful assessment of multiple domains can identify and inform the development of an appropriate treatment plan. Not all delinquent youth require interventions such as mental health or drug treatment services. Providing appropriate interventions based on identified needs is an important component of effective treatment.

Within the juvenile justice system, establishing the use of consistent screening and assessment instruments has proved altogether more complex even than in drug treatment programs, most of which still use their own untested questionnaires. The typical juvenile intake process is already lengthy and cumbersome, and assessments generally focus on criminological risks that use a different set of measures than most drug treatment assessments.

Operationally, there is also widespread systemic resistance to increasing what is already perceived to be onerous intake tasks by adding new screening and assessment requirements. However, without building these systems into the front end of juvenile justice processing, only a fraction of youth who need treatment services can be correctly identified. The Reclaiming Futures initiative, funded by the Robert Wood Johnson Foundation, is working with ten communities to incorporate new screening and assessment tools into the juvenile justice intake process. After initial resistance, judges and other juvenile justice personnel have come to recognize the benefits of being able to match youth more effectively and consistently to services.

Recognition of Co-Occurring Disorders

The rate of mental disorders among youth in the juvenile justice system is very high. Recent studies indicate that three-quarters of the juveniles in public and private juvenile facilities reported mental health problems during screening. In addition, more than half reported that they had previously received treatment of some kind for mental health problems.

The juvenile justice system is now the largest single source of youth referrals to drug treatment. Almost half of all adolescents currently in treatment have been mandated to programs by the juvenile justice system, or in the case of older teens, by the adult criminal courts.

Substance abuse and psychiatric disorders share common biological, behavioral and environmental risks and may be precipitated or exacerbated by each other. For example, an adolescent may have a mood disorder that was induced by substance abuse or a conduct disorder that resulted in substance abuse.

Youth in the juvenile justice system often have a broad range of mental health disorders, learning difficulties and problem behaviors including substance abuse. Juveniles may also have difficulties in other areas of life, including school, family, physical health and peer relationships. It is critically important that these multiple problem areas in individual youth be identified early and addressed with the necessary professional services.

Dual diagnosis of both substance abuse and mental health problems is one of the most important challenges in treating juveniles. Detailed measures of mental health severity and needs, including depression, anxiety, ADHD, conduct disorder and trauma are needed but usually lacking. Screening and assessment of youths in the juvenile justice system for co-occurring disorders are often not priorities in the intake process, where too few trained staff may be available to conduct structured interviews. Even when well-standardized interview instruments, such as the Diagnostic Interview Schedule for Children (DISC), are used, accurate diagnosis is often difficult. Moreover, treatment resources for dually diagnosed juvenile offenders are scarce and many youths go untreated.

Comprehensive Treatment Approach

Adolescents entering the juvenile justice system often have a constellation of personal and family problems. In addition to substance abuse and mental health disorders, these teens may have learning disabilities, a
Treatment programs should also strive to expand the adolescent’s horizons and aspirations through recreational, educational and cultural activities and by connecting teens to mentors in the community who will encourage emotional and intellectual growth. Collaboration with the home school system and vocational training help ensure that adolescents have a promising future after treatment. Continuing care is essential to address relapse prevention and provide social support and necessary services after the adolescent leaves the treatment program or the juvenile facility.

Qualified Staff
The challenge of finding and retaining qualified staff is central to providing effective drug treatment for juvenile offenders. Staff salaries may not be competitive, resulting in high turnover rates. Some states outsource juvenile justice services, with contracts going to the lowest bidders who in turn hold down their costs through low salaries. The challenge is further complicated by differences in perspective and background among court, probation and correctional staff and treatment providers. Professional staff who are trained to recognize psychiatric problems, understand adolescent development and are able to work effectively within the current realities of the juvenile justice system are critically important to treatment success. In addition to professional training and credentials, caring staff attitudes are also important in connecting adolescents to the treatment process.

Some programs do not have staff who are qualified to conduct accurate screenings and comprehensive assessments, which form the basis for developing an effective treatment plan. In some areas, centralized juvenile intake centers provide essential screening and assessment services. However, in many areas, these resources are not available. In addition, when specific treatment approaches are used, staff must receive intensive training in order to implement the intervention successfully.

Very few states in their certification standards for treatment programs require that staff have any specific knowledge or experience in treating youth. In the absence of state standards, counselor qualifications vary.

Providing medical, mental and sexual health services whether onsite or by referral is another critical component of comprehensive care. Treatment providers must address the attitudes and behaviors that put juvenile offenders at high risk of developing health problems, including HIV and sexually transmitted diseases. A 2003 study of juvenile offenders in a Chicago detention center found that 95 percent of the juvenile detainees said they had engaged in at least three behaviors that could put them at risk of HIV, and roughly two-thirds of them reported 10 or more behaviors that increased their chances of contracting the virus, such as having unprotected sex while drunk or high.

A comprehensive treatment approach takes into account the full range of diverse issues the juvenile faces. Compared to adults, adolescents have relatively little control over their environment, including where they live, their economic status, access to transportation, and community support services. Rather than focusing only on substance abuse and criminal involvement, good treatment plans address the various social systems that shape the daily life of adolescents: family, peers, school and community.

The first step in developing a comprehensive treatment plan is thorough screening and assessment, conducted when the youth first enters the juvenile justice system. Thorough assessment provides the basis for an individualized treatment plan that can be revised throughout the course of treatment. To be effective, a comprehensive approach requires dynamic case management. Case managers help juveniles and their families navigate the considerable complexities of juvenile court, probation, substance abuse treatment and other services. This coordination of care helps ensure that the adolescent and the family are receiving services that will contribute to treatment success.

History of delinquent and/or violent behavior, sexual abuse, dysfunctional families as well as medical and other problems. Addressing these multiple challenges comprehensively is critical to the juvenile’s success in treatment. Many states struggle to provide comprehensive, integrated services or case managed access to services in the community. Despite the challenges, some programs are finding new ways to bring these elements together.

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cognitive transitions as well as important physiological growth. Nonetheless, relatively few programs take developmental differences into account in treating adolescents. Most drug programs continue to rely on treatment models originally developed for adult addicts, whose history of substance abuse and behavioral problems is often much longer, destructive and more complex.

Adolescents also think and behave differently than adults. Teens are beginning to move away from family-based to peer-based identity on the way to defining themselves as individuals. They are also ready to try new, often quite risky behaviors with little regard to the consequences, including drinking, drug use and delinquent activity. Even when substance abuse poses acute risk of injury, overdose, or addiction, adolescents usually do not think they have a problem. They are unlikely to seek treatment on their own. Their first experience with treatment is often through the juvenile justice system, where the court mandates them to participate in outpatient or residential drug programs.

Compared to adults, adolescents also think more in concrete than in abstract terms. Program materials and activities should take these developmental differences into account, such as using examples that are meaningful to adolescents, particularly in terms of imminent effects and immediate consequences. In practical terms, adolescent programs must address the many different contexts which shape the delinquent youth’s life, not only juvenile court and probation but also school, peers, family, medical care and vocational development.

The need for developmentally appropriate programs for adolescents in the juvenile justice system is particularly pressing since the ages of juveniles under court jurisdiction may vary widely. Each state establishes minimum and maximum ages for juvenile court jurisdiction, resulting in considerable age differences. For example, in North Carolina, the youngest children subject to delinquency laws are age 6, although the majority of states set the minimum age at 10. (Younger children are generally referred to family court.) Moreover, most states give juvenile courts continuing authority over a youth even after the upper age of original delinquency jurisdiction. For example, in New York, although a child of 7 can be charged with delinquency, once adjudicated, he can be retained under court supervision until the age of 20. In Wisconsin, the youngest age for original juvenile court jurisdiction is 10, although the court may retain jurisdiction until the age of 22. Juvenile justice systems face a particular challenge in making sure that programs are appropriately designed for youth at various stages of development, ranging from children to young adult offenders.

Developmentally Appropriate Program
Treatment experts agree that adolescents are not simply immature adults and that adolescent programs cannot be effective if they are essentially adult programs modified for children. Adolescence is a period of rapid developmental change involving major biological, behavioral and

Family Involvement in Treatment
Parents and relatives are a dominant reality in the lives of most adolescents, no matter how troubled those relationships are. For youths in the juvenile justice system, family ties may be particularly problematic. Nonetheless, family involvement in the treatment process is critically important. Recent research suggests that the more actively the family is involved, the better the outcomes will be. Several new treatment models that emphasize family involvement show promise in reducing both substance abuse and delinquent
Engage and Retain Teens in Treatment

Staying in treatment is the single most important factor in recovery. Recent research has found that juveniles who complete treatment reduce their substance abuse and delinquent activity substantially as well as show marked improvement in school, work and relations with others. Juvenile offenders with substance abuse problems are generally mandated to treatment in nonresidential programs in the community. They are subject to court sanction if they drop out or if regular drug tests show they have resumed using drugs. However, court supervision does not guarantee that a juvenile will remain in treatment.

For juveniles detained in correctional facilities or in residential programs, the likelihood of retention is greater. The critical question is whether juveniles in either setting will actively engage in the treatment process.

One widespread approach that seeks to engage adolescents in treatment is motivational enhancement therapy (MET), based on principles of cognitive and social psychology. Through motivational individual interviewing, MET seeks to encourage adolescents to develop a personal commitment and plan for recovery. Counselors work with clients to create a broad range of individualized long-term goals. MET can also include family members to further engage clients.

Another promising way to engage juveniles in treatment builds on the “strengths-based approach,” in which the counselor concentrates on strengths rather than on failures and focuses on developing solutions together. The goal is to validate the competence of the juvenile and his family in defining what needs to be done and to increase their belief that problems can be solved. This approach views the youth as healthy, capable and able; makes the participation of the adolescent and family central; and recognizes that successful outcomes depend on the resources identified during therapy. The interaction and exchange between the counselor and youth during this process tends to strengthen the therapeutic alliance—a climate of trust, confidence, and acceptance—that is vitally important in treatment success.
Treatment for adolescents has to have tangible, concrete aspects and outcomes if the teen is to remain engaged. Some programs develop reward systems, such as giving vouchers for drug-free urine tests. Others provide services in sites that might be more convenient for teens and their families, including home visits or probation offices, and provide transportation where necessary. Programs can also offer activities that deal with sexuality, pregnancy and parenting—critical issues for many teens. The key is to find ways to make treatment relevant to the everyday concerns of the adolescent so that he or she will be motivated to make the necessary effort to change fundamental behavior patterns.

Parents’ perceptions and attitudes strongly affect whether a teen remains in treatment, according to a recent study of juvenile offenders. Parental recognition that there is a serious problem increases the likelihood that the youth will stay in treatment, perhaps because these parents are more motivated to seek help than are parents who minimize or ignore these problems. Parental expectations about their children’s educational potential are also critically important in treatment engagement. Parents who believe their children can overcome their problems and be successful in school make a powerful difference even when faced with difficult circumstances.

**Gender and Cultural Competence**

Although girls are still a minority in the juvenile justice system, their numbers have increased sharply in recent years, largely because of drug law violations. Girls are involved in one-third of all arrests of youth ages 13 to 15 years old account for more than 25 percent of juvenile offenders. Most of them have both serious mental health and substance abuse problems.

Very few programs are designed for female adolescent substance abusers, including those detained in juvenile facilities, with gender-specific services that take into account female socialization and pathways to substance abuse and delinquency. Depression and trauma, including physical and sexual abuse, usually precede drug use; many adolescent girls say they drink and use drugs to make themselves feel better and more “connected” to others. Often they develop problems with drugs in the context of relationships with drug-abusing partners or family members. Abandonment, abuse and depression are key issues girls must address in treatment. They also must be physically safe and free from sexual and psychological harassment both from staff and other adolescents. Programs should provide the opportunity for girls to participate in single-sex groups and to have female counselors for individual sessions. Girls may be reluctant to talk freely in front of men about their own experiences, particularly sexual abuse, which many regard as shameful. Moreover, juvenile justice programs often reward girls for compliance and silence, even if that means not voicing important issues related to their recovery.

Although research is still very limited, many experts believe that understanding cultural differences is critically important in being able to treat minority youth effectively. In the juvenile justice system, black youth are disproportionately represented at every stage of the process. One in three (36 percent) of all detained cases involve blacks, although they represent only 15 percent of the juvenile population ages 12-17. The further one moves into the system, the greater the concentration of minority youth. Indeed, the rate of residential placement for black juveniles is five times higher than that of white juveniles.

Very little information is available about the numbers of Hispanic juvenile offenders, in part because national statistics include Hispanics in the category of “other races.” Nonetheless, it is known that the residential placement rate for Hispanic juvenile offenders in 1999 was more than twice as high as the rate for white youth. National studies of Latino adolescents indicate that ethnicity and acculturation are likely to impact various aspects of treatment. Some programs, like Brief Strategic Family Therapy (BSFT) in Miami, Florida, are specifically designed for Hispanic youth and their families. Retention rates are significantly higher than in other outpatient programs that do not address cultural issues.
Continuing Care
The majority of adolescents relapse in the first three months following treatment. Gains that teens make in treatment can quickly disappear without continuing support. For juveniles under court supervision, relapse can result in more severe sanctions, including a longer, more intense period of probation or incarceration in a juvenile facility. For juveniles returning to the community from correctional facilities, jails or detention centers, a system of care that provides help with this transition is critically important. Wherever drug treatment has taken place—in outpatient programs, residential treatment facilities or correctional institutions, supportive services must be extended beyond the active intervention phase to provide continuing care as a youth builds a new identity in the community. This can be particularly challenging once a youth leaves the security of a locked setting or the structure of regular meetings with a probation officer.

The transition from juvenile court jurisdiction to school can also be difficult. Some states do not obligate schools to admit children over the age of 15. Education within juvenile facilities is often not based on grade levels, so that older children who may already have learning problems face significant obstacles in returning to the public school system. Providing educational support as an essential aspect of continuing care can reduce the likelihood of dropping out of school.

Programs vary widely with regard to continuing care. Most programs provide referrals to community resources, including Twelve Step meetings and group therapy where available. Less frequently, programs develop a continuing care plan while the juvenile is still in treatment. Some programs provide ongoing services, including counseling, education, and continuing contact with probation officers, and a few have counselors who specifically follow up with juveniles who have completed the formal treatment program.

Continuing care planning should begin early in the juvenile justice process as part of a clear continuum throughout the course of treatment and after treatment completion. Young offenders often have a number of different probation officers and treatment counselors. Continuing care should provide consistency in personnel as well as a range of services that includes relapse prevention, intervention and treatment for at least a year or longer. The goal is to open productive avenues for youths as they work to develop positive identities, jobs, educational and social skills that can provide powerful alternatives to drug use and delinquency.

Treatment Outcomes
Research on the effectiveness of drug treatment for juvenile offenders is still limited. Several recent large-scale federally funded evaluations have found that drug treatment for adolescents, including many referred by the juvenile justice system, can produce significant reductions in substance use and related problems. These studies—Drug Abuse Treatment Outcome Studies for Adolescents (DATOS-A); Cannabis Youth Treatment Program (CYT) and Adolescent Treatment Models (ATM)—are discussed in the section on “Programs and Approaches.”

Very few adolescent treatment programs conduct formal outcome evaluations, largely because they are expensive, require a high level of research expertise, and often face added obstacles when multiple systems are involved (e.g., mental health services, juvenile drug court, child welfare). Following up with juveniles after they have completed treatment or are no longer under the jurisdiction of the court can be very difficult. Nonetheless, measuring effectiveness must remain a top priority, even if programs are not able to conduct formal outcome evaluations.

In the absence of formal outcome evaluations, many programs engage in some assessment of quality assurance and treatment impact. Programs can collect a range of information that will shed light on how they are performing and whether they are achieving their goals. Programs should routinely measure clients’ progress: Do regular urine tests come back clean (i.e., no drug use)? Has the juvenile violated probation or been rearrested? Are family relationships improving? Is there progress in education and employment placement? Retention rates are also valuable indicators of program effectiveness, since completion of treatment is the most consistent predictor of positive outcomes.
Programs and Approaches Illustrating the Key Elements

This section describes a wide range of programs and approaches designed to treat substance-abusing adolescents involved in the juvenile justice system. Each section highlights useful strategies and practices that illustrate one of the eleven key elements of effective treatment identified by the Expert Advisory Panel. In addition to discussing the practical application of each key element, the descriptions include a focus on program results, specific challenges faced by the program, and how these were addressed. We hope to provide the reader with a better understanding of the great diversity of current treatment efforts as well as a more detailed look at what may be involved in putting each key element into practice.

The selection of programs and approaches for this section was based on recommendations from members of the Expert Advisory Panel as well as from state alcohol and drug abuse agency directors. We recognize that there may be many other programs and approaches that might equally well illustrate the key elements, but space constraints required us to select only a few. Drug Strategies does not endorse any particular program or approach described in Bridging the Gap.

This section does not provide information on the cost of treating individual juveniles, although this is an important practical consideration that greatly affects treatment availability. While many programs maintain overall annual budget figures, relatively few are able to provide the actual average cost of treatment per juvenile. Two major federally funded studies, the Cannabis Youth Treatment Program (CYT) and Adolescent Treatment Models (ATM), discussed later in this section, did assess the cost-effectiveness of various programs and treatment models. Each of the CYT treatment protocols appeared to be both clinically effective and cost-effective when compared with the average cost ($365/week) for treating adolescent marijuana abusers reported in the National Treatment Improvement Evaluation Study (NTIES).

Recent studies by the University of Pennsylvania’s Treatment Research Institute (TRI) provide additional perspective on costs. TRI developed standardized treatment costs by recalculating the weekly cost of adolescent and adult treatment in 2004 dollars. The TRI study found that outpatient treatment is somewhat more expensive for adolescents than for adults. TRI reported that costs for research-based adolescent outpatient programs with a median stay of 12 weeks ranged from $1,474 to $3,730 per treatment episode. Residential therapeutic community costs for clients with co-occurring disorders are relatively higher, reflecting long-term residential costs as well as more intensive services.

Incarceration remains far more expensive than treatment. Putting a juvenile in jail costs about $40,000 annually, compared to $13,000 for residential treatment and $3,000 for outpatient care (depending on geographic location, type of staff and treatment intensity).
The new process does not require the providers to come to court to make recommendations, which saves valuable staff time. The service plans are more comprehensive, addressing mental health, substance abuse, supervision, and school and family problems. All necessary services are coordinated before the youth enters treatment. The streamlined approach allows a juvenile to go from an initial hearing to treatment within 48 hours, a process that used to take more than 6 weeks. The reduction in time also reduces the recidivism that often occurs during the time a juvenile is waiting to enter treatment.

RESULTS

In 2003, the Network provided 775 juveniles with outpatient and residential treatment. In 2004, the Network served 1,051 juveniles and projections for 2005 are even higher. Most youth served by the Network typically have multiple offenses with the average in 2003 being 10 referrals per youth. In 2003, 60 percent of youth that participated in the program successfully completed the program. None of those youth re-offended or were committed to the Texas Youth Commission within one year of discharge, and all of them attended school regularly.

CHALLENGES

As funding cuts have affected local providers, the Network has had to find treatment slots to ensure that juveniles in the program have access to services. Because of its successful outcomes, the Network has been able to attract providers from outside the County to join the Network, thus expanding the list of providers that will accept and treat juveniles from Travis County. Many of the new treatment slots available to the Network are state-funded, thus the Network can access them at little to no cost.

Treatment programs are under increased pressure to achieve positive outcomes to retain government funding, which makes joining the Network an appealing opportunity. Another attractive feature is that the Network sends teams of probation officers to the participating programs to ensure that juvenile offenders are not causing problems within the treatment setting.
**Assessment and Treatment Matching**

**Tampa Juvenile Assessment Center**

8605 North Branch Avenue
Tampa, FL 33604
(813) 936-9099

In Florida, arrested juveniles are screened at one of twenty Juvenile Assessment Centers (JAC) located across the state. Created in the 1990s, these Centers coordinate the many different community agencies that deal with juveniles.

The JAC in Tampa, which opened in May 1993, serves as a centralized intake point for most arrested youth in Hillsborough County. Representatives from law enforcement, juvenile justice, and human service agencies are co-located in the JAC, increasing accessibility and efficiency of services, easing the youth’s transition between agencies, and enhancing the quality of referrals. Trained clinicians, psychologists, and medical professionals are available offsite by referral. While the Tampa JAC does not offer any direct treatment services, it provides 24-hour intake services for arrested juveniles, including early intervention, screening and assessment, monitoring of service provision, and case management.

Information in the assessment is based on self-report, as well as contributions from police departments, the county sheriff’s department, the Florida Department of Juvenile Justice, the state attorney’s office, and the county schools information system. In addition to collecting information about the juvenile’s alcohol and other drug use, including urinalysis results, the program assesses demographic characteristics, abuse and neglect history, mental health status, economic and vocational situation, sexual risk behavior, and educational history and needs.

**ASSESSMENT AND TREATMENT MATCHING**

The goal of the Tampa JAC is to assess the needs of the youth and the family in order to quickly match them with appropriate interventions. Police officers bring the youth directly to the JAC, where staff usually conduct a screening and assessment within 6 hours.

The JAC collects a wide variety of information about each youth, including a preliminary psychosocial screening and the Massachusetts Youth Screening Instrument (MAYSI-2). Fingerprints, photographs, drug screens and breathalyzer tests may also be taken. If screening results suggest psychosocial problems, the JAC may seek an in-depth assessment of the youth and the family.

In 2004, the Tampa JAC admitted and processed more than 11,000 cases, and referred an estimated 6,100 youths to juvenile court. The center has an annual operating budget of $2,794,854 and receives funding from federal, state, and county sources.

A study of 143 youths processed at the Tampa JAC between 1994 and 1996 indicated that the intake staff were accurately identifying high-risk youth and making appropriate referrals based on the youth’s multiple-occurring disorders.

**RESULTS**

When the Tampa JAC was launched in 1993, state statutes hindered information sharing between school system officials and the juvenile justice system. Lobbying efforts by officials connected to the JAC convinced the legislature to change these laws. Since the late 1990s, every JAC is required to have an advisory board that meets periodically to facilitate interagency cooperation and information sharing. In addition, each agency receiving or accepting referrals from the JAC must sign an interagency agreement that further enhances communication and information sharing.
Recognition of Co-Occurring Disorders

King County Juvenile Treatment Court

King County Superior Court
1211 East Alder
Seattle, WA 98122
(206) 205-9425

King County Superior Court used the Reclaiming Futures Initiative, funded by the Robert Wood Johnson Foundation, to develop better ways to identify and treat juvenile offenders with substance abuse and co-occurring mental health problems. The Treatment Court was established in November 2003 to address the unique needs of youth in the juvenile justice system with co-occurring disorders. Rather than being developed as a specialty court with one presiding judge, the Treatment Court originally spanned all three courtrooms in the King County juvenile justice system, with all juvenile court judges participating. Currently, King County is planning to reduce the span of the Court from three courtrooms to two. The Court accepts eligible referrals up to 30 youth at one time, at which point juveniles are placed on a waiting list. In addition, the court serves at least 50 percent youth of color in an effort to decrease disproportionate confinement of youth of color in King County.

Comprehensive substance abuse and mental health assessments are conducted earlier in judicial processing to guide treatment recommendations and disposition alternatives. Advocacy Teams, consisting of community members, service providers, and family members provide case management, wraparound services and mentoring.

RECOGNITION OF CO-OCCURRING DISORDERS

Youth with a range of dispositions may enter the Treatment Court and in order to participate, must be assessed with both an Axis I psychiatric disorder (a major psychiatric disorder such as schizophrenia or major depressive disorder) and any substance abuse or dependence disorder. Each juvenile offender entering the program is assigned to a Treatment Court Team, which is composed of a judge, prosecuting attorney, public defender, Juvenile Probation Counselor, mental health/chemical dependency clinician, law enforcement officer, and an Advocacy Team liaison. Team members are collectively responsible for determining the most effective treatment plan for each youth and for ensuring continued support throughout the Treatment Court process and after the youth leaves the judicial system.

The treatment model provides each youth with Multisystemic Therapy, an Advocacy Team, a trained mentor, and individualized substance abuse interventions and treatment recommended and closely monitored by the Treatment Court Team. Treatment services include detoxification, modified inpatient treatment, short-term psychiatric hospitalization, and short-term secure detention stays.

The Treatment Court holds regular bi-weekly reviews for each youth with the assigned judge, at which the judge and Treatment Court Team evaluate the youth’s treatment progress. Continued participation in the Treatment Court depends upon the youth’s progress as well as compliance with court orders. The length of stay in the program is individualized with an expected average of 9-12 months of supervision.

RESULTS

Data regarding assessment, treatment and supervision costs are being collected, and a cost benefit analysis will be conducted, as part of a three-year Reclaiming Futures outcome evaluation. In addition to Federal and state funding, foundation funding allowed King County to hire a local evaluator who is currently studying the effectiveness of the Treatment Court.

CHALLENGES

The integration of Treatment Court across all of the County’s juvenile courts has presented the challenge of attorneys and probation officers rotating in and out of the Treatment Court, as there is not a single dedicated team that works with the identified juveniles. Thus, a larger group of participants must be involved and educated, which is time consuming and can lead to confusion. However, educating a larger number of individuals who are involved with the youth does promote the court’s overall goal of systems change. As a compromise between the two goals of inclusion and coordination, King County reduced the number of active courtrooms from three to two. The third judge will remain involved with Treatment Court, occasionally hearing cases and sitting in on the bi-weekly reviews.
Adolescent Portable Therapy (APT), launched in 2001, provides intensive outpatient substance abuse treatment to New York City adolescents referred to Family Court. In New York City, all youths under 16 are under Family Court jurisdiction; those over 16 are referred to the adult criminal justice system.

APT screens 90 percent of the city’s detained youths, using the self-administered Drug Use Screening Inventory (DUSI). If the DUSI indicates heavy drug use, APT conducts a more comprehensive assessment. To be eligible for APT, an adolescent must meet clinical criteria for substance abuse or dependence, and be under Family Court jurisdiction. Forty-five percent of eligible juveniles enroll in APT. Once a youth has enrolled, more than 95 percent of parents agree to participate in treatment.

APT provides treatment across all systems involved in the care and supervision of youth. APT works with the youth and family while the adolescent is in detention or residential placement, and APT therapists continue treatment for approximately four months when the youth returns to the community. APT is the only substance abuse therapy provider in New York State licensed to provide treatment in the home.

Comprehensive Treatment Approach

APT provides comprehensive treatment without interruption from the beginning of a youth’s involvement with Family Court through return to the home community.

APT assesses the youth and family using the Global Appraisal of Individual Needs (GAIN), which includes numerous mental health indicators. The resulting strengths-based treatment plan addresses the youth’s mental, physical, social and educational needs by focusing on four key areas: family, peers, school and the community.

APT maintains regular contact with families when a youth is in custody, and often conducts family therapy sessions in detention centers prior to community reentry. In the first phase of treatment, family and individual sessions use cognitive behavioral therapies and family-centered treatment in order to determine factors that trigger the adolescent’s drug use and other behavioral and mental health difficulties. Family therapy sessions are geared toward strengthening relationships and improving communication.

When the youth returns home, APT focuses on the transition from detention back to the community. This phase consists of 4 months of intensive family-focused treatment, which contains an average of 26 face-to-face contacts through individual or family sessions. APT therapists conduct intensive family therapy in the youth’s home, school, and anywhere else in the community where the adolescent and family may need support.

The program helps the adolescent and parents make stronger connections to the school and other community and treatment resources that will help maintain treatment gains. The APT therapist reinforces progress, works with the youth and family on remaining goals, and establishes links to ongoing community services.

RESULTS

The Vera Institute recently concluded a controlled three-year evaluation of APT, aided by a database that tracks every therapeutic and administrative action in the program. The evaluation found that 73 percent of youth remain in treatment for 3 or more months, and that they have significantly fewer reported mental health needs, better school attendance rates, significant reductions in marijuana and alcohol use, and improved family functioning when compared with a control group.

CHALLENGES

A major challenge for APT is navigating the complicated New York system to ensure comprehensive treatment services for its clients. To overcome this obstacle, APT focuses on building positive relationships with all involved parties, including families, courts, probation departments and residential facilities. The APT treatment manual describes a number of ways in which APT therapists can collaborate and build relationships with other agencies. APT is planning pilot treatment models for youths referred from schools, the child welfare system and other settings where home-based, family-focused services are indicated.
Qualified Staff

Thunder Road Adolescent Treatment Center

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

QUALIFIED STAFF
Thunder Road Adolescent Treatment Center has a staff of 75 full-time employees. The intensive outpatient staff to client ratio is 1 to 10, and varies within the inpatient and residential programs depending on treatment activities. The clinical staff includes three part-time psychiatrists, a pediatrician, two full-time nurses, four marriage and family therapists, and more than ten registered addiction specialists who are substance abuse counselors. Former clients also function as volunteer role model peer counselors. The educational staff from the onsite school attend treatment planning meetings with counselors, therapists, and medical staff.

About one-third of the staff have advanced training in adolescent development, and over a dozen staff members have training in mental health services or family therapy. Staff supervision and mandatory ongoing training are conducted in weekly multidisciplinary treatment clinical staff meetings and a weekly all-staff training meeting.

An adolescent’s involvement with Thunder Road begins with an intake screening conducted by an admissions counselor. If the adolescent is admitted, a multidisciplinary team, including a psychiatrist, pediatrician, nurse, and certified substance abuse counselors, conducts a comprehensive assessment. In addition, the pediatrician and nursing staff conduct a health and physical examination, and the psychiatrist conducts an extensive mental health evaluation. The assessment team develops an individualized treatment plan within seven days and provides referrals to services that may not be available at Thunder Road. Working with the individual juvenile, recovery counselors update treatment plans semi-weekly.

As most clients have co-occurring disorders, Thunder Road’s staff psychiatrist reviews psychotropic medications and the medical director supervises mental health treatment. The psychiatric staff also supervises weekly multidisciplinary treatment planning meetings. In addition, clients and caregivers negotiate a Continuing Care Contract that covers relapse prevention, substance use in the family, behavioral expectations and how clients and families can work on recovery one day at a time. Families continue to receive continuing care services for 6 months to one year after completion of treatment.

RESULTS
Thunder Road was part of the federally-funded Adolescent Treatment Model (ATM) Study (1999-2002), which found that the program significantly reduced the use of alcohol and marijuana. Thunder Road is currently participating in a five-year federally-funded Strengthening Communities Youth initiative to improve youth systems in support of earlier identification, referrals, and access to treatment services. The initiative also has a rigorous evaluation component.

CHALLENGES
To improve staff communication, Thunder Road has introduced a collaborative staff management system that facilitates the flow of information, involves staff in decisions that affect their jobs and the program, and minimizes managerial and professional hierarchies. The initiative has had a positive impact on staff stability and morale, as well as on client satisfaction and outcomes.
Developmen tally Appropriate Program

Chestnut Health Systems

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

Chestnut Health Systems (CHS), established in 1985, provides residential, outpatient, intensive outpatient, day treatment and aftercare services for a total of approximately 100 adolescents ages 12 to 18. Around 45 percent of clients are referred from the juvenile justice system, and the program has a specialized treatment unit to deal with youths with extensive juvenile justice involvement. There is also an onsite alternative school staffed by two teachers and two aides from the local school district. Services offered include individual, group and multifamily therapy sessions as well as gender-specific groups. The program is financed in part through state grants.

DEVELOPMENTALLY APPROPRIATE PROGRAM

CHS clients are evaluated by case managers and therapists with the Global Appraisal of Individual Needs (GAIN) instrument. The GAIN includes in-depth questions on substance use, environmental issues and emotional/behavioral disorders. Individualized treatment plans are then developed by staff based on American Society of Addiction Medicine criteria, and are reviewed every seven to ten days to determine if modifications are necessary.

Treatment services at CHS are based on the developmental level of the adolescent rather than his or her specific age, as factors such as emotional maturity are taken into account. In addition, the curriculum at the program was developed by a Licensed Clinical Professional Counselor with a doctorate in education. Lessons in the curriculum are a combination of lecture and hands-on activities, and use realistic examples and visual depictions of the skill being taught. The curriculum covers ten content areas, including relapse prevention, coping skills, and self-esteem. Adolescents progress at their own pace in the curriculum, and must illustrate competency in each skill before proceeding to develop the next skill. Treatment plans and the group curriculum can be adjusted for younger clients, and older peers will be assigned to help these clients with written work.

RESULTS

CHS has a research division that includes approximately 20 employees who work on studies with clients. Using the GAIN family of measures, several studies have provided data to examine outcomes from over 400 CHS outpatient/intensive outpatient and residential adolescent clients during the past seven years. The GAIN was administered at intake and the follow-up version was administered at several intervals after admission (for outpatient/intensive outpatient clients) or after discharge (for residential clients). The 229 outpatient/intensive outpatient clients reported a 15 percent decrease in the number of days (out of 90) of marijuana use and a 49 percent decrease in the number of days of other drug use, when comparing intake data to that from 12 months after admission. The 222 residential clients reported a 53 percent decrease in the number of past days of marijuana use and an 84 percent decrease in the number of past days of other drug use between their admission and nine months after discharge from treatment. In addition, over 80 percent of clients in both the outpatient and residential studies were in school or employed approximately one year after discharge.

CHALLENGES

A particular challenge in designing the CHS curriculum was developing group sessions to meet the needs of clients who varied in their developmental stages. While many types of groups are divided into developmentally appropriate formats, there are also other groups that need to be relevant for all levels. CHS works to ensure that clients who are functioning at a higher developmental stage are not bored by groups they may view as too “childish.” CHS has geared many of the groups toward a mid-level developmental stage and then supplemented these groups with additional one-on-one counseling and tutoring for lower-functioning clients. While the CHS program is largely group focused, the multifaceted approach to learning (with lecture, hands-on, experiential and individual tutoring) has assisted in meeting these challenges.
Family Involvement in Treatment

**Multidimensional Family Therapy**

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

Multidimensional Family Therapy (MDFT) outpatient therapy concentrates on the individual adolescent, the parents, the family and youth together, and systems that affect the youth's life, including schools, juvenile justice, peer groups and the community. Based on a strong theoretical structure of developmental psychological principles, MDFT views any interaction between the therapist and the client/family as an opportunity to provide treatment. Three-quarters of the program's clients are referred by the juvenile justice system. The program has been implemented in more than a dozen sites nationwide and six other countries. Federally funded since 1985, MDFT costs one-third less on average than standard outpatient or residential treatment.

**FAMILY INVOLVEMENT**
MDFT believes that a good parent/child relationship is a powerful protective factor against substance abuse. Therapists work on resolving parents' personal mental health and substance use issues, teaching parenting skills and addressing the family environment as a whole. An MDFT therapist conducts an initial assessment of various risk factors, including familial drug use, family relationships, communication and conflict. Observation, interaction and clinical interviews are used to assess individual and family functioning. In order to gain parental cooperation, therapists acknowledge participants' past efforts and encourage them to express their frustrations with their children's drug use and behavioral problems. Earlier hopes and dreams of parents for their children are discussed, which often motivate parents to try once more. Therapists refer families to any needed services, and remain in close contact with the juvenile justice system, schools, peer groups, and other community services in order to coordinate services and monitor progress.

Family sessions, individual sessions with parents and adolescents, and meetings with relevant social service agencies and the teen and parent occur one to four times a week for four to eight months, depending on the level of treatment intensity. Phone calls are used extensively both to check in on progress and to give new tips on how to effect changes between face-to-face sessions.

Topics addressed in family therapy include the family's mental health and substance use, how to adjust parenting strategies based on the child's developmental level, and how family relationships can support the developmental challenges of adolescents and parents. Adolescents and families also work on relapse prevention strategies following completion of treatment.

**RESULTS**
Located in a research center at the University of Miami, MDFT has been found to be effective in four separate randomized clinical trials as well as several therapy process studies over the past ten years. MDFT participants in one randomized study from 2001 showed a clinically significant reduction of drug use at one year post-treatment and improvement in family functioning when compared to two alternative treatment approaches. Outcome measures were taken at 6 and 12 months post-treatment with abstinence confirmed through urinalysis. At one-year post-treatment, 45 percent of youths who had received MDFT reported clinically significant reductions in drug use, compared to 32 percent and 26 percent of adolescents in the other two groups. Grade point average (GPA) also improved significantly. At intake, 20 percent of the MDFT population had a GPA of 2.0 or better. At one-year follow-up, the percentage increased to 76 percent.

Challenges: MDFT researchers are currently seeking to facilitate the adoption of the program in a variety of non-research clinical settings. The challenges of applying MDFT in real world environments are largely related to staff training issues and providing the necessary time and resources to teach clinicians how to implement MDFT.
Family Involvement in Treatment

Multisystemic Therapy

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

MST provides intensive, comprehensive mental health and substance abuse services for juvenile offenders ages 12 to 17 years and their families in the home. The MST model views the family as central to successful treatment outcomes and concentrates on identifying and addressing the individualized needs of each family. Centered at the Medical University of South Carolina in Charleston, MST researchers worldwide continue to conduct randomized trials to assess the program’s effectiveness with new and diverse populations. MST programs are operating in more than 30 states and nine countries. MST costs approximately $5,500 per family.

FAMILY INVOLVEMENT

At the beginning of MST treatment, a “functional analysis” is conducted to determine the underlying and maintaining causes of a child’s antisocial behavior. This analysis, which is used throughout treatment, identifies situations contributing to specific problems. For example, if the juvenile is fighting in school, the therapist identifies the frequency, duration and intensity of the fighting as well as its antecedents and consequences. Setting events that set the stage for problem behavior can include such factors as the adolescent having Attention Deficit Hyperactivity Disorder (ADHD) and not taking his/her medication as prescribed or experiencing conflict at home. The therapist initiates strategies to break sequences of events leading to inappropriate behavior, such as improved monitoring of school behavior, and developing contingencies for medication compliance and inappropriate behavior. MST aims to reduce identified problems and provide parents with the skills and resources to also increase more constructive behavior.

Focusing on the unique problems of each family, the program allows parents to set clinical priorities. Therapists assist parents in identifying treatment goals and developing skills to accomplish those goals. Therapists work with a few families at a time, so that they are more accessible in order to maximize interaction and build trust. During treatment, parents are taught skills to preserve treatment gains, including how to work with school system officials after the adolescent completes treatment.

MST is completed when the treatment goals have been realized, which usually occurs four months after the intervention begins. Failure to make progress is viewed by MST as a failure of the program, not the family. MST devotes substantial clinical resources to identifying and overcoming obstacles to progress.

RESULTS

More than a dozen outcome studies have been completed and published on MST. Over the past 15 years, three studies involving chronic and violent juvenile offenders showed that MST reduced long-term arrest rates by 25% to 70% when compared with control groups. In addition, the Washington State Institute for Public Policy ranked MST as the most cost-effective of 16 major crime-cutting programs in 1998:

In a 1999 study, 118 juvenile offenders meeting DSM III-R criteria for substance abuse were randomly assigned to MST or to the usual community services (e.g., weekly group meetings based on the 12 Step model, mental health services, school-based intervention and family preservation). The study found that MST reduced self-reported alcohol and drug use. At six months follow-up, total days of out-of-home placements for MST graduates were 50 percent less than for those who had received traditional treatment services. At four-year follow-up, MST youths had committed significantly fewer violent offenses and were less involved with drugs. Likewise, a more recent MST study with substance abusing youths in juvenile drug court has shown that the integration of this evidence-based treatment enhanced substance use outcomes for juvenile drug court.

CHALLENGES

MST faces many challenges in achieving favorable outcomes for youths. For example, serious caregiver mental health and substance abuse problems can interfere with the attainment of treatment goals for the adolescent. To address this challenge in particular, MST therapists are taught to use or support the use of evidence-based treatments for caregiver substance abuse or mental health difficulties. Effective caregiver functioning is viewed as critical to the sustainability of youth treatment gains.
Engage and Retain Teens in Treatment

Phoenix Academy of Los Angeles

11600 Eldridge Avenue
Lake View Terrace, CA 91342
(818) 896-1121
www.phoenixhouse.org

Founded in 1987, Phoenix Academy of Los Angeles is a therapeutic community that provides residential and after-care substance abuse treatment for approximately 140 adolescents ages 12 to 18. About 75 percent of adolescents in the program are referred by the juvenile justice system, and two Probation Officers work at Phoenix Academy to help coordinate services. Treatment, which generally lasts six months, includes group, family and individual therapy. In addition, Phoenix Academy has an accredited onsite junior high/high school and a dedicated unit for youth with co-occurring mental health disorders. Phoenix Academy of Los Angeles is one of 12 Phoenix Academies operated in seven states by the Phoenix House Foundation, one of the largest non-profit substance abuse treatment providers in the country. The foundation operates a total of more than 11600 Eldridge Avenue
Lake View Terrace, CA 91342
(818) 896-1121
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ENGAGE AND RETAIN
Phoenix Academy takes a comprehensive approach to engage adolescents actively in the program. An individual treatment plan is created for each client and updated every 90 days to ensure that services are relevant and appropriate. Components include progress goals, education, family therapy, and behavioral milestones. A wide variety of group therapy sessions include encounter groups, multifamily groups, anger management sessions, and gender-specific programs. Motivational enhancement techniques are used to encourage clients to develop their own commitment to change.

Program materials, designed specifically for adolescents, emphasize education and prevocational training. The onsite school offers a full curriculum, including computer courses, dance and drama classes. Phoenix Academy collaborates with community organizations to bring public speakers to the program, and organizes a “Speakers Bureau” of their own clients who give presentations at schools, law enforcement agencies, and community groups about drug abuse. As clients progress in the program they may be allowed to attend community college classes or hold part-time jobs. Clients gain privileges such as watching movies and being able to leave the facility based on their progress and actions, and may lose privileges with negative behavior.

While the therapeutic community model emphasizes personal responsibility for one’s own problems, the self-help dynamic of client participation is carefully controlled by the staff. Staff members, many of whom have personal experience with substance abuse, play a key role in engaging clients. The staff-to-client ratio at Phoenix Academy is approximately one to one. Staff members direct all clinical activities, develop treatment plans, provide individual counseling, and guide the encounter and therapy groups.

RESULTS
The RAND Drug Policy Research Center conducted a rigorous outcome study of Phoenix Academy of Los Angeles from 1999 to 2001, comparing 175 youths from the program who were on probation to 274 other youths on probation with similar criminal and substance abuse histories who had been at group homes of comparable size and treatment duration but did not receive specialized, intensive drug treatment services. Published in 2004 in Psychology of Addictive Behaviors, the study found that the Phoenix Academy group had significantly greater reductions in drug use and psychological symptoms one year after treatment than the control group.

CHALLENGES
Among the toughest challenges Phoenix Academy has faced is maintaining the integrity of the program agenda, including the academic schedule, peer driven groups and family therapy. State laws, payment and accounting decisions, and shifting political tides each can have an influence on program direction. In order to sustain the program model, Phoenix Academy pursues an active dialogue with educators, probation officials, judges, and others involved in the juvenile justice process so that they can better understand the Phoenix Academy approach and why it has proven to be successful.
Cultural Competence

La Bodega de la Familia

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New York, NY 10009
(212) 982-2335
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cshapiro@familyjustice.org

Since 1996, La Bodega has provided substance abuse treatment services for families of clients on probation or parole returning to Manhattan’s Lower East Side. Approximately one-quarter of La Bodega’s clients are under the age of 18. The program offers a range of 24-hour services, including crisis support, referral follow-up, home visits and family support groups. The program also acts as an advocate in law enforcement settings.

La Bodega has recently collaborated with the New York State Division of Parole on the Parolees and Relatives toward Newly Enhanced Relationships (PARTNER) Project. This Project brings together parole and probation officers and the families of substance-abusing offenders in order to enhance the community’s role in reintegration and to reduce recidivism.

La Bodega maintains an average caseload of 110 families, 35 percent of whom reported multigenerational involvement with the criminal justice system. The program is led by two advisory boards: a local one providing expertise on treatment, facilitating referrals, and resolving medical, financial and legal problems; and a national board that helps guide the staff and put them in touch with experts nationwide. La Bodega has an annual operating budget of less than $1 million, with funding from city and state organizations. The success of La Bodega prompted the founding in 2000 of Family Justice, Inc., a nonprofit organization that applies the family-focused approach to treatment programs nationwide through training, technical assistance and policy work.

La Bodega serves the Loisaida community of New York City, which includes a large number of Hispanics, Asians and African Americans. All direct service staff are bilingual in English and Spanish, as are program materials and literacy tools. Family case managers participate in workshops on cultural competence organized by Family Justice.

La Bodega broadly defines “family” to include friends and neighbors of the client. The family-focused approach, which relies on a strengths-based model, allows staff and juvenile justice officials to build more trusting relationships with adolescents. The program helps the family develop an action plan that draws on community-based services and assists them in working with various social service agencies. In addition, La Bodega staff serve on a number of community advisory boards, in order to better refer youths to local services.

RESULTS

A 2002 formal outcome study conducted by the Vera Institute of Justice of 100 Bodega families and 100 control families found reduced drug use in all categories, fewer rearrests when compared with the control group, and improved treatment outcomes. La Bodega was a winner of the prestigious 2003 Innovations in American Government Award, presented by the Council for Excellence in Government and the John F. Kennedy School of Government.

CHALLENGES

When La Bodega began to work with parole officers and parolees in the community, the program encountered two distinct cultures with conflicting goals and expectations. Parolees and their families sought to stay out of jail by forming family support networks, while parole officers often used intimidation and the threat of reincarceration to ensure public safety. To address this conflict, La Bodega staff and parole officers held monthly meetings and signed an agreement of shared principles and expectations. This dialogue helped families, La Bodega staff, and parole officers to resolve potential conflicts.
activity is used to create a treatment plan based on criteria developed by the American Society of Addiction Medicine. Treatment plans are re-evaluated once a month.

Many of Cornell Abraxas’ clients arrive in poor physical health and may have sexually transmitted diseases as well as vision, hearing, and dental problems. Some clients are pregnant and need prenatal care. An onsite Registered Nurse coordinates all medical services, and regularly works with a nearby Children’s Hospital that provides physical and gynecological examinations. The program also has an in-house psychiatrist and an onsite dental office.

One of the most important goals at Cornell Abraxas is to help the girls understand why they need to be in treatment. The early focus of the program is on the damage that clients have done to their lives, and peer groups are used to reinforce therapeutic activities. These peer groups provide a safe environment for clients, and incorporate role-playing and social events.

Most clients at Cornell Abraxas have been sexually, physically, and/or emotionally abused, and many also have troubled family backgrounds; these factors can cause clients to have little belief in their own capacity for success. Daily group sessions at the program therefore focus on a variety of issues in these girls’ lives, including emotional health, relationship issues, self-esteem, life skills, and coping with past history of abuse and victimization. All group materials were created for adolescents, and the materials are appropriate to the developmental level of each client.

Cornell Abraxas maintains a minimum direct-care staff to client ratio of 1 to 6, ensuring that clients will receive necessary supervision and interventions from staff. About 70 percent of the program’s direct service staff are women. All staff receive three weeks of intensive training on issues relating to treating female clients.

RESULTS
Cornell Abraxas has a centralized database system dating back to 1973 that tracks all client enrollments, including successful completion and retention data. Clients also complete an exit questionnaire that asks them to rate their satisfaction with various aspects of the program. A sampling of 42 clients who had graduated from the program in 2004 showed that none had been arrested and 95 percent had abstained from substance use in the 30 to 45-day follow-up period. In addition, significant majorities of clients have reported that the program helped them learn about AIDS, STDs, and building self-respect.

CHALLENGES
In treating adolescent females, Cornell Abraxas has experienced a number of challenges in helping girls develop their own identities, deal with histories of sexual and physical abuse as well as co-dependency. Since most clients have multiple problems, it can be difficult to determine which to address first. The program emphasizes having clients help decide what to discuss and to allow the therapeutic conversation to evolve during the weekly individual sessions. Additional concerns are discussed during the curriculum-guided group sessions.
Continuing Care

The Bridge

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The Bridge provides continuing care to youths in transition from juvenile justice facilities, inpatient substance abuse treatment or other residential settings back to the community. Established in 1994, the program seeks to reduce substance use, rates of school dropout and rearrest as well as decrease high-risk sexual activity and violent behavior. The approximately 250 clients served annually at the Bridge’s four locations in South Carolina are on average between 15 and 16 years old, and have had more than three prior delinquency referrals. More than half of client families have histories of criminal behavior.

Funded by the federal Substance Abuse and Mental Health Services Administration, the Bridge is administered by the South Carolina Department of Alcohol and Other Drug Services through subcontracts with four county alcohol and drug abuse authorities. The statewide program has an annual budget of approximately $700,000, and wrap-around services cost approximately $1,000 per adolescent annually.

CONTINUING CARE

The Bridge offers gradual “step-down” services to facilitate a youth’s transition from detention or inpatient treatment back to the community. The first “intensive assessment” stage, which lasts four to six weeks, involves interviews, home visits and obtaining information about the youth from other agencies. This assessment becomes the basis for developing an individualized treatment plan, which is updated monthly. Referrals are made as necessary to mental health providers, vocational rehabilitation, and specialized family counseling.

The second phase involves four to six weeks of intensive case management. A case manager maintains daily contact with the client, family and any relevant agencies. (One case manager serves about 25 clients.) The youth and his family receive intensive services during this period, including substance abuse treatment, home-based support, and parenting skills education. A relapse prevention plan is also created for the next several years of the client’s life.

The final stage, continuing care, begins when the client demonstrates not only abstinence but also improvement in education, employment and family relations. The Bridge provides less intensive treatment and other services for both the client and family for as long as seven months. Case managers have face-to-face contact with clients and the family at least monthly in this stage. Counselors, who are responsible for about 15 clients each, coordinate and monitor services, meet with clients and the family at least once a month and reassess clients’ needs. Services decrease in intensity as clients gain access to other support systems.

Youths do not leave the Bridge unless case managers are confident that their employment or education is secure, and that family dynamics have improved. At the conclusion of the continuing care plan, a formal graduation ceremony is held. Staff conduct six-month follow-ups after graduation to evaluate progress. The Bridge also reviews juvenile justice arrest sheets and inpatient facilities to check whether a youth has been readmitted. If so, the family is contacted in order to reconnect them with the program.

RESULTS

The Bridge has been widely recognized by national professional organizations as an exemplary program. An independent evaluator found that one year after having completed the program, only 10 percent of youths had been reincarcerated, and 16 percent had been readmitted to inpatient treatment programs. At the time of graduation, 78 percent of clients were abstinent and an additional 11 percent had reduced their level of substance use. The evaluator also reported improved vocational and educational performance.

CHALLENGES

A major obstacle is finding jobs for clients once they leave the program. Local businesses are often reluctant to employ adolescents with prior involvement in the juvenile justice system. The Bridge focuses on developing clients’ skills by connecting them with vocational rehabilitation programs and placing them in trade schools. The Bridge has developed a good relationship with these schools, and also provides clients with a mentoring program and takes them to a yearly job fair.
Research on adolescent substance abuse treatment is still in its infancy. Research funding has focused largely on adult addiction and treatment effectiveness. Moreover, the small number of adolescent treatment studies that have been done often have had methodological problems that make definitive conclusions very difficult. These problems include small sample sizes, lack of control groups, poor follow-up rates, and the failure to include treatment dropouts in the results. However, in recent years, several large federally funded evaluations have found that adolescent drug treatment can produce significant reductions in substance use and related problems.

The National Institute on Drug Abuse (2000) supported a major study of adolescents treated in therapeutic communities; more than half the group had been mandated to treatment by the juvenile justice system. One year after treatment, these adolescents reported significantly reduced drug use and criminal activity. The most consistent predictors of positive outcomes were completion of treatment and not associating with deviant peers post-treatment. A five-year follow-up of adolescents admitted to one of the programs in the original study found continued reductions in criminal involvement. Additionally, drug use other than marijuana and alcohol was infrequent.

In addition, in 2002 NIDA started the Criminal Justice-Drug Abuse Treatment Studies (CJ-DATS), a national collaborative research program that brings together prominent researchers, policymakers, criminal justice and drug treatment professionals in ten research centers across the country to develop and implement effective treatment programs that address substance abuse, criminal behavior, HIV risk and other outcomes. The National Criminal Justice Treatment Practices (NCJTP) survey, begun in 2004, is examining how different jurisdictions deliver health and treatment services to the criminal and juvenile justice systems. More information is available at www.cjdats.org

The Drug Abuse Treatment Outcome Studies for Adolescents (DATOS-A) (2001), an evaluation of more than 1,100 adolescents treated in residential, inpatient and outpatient programs, reported significant reductions in drinking, marijuana use and criminal activity as well as improved school performance and psychological adjustment. Better outcomes were reported for youth who remained in treatment longer.

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) funded two major adolescent treatment research projects: Cannabis Youth Treatment Program (CYT) (1997-2001) and Adolescent Treatment Models (ATM) (1998-2002). CYT evaluated five outpatient treatment approaches for adolescent marijuana users and found that they were all effective in reducing drug use during treatment as well as one year after completion of treatment. Family, school and behavioral problems also decreased. The CYT approaches have been codified into manuals to allow staff training and program replication in other communities.

The ATM project supported evaluations of ten potentially exemplary programs that combine a variety of treatment approaches in multiple settings (intensive outpatient, short-term and long-term residential). Client outcomes and cost were evaluated in a consistent manner allowing for comparisons with the CYT approaches. Each of the ATM models showed significant reductions in substance use and related problems for ATM program participants that were comparable to those achieved in CYT. This was consistent for youth regardless of the severity of their problems at intake. The ATM study participants had reduced substance use, emotional problems and illegal activities in the year following treatment. The project also found that all the adolescents—whether in short-term residential, long-term residential, or outpatient treatment—achieved a similar level of recovery at the 1-year point. These ten model programs have developed manuals that describe their interventions that are now being used by treatment providers.

In 2003, the Center for Substance Abuse Treatment (CSAT) funded 22 treatment sites and an additional 16 sites in 2004 to replicate one of the CYT interventions (Motivational Enhancement/Cognitive Behavioral Therapy – 5 sessions). A process evaluation of this effort is underway to determine how community treatment programs can effectively adapt and implement a proven effective manualized intervention.
Key Terms

**Adjudication:** Judicial determination that a juvenile is responsible for offense.

**Brief Strategic Family Therapy:** Intensive problem-focused intervention with youth and families, generally lasting three months.

**Case Management:** Addresses individual healthcare, treatment and other needs and coordinates resources to achieve optimum results.

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

**Co-Occurring Disorders; Dual Diagnosis:** Client diagnosis of both substance abuse and mental health problems.

**Delinquency:** Conduct in violation of criminal law.

**Detention:** Court-ordered placement of a youth in a secure facility between the time of arrest and referral to court.

**Detoxification:** A process of allowing the body to rid itself of a drug while managing the symptoms of withdrawal; often the first step in a drug treatment program.

**Disposition:** Sanction or treatment plan ordered in a juvenile’s case.

**Diversion:** Directs juvenile to alternative educational, treatment, or work programs in lieu of juvenile court proceedings.

**Family Effectiveness Training:** Teaches family management skills, and offers planned discussions in which the therapist intervenes to improve communication among family members.

**Functional Family Therapy:** A short-term intervention that focuses on motivating families to change by concentrating on their strengths; has proven successful in reducing criminal behavior, treatment costs, and the onset of criminal behavior among siblings.

**Family Systems Therapy:** Focuses on family interactions, pinpoints problems and helps improve family relationships by clarifying roles and reshaping dysfunctional behaviors.

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

**Intake Decision:** Determination whether a case should be handled informally or formally in juvenile court.

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

**Juvenile:** Youth below age 18, although some states define juveniles as youth ages 16 or 15.

**Multidimensional Family Therapy:** Addresses adolescent substance abuse in the context of family, community, peers and other social systems by working intensively with the adolescent and family in a number of settings; has proven effective in reducing drug use and improving family functioning.

**Multisystemic Therapy:** Addresses the multiple determinants of youth and family problems through individualized case management and therapeutic services in the client’s home environment; has proven effective in reducing drug use and long-term arrest rates.

**Outpatient Treatment:** Wide range of non-residential treatment services.

**Parole:** Conditional release from incarceration after serving part of sentence, generally under supervision of a parole officer.

**Petition:** A document filed in juvenile court containing the allegations of delinquency or criminal offense.

**Probation:** Voluntary or court-ordered supervision of juvenile in the community.

**Psychotherapy:** Treats mental and emotional problems by helping clients develop new insights and change behavior.

**Residential Treatment:** Provides round-the-clock supportive living arrangements for clients in treatment.

**Status Offenses:** Conduct considered an offense only when engaged in by a juvenile, such as running away; being beyond control of parents; truancy; possession of liquor; underage smoking; and curfew violations.

**Strength-based Therapy:** Builds on the strengths of the juvenile and family to show how problems can be resolved.

**Structural Family Therapy:** Teaches families appropriate interaction through the assignment of tasks requiring cooperation and consensus.

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

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

**Waiver:** Juveniles (usually 14 or older) whose cases are transferred to adult criminal court.
Sources


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


Complete list of sources may be obtained at www.drugstrategies.org
Drug Strategies, a nonprofit research institute, promotes more effective approaches to the nation’s drug problems and supports private and public initiatives that reduce the demand for drugs through prevention, education, treatment and law enforcement.

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We honor the memory of our valued friend
and colleague Rosalind Brannigan,
Vice President of Drug Strategies from 1993-2004,
who made major contributions to the field of