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Adolescent Substance Abuse Treatment: Expectations Versus Outcomes

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Alcohol- and other drug-related problems are once again demanding priority attention of student assistance professionals. After a decade of decline (1981-1991), youthful drug experimentation rose through the 1990s. Between 1991 and 1999, past-year illicit drug use increased from 29% to 42% for high school seniors and from 11% to 21% among 8th graders. Concern also rose regarding an expanding illicit drug menu, heightened drug potency, and lowered age of onset of alcohol and other drug use. At the opening of the twenty-first century, 7,066,000 (3.2%) of U.S. adolescents meet diagnostic criteria for past year substance dependence and another 8,105,000 (3.6%) meet criteria for substance abuse. While the number of adolescents entering treatment each year has risen to 150,000, this is less than 10% of those in need of treatment for substance abuse or dependence (see <http://www.samhsa.gov/oas/Dependence/toc.htm>).

To assist the student assistance (SA) professional in educating parents about the nature and treatment of adolescent substance abuse disorders, we conducted two focus groups. The first contained parents of children undergoing treatment at Chestnut Health Systems. This focus group identified the most common questions parents have about substance use disorders and their treatment. The second focus group included three senior research scientists (Michael Dennis, PhD, Mark Godley, PhD, and Susan Harrington Godley, RhD) within Chestnut Health Systems' Lighthouse Institute who possess extensive experience in conducting adolescent treatment outcome studies. We asked these research scientists what insights from their studies were most important for parents to understand. Here are the highlights of what we discovered.

The Parents: Perceptions and Expectations

The concerns of parents coming to grips with the substance use of their children fall into three broad areas. The first concerns focused on the sources of such use. Source questions reflected the parents' feelings of culpability and, for some, their need to project blame on others for the problems of their children. These questions reflected the difficulties parents have understanding the potentially complex roots of adolescent substance use.

The second set of questions raised by parents involved how best to respond to their child's drug use. When professional treatment was under consideration, the parents had a whole range of other questions regarding the availability, length, nature and costs of various treatments. They also raised questions about how to determine the quality of a treatment program, and they raised concerns about the security of the treatment environment (e.g., physical safety, exposure to drugs).

The third set of concerns identified in the parent focus group involved what all this meant for the future of their children and their families. Here they discussed their expectations for what a desirable treatment outcome would be and what such treatment would mean for the future of their son or daughter. When given a list of possible treatment outcomes and the freedom to add others, parents overwhelmingly focused on "no alcohol or drug use following treatment" as the only acceptable primary treatment outcome. Secondary expectations included increased happiness of their son or daughter, increased trust between parent and child, improved relationship with a step-parent, greater respect for authority, greater self-respect of child, and better choices of friends. What is interesting about this list is that all of the secondary choices are measured in gradations of change, whereas the primary expectation constitutes intolerance for anything short of complete and enduring abstinence. (The option of "significantly reduced alcohol and drug use" and "absence of alcohol- and drug-related problems" were not considered acceptable outcomes by any parents in the focus groups). We shall discuss shortly whether these parental expectations of substance abuse treatment are realistic and the role the SA professional can play in clarifying and refining these expectations.

In summary, parents of substance-involved adolescents need help understanding the sources and significance of substance use, the potential options for addressing substance abuse, the most likely outcomes of professional intervention, and what role they should play during and after such an intervention.

The Research Scientists: Lessons for Parents

When we asked the research scientists at Chestnut Health Systems to share the most important conclusions they had drawn from their studies of adolescent treatment, including the Center for Substance Abuse Treatment's recently completed Cannabis Youth Treatment (CYT) study (see www.chestnut.org/li/cyt), they offered the following twelve lessons for parents and those who work with substance-involved adolescents.

1. *Many adolescents mature out of substance-related problems in the transition into adult role responsibilities.* This fact does not offset the risks of

substance-related developmental delays, disability and/or death that can result from such use. Parents would be ill-advised to assume that substance experimentation is simply a “passing phase” that will dissipate over time without enduring harm. There is a poor understanding of the line between volitional substance experimentation and the emergence of a serious substance use disorder characterized by compulsivity and chronicity.

2. *For other adolescents, substance abuse already constitutes a chronic, debilitating disorder.* In the CYT study, 41% of adolescents who had been diagnosed with cannabis abuse or dependence reported having failed prior attempts to stop drug use, 25% had prior episodes of formal treatment, and 33% were re-admitted to treatment during the year following their treatment in the CYT study.

3. *Many factors increase the risk of substance-related problems and inhibit the process of maturing out.* The most significant of these factors include a family history of alcohol and other drug problems, early age of initiation of regular use, co-occurring emotional/behavioral problems, and a low level of positive family and peer support. In the presence of these factors, substance-involved adolescents may need significant and ongoing support to initiate and sustain recovery.

4. *The earlier the intervention (in terms of age and months/years of use) with a substance use disorder, the better the clinical outcomes and the shorter the addiction career.* These research findings suggest the potential utility of standardized screening instruments for early identification, the use of global assessment instruments to evaluate at-risk adolescents, and strong linkages between schools and substance abuse treatment and recovery resources.

5. *There are evidence-based, brief therapies that are effective for many substance-involved adolescents.* In a twelve-month follow-up of 600 adolescents who completed one of five brief (5-13 sessions) outpatient treatments within the Cannabis Youth Treatment study, 24% of participants either achieved sustained recovery or achieved recovery after one or more brief post-treatment relapses. (The treatment manuals utilized in this study are available by calling 1-800-729-6686).

6. *Viewed as a whole, the most common outcomes of adolescent treatment are enhancements in global functioning (increased emotional health and improved functioning in the family, school, and community) and reduced substance use (to approximately 50% of pre-treatment levels) rather than complete and enduring cessation of alcohol and other drug use.* Post-treatment abstinence and relapse are not static phenomena, but alternating states for many adolescents. A study that examined outcomes three months following discharge from treatment found that 17% of the adolescents reported no use or problems following treatment, 53% reported minor relapse (isolated use without heavy use or associated problems), 18% reported moderate relapses (weekly use with some associated problems in past month), and 11% reported major relapses (heavy or daily use with problems

experienced on most days of use). The implication of these figures is not that treatment is ineffective for the majority of adolescents, but that, like other chronic disorders, multiple episodes of intervention may be required to resolve severe and persistent substance use disorders. The predictable time point at which recovery is fully stabilized (point at which risk of subsequent relapse dramatically declines) is not known for adolescents. No such longitudinal studies have been completed. The SA professional can help parents develop realistic expectations of treatment and understand that relapse is often a part of the process of long-term recovery.

7. *All treatment programs are not the same.* Those programs with the best clinical outcomes: a) treat a larger number of adolescents, b) have a larger budget, c) use evidence-based therapies, d) offer specialized educational, vocational, and psychiatric services, e) employ counselors with two or more years experience working with adolescents, f) offer a larger menu of youth-specific services (e.g., art therapy, recreational services), and g) are perceived by clients as empathic allies in the recovery process.

8. *Most adolescents are precariously balanced between recovery and relapse in the months following treatment. The period of greatest vulnerability for relapse is in the first 30 days following treatment; the adolescents' status at 90 days following treatment is highly predictive of their status at one year following treatment.* The fragility of early recovery is underscored by the fact that few treated adolescents participate at any significant level in professionally directed aftercare groups or mutual aid groups such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA).

9. *The stability of recovery is enhanced by post-treatment monitoring and periodic recovery checkups.* Assertive continuing care is characterized by sustained continuity of contact and support, and assumption of responsibility for such contact by the service professional rather than the adolescent. Placing recovery support services within the adolescent's natural environment (e.g., recovery home rooms, in-school recovery meetings, and recovery schools) also offers great promise for boosting treatment outcomes.

10. *The adolescent's post-treatment peer adjustment is a major determinant of treatment outcome. Adolescents who experience major relapse have the highest density of drug users in their post-treatment social milieu.* Adolescents entering recovery often find themselves in a social limbo. They may have been rejected by their non-using peers, are trying to disengage from their drug-using peers, and have yet to establish a peer-oriented recovery network. Finding ways to re-negotiate contact with the existing peer network and getting linked to other recovering adolescents may be crucial for adolescents caught between these social worlds. Parents can help manage the risks of this limbo period by supporting involvement in relationships and activities that do not involve alcohol or other drug use. While a

change in friends is a common recommendation for adolescents entering recovery, the truth is that few adolescents are able to completely change their social networks. We need to find ways to work with such networks to enlist their support and neutralize their ability to sabotage recovery efforts.

11. *The post-treatment home environment also plays a significant role in recovery/relapse outcomes.* Parents can do everything right and still have an adolescent relapse following treatment, but there are things parents can do to help tip the scales toward post-treatment recovery. We know, for example, that relapse among adolescents is more common in homes with less family cohesion and more family conflict, and where parents are consuming alcohol or other drugs in the home. The best advice we can give parents wishing to support their child's recovery is to: a) refrain from using alcohol or other drugs in the home, b) become involved in their child's recovery activities, c) actively monitor their child's recovery progress, d) recognize and praise positives in the child's post-treatment adjustment, e) participate in their own family recovery meetings, and f) help their child develop pro-recovery supports outside the family.

12. *Recovery mutual aid networks (AA, NA, etc.) can offer considerable support for long-term recovery, but they suffer from low teen participation rates and their effect is dependent upon intensity and duration of participation.* Recovery outcomes improve with increased meeting attendance and participation, increased knowledge of a particular recovery program (e.g., reading AA literature, AA sponsorship), and involvement in pro-recovery social activities.

The Future of Adolescent Treatment

There are a number of prospects for improving adolescent recovery outcomes. These include refinements in treatment methods (particularly the use of evidence-based, manual-guided therapies); better pharmacological adjuncts to treat both substance dependence and co-occurring psychiatric disorders; the development of systems for post-treatment monitoring; support and early re-intervention; and building youth-oriented recovery cultures within local communities (within the neighborhoods, schools, and churches). We envision a day when SA professionals all across America will join hands with parents, treatment professionals, and research scientists to make this vision a reality.

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Resources: For a listing of the research studies upon which the conclusions in this article are based, see the adolescent treatment bibliography at <http://www.chestnut.org/LI/downloads/bibliographies/adolescentbib053102.pdf>