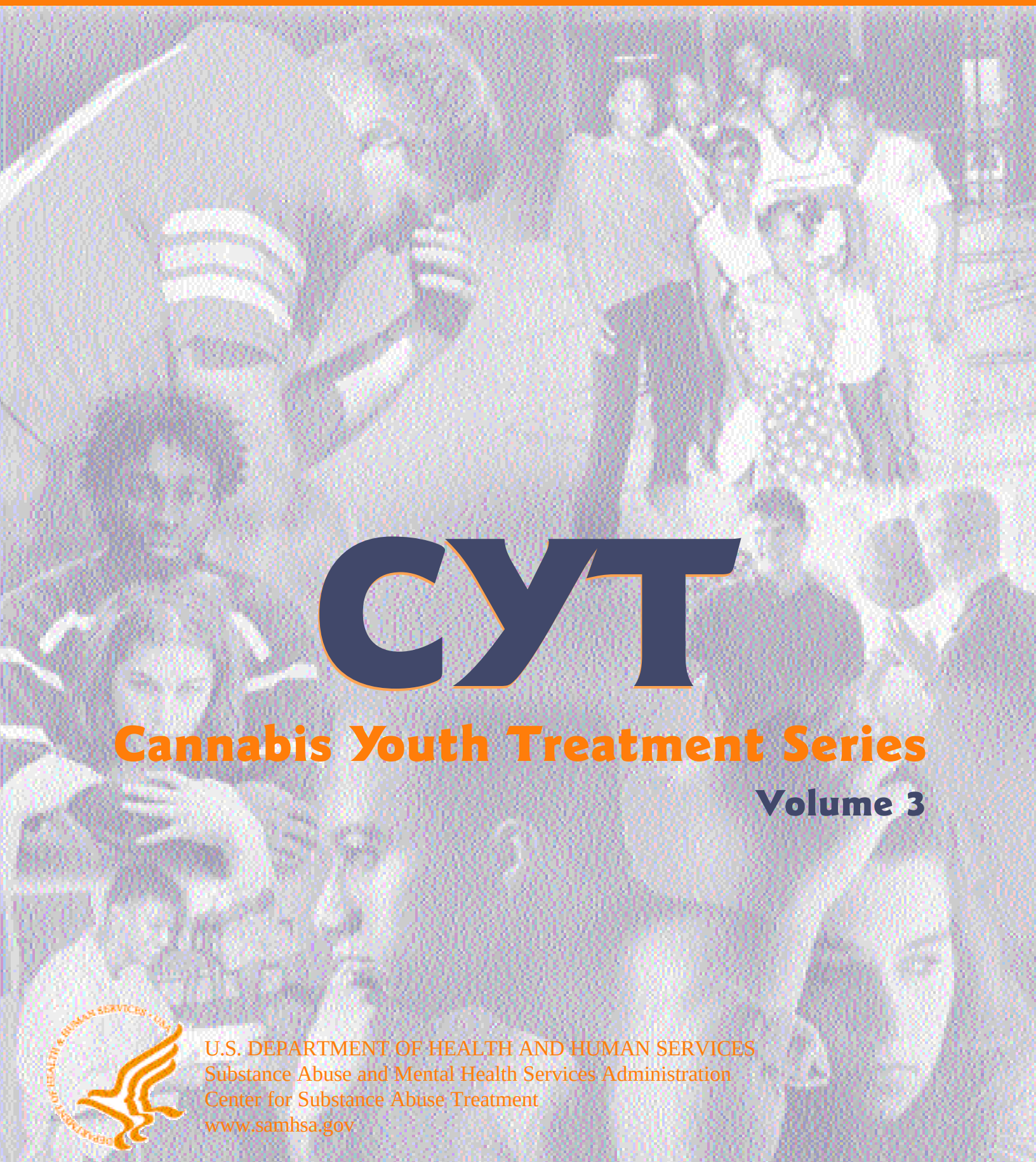
Family Support Network for Adolescent Cannabis Users



CYT

Cannabis Youth Treatment Series

Volume 3

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
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I. Introduction to and Overview of the Family Support Network Intervention

Overview

The development of drug abuse is multidetermined. Henggler (1997) points out that "with rare exception, treatment programs address only a limited portion of factors contributing to adolescent drug abuse" (p. 265). Teaching life skills, refusal skills, and coping skills may contribute to recovery; however, family support has been cited repeatedly as an important determinant of both intreatment and posttreatment outcomes (Barrett, Simpson & Lehman, 1988; Brown et al., 1994).

Thus, substance-abusing adolescents experiencing inadequate family structure and functioning will be at a serious disadvantage with regard to recovery. Their recovery, however, is likely to be enhanced if family functioning can be improved. Deficits in family functioning may be related to dimensions of authority, roles, boundaries, communication, and routines. Parental authority may be eroded and roles confused; boundaries may be blurred or violated; communication may be dysfunctional and conflict laden; and family structure or routine may be lacking. Inadequate parenting skills or poor understanding of family dynamics may also contribute to a chaotic or otherwise dysfunctional family context.

The family support network (FSN) intervention seeks to extend the focus of treatment beyond the world of the adolescent by engaging the family, a major system in his or her life. Family therapy has been cited as a potentially valuable tool in the treatment of substance abuse, and a substantial amount of literature about it exists (Stanton & Shadish, 1997; Liddle & Dakof, 1995; Steinglass, 1994; Kaufman, 1994). Studies have shown that retention of adolescents in treatment increases dramatically when a family intervention is provided (Henggler et al., 1991; Liddle & Dakof, 1995). Although the value of family therapy is recognized, providing this intervention is beyond the resources of many programs, especially in view of the well-documented erosion of services in community-based treatment programs (Etheridge et al., 1995).

Because of declining resources and the restriction of services by managed care, Operation Parental Awareness and Responsibility (PAR), Inc., developed the FSN approach. The FSN model uses only a limited number of the more costly inhome therapy sessions coupled with several less costly group sessions. Designed to increase parental support of a child's recovery, the FSN approach seeks to engage families in the treatment process, improve parents' competence in supporting their child's recovery, and shift therapy from time-limited formal treatment to a support group for parents.

The FSN process is a family intervention designed to be used in conjunction with any standard adolescent treatment approach. The FSN approach was followed in two locations—Operation PAR, Inc., and the University of Connecticut Health Center. It was effective at treating teens for cannabis

use at both locations. Other approaches may be just as effective. The scope of the study was not to compare family approaches but rather to test treatments for adolescent marijuana users.

The FSN approach consists of several components, each designed to achieve specific objectives:

- Case management
- Six parent education (PE) groups
- Three or four inhome family therapy sessions.

Case management includes referrals to community support groups and other support services for both parents and adolescents. The procedures presented in this manual combine motivational enhancement and cognitive behavioral therapies as one possible treatment overlay for the adolescent. The motivational enhancement therapy (MET) and cognitive behavioral therapy (CBT) approaches used in the Cannabis Youth Treatment (CYT) study are presented in *Motivational Enhancement Therapy and Cognitive Behavioral Therapy for Adolescent Cannabis Users: 5 Sessions, Cannabis Youth Treatment (CYT) Series, Volume 1*, by Sampl and Kadden (2001) and *The Motivational Enhancement Therapy and Cognitive Behavioral Therapy Supplement: 7 Sessions of Cognitive Behavioral Therapy for Adolescent Cannabis Users, Cannabis Youth Treatment (CYT) Series, Volume 2*, by Webb, Scudder, Kaminer, and Kadden (in press). Thus, while an adolescent is receiving a special MET/CBT program for adolescents, the family is involved in the FSN intervention. This manual guides counselors and therapists, so they can consistently conduct effective case management, PE groups, and home visits.

Treatment Goals

The FSN approach is a multicomponent intervention aimed at improving the family context in which adolescent recovery takes place. It is based on an assumption that the adolescent's outcomes will be improved if the family is involved in the treatment process. Although no short-term treatment can resolve all problems and heal families completely, the goal of FSN is to improve an adolescent's outcomes by:

- Including the family in the recovery process
- Enhancing family functioning through communication and relationship building
- Improving parental effectiveness in dealing with substance abuse and the behaviors accompanying drug use
- Assessing the family's commitment to the recovery process and suggesting changes in the way the family approaches problems.

FSN recognizes that the program's opportunity for influence is of limited duration and that responsibility for aiding recovery must be transferred

from the program to the family in a short time. The FSN approach provides a strategy for effecting that transfer in a systematic and responsible way.

Service Components: Overview and Objectives

The FSN model is designed to treat youth who meet American Society of Addiction Medicine (ASAM) Level I (outpatient) or Level II (intensive outpatient) criteria and who report marijuana as their primary drug of choice. Although youth abusers may occasionally use alcohol and other drugs, such as lysergic acid diethylamide (LSD), polysubstance abusers with long histories of drug use, especially use of cocaine and heroin, who have ASAM diagnoses at higher levels or those with serious psychiatric or criminal issues may be inappropriate for this level of treatment.

Urban, suburban, and rural youth and families were part of the original research study as were families with parents who had current or past histories of use or abuse of alcohol and drugs. Youth and families of color also participated in the study. No socioeconomic group prevailed in the original sample. Most families were from working-class or lower socioeconomic groups. The study involved families of all sizes and situations—single, divorced, or separated parents; blended families; and intact families. Because of limited resources, the study required participants to speak and understand English, although it need not be their first language. Future FSN manuals can be developed for use with youth and families who are not English speakers.

The FSN service components are case management, parent education, and home visits.

Case Management

Case management engages families in the treatment process by providing a means to solve problems and motivate family members. Methods of engagement include telephone outreach to remind families of scheduled meetings, reduction of barriers to treatment participation (e.g., overcoming difficulties with transportation, scheduling, and child care), and prompt intervention to reengage any adolescent or parent who has missed a treatment session.

Case managers work with families by assisting them in resolving issues that prevent participation. For example, case managers may provide information about local bus routes or referrals to local resources that provide assistance to families in need. Some providers may have resources that allow them to send vans to the family's home to pick up clients or provide bus tokens. Case managers work with the family to recognize child care issues that may prevent participation. Solutions for child care problems include care by a relative, referral to local child care agencies, or onsite child care services. Other ways to overcome child care and transportation barriers include getting the families to act as a cooperative—one family helps another with transportation or child care. A good case manager works to assist the families in becoming empowered to solve their problems in creative ways.

Major responsibilities of the FSN case manager are to:

- Contact and engage families in the treatment process
- Assist families in overcoming barriers to active participation
- Identify appropriate service and treatment needs
- Provide links for the families to needed services, including community support groups
- Monitor the adolescent's and family's progress
- Provide motivational enhancement
- Monitor attendance and act quickly to prevent clients from disengaging or dropping out
- Make appropriate referrals (including treatment reentry)
- Engage the family and the adolescent in a community support group.

An important, but difficult, activity of the FSN case manager is to engage the family and the adolescent in a community support group. The purpose of this is to transfer the responsibility of recovery from the FSN program to the family in the limited time available. The case manager should identify primary referrals for community support groups (e.g., Alcoholics Anonymous [AA], Narcotics Anonymous [NA], Al-Anon/Alateen, Children and Adults with Attention-Deficit/Hyperactivity Disorder [CHADD]) within the first 6 weeks of the program. Contacts for these types of organizations can be found in local phone directories and by calling local hotlines. The case manager should prepare a list that includes addresses, phone numbers, and meeting times as a handout for families. Parents should be contacted regularly and encouraged to use the support group as a source of support after their child completes treatment.

Case managers should receive special training in techniques of outreach to and motivation of adolescents and families. Training also should be provided to increase their cultural competence for engaging families of color and those with special cultural, religious, or ethnic needs.

Parent Education

The PE component is designed to:

- Build competence among parents that leads to healthy families
- Offer methods for coping with the pressures of parenting

- Promote ways to establish or restore appropriate authority, roles, rules, boundaries, communication, and routines.

The six PE sessions, each designed to last 90 minutes, should be scheduled for the same time and location as the adolescent's CBT sessions. Each PE session has clear objectives and is taught in a didactic manner, and time is allowed for questions and discussion.

At the didactic sessions information is presented, and discussion provides clarification and facilitates assimilation of the information into personal frames of reference. To build a "collaborative learning" experience, the counselor should guide and focus the discussion and invite maximum participation by the parents. To prepare for the sessions, the counselor must also consider the following:

Size. The size of PE groups may vary but should not exceed 10 parents per session. A larger group may be too impersonal, and groups of fewer than five parents may deprive the parents of an adequate opportunity for discussing and exchanging views with others. To facilitate discussion, the chairs in the room should be arranged in a circle.

Objectives. The PE sessions are designed to enhance parental motivation and increase knowledge of parenting skills, family life, and drug/health issues. The ultimate goal of the PE component is to improve parenting and family functioning for a more global improvement of the family environment. Meeting this goal will in turn allow families to better support the recovery of the substance-abusing adolescent.

Manual and handouts. The format of the manual for these six sessions is content, major lecture points, and discussion topics. Handouts are provided to participants, and parents are encouraged to review the handouts at home.

Preparation. Before each session, the counselor should review the lesson plan and have all necessary materials on hand. Each individual should have a copy of the handouts. Audiovisual equipment (VCR and videotapes, slides and projector, overhead transparencies and projector), magic markers, and any other required materials should be available. The counselor should have a visible watch or clock to time segments of the lecture and discussion.

Sequencing of sessions. Missed sessions and home visit schedules may mean that not all parents will have attended sessions in the proper sequence. However, the sessions were designed to be conducted in sequence and should be held in order when possible. Therefore, the therapist should coordinate scheduling of PE sessions and home visits and ensure that the sequence of parent education sessions 1 and 2 is maintained. The FSN model was pilot tested without rolling admissions. Therefore, if the treatment calendar can be set, the following schedule or order is preferred:

1. PE session 1
2. PE session 2
3. Home visit 1

4. PE session 3
5. Home visit 2
6. No session
7. PE session 4
8. Home visit 3
9. PE session 5
10. No session
11. PE session 6
12. Home visit 4.

If rolling admissions are necessary, a proposed method for scheduling is shown in exhibit I–1. Based on the following schedule, clients would enter treatment only in session 1 or 7. This schedule assumes a 12-week cycle with three to six incoming participants per week. Two treatment calendars are scheduled simultaneously during the 12-week cycle. For staffing, this schedule allows for combining groups when possible (e.g., PE sessions 3 to 6 would include group 1 and group 2 members) and alternate weeks for home visit/no session schedule for group 1 and group 2.

Exhibit I–1: Proposed FSN Schedules

Treatment Week: Group 1 (Group 2)	Group 1 Schedule	Group 2 Schedule
1 (7)—start Group 1	PE Session 1	(Home Visit 2)
2 (8)	PE Session 2	(Home Visit 3)
3 (9)	PE Session 3	(PE Session 3)
4 (10)	Home Visit 1	(No Session)
5 (11)	No Session	(Home Visit 4)
6 (12)—end Group 2	PE Session 4	(PE Session 4)
7 (1)—start Group 2	Home Visit 2	PE Session 1
8 (2)	Home Visit 3	PE Session 2
9 (3)	PE Session 5	PE Session 5
10 (4)	No Session	Home Visit 1
11 (5)	Home Visit 4	No Session
12 (6)—end Group 1	PE Session 6	PE Session 6

Overview of sessions. Exhibit I–2 provides a brief description of the six PE sessions. Specific procedures for each session are included in Part II of this manual.

Exhibit I–2: Parent Education Sessions

Session	Description
PE Session 1	**Introduction to the Family Support Network, Adolescent Development, and Functional Families**—This session provides an understanding of the family support network, adolescent development, and the role of the family in this development. The session focuses on how healthy family functioning can make the family a source of strength for its members. Emphasis is on understanding the individuation process of developing adolescents and how families can help make it a positive experience.
PE Session 2	**Drugs and Adolescents**—This session helps parents understand drug abuse and dependence and how adolescents become involved with drugs. It addresses the nature and objectives of treatment and stresses the importance of parents in a child's recovery.
PE Session 3	**Relapse Signs and Recovery**—The issues presented in this session are the recovery process in the context of a healthy family, ways parents can help their child avoid relapse and when to appropriately intervene, how to develop healthy partnerships within the family, and committing to a drug-free life.
PE Session 4	**Boundaries, Limits, Authority, and Discipline**—The concept of boundaries is introduced in this session as a major issue in child and adolescent development. Clarification of major issues in family functioning is provided, and appropriate approaches to discipline and parental authority are suggested. This session helps parents understand the sources of authority in the family and how to maintain that authority in a healthy way.
PE Session 5	**Communication, Conflict Resolution, and Fighting Fair**—This session enhances parents' understanding of how and why conflict inevitably occurs, imparts concepts and methods of healthy communication, and teaches techniques for engaging family members in open and fair resolution of conflict. Conflict is presented as a learning process, and ways to prevent conflict from becoming dangerous are discussed.
PE Session 6	**The Family Context**—This session helps adolescents and parents understand the importance of family in the recovery process and the nature of the family as an interdependent system. Parents are taught how family functioning has both a direct and an indirect influence on the child's behavior.

Home Visits

The objectives of the home visits are to:

- Assess the family environment
- Individualize the treatment process
- Develop a family commitment to recovery
- Encourage a three-way therapeutic alliance (family, adolescent, and program), and translate the lessons parents and adolescents are learning into specific changes in family functioning.

The four home visits are to be scheduled by agreement between the family therapist and the family. Ideally, to spread out the treatment experience as much as possible, the home visits should be coordinated so they do not take place during the same week as parent education and discussion sessions. However, depending upon the therapist's caseload, this coordination may not be possible. Flexibility in scheduling home visits is necessary when time is limited. If this is the case, home visits should be scheduled continuously throughout treatment to ensure that each family receives the full treatment.

Each home visit should last approximately 90 minutes. During the first home visit, the family therapist assesses the family environment, motivates the family to actively participate, and obtains a commitment for future family meetings. In the second home visit, the therapist helps the family discuss rules, roles, and routines. The therapist builds therapeutic alliances with the adolescent and the family and acts as a mediator to clarify issues.

At the third home visit, the therapist assesses progress and provides feedback on major family and adolescent issues. Some families may require only three visits.

Based on the family's need or request, the final home visit is used to reinforce therapeutic alliances and obtain a family commitment to work together on recovery. The parents also are encouraged to become or remain involved in a community support group. Home visit guidance is detailed in Part III of this manual.

Overview of Cannabis Youth Treatment Research

This overview presents the development and research phase of this model. Appendix 2 includes an overview of the full research design for the CYT Project Cooperative Agreement.

Referrals to the CYT program were provided by juvenile assessment center staff, juvenile addiction receiving facility personnel, community mental health and substance abuse treatment providers, juvenile justice workers, school system staff, and family members. A preliminary screening determined the appropriateness of the level of care provided by this model for an

adolescent. During the initial research project, participants were randomly assigned to one of three treatment groups. Information provided in this manual is pertinent only to those clients assigned to the FSN treatment group. Participants were included in the FSN treatment model if they (1) met the inclusion criteria, (2) did not meet the exclusion criteria, and (3) agreed to participate in the research study being conducted. Once acceptance criteria were met, full baseline assessments and intake procedures were initiated.

Those participating in FSN treatment received services for both the adolescent participant and the family. Adolescents in the CYT study received state-of-the-art treatment that included both MET and CBT. Adolescents in the study received 2 individual MET sessions and 10 group CBT sessions (subsequently denoted by MET/CBT5 and CBT7). Separate manuals were developed for each treatment model (Kaminer et al., 1998; Sampl & Kadden, 2001; Webb et al., in press). This manual presents the FSN therapy.

In addition to the MET/CBT5 and CBT7 treatment for the adolescent, the family received three or four home therapy sessions, six parent education sessions, and case management services. As mentioned earlier, the FSN and MET/CBT interventions were designed for adolescents meeting American Society of Addiction Medicine Level I (outpatient) or Level II (intensive outpatient) criteria and using marijuana as their primary drug of choice. Exhibit I–3 shows the overview of the FSN process.

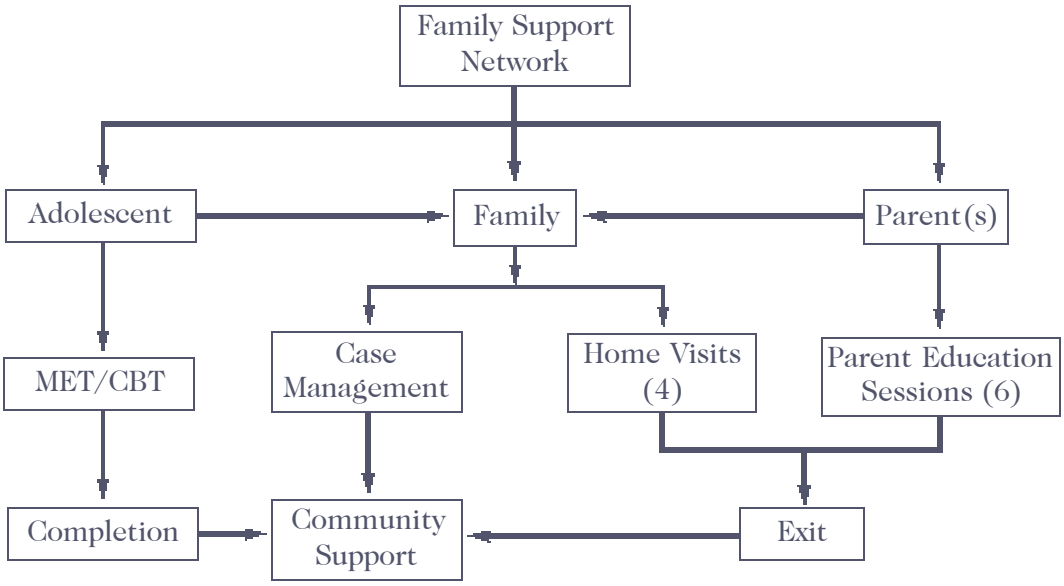
Staff Requirements

Staff requirements for FSN include case managers, parent education specialists or counselors, and home visit therapists.

Case managers. A bachelor of arts (B.A.) degree or equivalent and formal or informal training in addiction and substance abuse treatment are required (certification as a certified addiction professional [CAP] is helpful). Specialized training in case management, cultural competence and sensitivity, and sales/motivational techniques should be provided. Personal qualities of empathy, assertiveness, and the ability to persuade others effectively are also valuable.

Parent education specialists or counselors. B.A. degree or equivalent certification (e.g., CAP) or higher certification in psychology, sociology, or human development, with specialization in family relations and skill in facilitating discussion groups, is required. Training to increase cultural competence and sensitivity is essential.

Exhibit I–3: The Family Support Network



Home visit therapists. A master's-level therapist with CAP or a licensed mental health counselor (LMHC) qualifies; however, a licensed clinical social worker (LCSW) is preferred. Training in family dynamics, with at least 1 year of experience in family counseling and intervention, is required. Training to increase cultural competence and sensitivity is essential.

Clinical Supervision Requirements

Clinical supervision, held on a weekly basis, allows the interdisciplinary team to better meet the needs of the individuals, families, and therapists involved in FSN. The clinical supervision staffing allows time to clinically review each case and discuss the progress of the application of the model. This review allows both clinical supervision and supervision of adherence to the FSN model. The original research design called for weekly onsite meetings and cross-site conference calls to ensure adherence to the design.

Staff Meetings

Staff meetings should be held weekly and should last approximately 1 hour. During a meeting, each family's case should be reviewed, including treatment goals, progress, further interventions that may be necessary, problems encountered, recommendations, and any other issues. The case manager should report on every family. The report should include such issues as referrals made, difficulty with compliance, and any barriers that might prevent a family from successful completion of treatment.

Standardization of the FSN model should be reviewed. Discussion should include:

- Difficulties in complying with the process and procedures
- Problems with recruitment, issues involving retention and census, recommendations for improvement, and development of an action plan
- Personal or professional difficulties in treating the adolescents and their families.

A clinical supervision log should be kept. Attendance, comments on each agenda item, recommendations, and action plans should be recorded in the log. All clinical staff (e.g., therapist, therapist coordinator, parent education therapist, adolescent counselors, and case manager) should participate in all staff meetings.

Adherence and Quality Assurance

Procedures have been developed to monitor adherence to the protocol and provide a quality assurance check. After each session, the therapist should use the rating sheets provided in appendix 1 to rate adherence to the protocol and the overall effectiveness of the session. These forms are completed for each parent education session and home visit. The forms can be used to assess the progress of the intervention and to improve the protocol.

These rating sheets were developed not to evaluate the therapist but rather to evaluate the protocol. A low rating does not indicate lack of ability on the therapist's part. Therapists are encouraged to write comments in the spaces provided and discuss particular successes or difficulties with implementation of FSN with their clinical supervisor and in staff meetings.

II. Parent Education Sessions and Discussion Procedures

The six parent education sessions, each designed to last 90 minutes, provide information that complements the family support network (FSN) home visits as well as the education that the adolescent receives in motivational enhancement therapy (MET) and cognitive behavioral therapy (CBT). These sessions are interactive and allow parents to discuss and review the following topics:

1. The family support network, adolescent development, and functional families
2. Drugs and adolescents
3. Relapse signs and recovery
4. Boundaries, limits, authority, and discipline
5. Communication, conflict resolution, and fighting fair
6. The family context.

A brief overview of FSN is presented at the first session, and the importance of the family's commitment in the adolescent's recovery is stressed in all sessions. The philosophical foundation of the parent classes is strength based: by increasing the parents' understanding of issues that influence families, the family will grow stronger. One of the overriding goals of FSN is to help the family members develop lifelong support of one another. In addition, the experience of FSN helps families consider attending support groups. Some tips on conducting the sessions follow:

- Always start the first session with introductions. (Parent Education Session 1)
- Distribute name tags or provide new ones. (These can be collected at the end of each session and used in subsequent sessions.) (All Parent Education Sessions)
- If name tags are not used, be sure you know the parents' names (use a card for reference). (All Parent Education Sessions)
- Invest 15 minutes of the initial session in having participants talk about why they are attending the group or what they hope to get out of the group. (Parent Education Session 1)
- In the beginning of the first five sessions, take 5 minutes to develop rapport and settle in. (Parent Education Sessions 1, 2, 3, 4, and 5)

- For each session, provide a handout with some essential points for parents to take with them for reference. Handouts are grouped together at the end of each session narrative. (All Parent Education Sessions)

Parent Education Session 1:
Introduction to the Family Support Network,
Adolescent Development, and Functional Families

General Overview—The purpose of this session is to provide an understanding of adolescent development and the role of the family in this development. The session focuses on how healthy family functioning can make the family a source of strength for its members. One emphasis is understanding the individuation process of normal adolescent development and how families can help make it a positive experience.

Rationale—The more information parents receive on normal adolescent development and functional families, the better they can identify family issues and resolve them.

Materials—

- Overhead equipment
- Handouts:
  - *Productive Group Rules for FSN Parent Education Participants*
  - *Parent Education Sessions*
  - *Home Visits*
  - *Summary of Adolescent Classes*
  - *Typical Teen Beliefs and Rationalizations and Ways Parents Can Cope*
  - *Healthy Versus Troubled Families*
  - *Effective Parenting Questionnaire*
  - Life Stressors and Social Resources Inventory*
- Functional Family Qualities poster (purchased or made by the therapist)
- Treatment calendar (a 12-week calender with parent education and adolescent education sessions preprinted. Parents can add home visits as they are scheduled.)

Preparation for the Session

- Review the handouts.

- Purchase or create posters to decorate the family meeting space that promote positive healthy family behaviors. If you are creating them, make them big and colorful. Include the following information: Healthy families communicate and listen to, affirm, and support one another; teach respect for others; develop a

*Available from Psychological Assessment Resources, Inc., 16204 North Florida Avenue, Lutz, FL 33549, 813–968–3003, www.parinc.com.

sense of trust; have a sense of play and humor; share responsibility; teach a sense of right and wrong; have family traditions; have a balance of interaction; have a shared religious core; respect one another's privacy; value service to others; value shared meals and conversation; share leisure time; and admit to and seek help with problems.

Goal: To communicate an overview of the FSN model and the importance of family participation

1. Present the FSN model, and discuss the importance of family participation.

Give a brief description of the course of treatment, including the number of meetings, length of time in treatment, and so forth. Explain that families participate in six parent education (PE) groups. Distribute the *Productive Group Rules for FSN Parent Education Participants* and *Parent Education Sessions* handouts. Discuss the three or four inhome family therapy sessions. Distribute the *Home Visits* handout and the *Summary of Adolescent Classes* handout, and briefly describe what the children will be learning and the plan for family involvement. Talk about how the families are assuming responsibility by their participation and how the parents can take advantage of community support groups.

Hand out preprinted 12-week treatment calenders. These can easily be created on most computers. Explain that the parent education sessions and the adolescent education sessions are on the treatment calender. Explain that the parents can write the dates for the home visits on the calendar once they schedule them with the therapist or case manager. Encourage parents to post this calendar in a place where the family can readily see it. Explain that this will help the family schedule its time and avoid conflicts that may interfere with successful completion of treatment.

Goals of FSN:

- Include the family in the recovery process. Family participation will improve an adolescent's success in recovery.
- Improve family functioning, primarily by improving communication and relationships.
- Improve parents' effectiveness in dealing with substance abuse and accompanying behaviors.
- Assess the parents' and family's commitment to the recovery process. Commitment to recovery requires changes in how the parents and family approach the problem.

Goals of home visits:

- Reestablish relationships.
- Develop a new contract for rules.
- Improve communication skills.
- Develop a *Family Relapse Prevention Plan* (which is discussed in detail in PE Session 3).

2. Present information on typical teen rationalizations.

Define rationalization. Explain to parents that rationalizations are excuses people use to minimize their responsibility for their behaviors. Say: "When we experience consequences that are unpleasant, we seek excuses for why we should be exempt from such consequences. Adolescents often fluctuate between being autonomous one day and dependent the next. When teens seek to do what they want and experience resistance, they blame adults, particularly parents, for failing to understand their needs."

Discussion. Distribute the *Typical Teen Beliefs and Rationalizations and Ways Parents Can Cope* handout. Ask parents to interject any recent situations at home that are examples of these beliefs (this should be a light-hearted discussion). It is important for the therapist to provide examples of what is harmful and what is harmless behavior.

3. Present material on functional family qualities.

Discussion. Provide the *Healthy Versus Troubled Families* handout.

Discuss the differences between healthy and troubled families regarding rules, communication, alliances, feelings, self-worth, openness to change, defense mechanisms, stress, growth, and control. Discuss the handout with the parents, and allow them to ask questions.

Show parents the posters of qualities of healthy families that the therapist purchased or made prior to the session (see Preparation for the Session). Have the parents discuss the information on the posters. Ask them to add other qualities.

Discuss ways that families can enjoy more quality time together (e.g., take meals together, play together). Have the parents make a list of characteristics they like about their child or identify at least one good quality in the child. Discuss with the parents feelings they experience while making the list.

4. Discuss effective parenting behaviors.

Distribute the *Effective Parenting Questionnaire* handout, and ask the parents to rate themselves.

Discussion. Have parents share where they see themselves today and how they would like to rate themselves following treatment.

5. Present material on ineffective parenting behaviors that will help parents identify habits that may potentially prove unproductive to healthy communication.

Discussion. Information on styles that can inhibit effective parenting include the following:

- Sometimes parents cannot be effective because they are preoccupied with their own problems. These problems can include chemical dependence or psychological impairment; however, problems can also include less complicated situations such as stress from work or a relationship. It is important for parents to recognize their own problems and realize that their parenting style will be affected by personal factors they deal with daily.

- Sometimes parents attempt to protect their child by overreacting to inappropriate behaviors. Parents have a tendency to discount the opinion of a child, and this can hinder individuation of the child. In extreme cases, parents may be so angry with a child that they lose respect for the child and feel they need to be strict disciplinarians. The child is often pronounced guilty without a trial.

- Some parents may be interested in keeping things well under control. When this happens in extreme cases, the child can become insecure and timid or rebellious.

On occasion, parents may be insecure with their parenting style. As a result, they may lose the ability to set and enforce limits or rules for their children. These parents have difficulty seeing how the problem behaviors affect their family. Sometimes their children will have a difficult time in school because they are not used to taking direction and cannot accept authority.

When parents have personal needs that are not being met, they sometimes look to their children to fulfill those needs. These parents tend not to punish but to love their children to extremes. Children of such parents find it difficult to achieve independence from their parents.

People with strong beliefs are often rigid and strongly opinionated. They have a tendency to approach all people and all problems in the same manner. Sometimes, as parents, they are perceived as uncompassionate and unemotional parents. They have a difficult time seeing beyond their beliefs to the individual needs of others. These parents tend to lecture and advise often.

Summarize by pointing out that "we all face many stressors—every day. It is important to be aware of how we relate to others, especially when we are feeling pressure and stress. Parents are people, too. With strong

self-understanding, parents can become aware of factors that keep us from being effective parents."

6. Process, reflect on, and review information introduced on normal adolescent development and functional families.

Discussion. Open up the discussion by asking for reactions to the material covered. Ask parents whether they recognize any of the parenting styles discussed, and talk about ways to avoid bad habits. Talk about knowing when a teen's behavior is normal (even though it's still difficult to deal with) and when behavior is extreme and should be considered a warning sign. Ask everyone to look at the *Effective Parenting Questionnaire* handout. Ask the group to brainstorm different examples of activities that can be used to demonstrate each of the 10 categories.

7. Discuss life stressors with parents.

Introduce the Life Stressors and Social Resources Inventory (LISRES). Give parents a copy of both the adult and juvenile versions. (LISRES—Adult Version ©1994 and LISRES—Youth Version ©1984, revised in 1994, are available from Psychological Assessment Resources. Visit www.parinc.com.). It is not necessary to use this particular inventory. Similar assessment tools exist that will provide parents and adolescents with insights into the stressors that affect their lives (Butcher et al., 1992; Achenback & Edelbrock, 1987; Kaminer et al., 1997; Meyers et al., 1995; Miller 1985; Winters & Henly, 1989; Dennis, 1999).

Explain that this inventory will be scored and placed on a graph. Explain that understanding the types and degrees of stressors helps people develop strategies to decrease stressors and lessen the effects of them.

Ask parents and adolescents to fill out the questionnaires.

Ask that they return these forms before the first home visit to ensure that the instrument can be scored.

Tell them that during the first or second home visit, the therapist will review the results and discuss strategies with the parents and youth for reducing stress.

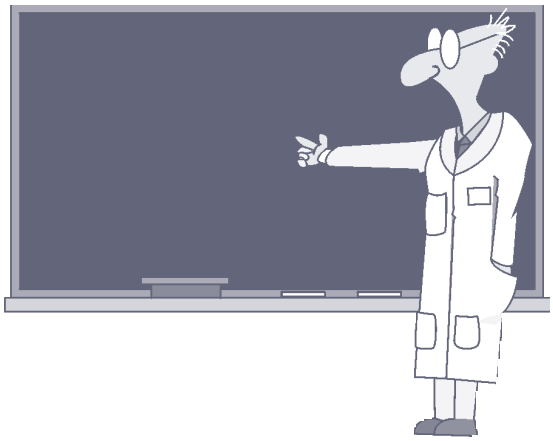
PRODUCTIVE GROUP RULES FOR FSN PARENT EDUCATION PARTICIPANTS

- I have made a commitment to attend this group on a regular basis, and it is my responsibility to inform the case manager or family therapist if I am unable to attend a session.

- By participating, I will be supporting other group members while gaining support from them.
- It is my responsibility to keep what others say and do in the group meetings confidential, that is, "What's said in the group stays in the group!"
- I should be myself and accept responsibility for my behavior.
- I will listen with an open mind and not be judgmental.
- I will respect others' ideas and suggestions discussed in the group.

PARENT EDUCATION SESSIONS

PE Session 1: Introduction to Adolescent Development, and Functional Families. This session provides an understanding of adolescent development and the role of the family in this development. The session focuses on how healthy family functioning can provide a source of strength for the family members. Ways families can help a child make the journey from adolescence to adulthood a positive experience are presented.



PE Session 2: Drugs and Adolescents. This session helps parents understand the nature of drug abuse and addiction and how adolescents become involved with drugs. The nature and objectives of treatment are addressed, and the importance of the parents' motivation to be part of their child's recovery is stressed.

PE Session 3: Relapse Signs and Recovery. The issues presented in this session are how to understand the recovery process in the context of a healthy family, ways parents can be effective in helping their child avoid relapse (a return to substance abuse), and how they can know when to appropriately step in to assist their child. Developing a healthy partnership within the family and making a commitment to a drug-free life are discussed.

PE Session 4: Boundaries, Limits, Authority, and Discipline. The concept of boundaries is introduced as a major issue in adolescent development and family life. Clarification of major issues in family functioning is provided, and appropriate approaches to discipline and parental authority are suggested. The session materials help parents understand the sources of family authority and healthy ways to maintain it.

PE Session 5: Communication, Conflict Resolution, and Fighting Fair. This session enhances parents' understanding of how and why conflict inevitably happens in families, provides concepts and methods of healthy communication for families, and presents techniques for engaging family members in open and fair resolution of conflict. Conflict is presented as a learning process, and ways to prevent conflict from becoming dangerous to the individual and family are discussed.

PE Session 6: The Family Context. This session helps adolescents and parents understand the importance of family in the recovery process and the nature of the family as an interdependent system. Parents learn how family functioning has both a direct and an indirect influence on a child's behavior.

HOME VISITS

Goals of FSN:

- Include the family in the recovery process.
- Improve family functioning, primarily by improving communication and relationships.
- Improve your effectiveness as parents in dealing with substance abuse and accompanying behaviors.
- Assess your commitment to the recovery process because commitment to recovery requires changes in how you and your family approach the problem.

Goals of Home Visits:

- Reestablish relationships.
- Develop a new contract for rules.
- Improve communication skills.
- Develop a *Family Relapse Prevention Plan*.

First Home Visit:

- Discuss the adolescent's progress in treatment and urinalysis (UA) results.
- Develop family treatment goals and a treatment contract.
- Discuss the adolescent's treatment issues.
- Conduct the "family sculpting" exercise.

Second Home Visit:

- Discuss the adolescent's progress in treatment and UA results.
- Discuss family rules, fair fighting, and conflict resolution.
- Develop the family mission statement.

Third Home Visit:

- Discuss the adolescent's progress in treatment and UA results.
- Practice problem solving and improving communication.
- Develop the *Family Relapse Prevention Plan*.

Fourth Home Visit: (conducted when indicated by treatment progress or requested by family)

- Discuss the adolescent's and family's progress in treatment and the adolescent's UA results.
- Address any family-specific treatment issues, and seek closure.

SUMMARY OF ADOLESCENT CLASSES

	Modality	Main Topics To Be Covered
Session 1	Individual	Motivation building, CYT Volume 1 (Sampl & Kadden, 2001)
Session 2	Individual	Goal setting, introduction to functional analysis, and preparation for group, CYT Volume 1 (Sampl & Kadden, 2001)
Session 3	Group	Marijuana refusal skills, CYT Volume 1 (Sampl & Kadden, 2001)
Session 4	Group	Enhancing the social support network and increasing pleasant activities, CYT Volume 1 (Sampl & Kadden, 2001)
Session 5	Group	Planning for emergencies and coping with relapse, CYT Volume 1 (Sampl & Kadden, 2001)
Session 6	Group	Problem solving, CYT Volume 2 (Webb et al., in press)
Session 7	Group	Anger awareness, CYT Volume 2 (Webb et al., in press)
Session 8	Group	Anger management, CYT Volume 2 (Webb et al., in press)
Session 9	Group	Effective communication, CYT Volume 2 (Webb et al., in press)
Session 10	Group	Coping with cravings and urges to use marijuana, CYT Volume 2 (Webb et al., in press)
Session 11	Group	Depression management, CYT Volume 2 (Webb et al., in press)
Session 12	Group	Managing thoughts about marijuana, CYT Volume 2 (Webb et al., in press)

TYPICAL TEEN BELIEFS AND RATIONALIZATIONS AND WAYS PARENTS CAN COPE

"Everything is great." Teens can be on top of the world one minute and depressed and disagreeable the next. Remember that rapid and frequent changes in feelings are normal for teens.

"Private—stay out!" This refers not just to teens' physical space (e.g., their bedroom) but also to their thoughts and feelings. They may be so confused by their feelings that they don't know how to express them. Let your teen know that you are willing to listen.

"Adults don't know anything." Teens are in the process of deciding what they believe in and what they value. It is normal for them to rebel—at least temporarily—against what they have been told by parents. By ignoring harmless rebellions about food and clothes, you give your teen a safety valve to express himself or herself. This may prevent your teen from getting into self-destructive rebellions such as drug abuse.

"They're my friends." Teens want the acceptance and approval of people their own age, just as adults do. The more teens feel accepted and supported at home, the less likely they are to be negatively influenced by their peers.

"Sometimes I hate myself." Nearly all teens have periods of low self-esteem. They need your encouragement. Look for honest ways to boost your teen's self-esteem.

"No one else has to be in by 11 p.m." Teens often test the boundaries their parents set for them. They need to know that you are going to prevent them from harming themselves. Establishing some basic ground rules about chores, dating, driving, and curfew gives teens something to fall back on as they develop their own decisionmaking abilities. Rules should be few, arrived at by negotiation between you and your teen, and clear to everyone involved. Writing them down is a good idea.

"But everyone drinks and tries pot!" Sooner or later teens find themselves in a situation in which they must decide whether to use drugs. You can help by modeling infrequent use of alcohol and prescription or over-the-counter drugs. If you overuse alcohol or drugs, it is likely that your teen will as well. Plan with your teen, ahead of time, how he or she can handle a drug-using situation, and specify ways you can help.

Note: The above behaviors are exhibited by non–drug-using teens as well as drug-using teens. It is important to learn when your teen is using these beliefs to manipulate you or to cover up inappropriate behavior. Unfortunately, there is no certain way of knowing which is the case.

HEALTHY VERSUS TROUBLED FAMILIES

Remember, there is no right or wrong, good or bad, black or white. If emotional pain exists, we have a choice to stay in the pain or make changes to remove the pain.

	Healthy Families	Troubled Families
1. Rules	Few rules exist, and they are clear and specific. Rules are respected, consistently enforced, fair, and negotiable. Rules lead to a predictable environment.	Some rules are occasionally enforced, but others are not. Often no discussion is allowed on changing or modifying rules. In some cases rules are completely absent, making members feel uncertain or anxious because they do not know what is OK and what is not.
2. Communication	Clear responsibility is taken for statements, which are open and considerate of others. People take risks to express feelings, ideas, and beliefs. If a problem exists, the family discusses it and seeks outside help if necessary.	Communication is almost nonexistent. There is a lot of talking about the person instead of to the person. Double messages, secrets, and a lot of "should's" and "ought to's" are frequent. Family secrets are protected at all costs, and there is fear of seeking outside help.
3. Alliances	Members take time with one another individually and together. There is a strong parental relationship.	Family members take sides and reject other members. They form hidden relationships (even across generations). The parental relationship is weak or nonexistent, or one parent may dominate.
4. Feelings	Members allow and respect feelings. There is an honest expression of vulnerable feelings.	Members do not discuss or allow feelings. There is fear of feelings; people try to hurt one another. Some feelings are OK, whereas others are not.
5. Self-worth	High self-worth exists. Persons are separated from their behavior. Members listen with interest and respect. Members respect others' views.	Individuals are treated without respect (this includes adults and children). Children are seen but not heard. A person is condemned, not his or her behavior. Shame is used for punishment. Blaming is common. Cynicism and negative attitudes exist.
6. Change	Members are open to change.	Members are rigid, fixed, and not open to change. "Nothing can be done; what is the use."
7. Defenses	Members display defenses that are functional and appropriate to the situation.	Problems and feelings are denied. Pain is hidden. Strange or unusual behavior is ignored. There is a "no talk" rule—even about serious problems.
8. Stress	Members know how to deal with stress. They can see when others are in pain and can nurture and comfort.	Members avoid pain in themselves and others. They deny stress and often feel they can't cope.
9. Growth	Members accept and welcome life stages.	Parents may compete with children, growth is painful, and change is feared.
10. Control	There is less need to control. Parents are in charge but can negotiate. They respect children's opinions.	There is rigid control or shifting patterns of domination, possible upside-down family (children running the family).

EFFECTIVE PARENTING QUESTIONNAIRE

Rate yourself in the following categories on a scale of 1 to 10. A rating of 10 is the highest score.

1. Listening without judging _____
2. Showing love and affection _____
3. Developing regular family times _____
4. Asking questions about your teen's daily and weekly activities _____
5. Criticizing behavior—not the person _____
6. Supporting your teen's problem-solving efforts _____
7. Being courteous _____
8. Praising your teen _____
9. Spending time with your teen _____
10. Delaying some gratifications _____

Parent Education Session 2:
Drugs and Adolescents

General Overview—This session helps parents understand the nature of drug abuse and dependence and how adolescents become involved with them. It presents the nature and objectives of treatment and the importance of parents' motivation to be part of their child's recovery.

Rationale—The more information parents receive about adolescence, drug use, and its signs and symptoms, the better able they are to intervene and help their children.

Materials—

- The National Institute on Drug Abuse video *Drug Abuse and the Brain**
- Markers and whiteboard
- Handouts:
  - *Disease Progression Chart*
  - *Drug Category Information and Consequences of Use*
  - *Drugs of Abuse Detection Times*
  - *Developmental Changes for Adolescents*
- Overheads
  - Developmental Changes for Adolescents
  - Questions About Drug Issues

Goal: To provide parents a better understanding of adolescent drug abuse

1. Discuss the disease concept of addiction and what it means in the process of recovery.

Discussion. Share with parents that their children may be at different stages of drug use. Some may be in the experimental stage. This means that they are just now trying substances and have not established a regular pattern of use. However, some may have established a regular pattern of use, meaning that they regularly use and look forward to using. This pattern could be monthly, weekly, or daily.

Explain that if their child uses in a regular pattern, this means that the adolescent is abusing drugs. Most of the time, but not always, establishing a pattern takes time. But for some people, a regular pattern of use can develop quickly. They try a substance, and in a short time they can be using daily. Explain, "Once anyone, youth or adult, has established a pattern of use, we need to examine whether the process of addiction has begun. Not everyone who uses becomes addicted. We will talk about all the factors that influence a youth's desire to pick up and maintain continued use."

*Information on ordering the video is available from the National Institute on Drug Abuse online publication catalog. Visit www.nida.nih.gov/PubCat/PubsIndex.html.

Distribute the *Disease Progression Chart* handout. Discuss addiction and how a person's body responds to drugs and alcohol. Explain that a video will be shown that will explain how drugs affect the brain. Tell parents that there is a *real* physical basis for addiction, including addiction to marijuana. Addiction ultimately means that the substance, whether it is alcohol or a drug, takes over the person's life. Remember to take time to answer any questions on this issue.

2. Distribute the *Drug Category Information and Consequences of Use* and *Drugs of Abuse Detection Times* handouts.

Discussion. Discuss the urinalysis (UA) for drug screening and how it works, explaining what it means and what it does not mean. Briefly cover information on the handouts, stressing the following points:

- A negative UA, or one that indicates that marijuana is not present, does not "prove" that the child is not using but only that the child has not used within the window of detection for testing or that the amount is below the level needed for identification.

- Testing for tetrahydrocannabinol (THC) is not 100-percent accurate. It is possible to obtain a positive result, or a result that indicates that marijuana is present, even if the child has not recently used because THC is stored in fat cells. If the child changes his or her exercise pattern or diet and loses weight rapidly, a positive result can be obtained without the child recently using the drug. Subsequent UAs should result in lower levels of THC if the child is no longer using.

Answer any questions.

3. Initiate a discussion based on essential points.

Discussion. Initiate a discussion with the group on the following points:

- *Parental ambivalence.* Research has shown that an important protective factor for adolescent drug use is parental attitudes. Adolescents perceive parental ambivalence the same as parental acceptance of drug use. This is particularly true for baby boomer parents. Not saying anything to your kids is the same as telling them it is OK.

- *Parental use.* Some parents use alcohol and drugs. If adolescents are aware of their use, it will be very difficult to motivate them to quit. Parents who do not currently use drugs but used them when they were younger may feel guilty when talking about not using drugs to their children and will often avoid the discussion. Parents in this situation should not let the child know about past drug use. The parents' admission usually only gives the teen permission to use drugs. If children know about their parents' drug use, parents should do the best they can to explain the

negative consequences they experienced. If children ask about parents' past drug use, parents should avoid the topic by saying, "Let's stay on track; this conversation is about you, not me."

- *Other life problems.* Children often turn to substance abuse to meet a need. Therefore, substance abuse is often a symptom of another problem. The problem could have a multitude of factors. It may be beneficial to explore what a child might be experiencing that caused him or her to turn to drugs by asking the following questions:
  - Were there any recent events that might have been a trigger to use?
  - What personality characteristics or tendencies does the teen have that may lead him or her to use?
  - Has the teen experienced any difficulties in relationships, either inside or outside the family?
  - How does the teen cope with stressful life events?
  - How does the teen cope with feelings?
  - How is the teen's self-esteem? What can parents do to help boost the teen's self-esteem?
- *Substitution of one drug for another.* It is important to be aware that, as adolescents progress through treatment, they will often switch drugs. Therefore, it is important to watch for signs and symptoms of all the drugs discussed earlier, not just the ones the teen is currently using. Often alcohol use will increase as a substitute for the drug of choice, especially if the youth's urine is being tested regularly.
- *Negative consequences of marijuana use.* Adolescents believe that marijuana is not harmful. It is a difficult battle to convince them that marijuana has negative consequences. Parents should share with their child any information they have that would change the child's perception. Let the child know the following:
  - Continued marijuana use in early years interferes with the ability to learn and remember.
  - Childhood and adolescent learning provides the foundation for the years to come.
  - Marijuana affects the ability to be responsible. (Remind children that parents believe they desire to be mature and responsible.)

4. Introduce, show, and discuss the *Drug Abuse and the Brain* video.

Discussion. Before showing the video, ask participants to look for two or three key messages in the video. Show the 25-minute video. Initiate a discussion about the video.

5. Introduce the stages of adolescent development.

Point out that there are special issues to consider when dealing with adolescent substance abuse. Teens are going through developmental stages that can be affected by drug use. Introduce the effects drugs have on an adolescent's developmental stages.

Distribute the *Developmental Changes for Adolescents* handout. This handout provides a comparison of normal development with developmental changes due to chemical dependence. Make an overhead of the handout if appropriate.

Discussion. Direct parents to the first grid that describes normal adolescent development for early and late teen years. Explain that some adolescent behaviors, although less than desirable, are normal and are part of growing up. Direct parents to the second grid that compares normal and chemically dependent phases. Make sure parents understand the terminology and the difference between normal development and inappropriate developmental changes associated with drug use. Finally, mention the last grid that gives some reasons why adolescents may turn to drug use. Have the parents relate the characteristics listed in the grid to their own children and try to understand why their children may have started using drugs. Have parents openly discuss the possible reasons their children may have turned to drugs.

6. Initiate a wrapup discussion using probing questions to reinforce the valuable information introduced in this session.

Discussion. Show an overhead of the following questions:

- How do drugs create problems for families?
- Why do children use drugs?
- Are families powerless in helping their children?
- What do you expect from treatment?

The purpose of this overhead is to generate group interaction and encourage participants to share responses. There are no right or wrong answers to the questions. Discuss these questions, and then spend a few moments writing down additional questions from the group and sharing some answers. Responses should be general feelings rather than personal answers. Reinforce positive responses, and write essential observations on the board.

7. Obtain a commitment from parents to continue attending the group sessions.

Discussion. Ask for a commitment from the parents, for the sake of their child and other group members, to continue with the group. Close the session by stating the topic of the next meeting and encouraging parents to do a family activity before that meeting. Suggestions for a family activity should be simple, short in duration, and cost no money. These suggestions should provide the family with some guidance but should not be an unnecessary strain on their functioning in the beginning of treatment. Examples include having at least one family meal at which everyone agrees to discuss only an interesting event they observed that week. Explain that the family can agree that during this meal no one will be allowed to criticize or make fun of others at the table. Another event could be watching an appropriate television show or movie that everyone would like to see. Tell parents that they will be asked to share how the event went with the other members of the group at the next session.

Thank everyone for attending and being supportive parents, and remind them how important their attendance and commitment are to their teens.

DISEASE PROGRESSION CHART

Early Stage

1. Sneaks drinks/drugs
2. Is preoccupied with alcohol/drugs
3. Gulps drinks
4. Avoids reference to alcohol/drug use
5. Has memory blackouts
6. Has increased alcohol/drug tolerance
7. Drinks/uses before and after social occasions
8. Begins relief drinking/using
9. Is uncomfortable in situations without alcohol/drugs
10. Experiences loss of control
11. Is dishonest about alcohol/drug use
12. Has increased frequency of relief drinking/using
13. Hides and protects supply
14. Experiences urgent need for first drink/drug
15. Tries periods of forced abstinence
16. Receives disapproval from others for drinking/drug use
17. Rationalizes drinking/drug use
18. Experiences flashes of aggressiveness
19. Exhibits grandiose behavior
20. Has guilt about drinking/drug use
21. Neglects eating
22. Builds unreasonable resentments
23. Devalues personal relationships
24. Considers geographic escapes or geographic “cures”
25. Has decreases in sexual drive
26. Quits or loses job
27. Exhibits unreasonable jealousy
28. Drinks/uses alone
29. Tries to control drinking/drug use
30. Experiences tremors and shakes
31. Drinks/uses in early morning
32. Has persistent remorse
33. Participates in lengthy drinking/drug binges
34. Experiences impaired thinking
35. Drinks/uses with inferiors
36. Loses tolerance for alcohol/drugs
37. Has indefinable fears
38. Is unable to work
39. Has deteriorating physical state
40. Has deteriorating moral standards
41. Is admitted to hospital
42. Feels persistent remorse
43. Loses family and friends
44. Exhausts all alibis

Middle Stage

Late Stage

DRUG CATEGORY INFORMATION AND CONSEQUENCES OF USE

ALCOHOL—Alcohol is the substance most commonly abused by Americans. It is a potent depressant, quickly assimilated into the bloodstream. On reaching the brain, it acts on the central nervous system to depress brain activity on all levels and reduce coordination.

Slang Names:	booze, brew, spirits
Effects:	relaxation, decreased alertness, impaired coordination, repression of normal fears and inhibitions
Duration of Physical Effect:	one drink lasts between 1 hour and 2 hours (maximum)
Symptoms:	flushed face, vessel dilation, loss of motor control
Symptoms of Overdose:	blue clammy skin, shallow respiration, weak pulse, arrested cardiac functioning
Chronic Use:	heart, brain, liver, circulatory system, and intestinal damage; also, damage to the fetus of a pregnant woman
Dependence:	moderate to high
Method of Ingestion:	oral

NICOTINE—Tobacco is the leading drug problem today in terms of health consequences. There are an estimated 56 million users in the United States alone.

Slang Names:	coffin nails, butts, smokes
Effects:	relaxation and easing of tension, appetite suppression
Duration of Physical Effect:	1 to 6 hours
Symptoms:	smell of tobacco, stained teeth, increased blood pressure and heart rate
Chronic Use:	cancers of the lung, throat, mouth, esophagus; bronchitis; stomach ulcers; lowered immunity; heart disease; emphysema
Dependence:	high
Method of Ingestion:	smoked, chewed

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MARIJUANA—Marijuana comes from the hemp plant, *Cannabis sativa*, which grows in many parts of the world. The dried flowers and leaves are usually smoked in a cigarette, or "joint," or a pipe. Marijuana can also be eaten. Marijuana contains hundreds of different chemicals that produce diverse effects on the mind and body. The most significant of these chemicals is THC, the major psychoactive (i.e., mind-altering) ingredient. The average "joint" contains 2 to 7 percent THC; however, stronger strains with a THC level of 13 to 14 percent are now available on the street, posing a significant risk to users.

Slang Names:	pot, reefer, Mary Jane, hash, loco weed, hemp, blunt
Effects:	relaxation, euphoria, alteration of inhibitions
Duration of Physical Effects:	euphoria lasts 2 to 4 hours; heavy use lasts 24 hours; drug may be detected in urine and blood for several weeks
Symptoms:	drowsiness; impaired coordination; confused speech; eyes red, but pupils appear normal; coughing; dry mouth and throat
Chronic Use:	memory distortions, reproductive system effects, lung and lung function damage, psychosis
Dependence:	moderate to high
Method of Ingestion:	smoked, eaten

STIMULANTS—These drugs stimulate the central nervous system and include cocaine, amphetamines, caffeine, nicotine, Ritalin, and methylenedioxymethamphetemine (MDMA also know as ecstasy). Stimulants were once known as the drug of the rich and famous, but they are now used by individuals at all economic and social levels. Cocaine is the most reinforcing drug used by people to produce pleasure.

Slang Names:	coke, snow, toot, white lady, happy dust, speed, uppers, pep pills, bennies, dexies, meth, crystal, crank, ice, black beauties, hearts, co-pilots, cartwheels, greenies, browns, whites, diet pills
Effects:	loss of appetite, indifference to pain, feelings of intense sexuality, exhilaration, increased alertness, anxiety, irritability
Duration of Physical Effects:	from a few minutes to 2 to 4 hours; smoked ice can last up to 24 hours
Symptoms:	restlessness, intense short-term high, dilated pupils, excess activity, mood swings, needle marks, burn marks on lips or fingertips, burned holes in clothing
Chronic Use:	nausea, deterioration of the lining of the nose, stomach disorders, paranoia and "formication" (the feeling that insects are crawling beneath the skin), death occurring from overdose, psychosis, hallucinations, convulsions, coma

(Continued on next page)

Dependence:	high
Method of Ingestion:	snorted, injected, oral; ice can be smoked, snorted, or injected

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INHALANTS—Inhalants are legal products abused by sniffing (e.g., spray paint, hairspray, gasoline, lighter fluid, airplane glue, paint thinner, nail polish remover, typewriter correction liquid).

Slang Names:	poppers, laughing gas, rush, white-out
Effects:	euphoria, relaxation, violent behavior, hallucinations, alcohol-like high
Duration of Physical Effects:	a few seconds to several hours
Symptoms:	numbness, confusion, nausea, vomiting, tremors, memory loss, visual impairment, possible respiratory arrest, coma, death
Chronic Use:	lung, kidney, bone marrow, and brain damage
Dependence:	high
Method of Ingestion:	inhaled

HALLUCINOGENS—Hallucinogens are drugs that alter perceptions of reality, including phencyclidine (PCP), lysergic acid diethylamide (LSD), mescaline, and psilocybin.

Slang Names:	angel dust, killer weed, supergrass, hog, peace pill, LSD, acid, trips, cubes, sunshine, windowpane, purple haze
Effects:	varies from relaxation and euphoria to vivid distortions; paranoia; psychosis; visual, tactile, auditory, and olfactory hallucinations; altered perceptions; breakdown of inhibitions; dilated pupils; mood swings
Duration of Physical Effects:	PCP lasts 2 to 4 hours, PCP-related psychosis may last for weeks; LSD lasts 8 to 12 hours, flashbacks may last for weeks or up to 1 year
Symptoms:	users are physically anesthetized and may appear to possess superhuman strength; respiratory depression, seizures
Chronic Use:	memory disturbances, speech problems, anxiety, extremely violent behavior, paralysis, death occurring from both accidents and overdose, increased delusions, panic, psychosis, emotional breakdown, brain damage

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Dependence:	moderate to high
Method of Ingestion:	oral, smoked, snorted; acid can also be placed on mucous membrane areas—eyes, anus, etc.

DEPRESSANTS—Depressants are drugs that relax the body muscles, temporarily relieve feelings of tension and worry, and bring on sleep. Low doses produce mild sedation; high doses induce euphoria. Depressant overdose is the leading cause of suicide among American women. These drugs are extremely dangerous when consumed with alcohol. Types of depressants are barbiturates, tranquilizers, Rohypnol, benzodiazepines, and methaqualone. All are easily available by medical prescription.

Slang Names:	downers, reds, pinks, yellow jackets, bluedevils, Christmas trees, barbs, Xanax, Valium, roofies, Ativan, Quaaludes, black beauties, goof balls
Effects:	depresses central nervous system and respiration system, slows heartbeat rate, and relaxes muscles
Duration of Physical Effects:	3 to 24 hours
Symptoms:	drowsiness, confusion, slurred speech, impaired judgment, belligerent behavior, needle marks in people who are severely addicted
Chronic Use:	rapid physical and psychological dependence, addiction with severe withdrawal symptoms, loss of appetite, death from overdose
Dependence:	high
Method of Ingestion:	oral, injected

Drugs of Abuse Detection Times

Substance	How Used	Possible Dangers	Approximate Detection Time in Urine
Alcohol	Orally	Liver disease, respiratory failure, anxiety, depression, coma, psychological or physical addiction, death	3–10 hours
Uppers/Stimulants (amphetamines, speed, dexedrine, ice, Ritalin, ecstasy)	Orally, injected, or inhaled	High blood pressure, loss of appetite, stroke, fever, heart failure, psychosis, death	2–4 days
Downers/ Depressants or Sedatives (barbiturates, black beauties, goof balls, nembies, seccies)	Orally	Respiratory failure, depression, anxiety, convulsions, insomnia, coma, psychosis, psychological or physical addiction, death	Short-acting or immediate: 2–4 days Long-acting: up to 2–4 weeks
Tranquilizers (benzodiazepines, roofies, Xanax, Valium)	Orally	Respiratory failure, depression, anxiety, convulsions, insomnia, coma, psychological/physical addiction, death	1–5 days or up to 2 weeks following heavy abuse
Marijuana, Hashish (cannabinoids, reefers, grass, blunts)	Smoked or eaten	Damage to short-term memory and lungs, psychosis, psychological dependence, birth defects	Infrequent user: up to 10 days Chronic user: 30 days or more
Cocaine (coke, crack, blow, nose candy)	Inhaled, injected, or smoked	Damage to nasal passages, weight loss, high blood pressure, heart attacks, strokes, convulsions, psychological or physical addiction, death	2–4 days
Hallucinogens (LSD, white lightening, acid, microdot)	Orally or in eye drops	High blood pressure, loss of appetite, sleeplessness, anxiety, flashbacks, tremors, psychological disorders	1–2 days
Heroin, Morphine (opioids, smack, china white, brown sugar, percs)	Orally, injected, inhaled, or smoked	Loss of appetite, nausea, vomiting, respiratory failure, convulsions, coma, psychological or physical dependence, death	2–3 days
PCP (phencyclidine, angel dust, rocket, fuel, hog)	Orally, injected, or inhaled	Dulled coordination and senses, anxiety, depression, high blood pressure, convulsions, violent behavior, heart failure, stroke, coma, death	3–8 days
Synthetic Narcotics (Demerol, Dilaudid, Darvon, methadone)	Orally, injected, or inhaled	Nausea, vomiting, respiratory failure, infections from needles, convulsions, psychological/physical addiction, death	1–4 days

DEVELOPMENTAL CHANGES FOR ADOLESCENTS

Normal Development in Adolescents	
Characteristics of Early Teen Years	**Characteristics of Late Teen Years**
Often has extreme emotions	Has somber, quiet demeanor
Begins to assert himself or herself; is no longer a child	Establishes his or her own beliefs
Shifts back and forth from relatively mature to childish	Wants to know where adults stand on issues
Is concerned about appearance to others	Is relatively uncommunicative
Searches for self-understanding	Resents infringements on his or her freedom
Is often happy and outgoing	Divorces himself or herself from family activities
Relates successfully to adults and peers	Has group friendships
Can be sensitive	Is in the first stage of real independence
Likes developing his or her own ideas	Has increased interest in sexual activities
Has more worries than fears	Is more autonomous with respect to parents
Likes showing individuality	

(Continued on next page)

Adolescent Developmental Phases	
Normal	**Chemically Dependent**
Becomes more egocentric and self-involved	Cannot see reality of his or her own condition
Anticipates consequences of actions	Confuses "what I am" with "what I do"
Looks for "fairness"; can detect logical inconsistency	Thinks drug is "me"
Is preoccupied with his or her own thoughts	Blames others for his or her own feelings
Is somewhat withdrawn and isolated	Identifies himself or herself as a "druggie"; is obsessed with drugs and drug-using activities
Is moody	Is socially withdrawn
Has intensified feelings	Becomes excessively moody due to chemical use
Debates and argues for the sake of argument	Has inflated image of his or her own importance
Questions adult decisions and authority	Feels indifferent to criticism
Changes previously held values	Debates and argues with authority
Questions values and family rituals	Rejects previously held values and authority
	Rejects previously respected authority figures
	Remembers selected information

Motivation for Adolescent Drug Use	
Feels accepted by chemical users	Finds it easier to have a relationship with chemicals than with a person who can reject him or her
Feels pressured to conform to drug group	Feels less inhibited when using chemicals
Feels chemicals work "first time, every time" to make a person feel good	Uses drugs to numb bad feelings about self and others
Feels more self-accepting	

Parent Education Session 3: Relapse Signs and Recovery

General Overview—This session focuses on understanding the recovery process in the context of a healthy family and presents ways parents can effectively help their child avoid relapse and how they can know when to intervene appropriately. It also focuses on developing a healthy partnership within the family and a commitment to a drug-free life as well.

Rationale—The more information parents have regarding the signs and symptoms of relapse, the better able they are to intervene.

Materials—

- Handouts:
  - *Signs and Symptoms of Substance Abuse*
  - *Relapse Prevention Plan*
  - *Fire Drill Plan for Staying Drug Free*
  - *Signs of Recovery*
  - *Recovery Expectations*
  - *Plan for Recovery*
  - *Family Relapse Prevention Plan* (in preparation for home visit)

Goal 1: To develop an understanding of the potential problems resulting from continued use of drugs, including the process of addiction

1. Assist parents in recognizing the difficulties of parenting.

Write on the board:

Our children are in trouble, and drugs have become a major part of the trouble; our goal is to set out a new life for them and our families.

Ask a parent to read the statement and share his or her feelings about trying to meet this goal, the importance of reaching the goal, and the difficulties he or she foresees in reaching the goal.

2. Introduce the topic of recovery, and discuss the importance of family involvement in the adolescent's recovery.

Write on the board:

The adolescent can't do it alone.

Discussion. Briefly present information on the importance of the family's involvement in the treatment and recovery processes of the adolescent. Family involvement helps build mutual responsibility and empathetic interactions between the parents and children. For example, say, "The family is involved, like it or not. Whether children grow up to be healthy or to be long-term drug abusers may be up to us. That is why we are here. We care. We want to make a difference in their lives. We want our children to

be healthy and have a good life. This is our chance, but we have to go about it intelligently."

3. Discuss the signs and symptoms of substance abuse.

Distribute the *Signs and Symptoms of Substance Abuse* handout.

Advise parents that in addressing relapse prevention, they will look at two issues: (1) signs and symptoms and (2) addiction.

Remind parents that their children have made progress in their commitment to treatment and not using substances.

State that parents must still remain alert. This does not mean that they should distrust their child. However, they must remember to stay aware because the child may not be completely out of trouble. Parents should watch (though not obsessively) for the signs and symptoms of relapse that are presented in the handout. Review the handout.

Goal 2: To develop an understanding of the recovery process and to learn that recovery is a long process and that part of this process is relapse prevention

1. Discuss the recovery process, ways to prevent relapse, and subtle signs of relapse.

Discussion. Recovery begins with some type of intervention. This intervention means that the person will receive knowledge and tools to help maintain abstinence.

In addition to remaining drug free, it is extremely important that the youth work on making healthy personal changes and understand relapse prevention. This is where the family can make a difference.

Relapse prevention involves:

- **Maintaining health.** It is important to develop good health habits to stay strong. This strength will give the youth the necessary energy to combat problems and take care of himself or herself.
- **Identifying all triggers.** Triggers are events or things that initiate a desire to use.
- **Identifying all danger points.** Some days will be exceptionally difficult in the process of recovery. These critical times are related to the withdrawal of drugs from the body. The process of withdrawal is different for different substances.
- **Determining emotional growth issues.** The individual must learn to (1) deal with negative feelings (e.g., anger, guilt, loneliness, stress, fear), (2) establish or reestablish values (e.g., not

lying/being honest with oneself and the family), and (3) find new challenges.

- **Addressing environmental or social issues.** The affected individual must find new activities, new friends, and new surroundings.

- **Developing support groups.** For some people, this is the most important determinant of recovery. A support group can help with all areas of life where triggers to relapse often occur. In this intervention, the family is the support group.

2. Discuss and identify potential problems that can lead to relapse.

Discussion. Relapse is a process that starts well before the actual use of drugs. If the individual is not practicing or using his or her coping tools on a *daily* basis, the risk of returning to substance use increases.

Relapse Prevention Guidelines:

- It is important not to let a child deteriorate physically. This will contribute to feeling poorly and will make it easier for urges to "sneak up" on him or her.

- It is important for a child to be aware that "old thinking" can return, which includes justifying negative behaviors and denial (e.g., I can use once in a while). It is important for the person to talk about the desire to use by letting someone know what is going on in his or her life to trigger the urge.

- It is important for both parents and their child to be aware of "danger points" and to plan to be particularly open and watchful with one another during these times.

- It is important for a child to share feelings. Feelings are always eventually expressed, either in a direct, healthy manner or in an indirect, negative manner. Painful feelings about past events may need to be discussed. Parents should share with their children how past events are still affecting the family to begin the healing process.

- It is important for a child to develop new interests and activities. Slowly, he or she needs to begin to become involved with new people and to explore ways to make new friends. Children should be aware that even adults have to do this sometimes.

- It is important for your child to identify a support system and maintain regular contact with that support system. This support could include a coach, minister, neighbor, and/or a relative.

Distribute the *Relapse Prevention Plan* and *Fire Drill Plan for Staying Drug Free* handouts. Discuss handouts with parents. Explain to parents that their

teens may be filling out forms similar to these during their counseling sessions.

3. Present the *Signs of Recovery*, *Recovery Expectations*, and *Plan for Recovery* handouts.

Distribute the *Signs of Recovery* and *Recovery Expectations* handouts, and discuss what parents can expect as their adolescent begins the recovery process. Review the *Plan for Recovery*, and explain that parents who understand the problems that adolescents may encounter during recovery can develop a plan to cope with situations. Explain that the more prepared parents are, the more they can help their child deal with potential relapse issues. Elicit discussion from all parents about the feelings adolescents may have during treatment and early recovery and how a parent can react effectively.

4. Introduce the importance of a family relapse prevention plan, and explain the need for the adolescent abusing drugs to have a relapse prevention plan.

Discussion. Present the research that shows that relapse prevention plans increase the chances of recovery and enable individuals and families to preplan strategies for troubling times. A good resource for information is Bell (1992). Bell is a prominent researcher and author on the subject of adolescent addiction, relapse, and recovery.

Discuss the essential components of an effective plan (e.g., awareness of the problem, problem-solving methods, where to get help, necessary changes in family routines).

Point out that relapse is a "process and not an event." Encourage a discussion that explores the concept that relapse starts long before the return to substance abuse or a return of family dysfunction. Refer to the *Signs and Symptoms of Substance Abuse* handout discussed earlier. Discussion should center on the need for awareness of typical signs and symptoms of family and individual relapse to prevent rapid deterioration.

Distribute the *Family Relapse Prevention Plan*. Instruct parents that they, and each member of the family, must briefly answer each item. For instance, under "Previous Signs," ask each member to name a sign or symptom that the family displayed that caused problems. An example from one child might be, "There was always a lot of yelling, and no one listened to anyone." Under the item "If the family has a problem," each member writes down something about the problem that he or she will commit to doing. For example, the parent might say that if there is a problem, he or she will bring it to the attention of the whole family immediately. Under "Support Groups and Meetings," each member writes down the name of the group he or she will commit to attending.

The importance of this relapse prevention plan is to acknowledge the previous signs of problems and commit to doing things differently as

individuals and as a family unit. The counselor should ask family members to work on it at home. The inhome therapist will review it with them during home visit 3. At that visit, all family members will discuss their ideas with the therapist. The therapist will help them finalize the plan and will ask each member to sign the final plan.

5. Provide parents with information about community support groups.

Discussion. Share information about Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and other community support groups. Provide information about where and when the meetings occur. Discuss the importance of having a support network after treatment, and note that the recovery process does not end with this program.

6. Discuss questions regarding relapse and recovery.

Allow parents to expand this discussion to address their concerns. Ask group members to share what they expect from treatment. Encourage them to discuss what they can do and to continue this discussion at home. Ask the following questions:

- What do you expect from treatment?
- How can you help with this process?
- How long term is the problem?
- What changes will you have to make?
- Are you willing to make changes in the way you do things?

SIGNS AND SYMPTOMS OF SUBSTANCE ABUSE

If you notice any of the following, you may want to seek help immediately.

- Physical signs of renewed substance use:
  - Peculiar odors of marijuana, alcohol, or solvents on your child, on his or her clothing, in the house, or in the car
  - Presence of drugs or drug paraphernalia in your child's environment or in dirty laundry (e.g., presence of seeds, leaves, or butts in ashtray or clothing pockets; use of small baggies, cigarette papers, or other unusual small containers)
  - Use of eye drops, room deodorizers, or incense
  - Slurred speech or intoxication (Note: Impairment of physical function may signal an event requiring *immediate medical attention*. In a medical emergency, call 911.)
- Noticeable change in school performance (e.g., drop in grades or attendance, disciplinary reports from the school)
- Sudden change in social pattern (new friends, activities, choice of music, etc.)
- Secretiveness about friends or activities
- Sudden change in family relations (withdrawal, belligerence, marked increase in family arguments either with parents or with siblings, especially regarding setting limits)
- Noticeable change in personality (lethargy, loss of motivation or interest)
- Sudden changes in mood (e.g., aggressive anger, sullenness, uncaring attitude and behavior)
- Deterioration in physical appearance (general unhealthy appearance, bloodshot eyes, lack of alertness, decrease in neatness or personal hygiene)
- Involvement in legal problems or delinquent behavior
- Unusual financial problems, repeated pawning or selling of personal effects
- Extreme dress, language, opinions, or behavior.

RELAPSE PREVENTION PLAN

Relapse is preventable. By answering these questions, you become aware of possible relapse-producing events or causes. This plan can work against your usual excuses. Please be specific, and, if possible, answer each question with more than one answer. Remember, the more you put into it, the more you get out of it!

How many 12-Step (or other self-help) meetings will you attend? Please indicate the place, day, and time.

_____

_____

_____

_____

_____

_____

What times are you most likely to use alcohol or drugs? What will you do instead? Be specific.

_____

_____

_____

_____

_____

_____

What actions will you take when you get angry or frustrated? Please indicate immediate and future actions.

_____

_____

_____

_____

_____

_____

(Continued on next page)

Describe your plan to handle situations that make you afraid.

What life events or losses could cause you to use drugs or drink?

Make a list of those people who can give you support in times of need. Indicate how often you will meet with them.

Will you be able to ask these people for help? Write down how you will ask them for help.

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How will you start each day? End each day?

What are some positive actions you can take when you are lonely?

What are some positive actions you can take when you're not getting along with friends or family?

What are some actions you can take if 12-Step meetings begin to feel boring or unimportant?

FIRE DRILL PLAN FOR STAYING DRUG FREE

_____	_____
Name	Phone number
_____	_____
Sponsor, AA, NA	Phone number
_____	_____
Counselor	Phone number
_____	_____
Other support	Phone number

Smoke Plan: If I am in a crisis situation, this is what I will do!

What emotions can trigger drinking/drug using?	Planned preventive action
_____	_____
_____	_____
_____	_____
_____	_____

What situations can trigger drinking/drug using?	Planned preventive action
_____	_____
_____	_____
_____	_____
_____	_____

If I return to drinking/drug using, this is what I will do!

_____

_____

_____

This is a plan of action—TOUGH LOVE—because I want to be part of the solution and not part of the problem. This fire drill may need to be updated at some time. I am open to discussing any changes and open to asking an influential person to help.

Date:_____ Signature of client:_____

Date:_____ Signature of counselor:_____

Date:_____ Signature of parent/guardian:_____

SIGNS OF RECOVERY

The Recovering Person:

- Continues to build a sober lifestyle
- Respects the boundaries of oneself and others—has reasonable expectations
- Builds relationships with people who share the same values and the desire to live responsibly
- Continues to trust others and to gain the trust of others
- Finds being honest and trustworthy gets easier and easier
- Has a network of support (AA, NA, faith-based groups, parents, coaches, teachers), and expresses a sober belief system in word, deed, and thought
- Makes reasonable short- and long-term goals, and begins to achieve them
- Avoids those who abuse drugs and places where they are being used.

The Recovering Family:

- Ensures that the family home is a place that becomes increasingly comfortable and peaceful for its members (It does not have to be "perfect" all the time—that's an unrealistic expectation.)
- Remembers to fight fair, respect one another, and give support when others need it
- Celebrates the accomplishments of each member, and shares feelings of joy, pain, fear, and excitement
- Continues to grow to form a lifelong FAMILY SUPPORT NETWORK.

RECOVERY EXPECTATIONS

1. **It is not necessary to promise sobriety. Slips happen, so plan to deal with them. Broken promises only increase guilt and failure.**

2. **Watch for unrealistic expectations. At this point in recovery, it is important to keep feelings of resentment and disappointment to a minimum. These feelings can be used as an excuse to return to substance use.**

3. **Be aware of how the adolescent deals with and expresses anger, frustration, and depression. Discuss plans to deal with these emotions as a family.**

4. **Physical and emotional pain will be more pronounced without substance use. Families need to be aware of this and have a plan to deal with emotional pain.**

5. **Rebuilding trust will take time for the family. Overcoming suspicion and distrust is a slow process.**

6. **Often, the early recovery stage includes the "pink cloud" effect. During this time, adolescents may feel happy with themselves and have a sense of power. This usually lasts between 1 and 4 weeks. Remember, nonusing adolescents' emotions are typically up and down as well.**

7. **When quitting substance use, some adolescents experience a feeling of loss. Grieving the loss of drugs is a healing process. Try to be patient.**

8. **Recovery is a time for adolescents to become honest with themselves and with others. This process of honesty can result in hurt or harm to the family as a whole and to its individual members. Family members may need to confront one another, apologize, listen, make amends, and leave the past behind.**

PLAN FOR RECOVERY

1. Adolescents need plenty of rest, and they need to eat properly. Sleep patterns are disturbed during early recovery by nightmares, short sleep periods, and restlessness.

2. The adolescent will have more free time, time that was previously spent using drugs. A plan needs to be developed to spend free time positively.

3. Alcohol and drugs need to be removed from the home. Prescriptions must be secured in a medicine cabinet. Parents need to be aware that other items around the house can be used to get high. These include gasoline, chemicals under the sink and in the garage, and whipped cream and other aerosol cans.

4. It is important for the adolescent and family to be involved in support groups.

5. It is important to keep the concept of sobriety as a priority.

6. Families need to understand triggers causing the adolescent to slip. (The relapse plan homework helps in understanding these triggers.)

7. Rewarding and celebrating are important areas to discuss and plan. Celebrations are often occasions when the adolescent would likely use drugs.

8. Stay focused on the "here and now." The idea of "never using again" is too overwhelming. It is important to "take 1 day at a time."

9. The adolescent needs to avoid settings where drugs and alcohol are being used. Relationships with nonusing peers need to be developed and encouraged.

10. Overall, be patient and communicate. Changes in the family, even good ones, are stressful. Everyone needs to work together.

FAMILY RELAPSE PREVENTION PLAN

Instructions: This worksheet will help you and your family think and talk about what each family member will do to prevent a relapse. Discuss each item with your family at home. To help get a discussion going, ask the opinions of each child. Remember that each commitment reinforces that the whole family is making a pledge to recovery. (Use the back of the form if more space is needed.)

The therapist will discuss the plan with your family during home visit 3. During that visit, the therapist will review the draft with the family, confirm all members' commitments, and ask that all members sign the plan. A copy will be made for each family member and the therapist.

Commitments						
	Mother	**Father**	**Client**	**Sibling 1**	**Sibling 2**	**Sibling 3**
Communication: *"I will improve my communications by always . . ."*						
Fair Fighting: *"I will fight fair by always . . ."*						
Improving Trust: *"I agree to improve trust and be more trustworthy by . . ."*						
Healthy Habits and Activities: *"I believe . . . are healthy habits and activities for me."*						

(Continued on next page)

Commitments						
	Mother	**Father**	**Client**	**Sibling 1**	**Sibling 2**	**Sibling 3**
Previous Signs of Problems: *"When . . . happened before, it was a sign that things were not going well."*						
Concerns on Warning Signs: *"I agree to accept concerns from all family members."*						
If the family has a problem: *"I agree to . . ."*						
Support Groups and Meetings: *"I agree to attend support group meetings."*						

We agree to do our part in meeting the Family Relapse Prevention Plan. (All members sign below.)

_____

_____

_____

_____

_____

_____

_____

Parent Education Session 4:
Boundaries, Limits, Authority, and Discipline

General Overview—This session provides clarification of major issues in family functioning and appropriate approaches to discipline and parental authority. It helps parents understand the sources of authority in the family and how authority is maintained in a healthy way. The concept of boundaries is introduced as a major issue in family structure.

Rationale—The more information parents have regarding parental authority, the better able they are to intervene in their child's behavior.

Materials—

- Handouts:
  - *Setting Boundaries and Limits*
  - *Characteristics of People With Unhealthy Boundaries*
  - *Parent Guidelines*
  - *Parent/Child Contract*

Goal: To teach participants how to set limits and boundaries, establish appropriate discipline methods for youth, recognize characteristics of unhealthy boundaries, and develop a parent/child behavioral contract

1. Discuss the process parents undergo in developing discipline.

Discussion. Present the following in narrative form.

"We are different from our children. We know the rules. We know that if you use your credit card, a bill will come in the mail and the bank will expect you to pay it. Small children are helpless and they depend on us entirely. As they grow and learn, we have to guide them by setting rules and expectations. When our children become teenagers, it is a confusing time for us, but an even more confusing time for them. So rules are important, even if the reason for the rules is not obvious. We are going to discuss how to develop a set of age-appropriate rules for your children, how to get their compliance with those rules, and what to do if the rules are broken.

"It is important to realize that drug behavior is associated with rebellion, risk taking, stress reduction, identity formation, and assertiveness. Parents must provide structure, limits, and direction for their teenagers. Parents can build contracts with teenagers allowing them freedom of choice (within structured limits) but also defining consequences for failure to maintain the contract."

Distribute the *Setting Boundaries and Limits* handout. Allow time for parents to read the handout.

Discussion. Answer questions or ask whether parents need clarification on the concepts before continuing. Ask parents whether they have examples to

help clarify the guidelines. Ask whether any guidelines are particularly easy or hard to do.

2. Define boundaries, and explain the need to develop boundaries with children. Distribute the *Characteristics of People With Unhealthy Boundaries* handout.

Discussion. State, "Knowing boundaries involves taking care of ourselves, no matter what happens or with whom it happens."

Write on the board:

Healthy boundaries are taught and are learned as a result of life lessons. Knowing healthy boundaries can be beneficial.

Boundary—something that indicates bounds or limits

Bound—inseparably connected with.

Boundaries emerge from:

- *Deep decisions about what we believe we deserve and don't deserve*
- *What we want and need*
- *What we like and dislike*
- *What is important to us*
- *A deeper sense of our personal rights, especially the right we have to take care of ourselves (Boundaries emerge as we learn to value, trust, and listen to ourselves.)*
- *Deciding what is good for us and for others.*

Discussion. Review the characteristics of unhealthy boundaries. Discuss the *Characteristics of People With Unhealthy Boundaries* handout. Ask the parents to discuss signs of unhealthy boundaries between parents and their children. Point out, "Unhealthy boundaries lead to resentment, unhappiness, and a feeling of dissatisfaction and can damage relationships. One person may be hurt in this kind of relationship and will eventually distance himself or herself and may leave the relationship."

3. Introduce the topic of setting limits with children.

Discussion. Distribute the *Parent Guidelines* handout to the participants and discuss.

Distribute and discuss the *Parent/Child Contract* handout. Conduct a practice exercise by having parents develop a contract for a 16-year-old 10th grader. Explain that parents may want to use this contract as a guide when filling out the *Family Contract* during home visit 1.

Assignment. Ask parents to practice setting limits and rules for teens by completing a parent/child contract with their child.

Before they start, ask, "What are the difficulties in setting limits and boundaries when your child is exhibiting rebellious behavior? What are reasonable limits and expectations?"

Then discuss the following:

- Feelings of uncertainty and guilt when disciplining teens
- How parents can know their own boundaries and limits of tolerating teen behavior
- How parents can take care of themselves
- Where to draw the line.

SETTING BOUNDARIES AND LIMITS

As a parent it is important that you:

1. Show confidence in the teen's ability to make decisions
2. Support your teen without suffocating his or her interests
3. Allow your teen to experience the consequences of his or her behavior
4. Learn to say "no" when appropriate
5. Exercise leadership without giving in and without fighting
6. Learn that both coercive and pampering approaches to parenting steal initiative and self-confidence from your teen.

Setting Rules and Limits

1. Establish and discuss rules and limits with your child before they need to be enforced. These rules should be appropriate for the child's age and abilities.
2. Make sure that the consequences for not abiding by the rules are clear.
3. Make only rules you can enforce. A child will test rules to see whether the consequences are real. It is crucial that you are consistent in enforcing the rules.
4. Remain fair but firm with your child.

(Continued on next page)

5. If you have a spouse or a significant other involved in the rearing process, make sure you and that person work together, that you agree on the set rules, and that you are consistent in disciplining. Unity of parents helps discourage the child from playing "divide and conquer" and provides a feeling of stability for the child.

6. Remember, if the child intentionally, willfully, or arrogantly breaks a major rule, the child has made the choice to be disciplined. Discipline is not something the parent does to the child but is something that is done for the child.

7. When grounding your child, set a realistic time that can be adhered to (e.g., 6 months is not realistic, but the weekend is realistic). Make the consequences natural and logical (e.g., the child didn't bring the car back on time so the child can't use the car for 1 week).

8. Make the rules explicit by forming a verbal or written contract with the child. The content of the contract includes behaviors you want from the child (e.g., cleaning his or her room) and behaviors you don't want from the child (e.g., staying out past curfew), rewards for exhibiting positive behaviors, and consequences for breaking the rules.

9. Let the punishment fit the crime. Consequences should be natural and logical. Solicit input from your child—what does he or she think the consequences should be? Focus on the most troubling behavior and not on the "little things."

CHARACTERISTICS OF PEOPLE WITH UNHEALTHY BOUNDARIES

- We have an overdeveloped sense of responsibility and more concern for others than for ourselves. This prevents us from looking too closely at our faults.
- We hide traumatic feelings from childhood, and we lose the ability to feel or express our feelings because it hurts too much.
- We have isolated ourselves from others and are afraid of people and authority figures.
- We have become approval-seekers and have lost our identity in the process.
- We are frightened by angry people and any personal criticism.
- We live from the viewpoint that we are victims and are attracted to friendships and love relationships that feed that weakness.
- We judge ourselves harshly and have low self-esteem.
- We have dependent personalities and are terrified of abandonment. We will do anything to hold onto a relationship, so we do not experience the painful feelings of abandonment that we have from caring about people who were never there for us emotionally.
- We experience guilt feelings when we stand up for ourselves.
- We confuse love and pity and tend to “love” people we can pity and rescue.
- We have become chemically dependent, married a chemically dependent person, or found another compulsive personality, such as a workaholic, to fulfill our own compulsive needs.
- We are addicted to excitement.
- We are reactors in life rather than actors.

PARENT GUIDELINES

Identify your limits as parents regarding your child's drug abuse problem and recovery.

Despite concerns, parents:

- ❑ *Cannot* control behaviors and attitudes of a drug-abusing teen
- ❑ *Cannot* prevent all bad things from happening
- ❑ *Cannot* dwell on guilt over past failures
- ❑ *Cannot* try to rescue teens who get into trouble because of their poor judgment and bad behavior
- ❑ *Cannot* try to rescue a teen because this will lead to irresponsibility and resentment in the child (We all learn from mistakes.)
- ❑ *Cannot* give in to unreasonable demands that will encourage more bad behavior
- ❑ *Cannot* scold, lecture, reason with, or threaten teen.

Parents can work for healthy survival of their family by:

- ❑ Managing their home the way they see best
- ❑ Practicing patience to become strong and skilled in dealing with drug-related behavior
- ❑ Loving with a firm approach that at times is difficult to implement
- ❑ Detaching themselves from the burden of worry and responsibility (The abuser must take responsibility for his or her behavior.)
- ❑ Continuing to care with clear, firm guidelines about what is acceptable behavior
- ❑ Making treatment available to the abuser and realizing parents cannot force adolescents to benefit from the treatment.

Remember:

- ❑ Recovery is a long process and begins with 1 day at a time, so try not to become disillusioned too quickly.
- ❑ Love, hope, faith, and patience are the cornerstones of recovery, especially for parents.

PARENT/CHILD CONTRACT

RESPONSIBILITIES	S	M	T	W	T	F	S	CONSEQUENCES	
								POSITIVE	NEGATIVE

Parent's/Guardian's Signature:_____

Child's Signature:_____

Date:_____

Parent Education Session 5:
Communication, Conflict Resolution, and Fighting Fair

General Overview—The purpose of this session is to enhance parents' understanding of how and why conflict inevitably happens in families, impart concepts and methods of healthy communication, and teach techniques for engaging family members in open and fair conflict resolution. Conflict is presented as a learning process, and ways to prevent it from becoming dangerous to the individual and family are discussed. Techniques for dealing with conflict through negotiation are also presented.

Rationale—The more information parents have about understanding healthy communication, conflict resolution, and timing negotiations with teens, the better able they are to improve communication in the home.

Materials—

- Whiteboard and markers
- Handouts:
  - *Tips for Fighting Fair*
  - *Ways To Improve Communication With Your Teenager*

Goal: To teach parents how to communicate effectively, how to have arguments using fair rules, and how to resolve conflicts with adolescents

1. Introduce and encourage discussion on conflict resolution, and motivate the participants to learn the information.

Discussion.

Write on the board:

When one seeks to win, both lose.

Ask the group to explain this statement. Lead the group to the concept of conflict resolution. Ask parents to indicate by a show of hands which members of the group have experienced a recent conflict with their teen. Ask whether any parents would like to share what the conflict was about. Encourage other parents to contribute to the discussion or acknowledge others in the room who are relating to the topic by nodding their heads, etc.

Ask the group to consider the question, "Why do conflicts occur between parents and their children?" Write the responses on the board. Examples could include because children want freedom and parents want to keep a handle on their children; because family members fight rather than listen to one another; because each member feels he or she is right.

Ask the group to identify the most important tool for conflict resolution. Encourage involvement until "communication" is mentioned. Let the group know this is the most important tool.

2. Introduce the topics of mutual respect in communication and effective communication tools. Identify specific guidelines for fighting fair.

Discussion. Present the following information in narrative form: "What we want is communication among family members to be based on mutual respect. Mutual respect is allowing each other to express beliefs and feelings honestly without fear of rejection. Although one may not agree with the other, both can demonstrate acceptance of each other's feelings. The goal of this communication technique is to help the person feel understood. Effective listening may also allow people to clarify their feelings and work out their own solutions."

Discuss personal qualities that can interfere with communication. Examples include the following:

- Being impaired or preoccupied with other personal problems
- Being angry
- Being insecure
- Not meeting personal needs
- Being task oriented
- Being too critical
- Being too busy
- Not accepting problems; wanting a perfect family.

Allow the group to come up with its own list, but use these ideas to stimulate conversation.

Briefly highlight ways to improve communication with teenagers, such as the following:

- Remembering that effective communication is based on mutual respect
- Having a willingness to listen
- Remembering to listen to ideas or beliefs that you may not agree with; you do not have to agree, just listen
- Trying not to criticize the other person
- Providing the opportunity to work through feelings.

Identify specific guidelines for "fighting fair."

Discussion. Distribute the *Tips for Fighting Fair* handout. Review and clarify the tips with parents. Ask whether parents have anything to add.

3. Distribute the *Ways To Improve Communication With Your Teenager* handout.

Briefly discuss each point and provide examples when necessary. Ask parents whether they have questions about the ways to improve communication. Ask whether anyone needs an example to make any of these ideas clearer.

4. Discuss how to build or rebuild relationships in the family.

Discussion. Explore ways to rebuild relationships in the family. Mention that the family should:

- Try to focus on other members' positive qualities
- Think about what the relationship would be like if the stress of substance abuse had not entered the picture
- Strive toward this ideal relationship
- Set time aside to have fun (During this rebuilding time, avoid disagreements.)
- Identify opportunities to communicate
- Identify areas of mutual interest
- Set aside time to do something together, even if it is only once every couple of weeks.

Discussion/Roleplay. Ask some parents to be volunteers to roleplay a scenario that another parent describes. An example may be a teenager wanting a curfew of 11 p.m. changed to 1 a.m. When the roleplay is over, discuss the conflict resolution techniques used; ask for other techniques that could also have been used.

Tell volunteers they should try to use the tips in the *Tips for Fighting Fair* handout and the *Ways To Improve Communication With Your Teenager* handout.

Wrap up the session by asking for questions and asking parents what conflict resolution techniques they could easily begin using at home.

TIPS FOR FIGHTING FAIR

Select a Time: Pick a time that is right for both participants.

Stay on Track: Discuss one issue at a time. If more than one topic/problem come up, write them down.

Maintain Respect: Do not allow sarcasm, put-downs, or discounts (disrespect for what another person says). A good way to keep this type of communication under control is to use a "buzz word." Pick a word the family will use to indicate a "low blow." When someone says something that is cruel or uses name-calling or profanity, use the buzz word as a signal. When the buzz word is used, the person has to restate what he or she said, in an appropriate manner.

Use "I" Statements: Remember that problems begin with any sentence beginning with "you." NEVER START A SENTENCE WITH "You always" or "You never." Sentences should begin with "I like, I dislike, I wish, etc." The important thing is to focus on the behavior that was disturbing, not the person.

Listen: When a person is finished with his or her side, encourage him or her: "I will listen now." This is the clue to the other person that he or she can start assured that there will be no interruptions (unless, of course, there is a low blow, in which case the buzz word can be used).

Stay out of the Past: Focus on here and now. Refer back to staying on track, and keep to one issue at a time.

Use Feelings: Don't just state what bothers you; explain how you feel when this happens. Often the other person will be willing to work on an issue if a reason is shown to handle the situation differently.

WAYS TO IMPROVE COMMUNICATION WITH YOUR TEENAGER

1. Keep talking with the child. Avoid breaking the lines of communication.
2. Exercise patience. Don’t expect overnight miracles. Be ready for setbacks.
3. Give attention to showing affection. Children of all ages need physical and emotional contact.
4. Be a good listener; understand what your child is saying to you.
5. Be a wise listener; don’t be naive, all-believing, or an overly judgmental listener.
6. Don’t be prejudiced.
7. Demonstrate mutual respect; respect confidentiality.
8. Don’t rush. Rushing gives the teen the impression that you don’t have the time for him or her.
9. Be supportive, encouraging, and friendly but also firm.
10. Present your ideas clearly, firmly, and simply. Mean what you say. Say what you mean. Be consistent and reasonable.
11. Be a good behavior model for the teen. Avoid double standards.
12. Avoid being caught in the middle. Don’t assume ownership of a problem if the problem is not yours.
13. Be yourself. Be honest, sincere, and aware.
14. Grow up with your teen. Don’t wake up to find yourself years behind the development of your child.
15. Encourage the teen to tell you his or her joys and sorrows but do not attempt to pry, force, tease, or nag.
16. Seek advice or develop yourself; you are never too old to grow.
17. Remember that the key to communication is understanding—not who is right or wrong.

Parent Education Session 6:
The Family Context

General Overview—This session helps adolescents and parents understand the importance of the family in the recovery process and the nature of the family as an interdependent system. Parents are educated on how family functioning has both a direct and an indirect influence on the child's behavior.

Rationale—The more information parents have on family dynamics, the better able they are to identify their own strengths and weakness and to intervene in improving their child's behavior.

Materials—

- Whiteboard and markers
- Family mobile (any mobile may be used to illustrate the rigid balance necessary when families operate in a dysfunctional manner)
- Handouts:
  - *Families as a Dynamic System*
  - Family Roles (*The Chief Enabler, The Family Hero, The Family Scapegoat, The Lost Child,* and *The Family Mascot*)

Presentation—Buy or borrow a mobile; make overheads of family roles

Goal: To provide an understanding of family dynamics in recovery

1. Introduce the term "family."

Discussion. Present the following in narrative form:

"We are participating in the program because our children have gotten into trouble. We are beginning the journey to make changes for them and our families.

"We have all lived in families, so we know all about them. We are experts. Right? You might be surprised just how little we all know about some of the most important aspects of family life and parenting. When we are being trained for a job, we learn things we did not know. When it comes to parenting, there is little formal training. There are aspects of parenting that no one ever taught us. Often we have to learn on the job. Now that our children have discovered drugs, it is more important than ever that we try to learn how the family interacts, how one family member's actions can affect the rest of the family, and what families can do to help their children.

"The family is not just a group of people living under the same roof, or at least it should not be. We are related; we care about one another; and we have obligations to one another. Sometimes, family members are lifelong friends; sometimes they don't get along at all. But we are in this together,

and we can perhaps make more sense of our dilemmas if we understand the concept of family."

2. Introduce the concept of the family as a dynamic system (the family as a whole).

Discussion. Introduce the mobile by holding it up or hanging it from the ceiling. Distribute the *Families as a Dynamic System* handout. Then read the handout aloud.

Illustrate these points with the mobile. Show how the movement of one part affects all the other parts.

Explain how members will adapt their roles within the family to reduce family stress. Sometimes the family attempts to survive by repressing or ignoring the problem behaviors and the resulting pain. The substance-dependent person develops a unique set of defense mechanisms to hide and protect his or her true feelings.

Write on the board:

Substance Abuse = STRESS
Stress Is Uncomfortable
Families Reduce Stress by:

- *Ignoring the problem behaviors, conflict, and pain*
- *Using defense mechanisms—both the chemically dependent and other family members*
- *Taking on roles to stabilize the family.*

3. Introduce the concept of family roles of individual members. Show overheads of each role, or distribute the Family Roles handouts to participants.

Discussion. Explain that the information about family roles is the work of many professionals in the field of substance abuse treatment and family counseling. Information about the roles is presented on the handouts and below.

Explain that teaching about family roles is not meant to imply that every family demonstrates every role in the exact manner described in the handouts. Learning about the concept is a way for parents to understand how families with substance-abusing members may experience stress. This stress often results in the development of these rigid roles. These roles allow the family to function, albeit painfully.

The Chief Enabler

Description: This is usually one or both parents. Because of the enduring love and concern for the using child, the enabler has a difficult time allowing the substance-abusing child to experience the consequences of his or her actions and thus learn from mistakes.

Benefits for the family (how the chief enabler balances the mobile): The chief enabler shelters or shields the chemically dependent adolescent from harmful consequences. Unfortunately, this action can result in more harm than good.

Inner feelings: Feelings of anger, hurt, guilt, and low self-esteem are often present.

Examples of this behavior: This person covers up for the substance-abusing child when he or she breaks promises; blames teachers and schools for the problems the child is having; and does not report crimes to the police such as stealing property, money, or the family car, vandalism such as knocking a hole in the wall in anger, or hitting parents or other family members.

The Family Hero

Description: This person is a high achiever and may excel in school or extracurricular activities.

Benefits for the family (how the family hero balances the mobile): He or she is the child whom the family brags about and who offers a sense of accomplishment for the family. Although the family may be having difficulties, members can still feel that something is going well because of this child's success.

Inner feelings: Unfortunately, this child is driven by his or her inner feeling of inadequacy. He or she has a sense of self-blame and hopes that if he or she is successful enough, the problems of the family will improve. No matter what the child accomplishes, the child never feels as if he or she is "good enough."

The untreated child: Throughout adulthood, this vicious cycle continues. This person continues to have an unrealistic sense of control and a need for control. Many times the untreated hero child becomes a workaholic and an enabler as an adult and marries a substance abuser.

The Family Scapegoat

Description: This person is the rebel in the family who tests the limits, breaks the rules, and is usually the one in trouble. The family scapegoat is often a middle child.

Benefits for the family (how the scapegoat balances the mobile): This child offers relief from the other problems in the home. It is easy to blame this child for the problems in the family. These problems may also serve as a

reason for the family to stay together because the family needs to work together to "fix" this child.

Inner feelings: This child blames himself or herself for the problems in the family and often has poor coping skills; therefore, using substances provides an outlet. However, this child usually sees the family more realistically than other members. This child is often able to identify other family problems and how he or she is sometimes blamed for them unfairly.

The untreated child: This child usually becomes a substance abuser. This child experiences problems in school and home. If untreated, this child chooses an unproductive path with negative results, such as ending up in a detention center.

The Lost Child

Description: This child is the quiet one who spends a great deal of time alone, quietly entertaining himself or herself. This child likes isolating activities such as coloring, reading, and setting up elaborate fantasies with dolls, toy soldiers, or other toys.

Benefits for the family (how the lost child balances the mobile) : This is the child who never causes trouble and whom the family never worries about. Similar to the hero child, the lost child provides a feeling of success in parenting because the child lacks problems. This is often a younger sibling.

Inner feelings: Often this child has little understanding of what is happening in the family. His or her interest in isolating activities allows the child to avoid the conflict that is going on in the family. This child lacks self-worth partly due to the little attention he or she seeks or receives.

The untreated child: Depression is highly likely for this person. Interpersonal relationships are difficult because of needed coping skills the child failed to master. This person may experience difficulty with his or her sexual identity. Substance abuse may develop because of an inability to cope with problems.

The Family Mascot

Description: This person is the clown and focus of attention in the home. He or she enjoys entertaining the family, seeks attention, and is often the baby of the family.

Benefits for the family (how the mascot balances the mobile): This child provides comic relief and a breath of fresh air that the family needs to escape the pain of other family issues.

Inner feelings: Self-worth is based on how others react. This child has a difficult time identifying his or her own feelings, being too busy trying to affect others.

The untreated child: Problems in school and other structured settings may develop because of the child's need to gain attention from others. This child has difficulty in intimate relationships because he or she has not "explored the inner self" and does not know his or her own needs. The child may use illicit substances to "clown around" or fit into the social lifestyle he or she enjoys.

4. Debrief families about the new and potentially disturbing information.

Discussion/Roleplay. Explain to parents that the information about family roles is often disturbing and may lead to misunderstandings if used inappropriately. As an example of how family roles interact, ask two parents to volunteer for a roleplay demonstrating a conversation between the chief enabler and the family hero about the scapegoat family member. Start the exercise by providing examples of the family hero's behavior. For example, the family hero always gets straight A's, is the pride of parents and teachers, always does his or her chores on time, and may join the enabling parent in discussing the deficiencies of the other family members, especially the one "causing all the problems"—the scapegoat. Give the following instructions: "You two are talking about how great the family would be if only 'you know who' would straighten up and do things the right way. The scapegoat got in trouble again at school, and the chief enabler has to take time off, again, to go to the school." Let them roleplay the conversation for about 3 minutes. At the end of the roleplay, ask group members to comment on what they saw.

Wrap up the roleplay by asking parents to share how closely it resembles their family. Remember, this information is difficult to process because the parents will begin to see reasons for the problems in their family and how and why they are occurring. Allowing for time to debrief is important so parents can share their surprise that much of this information is accurate and describes their family.

5. Prepare families for upcoming topics that address the family recovery process.

Discussion. This step can be presented in narrative form.

"What are the implications of family for the recovery process? The potential good news is that just as the chemically dependent person affects the family, the family also greatly affects the teenager. Thus, the healthy functioning of the family is critical at this point in the teen's recovery.

"We can't make all changes overnight. We need to concentrate on small but important ways to make positive changes. We need to understand that children need rules that are applied consistently. We need to understand that children know we care about them. But we need to hold children accountable for their own behavior."

Discuss how everyday events in family life can precipitate drug use. Use concrete examples.

Next, present the following information:

"Recognition, acceptance, and understanding of each member's role in the family disease of substance abuse are necessary for full family recovery. In the FSN treatment program, we provide information, teaching skills, and tools to recognize and address the issues of substance abuse in the family. When we say 'recovery,' we mean a lengthy process of healing. During this process, you will increase awareness, address feelings, and learn to forgive. This process of healing is ongoing and long term."

6. Provide parents with information that will help them choose a new direction for their families.

Ask families to recommit to the program, and stress the importance of continuing with treatment to help the child.

Discussion. The following questions can be provided on a handout, read aloud, or shown on the board. Encourage answers from the families:

- How can the information presented be of practical use in your own family?
- What important observations have you made during these sessions regarding family structure and function?
- Some caregivers are single parents; others are grandparents. How do these situations affect such aspects as authority and division of work in the house?
- Does the family have schedules and rituals? Are they strictly enforced or are they loosely constructed and seldom followed? How does the lack of either or both affect the recovery of the adolescent? How does the lack of either or both affect the recovery of the family? How can a family go about developing a better schedule? Are routines followed at suppertime, on holidays, or on birthdays? What sorts of rituals can a family develop that can be longlasting and meaningful and yet not create hardships on the family and its members?
- Who are the parents and who are the children? Why is it inappropriate to regard adolescents as "small adults"?
- How does the information presented help you understand what goes on in your family?
- How does your parental behavior affect your family? Discuss the topic of "enabling."

Wrapup. Encourage a wrapup discussion of the six sessions. Ask parents to think about key points covered in each session and how they can be applied

in their homes. Ask families to reaffirm their commitment to helping their children.

Families as a Dynamic System

Families operate as a system. Their parts are interdependent. A system is a body of parts that work together. They may work together for peace and harmony. They may work together for destruction. They may work together for survival. Roles, relationships, communication styles, and power distribution balance the system. Substance abuse unbalances that system.

Families react and adjust in a way that will rebalance the system; they try to achieve stability. In a healthy family (no family is healthy all of the time), both the system and individual needs are met. The family system is fluid yet predictable. In a family with one of the members who is chemically dependent, things are not stable and predictable. This disruption in the family system affects everyone in the family, not just the affected teen or the parent. Substance dependency is a family disease, not just a primary disease within the individual family member.

—Author Unknown

The Chief Enabler

Note: *May be one or both parents. One or both parents may have alcohol or drug problems.*

BEHAVIORS: Shelters and shields the substance-abusing family members, makes excuses for and may lie to protect the substance abuser, minimizes negative consequences, blames others for the problems, sometimes sabotages progress toward recovery

FEELINGS: Anger, hurt, guilt, resentment, anxiety, fear, desperation to control everything, helpless, hopeless, exhausted

Offers the family a sense of stability and protection

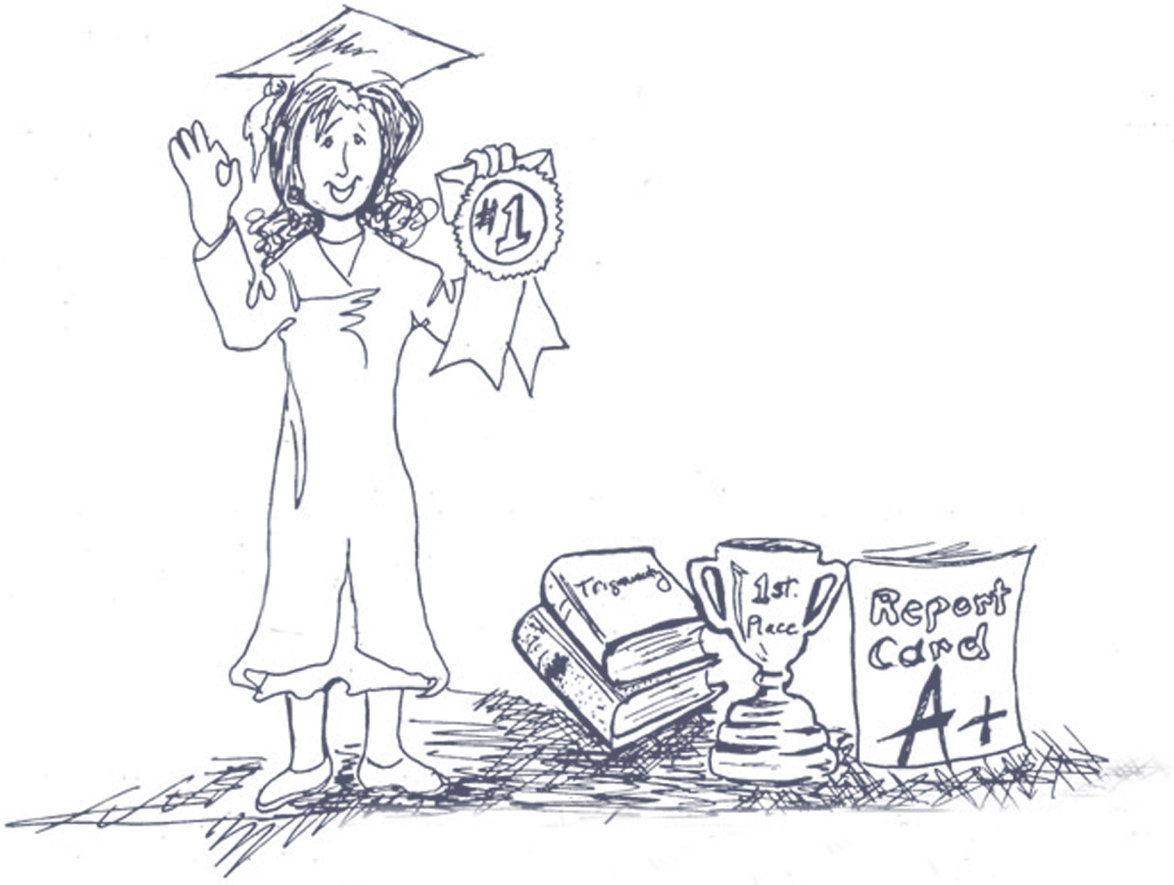
The Family Hero

BEHAVIORS: Is a high achiever, excels, leads, is very busy, takes on many tasks, almost never says no, responds to adults, is controlling

FEELINGS: Anxiety, inadequacy, unworthiness, resentfulness, self-blame, loneliness

AS AN ADULT: Has an unrealistic sense of control and a need to control, needs approval, feels overly responsible or may act irresponsibly when overwhelmed

Offers the family a sense of being OK



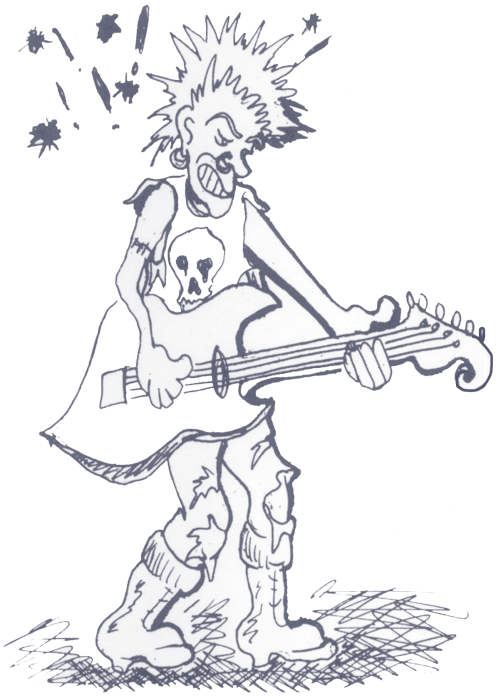
The Family Scapegoat

BEHAVIORS: Rebels, tests limits, breaks rules, usually gets in trouble, acts aggressively and angrily; uses substance abuse as an outlet and relief from pain; sometimes uses extreme language and behaves and dresses inappropriately (but usually has the most realistic picture of the family)

FEELINGS: Anger, confusion, resentment, inadequacy, self-blame for family problems, feeling of being "out of control"

AS AN ADULT: Typically has progressive substance abuse problems; has many problems throughout childhood, adolescence, and adulthood; may have progressive involvement with the criminal justice system

Offers the family a sense of purpose and provides the family with someone to blame for its problems



The Lost Child

BEHAVIORS: Is quiet, is a daydreamer, isolates himself or herself, fantasizes, avoids conflict, is passive

FEELINGS: Loneliness, fear, unworthiness, inadequacy, lack of fulfillment

AS AN ADULT: May have problems with depression and difficulty with interpersonal relationships; may have alcohol or drug problems due to inability to cope

Offers the family a sense of relief and success and is no trouble to the family

The Family Mascot

BEHAVIORS: Acts as class clown, seeks attention through humor and acting out, uses humor to keep people at a distance, is seldom serious

FEELINGS: Anxiety—measures self-worth by how others see him or her; anger; hurt; loneliness

AS AN ADULT: Has problems in school and at work, seldom forms intimate relationships, "clowns around" or is the "life of the party," may develop substance abuse problems

Offers the family a sense of comic relief from the pain

III. Home Visit Procedures

Introduction

Family involvement is essential in this method of treatment. Inhome services increase the likelihood that families will be involved in the recovery process of their children. Therapists who are able to view the family in the home environment are more likely to accurately assess the family dynamics that affect an adolescent's use and abuse of drugs and alcohol.

This manual does not give specific dialogs or examples for the home visits. To do so might impede the therapist's ability to adapt to the cultural, ethnic, or individual needs of the family. These sessions were not designed for counselors with minimal training. The therapist should have the experience and education to conduct the family sessions and be familiar with the family's dynamics. All families are unique. The therapist must be flexible and adapt to the particular needs of the family while working toward the goals and objectives of the family sessions.

Each 90-minute session has particular goals. The overall goal of the home visits is to motivate the family to actively participate in the treatment and recovery of the adolescent, thereby improving positive outcomes. Generally, the therapist makes four home visits. Some families, however, make such progress during the session that they are able to cover more material than that specified for the visit. In these cases, the therapist should be flexible and prepared to continue the session with the material scheduled for the next visit.

It is important to approach the family from a position of "assets" rather than "deficits" so that the family is hopeful and believes it has the power to overcome problems and achieve success. In addition, the therapist must act as "teacher" to increase the parents' ability to regain control of their family and establish a nurturing environment that encourages positive development. The therapist should incorporate effective cultural competence and sensitivity to the ethnic, religious, and cultural needs of the adolescents and their families. At every home visit, attendance at all treatment activities (12-session motivational enhancement therapy/cognitive behavioral therapy [MET/CBT], the parent education sessions, and any additional services [e.g., parent network support groups, 12-Step community recovery groups]) should be reinforced.

Rationale

Office visits often do not reveal enough information about a family to assist therapists in encouraging needed changes. By visiting the home and the neighborhood and by seeing the family function outside a formal office, therapists are more likely to increase their understanding of how the family **naturally** functions, who has the power in the family, and the conditions under which the family operates.

Review of Procedures

Appointments should be confirmed 1 week before the visit and reconfirmed 24 hours before the visit. The call that is made 1 week before may be made by an assistant; however, the 24-hours-prior-to-visit call should **always** be made by the therapist. Much care must be taken when confirming the appointment. If the family is to comply with the visit, it must not change the appointment or make excuses for why the members cannot participate at the agreed-on time.

Tone of voice and the language used during the calls are extremely important. Any perception by the parents that it is possible to rearrange the appointment will result in delaying the therapy. It is natural to avoid uncomfortable (perceived or real) situations. Nothing should be phrased as a question. The person making the call 1 week before should state in a clear, friendly manner, "This is _____ to remind you that the therapist will be at your home next week (state the day, the date, and the time)." A closing statement that indicates how important this visit is to all concerned should be made, such as "We are looking forward to this important session."

When the therapist calls 24 hours before the appointment, he or she should use "I" statements such as "Good evening, Mrs. Smith. I'll see you and the family tomorrow night at 7:30 p.m. I'm very excited about tomorrow's session and meeting your family." The call should be used as an opportunity to reinforce participation in the treatment project: "Your participation in this project is really going to benefit your child and your family. See you tomorrow night." It is important that the therapist is trained to overcome objections and to use proven "sales" and "marketing" techniques that increase the chances for compliance.

Time

Each visit is scheduled to last 90 minutes. The therapist should be prompt and try to end the visit on time. There may be a tendency to lengthen sessions, especially as the family and the therapist begin to form a relationship. This is counterproductive. The goal is to help the family function as a system and not become dependent on the therapist.

Preparation

Some material for the home visits should be specifically adapted for each family. Examples include items such as the urinalysis (UA) results that the therapist will discuss with the parents and the adolescent or the family-generated *Mission Statement* or *Family Relapse Prevention Plan.* To ensure that all information pertinent to the home visit is prepared, thoroughly review each inhome therapy procedure prior to each visit.

Closure

The end of each home visit should follow the same predictable routine to signal the family that the session is closing. The therapist should

summarize the session, reinforce the progress the family has already achieved by making the commitment to actively participate in the process, and market or sell to the family the importance of the next inhome session. The therapist should ask the family to be aware during the treatment period of the positive progress as well as any difficulty the family is having. The therapist should state that at the next session all family members will be allowed to express their assessment of how the family is doing.

Methods

Therapeutic interaction with the entire family, brief individual discussions with the siblings, and questions and answers should be used throughout the sessions. Brief activities should be used that illustrate information and provide a dynamic environment. Because people learn in many different ways, the more variety in the methods, the more likely that each family member will benefit from the experience.

Therapists should discuss safety issues with the clinical supervisor and the case manager prior to arranging home visits. In the original research study, staff members were trained to assess high-risk situations and to follow procedures established for dealing with them. For example, therapists were instructed to consider the neighborhood situation, parking availability, and family members who would be present during the sessions. Because the families had already been assessed and had agreed to treatment, few situations presented problems, even with parents who were known to have alcohol or substance abuse issues. The family support network (FSN) model emphasizes deliberate discussions on agreement of procedures among all participants, including the parents, the adolescent, and the clinical staff.

Generally, the therapist visited the home alone. Occasionally the case manager accompanied the therapist if the situation warranted. On rare occasions and only with the permission of the supervisors, the family sessions were held at the treatment center. This last situation should be avoided, because the FSN model includes home visits for specific reasons explained in the overview and introduction of this manual.

Additionally, staff members were advised to check out a mobile phone to carry for emergencies. They were also instructed in safety precautions, such as not leaving valuables locked in their cars, not carrying purses or wearing expensive clothing or jewelry, and ways to confront risky situations. In some cases, parents were asked to escort the therapist back to his or her automobiles after the sessions. In all cases, sensitivity must be used when discussing these circumstances with the families. They may see a therapist's fear of coming to their home or neighborhood as snobbery or, worse, based on some underlying prejudice about color, ethnicity, or poverty. Therapist safety is critical; however, sensitivity and compassion must guide the decision on home visit procedures.

Home Visit 1

Procedure—The case manager will set up the initial appointment. This will allow the family to have an additional contact with the case manager. Since this is the first visit, the therapist should explore with the parents the best location in the home for the session. This may be the kitchen, the living room, or the family room. If there are children who are too young for the session (usually children who cannot verbalize are inappropriate), the therapist should discuss with the parents how those children will be cared for during the session and help parents identify a babysitter.

The therapist must always be aware of his or her own reaction to the family, the home environment, and the neighborhood. Some homes may be cramped and chaotic. If families suspect that the therapist is uncomfortable, judging, or "afraid" of the environment, the therapeutic relationship will be impossible to establish. Training in cultural competence and sensitivity will increase the likelihood that the therapist will not offend the parents.

General Overview—The first session should be used to assess the family members in their home environment, refer them to additional services, if necessary, and motivate them to actively participate in the treatment contract. Every effort should be made to limit the session to 90 minutes. The therapist should follow the manual and cover the goals and objectives of each session. Referrals should be made if issues arise that need further therapeutic attention. At the beginning of the home visit, the therapist should review what will be covered.

To help in the assessment, the therapist should discuss the results of the Life Stressors and Social Resources Inventory (distributed in the first parent education [PE] session). This inventory allows the parents and the therapist to evaluate any life stressors and the need for additional services. The results of the inventory may also be discussed at the second home visit.

Rationale—This session helps the therapist and the family members form therapeutic alliances that will improve outcomes. Much care must be taken to make the family feel comfortable with the therapist and the sessions. The greater the trust the family places in this therapeutic relationship, the greater the likelihood of continued success. Marketing the methods used in the therapy, congratulating family members on their commitment, and helping them overcome barriers will increase the likelihood of their success and, thereby, the project's success. Determining what stressors exist that might impede success will allow the professional staff to assist the family in obtaining needed services and overcoming barriers that might inhibit completion of the program. The more control people feel they have over their environment, the more likely they are to believe that they can change. Self-efficacy improves outcomes.

Materials—

- Scores and charts from the Life Stressors and Social Resources Inventory.
- Handouts:
  - *Family Agreement*
  - *Treatment Contract*
  - Case manager contact information (phone numbers, addresses, etc.)
- Age-appropriate reading materials, videotapes, games, or other distractions for younger children if necessary
- The treatment calendar (e.g., times, dates, and places of the 12-session MET/CBT, the 6 parent education sessions, the parent support groups, and the family home visits) completed prior to the home visit with the case manager

Goal 1: To increase parental participation in the treatment process by identifying barriers to successful completion, including misunderstandings about the treatment process

1. Review the purpose and the objectives of the home visits in relation to the goals of substance abuse treatment.

Discussion. Explain the following points:

- There will be four home visits. Times that are convenient for all will be determined by the case manager. Sessions will last 90 minutes.

- The purpose of a home visit is to improve the adolescent's chance of a successful recovery and to rebuild relationships that have likely suffered because of drug use.

Talk to the adolescent. Say, "It is likely that you have pulled away from your family because of your drug use. It is important for your parents to become involved in your recovery process so they can support you. You and your family may need to learn new ways of doing some things."

Give an overview of each session and answer any questions. Reinforce the importance of the remaining sessions. Market the benefits of the therapy participation to the family. Stress how much parents and their child will learn from the information.

Choose an example from both the parent and the adolescent classes, and give specific examples of the information to be gained. For instance, "The session on adolescent relapse will really help you identify the warning signs before your child has a slip. You will also be given ways you can intervene effectively so that you can help your child stay drug free."

Explain the success rates for adolescents whose families participate in their treatment and recovery. Explain that although participation is no guarantee of success, experience and research indicate that family involvement increases successful outcomes. Solicit reasons from parents and the adolescent about why this may be true.

2. Review the adolescent's UA results.

Discussion. Discuss the results. If the test indicated drugs were present (positive), discuss what happened and how the use could have been prevented.

The adolescent may become upset or challenge the results. Power struggles or escalating arguments should be avoided. It is preferable to offer to retest the adolescent than to continue to argue. A good method is to get the adolescent to agree that, if the new test results are positive, he or she will accept the results and will work through the issue. The therapist should review the procedures and remind the parents and the adolescent of the education they received on urinalysis procedures and testing methods. The therapist should keep in mind that treatment is cumulative and a process not an event. The FSN model promotes overall results, not a confrontation over a single event. If the test indicated drugs were not present (negative), praise the good result and encourage this behavior. Regardless of the results, stress the importance of abstinence during this treatment program and in the future.

Sometimes parents will accept reduction of use because they want to believe that things will get better. Impress on the parents and the adolescent the need to remain abstinent, especially during the program. Solicit a commitment from the adolescent to remain abstinent and from the parents to require abstinence. The therapist should not be concerned about whether the commitment is sincere but only that it is made. "Acting as if" is an important therapeutic concept and signals the beginning of "precontemplation" by the adolescent.

Acting as if is a common term in the lexicon of substance abuse recovery. It describes the act of allowing the newly recovering individual to take on the behaviors of a sober person before those behaviors are internalized. As a result others begin to treat the recovering person differently, and that person begins to experience the rewards of positive behaviors. By experiencing positive regard of society, the newly recovering person not only will continue to exhibit these behaviors, but will internalize them over time.

Precontemplation refers to a stage in the process of change. In this stage a person does not connect his or her substance abuse to the negative consequences. As a person becomes aware that many of his or her problems are a direct result of substance use, he or she may enter into a "contemplation of change" stage. This is a positive step to deciding to change many negative behaviors.

3. Share some of the adolescent's reasons for quitting.

Share the reasons provided by the adolescent in his or her motivational enhancement treatment sessions. Ask for the parents' support. Demonstrate how the parents can support recovery by knowing the "motivators" for their child. Review the commitment to abstinence from marijuana and other substances.

4. Encourage the parents to commit to not using illicit drugs and to being aware of their alcohol use during the treatment period.

Discussion. Discuss how any overt or covert messages about alcohol use can have an impact on the adolescent's recovery. Explain how heightened awareness of the parents' substance use patterns can affect their child's participation and the likelihood of successful outcomes. This will be a delicate process. The therapist must take care not to offend or make the parents defensive. Using a "double-bind technique" may prove helpful. For example: "I know that you are very committed to your child's success in the program and to stopping his or her drug use. That is why I know you will make every effort to be aware of **your** alcohol use and the messages you may send (even without realizing it) to your child, especially during his or her participation in this program."

5. Explain what the program will and will not do for the adolescent and the family.

Discussion. Do not overstate the chances for success; say that, if the family and the adolescent participate and comply with the recommendations, the chances that they will be successful are great.

State, "This program cannot promise that all family problems will disappear, but it will improve your family's communication, and it will increase the chances that your child will modify his or her substance use. It may improve the chances that your other children may not start abusing substances. Participating in the program may also help you regain control of the family."

Goal 2: To develop an alliance with the family and begin to establish knowledge of the family history, environment, and stressors

1. Provide feedback from the Life Stressors and Social Resources Inventory.

Explain that the inventory assesses the level of stress the parents feel about their child's behavior and the level of social support available. The youth version helps adolescents realize that there are stressors that affect their functioning.

Discussion. Connect everything observed in the sessions (plus any test or inventory taken and all activities) to the overall goals of the treatment program. It is essential that the family understand how each activity is related to the family's and the adolescent's chances for success.

Solicit questions and discussion by asking open-ended questions. For example: "In what ways do you think stressors affect you and your family?" Since this is the first session, it is important to begin to "teach" the parents, the siblings, and the adolescent how to participate in family sessions. What is said is not important; what is important is that the members are willing to explore the questions. Remember, the more family members talk, the easier the session becomes.

It is important to create an environment in which all members of the family are free to speak and participate. This may require gentle redirection if one member "monopolizes" all the time. Remember not to offend the "power" in the family as this will certainly lead to alienation and an unwillingness to continue. Much care must be given in identifying the power in the family. This person is often not the most obvious choice. The power in the family usually gets his or her way in interactions regardless of his or her status within the family. The most powerful member may be the father or the mother, but it is often the substance-abusing adolescent who calls the shots in the family—especially in homes with only a mother who may feel guilty about the youth's lack of a father figure. A family member may use subtle manipulation or a parent may play the role of the injured party, getting the other parent to come to his or her defense. The adolescent may act out and intimidate the family into complying with what he or she wants. The therapist must use his or her training and skills to get the person with the power to believe that it is in his or her best interest to participate in the treatment sessions.

2. Explain the case manager's role, and observe the family in its home environment.

Explain how the case manager can assist the parents and the adolescent in achieving success. Let the family know that the case manager will help identify support groups in its community and is also available to eliminate any barrier to participation (e.g., transportation). Before any referrals are made to the case manager, the referral should first be discussed with the parents. Explain that the case manager may periodically contact them to see whether they need any assistance. Tell family members they can call the case manager directly or inform the therapist of a concern. The therapist will pass the information along to the case manager. If the therapist has a concern, he or she will discuss the issue with the parents before asking the case manager to intervene.

3. Conduct a brief "family sculpting" exercise.

Persuade the family to roleplay a family "sculpture." This roleplay is not meant to be a full-blown psychodrama; rather, it is a visual display of how the members see the family structure. The adolescent, parents, and siblings should take turns placing the members of the family around themselves in the sculpture according to the "closeness" they feel toward each person and whom they see as having "positions of power and control." If there is resistance to participating in the sculpting activity by some members of the family, pick the most willing or outgoing member of the family to begin the

process. This exercise need not be dramatic. It can be approached with a playful attitude. For instance, try asking a member to line the family up according to some theme—most verbal to least verbal or loudest to quietest. This exercise may get the ball rolling for other types of sculpting activities. The idea is to allow the family to be aware that each member may see the family structure in a unique way. There is no right or wrong outcome; this is an exercise in increasing the family members' knowledge of one another. This exercise will help each family member recognize what role he or she plays in the family structure and how that role affects his or her life. Remember to:

- Allow all member to place the others as they "see" the family.
- Help the family understand that there is no right or wrong picture and that negative comments or criticisms are not allowed.
- Act as a facilitator for family members as they make insights into how each sees the family structure, how helpful or destructive the structure is, and how the structure affects family dynamics.

4. Initiate a discussion of "How you would like your family to be different."

Start by using what was discovered in the family sculpting exercise. Be sure to solicit involvement from siblings. Sometimes when one child is commanding so much energy from the parents, other children in the home begin to feel neglected.

5. Provide the family with copies of the *Family Agreement* handout.

Have members read it aloud. Always ask small children whether they understand the meaning of the *Family Agreement*. Paraphrase it when necessary to ensure that all members of the family understand the meaning. Have parents and children sign one copy of the agreement. Explain that one copy will be made for the file and another copy will be returned at the next family session.

6. Review the *Treatment Contract* handout.

This contract should reflect the commitment to the recovery process of the parents and the adolescent receiving treatment. Remind parents of the *Parent/Child Contract* that they completed during parent education session 4, and instruct the family to use that as a guide for filling out the *Treatment Contract*. The therapist and family should discuss only additions to the contract that the parents or adolescent views as necessary to ensure a successful treatment experience.

Add additional items to the *Treatment Contract* as necessary. Explain that when family members sign the *Family Agreement* and make commitments in writing, they are more likely to honor the contract and follow through.

Have the parents and the adolescent who is receiving the treatment sign the *Treatment Contract*. Explain that one copy will be made for the file and another copy will be returned at the next family session.

Family Agreement

We have become more aware that substance abuse has negatively impacted our family. We are now actively involving ourselves in the necessary steps to work toward a healthy, happy family.

We are aware that we are taking risks and will be trying new ways to approach problems. We are aware that this may feel uncomfortable at times, but we are willing to try new ways.

We are excited about these challenges and commit to doing our best. At all times we will do our best to approach the new ways with patience, respect, kindness, and understanding.

Parent/Guardian Signature	Date
Parent/Guardian Signature	Date
Child Signature	Date
Child Signature	Date
Child Signature	Date
Therapist Signature	Date

Treatment Contract

I agree to attend all my scheduled sessions.

_____ _____ _____
Parent/Guardian Signature Child Signature Date

I agree to participate actively and honestly in the home visit sessions.

_____ _____ _____
Parent/Guardian Signature Child Signature Date

I agree to complete, to the best of my abilities, all homework assignments and family assignments given to me as part of the treatment program.

_____ _____ _____
Parent/Guardian Signature Child Signature Date

I agree to abstain from substance use while in this treatment program.

_____ _____
Child Signature Date

I agree to do my best to model appropriate, responsible behavior regarding medications and other substances.

_____ _____
Parent/Guardian Signature Date

I will do my best to learn skills necessary to foster a healthy home environment and to be more aware of future choices in my behaviors and how they impact others.

_____ _____ _____
Parent/Guardian Signature Child Signature Date

I agree to these additional items. _____

_____

_____

_____ _____ _____
Parent/Guardian Signature Child Signature Date

_____ _____
Therapist Signature Date

Home Visit 2

General Overview—The second home visit allows the family to explore further its own family dynamics, its communication style, and the rules, roles, and routines of the family. The overall goal of this session is to strengthen the family's commitment to the treatment process, to improve communication, and to provide "tools" to improve the family structure.

The Culture-Free Self-Esteem Inventory (30 true/false items for children and 40 items for adults) is an optional assessment that can be used if the therapist feels the feedback would benefit the family. (It can be purchased through PAR, Inc., at www.parinc.com.) The Culture-Free Self-Esteem Inventories help the therapist assess the individual member's level of self-esteem and to explain to the family the importance of esteem in achieving success in life. These inventories should be self-administered and returned to the therapist in the next session. Feedback will then be provided in the final home visit.

Rationale—The more family members know about how other members think, feel, and behave, the greater the likelihood that communication will improve. Understanding the importance of self-worth and the role it plays in the adolescent's recovery and the family members' lives will increase commitment to the program. Family sculpting exercises showed members in a visual way how they operate in the family system. Helping families recognize changes they are making builds on their strengths. A strength-based approach tends to increase compliance as well as hope that success can be achieved. Helping family members see setbacks as just part of the process and not as failures will increase the motivation for continued improvement.

Materials—

- A list of additional community services that, if needed, may assist the family
- Age-appropriate reading material that will help family members understand roles, rules, and routines and their importance in the treatment process
- In reserve, extra copies of the several handouts on family roles and learning to "fight fair" without aggression and violence that were distributed in the PE sessions
- A board game

Goal 1: To increase the family's understanding of the adolescent's urinalysis results and to solve problems, if necessary

1. Review the adolescent's and the family's progress, and respond to any problems or questions.

Discussion. It is important to avoid allowing the family members to make unrevealing responses (e.g., "fine," "great"). Ask **how** each is doing, in **what ways** things are improving, and **what** is different. With these types of questions, the therapist not only encourages more participation but helps the family increase its communication skills. Focus on how each family member is doing as well as how the family as a unit is doing.

Review the meaning of urinalysis results. If results showed that drugs were present (positive), discuss what happened and how the use could have been prevented. If negative, praise the good results. Stress the importance of abstinence during this treatment program and in the future.

Goal 2: To assist the family in preparing a family vision/mission statement

1. Introduce the family to the "vision" or "mission" exercise, and assist members in preparing a statement for the family.

This exercise helps the family focus on its goals and philosophy and helps the family visualize and verbalize the successful outcome for all members. The mission statement pronounces what the family envisions for itself. By blending ideas from all, the family members design one mission statement of who they are, what they want to accomplish, and how they will accomplish this goal.

Discussion. Guide the family in the mission statement/goal exercise. Provide the family with a method to develop a vision statement.

Use a large sheet of paper or a posterboard, and write at the top of the sheet who, what, and how. Ask family members to describe who they are, what they want to accomplish, and how they want to accomplish their goals. Have family members complete each section giving descriptive words for "who" they are, for "what" they want to accomplish, and for "how" they will accomplish it. Brainstorm ideas for how they will work on accomplishing the goals. Have parents and siblings of the adolescent verbalize how the family will be different if the mission statement becomes a reality.

Tell the family members that at the next home visit, you will present them with a typed and framed family mission statement.

Goal 3: To assist the family in understanding the concept of "fair fighting" and in assessing its current family rules for fighting

1. Discuss how the family fights and in what ways members could change their interaction to fight fair.

Explain that all families argue at times. Emphasize that families who learn to express their disagreement in a less abusive, less hurtful, and nonthreatening way, using respect for all members, can actually become closer following a disagreement. The therapist should be mindful of religious and cultural considerations. Reinforce the elimination of

name-calling; violence of any kind, including threats and intimidation; and other counterproductive behaviors that increase family problems.

2. Determine what rules exist in the family.

Step 1. Ask the family what rules exist in the family and how consistently they are applied. Ask what the consequences are for following or breaking the rules in the family. Discuss what would happen if families did not have rules.

Discussion. Introduce fair-fighting rules and give examples. Discuss why they are important in a family. A fair rule is developed for the benefit of the recipient, not the rulemaker. The rule benefits the recipient's physical, emotional, mental, and social development. Adolescents are much more likely to adhere to fair rules because the rules are rational and in the adolescent's best interest. Fair rules are flexible in certain, usually rare, circumstances (e.g., being allowed to stay up past bedtime because an out-of-town grandparent is visiting). Fair rules are in the best interest of everyone.

Explore family rules that are "fair" and productive. Ask the members to give examples. Try to get all members to respond. Younger siblings or those who have difficulty expressing their opinions may need gentle prompting. Care must be taken not to be intrusive. Remember, it is essential that the family begin to talk about its system rationally and productively.

It is hoped that the family will already have some rules that are fair. Exploit these, and reinforce the family's strengths.

Step 2. Discuss with the family which rules are unproductive, unnecessary, or counterproductive.

Discussion. Explain that some rules are established for the rulegiver with little consideration for the one who must obey the rule. Point out that "unfair rules" usually develop from strong emotion, frustration, or an urgency to "do something." Take extreme care when discussing these issues, or parental authority can be undermined. Honor cultural considerations. Steer the discussion to the benefits of eliminating unproductive rules and ways to accomplish this goal.

Step 3. Work with the family to develop one or two new productive rules.

Discussion. Guide the family into correcting unproductive rules and in developing "new," more helpful ones. First, ask the family to write down the top five rules in the house. Then discuss whether these rules are humane. Finally, have the family develop one new humane rule—one that is agreed on and that will work. Quantity is not the object. It is better to help the family develop one new productive rule than to construct so many that the family may have a hard time obeying the new rules. Record the rules, and have each family member sign a commitment to comply with them.

Step 4. Ask the family to determine the consequences for failing to follow the rules.

Try to get all members to verbalize their understanding of the consequences of rule infraction.

Discussion. Guide the family members in determining the consequences for failing to follow productive rules. Record these in the commitment contract.

3. Discuss family commitments to change.

Discussion. Solicit and record members' commitment to change specific behaviors. It is better to get a commitment about changing one behavior than changing several behaviors. The family members may be overwhelmed if they are asked to make too many changes at one time.

4. Ask the family to commit to changing family dynamics at least until the next session.

Discussion. Introduce or reinforce the concept of "acting as if" and its importance in the change process. Use the acting-as-if principle to elicit a commitment from all members that, at least during the treatment process, they will adhere to the "fighting fair" rules (refer to the handout in PE session 5).

5. Introduce a board game to improve communication.

Discussion. Ask the family to play a game at least once before the next session. The game should be one of chance, so that all players have an equal chance of winning. Explain that "playing" as a family allows all members to appreciate the individuality and talents of each member.

Home Visit 3

General Overview—The third home visit focuses on assessing the progress of the individuals and the family as a unit and encouraging the family to reaffirm its commitment to the *Family Relapse Prevention Plan* (presented in PE session 3). The parents, identified adolescent, siblings, and therapist summarize their observations and feelings about the progress the family is making, including successes and difficulties they encountered. The family reviews and revises its family vision/mission statement. The family also reviews its progress in fighting fair, following new productive rules, and solving problems. If the family and the therapist have decided that the family is ready to end its treatment, this is the last session. The therapist should ensure that parents are aware of how to seek help if the family should relapse. If this is the last session, the therapist should bring a treat to help family members celebrate that they completed their commitment to the home visits. The therapist should always check with the parents to determine what is an acceptable treat.

Rationale—Assessing the progress of the individuals and the family as a unit provides positive reinforcement for everyone as well as a chance to make necessary changes in the family goals. Getting the family to reaffirm its commitment to the *Family Relapse Prevention Plan* will help prepare the family if there is a slip in progress. Research shows that relapse prevention plans actually reduce the chances of relapse because the individual and, in this case, the family are better prepared to meet the inevitable struggles of recovery. Improving the family's ability to "self-assess" allows it to adjust its behaviors to increase positive outcomes.

Materials—

- A list of additional community services that may, if needed, assist the family
- Posterboard and markers for writing a mission statement
- Treats for the family if this is the last home visit

Goal 1: To provide the family with the typed and framed family vision/mission statement and to give the family the opportunity to solve any problems that may have arisen over the past weeks that affect the mission statement

1. Provide the family with its family vision/mission statement.

Have each family member identify with the family goal and express his or her individual commitment in the following areas: communication, fighting fair, trust, healthy habits, healthy activities, and social activities.

Reaffirm the commitments made by all members of the family in the last visit regarding who they are, what they want to accomplish, and how they will accomplish their goals. Then identify any problems that may have arisen since the last session. Use the opportunity to practice problem solving.

Have each family member present possible solutions. Explore the practicality of each solution and determine whether it is in line with the family's goals.

Then discuss any urinalysis results since the last home visit.

Goal 2: To increase the parents' and family members' ability to self-assess and adjust their behaviors to increase positive outcomes

1. Explore problems with communication experienced since the last home visit.

Ask family members how they resolved the problems or what new techniques were used to improve communication.

Review listening skills and using "I" statements. Focus on specific communication problems identified within the family.

2. Review overall progress with parents and family members.

Discussion. Ask the family to describe any disagreements since the last session and how the incidents were handled. Identify ways family members followed the fair-fighting rules and ways in which they did not. Seek suggestions from the parents and family members on ways to respond to any concerns or questions and methods for improvements.

Goal 3: To reinforce the necessity for all family members to support the recovery of the identified adolescent and the recovery of the family and to provide sources for support if stress or relapse occurs

1. Solicit from family members how they would know whether the family or the individual is in relapse.

Discussion. Review and discuss the completed *Family Relapse Prevention Plan* that was initiated in PE session 3.

Solicit agreement about the signs and symptoms of relapse. Write down these signals and symptoms for the family. Try to have members agree on the signs. Ask the family members to share their views, and solicit agreement from all members without allowing criticism.

2. Solicit from family members specific ways they can make one another aware of problems and agreement issues.

Solicit from all members ways they can make one another aware of problems and issues before they become overwhelming. Members must agree to help one another without criticism. Review with all members how they wish to be approached if they need to be confronted. This is especially important for younger siblings whose opinions or observations are often dismissed or ignored in the family. It is important to get parents to agree to listen to members' concerns, especially those of the younger siblings.

3. Review with each family member the names of the people who will be able to help and support them in times of stress or relapse.

Each family member should have a list of people (with their phone numbers) he or she can turn to for advice, comfort, or encouragement. If the family member has been a member of a formal support group, the phone number of the group contact should be on the list. These people could be teachers, members of religious organizations, or relatives with whom the family members or the family as a whole has close, trusting relationships.

These lists are important, and each member of the family may have different people on the list.

4. Review the *Family Relapse Prevention Plan*, and have all members sign it.

Discussion. Reinforce the necessity of the entire family's effort in the recovery process. Guide the family in a discussion that restates the individual and family "relapse triggers" and how to recognize them. Finally, reinforce that the parents' and adolescent's participation in a support group can play an important role in increasing positive outcomes for the family.

Closure

If this is the last session, congratulate the family on the commitment each member showed in following through with treatment, and stress the importance of following the *Family Relapse Prevention Plan*.

Praise the family's efforts, acknowledge its commitment and hard work, and reinforce that families that work together in recovery have more positive outcomes.

Emphasize how following the *Family Relapse Prevention Plan* will increase the likelihood of the family's success. Review how family members can seek help if they recognize relapse triggers.

Reiterate that there is help available to the family and that families who ask for help are doing the right thing for the entire family unit. (See home visit 4 for additional information on relapse.)

Home Visit 4

General Overview—The topics covered in this visit are very important. This fourth session focuses on assessing the progress of the individuals and the family as a unit and restating commitment and willingness to support the family as a unit. The parents, identified adolescent, siblings, and therapist summarize their observations and feelings about the progress the family is making and the successes and difficulties it encountered. The family will review its *Family Relapse Prevention Plan*.

Rationale—Completing commitments is an essential part of individual and family recovery. Assessing the progress of the individual and the family unit provides positive reinforcement and allows the family to make adjustments to its goals. Reviewing the *Family Relapse Prevention Plan* underscores the importance of ongoing recovery and commitment.

Materials—

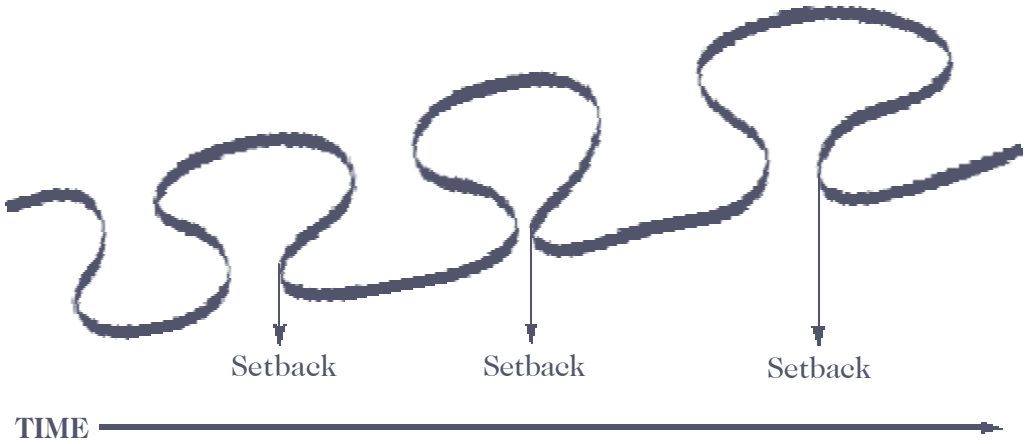
- A drawing pad to illustrate the concept shown in exhibit III–1
- A treat for the family to celebrate completing the home visits

Goal: To assess the progress of the individuals and the family unit during the treatment process and to gain continued commitment to and support for the individual and the family

1. Ask each member to evaluate his or her progress, express concerns or fears for the future, and ask questions.

Reemphasize that the process of recovery includes stops and starts and that a recovery has setbacks as well as progress. "Normalize" the stops and starts of regular recovery. Reinforce that most people in recovery repeatedly take two steps forward and then one step back over time. Families should not be discouraged when the person in recovery takes a step back. (Refer to exhibit III–1 below.)

Exhibit III–1: Two Steps Forward and One Step Back



2. Encourage each member to reiterate his or her commitment.

Ask each member to talk about his or her commitment and willingness to support individuals in the family as well as the family as a unit.

Restate the commitment to the family, and reiterate that this will be accomplished by adhering to family rules, structure, and routines; by respecting each others' boundaries; and by fighting fair.

Review the *Family Relapse Prevention Plan*. The plan is essential for helping the family remember its commitments made during the treatment process.

3. Individualize the treatment to the family.

Address any special needs or issues that may have arisen during the treatment process. These may be issues surrounding such things as communication, problem solving, and relationship building. Use the remainder of the time with the family to shed light on family-specific issues. Discuss observations with all family members, and allow them the opportunity to explore additional concerns they may have.

See home visit 3 for information on closure.

IV. Case Management Procedures

Introduction

Operation PAR recognizes that the family plays a major role in adolescent substance abuse through family dysfunction, enabling, or acceptance. For a typical adolescent, recovery is difficult without the active involvement of and continued support from the family. Research has shown that parental support can act as a stress-buffering element, allowing adolescents to deal with negative life events without turning to substance use (Wills & Cleary, 1996) and that family involvement in treatment is associated with improved outcomes (Stewart & Brown, 1993).

Family involvement can be greatly increased by a proactive stance from treatment programs (Morris, Gawinski & Joanning, 1991; Myers, Brown & Mott, 1993; Richter, Brown & Mott, 1991). To engage and keep the family of the drug-using adolescent involved in treatment, a case management model was developed. The model of case management is designed primarily to:

- Engage the family in the treatment process
- Overcome barriers to its active participation
- Identify appropriate service and treatment needs
- Provide links to needed services
- Monitor adolescent and family progress
- Provide motivational enhancement
- Prevent clients from dropping out of the program
- Encourage participation in community family support groups or initiate a peer-led parent support group.

The case manager, along with the interdisciplinary treatment team (counselor, therapist, and clinical supervisor), has primary responsibility for engaging the adolescent and the family in treatment and preventing the adolescent and the family from dropping out of treatment. The case manager addresses a broad and comprehensive array of barriers to treatment and achievement of treatment goals. As barriers arise, the case manager develops alternative or creative strategies for achieving desired outcomes.

Drug abuse treatment programs have unacceptably high dropout rates, which are a primary concern for case managers. Research findings suggest that attrition prevention in the early phase of counseling ought to focus on motivational ambivalence, scheduling conflicts, or financial impediments to continued involvement (Roffman et al., 1993). DeLeon and colleagues (1994) view the risk of dropping out as a function of readiness and motivation

and suggest that motivation can be enhanced through prompt intervention. In later stages of treatment, efforts to lessen the possibility that the clients will drop out should focus on understanding and dealing with the adolescent's dissatisfaction with treatment (Roffman et al., 1993).

Henggler and colleagues (1996) found that dropout rates could be lowered by increasing the accessibility of treatment services and by placing the responsibility for treatment engagement on the service providers. Therefore, a key responsibility of the case manager is to engage the adolescent's family in treatment and to overcome obstacles to receiving treatment.

Additional program features that have been found to lower dropout rates included home visits, short waiting time, frequent contacts with the adolescent, the provision of concrete services, and high levels of therapist commitment to and respect for the adolescent (Henggler et al., 1996). The case manager, as well as all the professional staff members involved in the treatment process, should demonstrate respect for the religion and culture of the adolescent and his or her family.

In the case management model, services are individualized to meet the multiple and fluid needs of adolescents and their families. The case manager does not obtain services for the adolescent but rather serves as a catalyst and a source of information. The case manager empowers the adolescent and the adolescent's family to obtain the services they need and to reach the goals they set for themselves. Family members are viewed as full collaborators in the treatment process.

Overview of Procedures

Case managers should establish and maintain contact with parents of adolescents and facilitate their engagement and participation in the treatment process. Case managers, therefore, should be trained in and use sales or motivational strategies to overcome the reluctance of parents to participate. The strategies include eliciting positive decisions, overcoming "sales resistance" (i.e., resistance to participating in treatment), providing transportation, and providing child care and other services to overcome barriers.

Sales skills can be used to encourage and entice families to participate with their adolescent in treatment at a more intensive level. By breaking down patterns of denial and resistance to treatment, staff members can bring reluctant parents into positive participation in treatment. One type of sales technique generally used in business is effective in substance abuse treatment—overcoming barriers or resistance. For example, an excuse by family members about their inability to attend a particular session is met with this response by the therapist: "No problem. You can make up the educational session on this date." Another excuse from the family may be, "We can't find child care that night." The therapist can respond, "No problem. Let's put our heads together and think of a good alternative or solution." An even better solution is to establish alternative arrangements at the time of the intake and actually have the case manager help the family arrange backup for transportation or child care in advance. This

information can then be part of the therapist's response: "I believe you said that you had arranged for your sister to watch the other children on therapy nights. Let's call her and see if she will help you." Sometimes just offering to help is enough to get the parents to solve the problem themselves. Breaking down denial can be accomplished by using the parents' own words gathered during the admission and assessment processes and using a double-bind technique. For example, a therapist might say, "When you first came in, you expressed how worried you were about your child's drug use and that you would do anything to help. It is evident that you really love your child. Let's work together to accomplish what you want most—a healthy child and a happy family." This motivational enhancement technique is described in detail in the motivational enhancement therapy/cognitive behavioral therapy (MET/CBT) manual (Scudder & Kaminer, 1998; Sampl & Kadden, 2001; Webb et al., in press) that is used in conjunction with the family support network (FSN) model. To maintain engagement in treatment and improve outcomes, staff members can use these skills, combined with an understanding of clinical principles, to reach out to adolescents and their parents who miss counseling sessions.

Missing a single treatment session should trigger immediate efforts by staff members to contact the adolescent and his or her family. The staff should find out the reason the adolescent missed the treatment session and develop a strategy for keeping him or her in treatment. These efforts significantly increase the number of adolescents completing the treatment program, thus enhancing favorable outcomes for both the participant and the program.

An individual service plan should be developed to fit each family. The intensity of services the adolescent receives depends on need. For families with multiple and complex needs, a more intensive service plan, which evolves into a more supportive service plan as treatment progresses, should be implemented. To maximize resource allocation, staff members may need to place some families directly in treatment based on the supportive case management model upon admission to the treatment program.

Intensive Case Management

Adolescents and families with multiple or complex needs should be treated with an approach based on an intensive case management model. Case management services should be initiated with the case manager's first contact with the family. The first phase should include:

- Meeting face to face with the adolescent and his or her family
- Explaining case management services
- Establishing a plan of action to meet the immediate needs of the adolescent and his or her family
- Making an assessment of additional needs not identified in the adolescent's initial assessment and intake processes.

In the second phase, case managers should maintain frequent contact with the family, the counselors, and the family therapist and continually assess needs of the adolescent and family. Case managers should monitor progress by regularly telephoning the family. This phase may include additional face-to-face contact if needed. Contacts with the child and family may be at the treatment facility, a community center, or the family's home. Using the results of the assessments, the case manager coordinates links to services and provides added support to the family in obtaining needed services. Case managers also actively participate in staff meetings of the adolescent's treatment team and ensure that resources are being used efficiently to meet the adolescent's and family's needs.

Supportive Case Management

During the last month of treatment, the family should be transferred to treatment based on a less intensive case management model to prepare the family for discharge. This treatment continues with face-to-face contacts with both the youth and his or her family, periodic drug testing, and telephone contacts. However, these services are not delivered as frequently as in the intensive case management model.

Case managers should continue to monitor the adolescent and the adolescent's family throughout the treatment experience. For those families who begin treatment based on the supportive model, the case manager should provide services on an as-needed basis. However, the primary counselor and the family therapist should continually update the case manager about the adolescent's and his or her family's additional needs and progress.

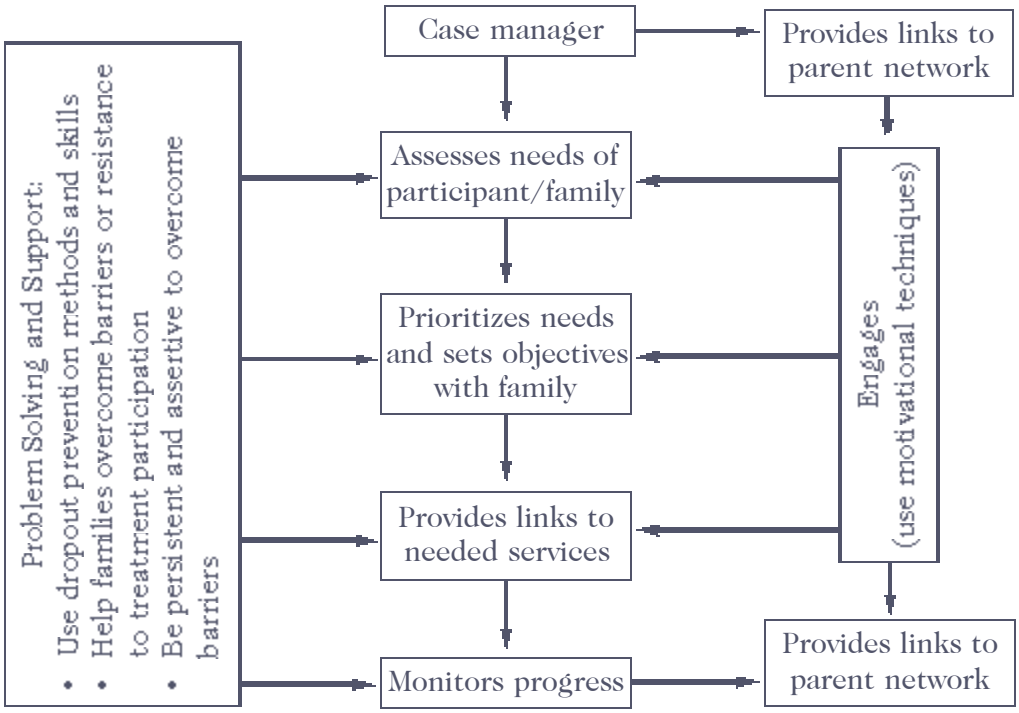
Components of Case Management

An overview of the case management model is shown in exhibit IV–1. This basic model is appropriate for both intensive and supportive case management. The services have different levels of intensity. An important responsibility of the case manager is engagement; the case manager provides motivational support for the adolescent and helps the youth overcome barriers or resistance to treatment participation.

The case manager should use sales and motivational skills at each stage of the process shown in exhibit IV–1. The case manager should participate with the treatment team (clinical supervisor, assessor, therapists, etc.) in developing a service plan that includes specific needs of the adolescent and family as they relate to ensuring participation in and completion of treatment. Once the adolescent's needs have been identified, the case manager should meet with the adolescent and his or her family to prioritize those needs and objectives.

Beginning with the adolescent's most critical needs, the case manager should provide links to services. The case manager must also teach families how to acquire services so they will have that knowledge when the support of the case manager is no longer available. For the case manager to release information to the referral agencies in accordance with Federal and State

Exhibit IV–1: Case Management Model



regulations, the adolescent and family must sign a release form. Once referrals have been made, the case manager is responsible for monitoring the progress of the adolescent and his or her family (e.g., checking whether the family members are keeping their appointments and whether their treatment plan is effective).

At each stage of the process, the case manager must provide support to overcome barriers to the successful completion of treatment. The case manager must be persistent and assertive to overcome barriers that prevent the adolescent from receiving treatment or obtaining needed services. Prompt intervention when obstacles arise (e.g., transportation, child care issues) helps decrease the dropout rate and increase positive outcomes. The case manager should also link parents to community support groups or initiate a peer-led parent support group.

Needs Assessment and Treatment Planning

Clinicians should develop an individual treatment plan based on a complete psychosocial assessment with the adolescent and the family. Timeframes for treatment activities are usually defined in administrative codes and regulations based on State statutes. For example, the timeframe for providing an individual treatment or service plan may be longer than that for administering intensive therapy. The initial treatment plan considers the adolescent's and the family's strengths, areas that need improvement, barriers to success, and discharge planning needs. This initial plan defines short-term, long-term, and deferred goals, as well as objectives and methods for their achievement. The plan delineates the responsibilities of the

adolescent, the family, the clinician, and the case manager. The adolescent, family, clinician, and case manager agree to the plan. Supervisory staff members then review and sign all treatment plans, treatment evaluations, and addenda.

For positive outcomes, treatment planning must be a truly collaborative effort among the clinician, case manager, adolescent, and family. The format for interdisciplinary treatment teams may vary depending on the organization providing the services and the resources available. At a minimum, a team approach should be followed during the initial treatment planning after the assessment process. Thereafter, there should be regular clinical supervision and reviews of the progress toward the treatment goals. Reviews must include the client or the family or both when appropriate. Case managers should be able to offer special insight into treatment planning because they see the adolescent and his or her family in their home environment. Continuous evaluation and assessment of progress should be made as the adolescent works on objectives that will help him or her achieve both short- and long-term goals. Treatment plans need to be reviewed at least monthly and updated as objectives and goals are achieved or as other issues are recognized. When it is a collaboration among clinicians, the adolescent, and the family, the treatment plan provides a clear "roadmap" for the adolescent to follow. Progress notes continuously document the adolescent's progress.

Treatment plans should include:

- Descriptions of the behavioral problems being addressed
- A description of the services or treatment to be provided to the adolescent and his or her family (including the type of service or treatment; frequency, duration, and location of services or treatment; and names of all accountable providers of services or treatment)
- A description of the treatment objectives that will result in measurable improvement of the condition of the adolescent.

Linkages

For case managers to provide effective linkages to community services for adolescents and their families, they must establish positive working relationships with other service providers in the area. Strategies have been developed for establishing relationships with external referral sources, such as the Department of Children and Families; diversion and truancy programs; county schools (dropout prevention programs, Safe & Drug Free Schools programs); community social services providers (timeout shelters, outpatient adolescent services); family services planning teams; community providers of mental health and substance abuse treatment; offices of public assistance; and law enforcement agencies. Resource lists of help lines or hotlines should be useful for identifying local service agencies.

Other useful support services to achieve or maintain successful outcomes include job placement, counseling, financial planning, independent living skills training, housing location services, and other continued support. To develop working relationships with community agencies, case managers should provide other agencies with information regarding their programs (e.g., tours of facilities, brochures of services, client eligibility requirements). The case manager should maintain open communication with each referral source's point of contact. Open communication should increase collaboration with each referral agency and increase the case manager's knowledge of each referral agency's service delivery process.

Finally, the case manager is also responsible for referring the family to a community support group for continuing help after formal treatment has ended. Parents should be encouraged to use this support group while their child is in treatment and to remain in contact with the group after their child has completed therapy. While a child is in treatment, parents should be contacted regularly and encouraged to attend these groups.

Monitoring the Adolescent's Progress

The case manager monitors the adolescent's and his or her family's progress. The case manager must follow up on referrals made, ensuring that the adolescent and family are keeping their appointments and that their needs are being met. The case manager must also periodically monitor the treatment plan of the adolescent and his or her family to make sure that the plan is effective and to make modifications as necessary.

Preparing for Termination

The intensity of case management services will decrease gradually over the treatment period to prepare the family for termination of services. The goal of the case manager is to empower the family to care for itself. The process of empowerment requires the case manager to educate the parents, prepare them to handle future needs, and teach them to remain focused on the short- and long-term goals they set with their child.

The process of gradual reductions in case management services should be explained to the parents in the early stages of treatment. Several weeks before the end of services, the case manager should begin discussing termination. If the parents are not already involved in a community support group, they should be strongly encouraged to become involved before termination. Parents must also be encouraged throughout treatment to widen their support system in other positive ways (e.g., getting involved with the Parent Teacher Association or the YMCA), especially ways that would involve teens as well as parents.

Availability of the Case Manager

Emergency services should be available 24 hours a day. These services may be provided by the treatment agency or within the community. The case manager should be available during "business hours." As in many treatment

programs, business hours should be flexible and extend into the evening on certain nights. The maximum caseload is 25 adolescents and their families. The frequency of contact by the case manager varies depending on the intensity of the service plan developed.

Monitoring and Tracking of Case Management Services

Case management records should capture the frequency, amount, and type of case management contacts. Documentation should occur as contacts are made. This will ensure accurate recording of events as well as provide information about the family for the treatment teams. Treatment agencies usually have forms for staff members to use to track activities. Many agencies use electronic methods that simplify managing data for analysis. Contact logs should be kept for any direct contact, such as telephone or face-to-face communication, with adolescents or their families. The frequency, amount, and type of service referrals also should be tracked, including whether the adolescent or referred family members kept their appointments. All missed appointments should be noted either on a form or electronically to facilitate followup. Examples of forms are provided at the end of this section.

Qualifications and Training

The case manager should have either a bachelor's degree or special training in case management techniques. The individual should have at least 2 years of experience in case management techniques and possess the abilities to persuade others and to solve problems creatively. In addition, the case manager should receive inhouse training if needed. The following are examples of training the case manager should receive as needed.

Safety Concerns

Case managers must understand that some service areas are high-risk crime locations, and they should receive training in recognizing these situations. Case managers should always prepare a daily schedule. Many include the times they will be traveling to high-risk areas. When necessary, the case manager should travel with a companion or consider meeting families in a safe, public place.

Time Management Techniques

Training on methods for the following will improve the case manager's performance: prioritizing and planning to maximize use of time, confirming appointments, using reminder postcards, knowing when a call is as effective as a face-to-face visit, being prepared to use "down time" while traveling to plan or do paperwork, and keeping extra copies of materials available.

Sales and Motivational Techniques

Training in motivational enhancement and other motivational techniques will improve the skills of staff members and increase their ability to motivate

participation and overcome barriers, so they can effectively encourage the adolescent and his or her family to participate fully in the program.

Cultural Competency

Training in cultural competency will help staff members engage the family throughout the case management procedures. Training should include understanding one's own cultural perspectives because these cultural biases affect judgment and clinical decisions.

Missed Appointment Form

Participant Name:_____

Date of Missed Appointment:_____ Type:_____

Case Manager Made Contact on:_____ By: ❑ Phone ❑ Face to Face

Barriers:

_____

_____

_____

_____

Action Plan:

_____

_____

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_____

_____

_____

Results:

_____

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_____

_____

Additional Comments:

_____

_____

_____

_____

_____ _____

Case Manager Date

Case Management Service Log								
ID#	Date	Type of Contact	Type of Service	Type of Referral	Agency Referred to	Followup Received	Additional Comments or Recommendations	Outcome of Service/Referral

Referral Form

Name:_____

Address:_____

_____

_____

Daytime Phone:_____

Evening Phone:_____

Referred by:_____ Date:_____

Comments:

_____

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Referral Source:_____ Phone:_____

Case Management Screening Log								
Referral Date	Client Name and Contact Number	Referral Source	Screening Date	Outcome of Screening	Informed Consent	Date of Assessment Appointment	Date Assessment Completed	Additional Comments or Recommendations

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Appendix 1. Quality Assurance

Continuous quality improvement requires diligence on the part of treatment providers and clinical staff. One method used in the Cannabis Youth Treatment (CYT) study required that clinical supervisors listen to videotapes of sessions and home visits. The clinical supervisors then rated the performance of clinicians using the quality assurance forms found in this appendix. These forms also provided clinicians the opportunity to rate themselves. Therefore, the procedure allowed the supervisor and the clinician to engage in a dialog about the sessions and improve their clinical skills. During the CYT study, all staff members improved their professional competencies, regardless of their level of experience. The quality improvement process and use of these forms are optional. However, providers should either videotape or audiotape all sessions, or randomly selected sessions, to help supervisors monitor counselors so they can improve their skills and to ensure adherence to the family support network model.

Quality Assurance Form: Parent Education Session 1			
PE 1: Therapist ID: _____ Rater ID:_____ Family ID:_____ Number Present:_____ Date:_____			
Objective	**Description**	**Ratings** 0 = Not covered 1 = Very ineffective 2 = Ineffective 3 = Acceptable 4 = Effective 5 = Very effective	**Comments**
Goal: To communicate an overview of the FSN model and the importance of family participation			
1	Present the FSN model, and discuss the importance of family participation.	0 1 2 3 4 5	
2	Present information on typical teen rationalizations.	0 1 2 3 4 5	
3	Present material on functional family qualities.	0 1 2 3 4 5	
4	Discuss effective parenting behaviors.	0 1 2 3 4 5	
5	Present material on ineffective parenting behavior that will help parents identify habits that may potentially prove unproductive to healthy communication.	0 1 2 3 4 5	
6	Process, reflect on, and review material introduced on normal adolescent development and functional families.	0 1 2 3 4 5	
7	Discuss life stressors with parents.	0 1 2 3 4 5	
Overall Effectiveness	**Overall, how effective would you rate this session?**	**0 1 2 3 4 5**	
Overall Comments:			

Quality Assurance Form: Parent Education Session 2			
PE 2: Therapist ID: _____ Rater ID:_____ Family ID:_____ Number Present:_____ Date:_____			
Objective	**Description**	**Ratings** 0 = Not covered 1 = Very ineffective 2 = Ineffective 3 = Acceptable 4 = Effective 5 = Very effective	**Comments**
Goal: To provide parents a better understanding of adolescent drug use			
1	Discuss the disease concept of addiction and what it means in the process of recovery.	0 1 2 3 4 5	
2	Distribute the *Drug Category Information* and *Consequences of Use and Drugs of Abuse Detection Times* handouts.	0 1 2 3 4 5	
3	Initiate a discussion based on essential points.	0 1 2 3 4 5	
4	Introduce, show, and discuss the *Drug Abuse and the Brain* video.	0 1 2 3 4 5	
5	Introduce the stages of adolescent development.	0 1 2 3 4 5	
6	Initiate a wrapup discussion using probing questions to reinforce the valuable information introduced in this session.	0 1 2 3 4 5	
7	Obtain a commitment from parents to continue attending the group sessions.	0 1 2 3 4 5	
Overall Effectiveness	**Overall, how effective would you rate this session?**	**0 1 2 3 4 5**	
Overall Comments:			

Quality Assurance Form: Parent Education Session 3

PE 3: Therapist ID:_____ Rater ID:_____ Family ID: _____ Number Present:_____ Date:_____

Objective	Description	Ratings 0 = Not covered 1 = Very ineffective 2 = Ineffective 3 = Acceptable 4 = Effective 5 = Very effective	Comments
Goal 1: To develop an understanding of the potential problems resulting from continued use of drugs, including the process of addiction			
1	Assist parents in recognizing the difficulties in parenting.	0 1 2 3 4 5	
2	Introduce the topic of recovery, and discuss the importance of family involvement in the adolescent's recovery.	0 1 2 3 4 5	
3	Discuss the signs and symptoms of drug use.	0 1 2 3 4 5	
Goal 2: To develop an understanding of the recovery process and to learn that recovery is a long process and that part of this process is relapse prevention			
1	Discuss the recovery process, ways to prevent relapse, and subtle signs of relapse.	0 1 2 3 4 5	
2	Discuss and identify potential problems that can lead to relapse.	0 1 2 3 4 5	
3	Present the *Recovery Expectations* and *Plan for Recovery* handouts.	0 1 2 3 4 5	
4	Introduce the importance of a family relapse prevention plan, and explain the need for the substance-using adolescent to have a relapse prevention plan.	0 1 2 3 4 5	
5	Provide parents with information about community support groups.	0 1 2 3 4 5	
6	Discuss questions regarding relapse and recovery.	0 1 2 3 4 5	
Overall Effectiveness	**Overall, how effective would you rate this session?**	**0 1 2 3 4 5**	

Overall Comments:

Quality Assurance Form: Parent Education Session 4			
PE 4: Therapist ID:_____ Rater ID:_____ Family ID: _____ Number Present:_____ Date:_____			
Objective	**Description**	**Ratings** 0 = Not covered 1 = Very ineffective 2 = Ineffective 3 = Acceptable 4 = Effective 5 = Very effective	**Comments**
Goal: To teach participants how to set limits and boundaries, establish appropriate disciplinary methods for youth, recognize characteristics of unhealthy boundaries, and develop a parent/child behavioral contract			
1	Discuss the process parents undergo in developing discipline.	0 1 2 3 4 5	
2	Define boundaries, and explain the need to develop boundaries with children. Distribute the *Characteristics of People With Unhealthy Boundaries* handout.	0 1 2 3 4 5	
3	Introduce the topic of setting limits with children.	0 1 2 3 4 5	
Overall Effectiveness	**Overall, how effective would you rate this session?**	**0 1 2 3 4 5**	
Overall Comments:			

Quality Assurance Form: Parent Education Session 5			
PE 5: Therapist ID:_____ Rater ID:_____ Family ID: _____ Number Present:_____ Date:_____			
Objective	**Description**	**Ratings** 0 = Not covered 1 = Very ineffective 2 = Ineffective 3 = Acceptable 4 = Effective 5 = Very effective	**Comments**
Goal: To teach parents how to communicate effectively, how to have arguments using fair rules, and how to resolve conflicts with adolescents			
1	Introduce and encourage discussion on conflict resolution, and motivate the participants to learn the information.	0 1 2 3 4 5	
2	Introduce the topic of mutual respect in communication and effective communication tools. Identify specific guidelines for fighting fair.	0 1 2 3 4 5	
3	Distribute the *Ways To Improve Communication With Your Teenager* handout.	0 1 2 3 4 5	
4	Discuss how to build or rebuild relationships in the family.	0 1 2 3 4 5	
Overall Effectiveness	**Overall, how effective would you rate this session?**	**0 1 2 3 4 5**	
Overall Comments:			

Quality Assurance Form: Parent Education Session 6			
PE 6: Therapist ID:_____ Rater ID:_____ Family ID: _____ Number Present:_____ Date:_____			
Objective	**Description**	**Ratings** 0 = Not covered 1 = Very ineffective 2 = Ineffective 3 = Acceptable 4 = Effective 5 = Very effective	**Comments**
Goal: To provide an understanding of family dynamics in recovery			
1	Introduce the term "family."	0 1 2 3 4 5	
2	Introduce the concept of the family as a dynamic system (the family as a whole).	0 1 2 3 4 5	
3	Introduce the concept of family roles of individual members. Show overheads of each role, or distribute the Family Roles handouts to participants.	0 1 2 3 4 5	
4	Debrief families about the new and potentially disturbing information.	0 1 2 3 4 5	
5	Prepare families for upcoming topics that address the family recovery process.	0 1 2 3 4 5	
6	Provide parents with information that will help them choose a new direction for their families.	0 1 2 3 4 5	
Overall Effectiveness	**Overall, how effective would you rate this session?**	**0 1 2 3 4 5**	
Overall Comments:			

Quality Assurance Form: Home Visit 1			
HV 1: Therapist ID:_____ Rater ID:_____ Family ID:_____ Number Present:_____ Date:_____			
Objective	**Description**	**Ratings** 0 = Not covered 1 = Very ineffective 2 = Ineffective 3 = Acceptable 4 = Effective 5 = Very effective	**Comments**
Goal 1: To increase parental participation in the treatment process by identifying barriers to successful completion, including misunderstandings about the treatment process			
1	Review the purpose and the objectives of the home visits in relation to the goals of substance abuse treatment.	0 1 2 3 4 5	
2	Review adolescent's UA results.	0 1 2 3 4 5	
3	Share some of the adolescent's reasons for quitting.	0 1 2 3 4 5	
4	Encourage the parents to commit to not using illicit drugs and to being aware of their alcohol use during the treatment period.	0 1 2 3 4 5	
5	Explain what the program will and will not do for the adolescent and the family.	0 1 2 3 4 5	

(continued on next page)

Goal 2: To develop an alliance with the family and begin to establish knowledge of the family history, environment, and stressors			
1	Provide feedback from the Life Stressors and Social Resources Inventory.	0 1 2 3 4 S	
2	Explain the case manager's role, and observe the family in its home environment.	0 1 2 3 4 S	
3	Conduct a brief "family sculpting" exercise.	0 1 2 3 4 S	
4	Initiate a discussion of "How you would like your family to be different."	0 1 2 3 4 S	
S	Provide the family with copies of the *Family Agreement* handout.	0 1 2 3 4 S	
6	Review the *Treatment Contract* handout.	0 1 2 3 4 S	
Overall Effectiveness	**Overall, how effective would you rate this session?**	**0 1 2 3 4 5**	
Overall Comments:			

Quality Assurance Form: Home Visit 2			
HV 2: Therapist ID:_____ Rater ID:_____ Family ID:_____ Number Present:_____ Date:_____			
Objective	**Description**	**Ratings** 0 = Not covered 1 = Very ineffective 2 = Ineffective 3 = Acceptable 4 = Effective 5 = Very effective	**Comments**
Goal 1: To increase the family's understanding of the adolescent's urinalysis results and to solve problems, if necessary			
1	Review the adolescent's and family's progress, and respond to any problems or questions.	0 1 2 3 4 5	
Goal 2: To assist the family in preparing a family vision/mission statement			
1	Introduce the family to the "vision" or "mission" exercise, and assist members in preparing a statement for the family.	0 1 2 3 4 5	
Goal 3: To assist the family in understanding the concept of "fair fighting" and in assessing its current family rules for fighting			
1	Discuss how the family fights and in what ways members could change their interaction to fight fair.	0 1 2 3 4 5	
2	Determine what rules exist in the family.	0 1 2 3 4 5	
3	Discuss family commitments to change.	0 1 2 3 4 5	
4	Ask the family to commit to changing family dynamics at least until the next session.	0 1 2 3 4 5	
5	Introduce a board game to improve communication.	0 1 2 3 4 5	
Overall Effectiveness	**Overall, how effective would you rate this session?**	**0 1 2 3 4 5**	
Overall Comments:			

Quality Assurance Form: Home Visit 3			
HV 3: Therapist ID:_____ Rater ID:_____ Family ID:_____ Number Present:_____ Date:_____			
Objective	**Description**	**Ratings** 0 = Not covered 1 = Very ineffective 2 = Ineffective 3 = Acceptable 4 = Effective 5 = Very effective	**Comments**
Goal 1: To provide the family with the typed and framed family vision/mission statement and to give the family the opportunity to solve any problems that may have arisen over the past weeks that affect the mission statement			
1	Provide the family its vision/mission statement.	0 1 2 3 4 5	
Goal 2: To increase the parents' and family members' ability to self-assess and adjust their behaviors to increase positive outcomes			
1	Explore problems with communication experienced since the last home visit.	0 1 2 3 4 5	
2	Review overall progress with parents and family members.	0 1 2 3 4 5	
Goal 3: To reinforce the necessity for all family members to support the recovery of the identified adolescent and the recovery of the family, and to provide sources of support if stress or relapse occurs			
1	Solicit from family members how they would know whether the family or individual is in relapse.	0 1 2 3 4 5	
2	Solicit from family members specific ways they can make one another aware of problems and agreement issues.	0 1 2 3 4 5	
3	Review with each family member the names of the people who will be able to help and support them in times of stress or relapse.	0 1 2 3 4 5	
4	Review the *Family Relapee Prevention Plan*, and have all members sign it.	0 1 2 3 4 5	
Overall Effectiveness	**Overall, how effective would you rate this session?**	**0 1 2 3 4 5**	
Overall Comments:			

Quality Assurance Form: Home Visit 4			
HV 4: Therapist ID:_____ Rater ID: _____ Family ID: _____ Number Present: _____ Date: _____			
Objective	**Description**	**Ratings** 0 = Not covered 1 = Very ineffective 2 = Ineffective 3 = Acceptable 4 = Effective 5 = Very effective	**Comments**
Goal: To assess the progress of the individuals and the family unit during the treatment process and to gain continued commitment to and support for the individual and the family			
1	Ask each member to evaluate progress, express concerns or fears for the future, and ask questions.	0 1 2 3 4 5	
2	Encourage each member to reiterate his or her commitment.	0 1 2 3 4 5	
3	Individualize the treatment to the family.	0 1 2 3 4 5	
Overall Effectiveness	**Overall, how effective would you rate this session?**	**0 1 2 3 4 5**	
Overall Comments:			

Appendix 2. Clinical Management of a Multisite Field Trial of Five Outpatient Treatments for Adolescent Substance Abuse

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Abstract

Bridging the gap between clinical research and clinical practice in the treatment of adolescent substance abuse requires empirically validated therapies and technology transfer strategies that reflect an awareness of the realities and resource constraints of local treatment service providers. This article describes the management of cross-site and cross-intervention clinical issues in the Cannabis Youth Treatment (CYT) study, a multisite, randomized, clinical trial of five outpatient therapies. The methods used in the management of such clinical trials could play an important role in elevating the quality of adolescent substance abuse treatment as practiced in the field. This technology involves 1) defining and delineating clinically relevant subpopulations of clients, 2) developing research-supported manuals that define the theory, active ingredients, and procedures of treatment, 3) monitoring therapist adherence to manual-based therapy, 4) monitoring client responses to the procedures as they are implemented, 5) individualizing and refining the delivery of these manual-based therapies within the context of clinical supervision, and 6) conducting rigorous and sustained followup to determine the enduring effects of the interventions.

Carroll and her colleagues (1994) detailed the strategies used to implement and to protect the integrity of three manual-based therapies evaluated within Project MATCH, a multisite study of adult alcoholism treatment (Project MATCH Research Group, 1993). This paper takes a similar approach in describing cross-site clinical coordination procedures within the Cannabis Youth Treatment study, the largest multisite, randomized field experiment ever conducted of adolescent substance abuse treatment. More specifically, the paper details the common clinical infrastructure within which these therapies were implemented across the treatment sites.

It is our collective experience that therapies can fail in the transition from efficacy (outcomes under ideal circumstances) to effectiveness (outcomes in the real world of adolescent treatment), not because of flaws in the interventions themselves, but because of the absence of a sound foundation of clinical management upon which empirically validated interventions are replicated. The construction of stable clinical infrastructures within local treatment programs is as important to the future of adolescent treatment as the availability of research-validated therapies.

The Cannabis Youth Treatment Study

After declining in the 1980s, both licit and illicit drug use among adolescents rose in the 1990s. In 1996, cannabis use by adolescents (8th, 10th, and 12th graders) reached its highest peak in 12 years for reported lifetime use, past year use, and past month use (ISR, 1997). As cannabis abuse/dependence emerged as the leading cause for admission to substance abuse treatment (OAS, 1997), demands increased for research-validated treatments for cannabis-involved adolescents. In response to this need, the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Substance Abuse Treatment (CSAT) of the U.S. Department of Health and Human Services (DHHS) funded the CYT study.

The CYT study is a multisite, randomized field experiment designed to test the efficacy of five promising outpatient treatment interventions for cannabis-abusing and cannabis-dependent adolescents. Its long-range goal is to provide validated and cost-effective models of intervention that can be widely replicated in local treatment agencies across the country. The study sites include Chestnut Health Systems in Madison County, Illinois (CHS–MC); the University of Connecticut Health Center (UCHC) in Farmington, Connecticut; Operation PAR (PAR) in St. Petersburg, Florida; and the Children's Hospital of Philadelphia (CHOP) in Pennsylvania. The sites represent both academic, research-oriented clinics (UCHC and CHOP) and community-based adolescent treatment programs (CHS–MC and PAR) (Dennis, Babor, Diamond, Donaldson, Goldley, Tims, et al., 1998; Herrell, Babor, Brantley, Dennis, et. al., 1999). The CYT study provides a test in geographically diverse environments of treatments that differ in theoretical orientation, delivery format and focus, and dose.

Between June 1998 and February 1999, 600 adolescents (approximately 150 per site) meeting the criteria presented in the *Diagnostic and Statistical Manual of Mental Disorders* 4th Edition-Revised (DSM–IV) (American Psychiatric Association, 1994) for cannabis abuse or cannabis dependence were randomly assigned to one of three conditions, with a total of five conditions used across the four sites. The five conditions include:

- Motivational Enhancement Therapy/Cognitive Behavioral Therapy—5 individual/group sessions (MET/CBT5) (Sampl & Kadden, 2001)

- Motivational Enhancement Therapy/Cognitive Behavioral Therapy—7 individual/group sessions (MET/CBT5 + CBT7) (Webb, Scudder, Kaminer, & Kadden, in press)

- Family Support Network (FSN) (Hamilton, Brantley, Tims, Angelovich, & McDougall, 2001) (FSN includes MET/CBT5 + CBT7 plus enhanced family supports: home visits, parent education classes, parent support groups)

- Adolescent Community Reinforcement Approach (ACRA) (Godley, Meyers, Smith, Karvinen, Titus, Godley, Dent, Passetti, & Kelberg, 2001)

- Multidimensional Family Therapy (MDFT) (Liddle, in press).

At UCHC and PAR, adolescents were assigned to a five-session brief intervention (MET/CBT5) or to one of two other interventions that combine more extensive individual and group sessions (MET/CBT5 + CBT7 or FSN). At CHS–MC and CHOP, adolescents were assigned to the five-session brief intervention (MET/CBT5) or to one of two individual/family approaches (ACRA or MDFT). All study participants were assessed at intake and at 3 months, 6 months, 9 months, and 12 months. Treatment completion rates were in the 70-percent range, and followup rates through 9 months after treatment exceeded 95 percent (Titus et al., 1999; Godley, Diamond, & Liddle, 1999).

Methodological Challenges

There were three important challenges in conducting this multisite field experiment. The first was to ensure the integrity of each of the interventions being tested (Moncher & Prinz, 1991). Following what has been referred to as the "technology model" (Carroll et al., 1994; Carroll & Nuro, 1996; Carroll, 1997), workgroups led by a technical expert in interventions and a therapist coordinator (TC) responsible for cross-site supervision of that intervention took the following six steps to enhance its integrity:

- Defined and manualized the active ingredients of each therapy, including the frequency, intensity, duration, and sequencing, and indicated responses to the most common problems that occur during delivery of the intervention

- Conducted 15 to 25 hours of centralized, competency-based training for the therapists delivering the interventions and followed this by local certification of staff in each intervention

- Developed a therapist's skillfulness scale to serve as a cross-site measure of general therapeutic competence

- Developed a service contact log to measure therapists' adherence to each of the five interventions and to document the dosage and types of services provided to each client

- Taped and rated sessions for model fidelity (all tapes were rated as part of the cross-site supervision by an expert in the intervention until each therapist was certified, after which two tapes per therapist, per month, were reviewed and rated)

- Conducted weekly (1-hour onsite or telephone) individual supervision and weekly or bimonthly (60 to 90 minute) cross-site group supervision for each intervention.

These procedures helped enhance treatment differentiability (the delineation of the ingredients and procedures that distinguished each treatment from the other treatments) and treatment adherence (the assurance that the interventions [as delivered] maintained fidelity to the original manual-defined procedures) (Hoffart, 1994).

A second challenge involved controlling extraneous factors that could compromise interpretation of the treatment outcomes. To accomplish this, every effort was made to ensure that all general clinical procedures, other than those involved in the specific therapies, would be handled similarly across sites and interventions. This was done to minimize the ability of these contextual issues to unduly influence the evaluation of the experimental interventions and was achieved in two ways. First, staff of the CYT coordinating center conducted two site visits at each of the four service delivery sites to ensure that each site met baseline standards related to arenas such as research protocol compliance, accessibility and appropriateness of clinical space, clinical supervision structure, recruitment strategies, intake and service procedures, confidentiality procedures, crisis and safety net procedures, clinical documentation, data security and storage, and followup procedures. Second, the TCs for each intervention coordinated similar responses to issues that were not part of the specific interventions in monthly conference calls facilitated by the CYT coordinating center. Details of this latter process will be described shortly.

The third challenge was to enhance the external validity of the interventions (the generalizability of study findings) by ensuring that the interventions could be implemented as designed within the resource constraints of settings that currently provide the bulk of services to drug-involved adolescents. It was the goal of the CYT TCs to do everything possible in the CYT study to bridge the traditional gap between efficacy research conducted under experimental (ideal) conditions and effectiveness research conducted in field (real) settings. We wanted to document the kind of clinical infrastructures and the management of day-to-day clinical issues that might need to accompany these unique interventions if they were to achieve comparable results in the field.

The monthly conference calls among the TCs for each of the five interventions and the staff from the CYT coordinating center were particularly helpful in facing the latter two of these challenges. The purpose of these meetings was to define how sites would manage common clinical issues that were not a unique part of the experimental interventions but which, if not identified and controlled, might corrupt the evaluation of these interventions. We were concerned, for example, that if therapists in one intervention expelled adolescents from treatment (and the study) for arriving at a session high, while another site either allowed such adolescents to participate or rescheduled their sessions, differences in completion rates between these sites would reflect not the power or weakness of the interventions but contextual policies unrelated to the active ingredients of each intervention.

What follows is a synopsis of how common clinical issues were managed across the four treatment sites and across the five interventions being

tested. It is hoped that this discussion will provide researchers and treatment practitioners alike with insights into the importance of managing such contextual influences. The discussion also represents a snapshot of baseline clinical practices in adolescent substance abuse treatment in 1998 and 1999.

Issues in Clinical Management and Clinical Care

A. Clinical Infrastructure. A rather complex clinical infrastructure was required to effectively manage clinical activities across the four treatment organizations and the five treatments in the CYT study. The care taken in constructing this infrastructure was based on the assumption that there is a close relationship between the quality of clinical supervision and treatment efficacy (Holloway & Neufeldt, 1995).

There were three levels of clinical coordination and supervision in the CYT study. First, local clinical supervisors at each service site coordinated cross-intervention clinical issues and day-to-day clinical problem solving. Second, a therapist coordinator for each of the five interventions used in the CYT study provided onsite and cross-site clinical supervision of staff working in their particular intervention. This supervision occurred weekly during the period in which therapists were being certified and bimonthly following staff certification. Third, a TC at the CYT coordinating center facilitated cross-site and cross-intervention coordination and problem solving. The centerpiece of this cross-site clinical coordination was a monthly meeting at which the respective TCs met with the cross-site TC and research coordinator via a conference call to discuss cross-site clinical and research issues. Particular problems or procedural questions emerging from these discussions were sometimes also referred to the CYT executive committee (all of the principal investigators, the CSAT project officer, and other CSAT staff) for consultation or decision making. The CYT coordinating center validated that the cross-site clinical procedures developed through these processes were in place by conducting two monitoring visits to each of the CYT research sites during the course of the study (*CYT cooperative agreement,* 1999).

Many problems and issues (administrative, fiscal, research, clinical, ethical, legal) were addressed in this multitiered supervisory structure, but the major goals were to meet the methodological challenges noted earlier: ensuring the integrity of the interventions, controlling factors that could confound outcomes, and enhancing the generalizability of findings. Several steps were taken to achieve these goals.

All sites used the same research and service intake and clinical assessment/screening procedures, the same inclusion and exclusion criteria, and the same approach to randomization and waiting list management. To maximize transferability of findings to the field, exclusion criteria were limited to adolescents 1) who needed a higher level of care than outpatient treatment, 2) who presented for treatment with confirmed histories of drug dealing or violence (particularly predatory behavior patterns reflecting a high frequency, high intensity, and long duration), 3) whose psychiatric comorbidity was so severe as to render them inappropriate for the CYT interventions, and

4) whose primary drug of choice was not cannabis. Although the study focused on adolescents with a primary drug choice of cannabis, most adolescents entering the CYT study reported using other drugs in addition to cannabis. Although abstinence from all alcohol and drug use was a goal of the treatments in the CYT study, at admission, adolescents were asked to agree to evaluate their drug use and its effects on themselves and their families. Therapists across sites and interventions agreed that many adolescents' commitment to abstinence was something that should emerge out of the treatment process, not something that should be a precondition for entry into treatment.

Mechanisms to enhance clinical fidelity to the interventions used in the study included centralized training and booster training of clinical staff delivering the interventions, the videotaping or audiotaping of all sessions followed by the use of self- and supervisory-scored adherence measures to monitor skillful execution of the intervention, formal procedures to certify each therapist in the intervention, continued postcertification tape reviews to minimize therapist "drift," and regular cross-site group supervision led by an expert in the intervention.

A considerable portion of the monthly meeting of the CYT TCs was aimed at ensuring baseline clinical processes and data collection procedures were being handled consistently across the four sites. There were discussions of just about everything—from drug testing procedures to appropriate responses to clinical deterioration of a study participant. The monthly agenda included a site-by-site review of particular issues, such as the status of therapists' certifications and the quality of communication between sister sites (those delivering the same interventions), and an opportunity to discuss the general problems and issues encountered. Below are some of the cross-site clinical issues that were of major concern throughout the course of the study.

B. Staff Recruitment, Training, and Retention. Most of the therapists working on the CYT project were trained at the master's degree level or higher, and most had prior training and experience in addiction treatment. The research sites, like the practice field, varied in their use of full-time and part-time staff. Most sites felt there were advantages to having full-time therapists working on the project because that increased their availability to clients, provided greater flexibility in scheduling, and created a greater degree of personal investment in the project. In general, sites looked for individuals with good clinical skills whose overall clinical orientations were congruent with the intervention they were going to deliver. A particular effort was made to find staff who had a good working knowledge of child and adolescent development—a qualification not often found in those working with adolescent substance abusers (Kaminer, 1994). Staff were paid salaries that were at or slightly above the geographical norm for addiction therapists. None of the sites experienced any significant problems recruiting qualified staff.

In the course of the project, there were a total of 26 full-time and part-time clinical positions at the 4 CYT sites. Nine staff left the CYT project during

this period—two due to changes in the communities selected as service sites and the majority of the others due to a return to school, family relocation, or promotion. The highest turnover rate was among the case managers. Several things worked to enhance staff morale and retention on the CYT project: a conscious effort to build team cohesion, a knowledge of the potential importance of the research being conducted, the training and supervision opportunities, the opportunity for cross-site contact with peers working on the same intervention, and the flexibility of the individual sites regarding scheduling of part-time employees on the project.

Although considerable effort is made to ensure that conditions in clinical trials are equivalent to natural conditions in the field, there are several characteristics of clinical trials staff that make them somewhat different from those in mainstream practice. Staff who seek clinical positions in clinical trials are not scared away by the limited timeframe of employment on such a project, are often attracted by the intense nature of training and supervision such projects afford, and are not put off by the rigorous record-keeping generally required in such projects.

Strategies used for managing clinical continuity in the face of staff attrition included replicating the training that was provided to all therapists at the beginning of the CYT project, having a built-in transition/training period for entering staff, and using videotaped sessions of the current therapists to train new therapists.

The safety of staff working in the field was enhanced by hiring staff from the local community, providing inservice training on safety management and access to beepers and cellular phones, and the option of working in teams to visit areas that posed higher safety threats. Office-based safety issues were addressed by ensuring that other staff were present while sessions were being conducted and by providing walkie-talkies or silent alarms to signal other staff if assistance was needed. There were no major safety-related incidents experienced by the CYT project.

C. Client/Family Recruitment, Engagement, and Retention. The major barriers in recruiting, engaging, and retaining adolescents and their families were fairly consistent across the CYT project sites:

- Low adolescent/parent motivation for treatment involvement
- The perception that other problems in the family were more important than the drug experimentation of one child
- Parental substance abuse
- The parental view that smoking marijuana is not that big a deal
- Failure to attend due to lack of transportation or child care
- A marital or relationship breakup during the period of treatment involvement

- Inconsistent messages from the parents to the adolescent about the importance of involvement in counseling
- Relocation of the child during the course of treatment
- Parents having given up on efforts to change their child
- A general and pervasive sense of hopelessness about life (felt by both the parents and the adolescent).

Study participants were recruited by direct appeals to youth and parents through newspaper and radio public service announcements and strategically placed bulletin board posters. Staff also oriented local youth service professionals regarding how referrals could be made to the program and the nature of the various treatments that youth would be receiving. These visits and mailings included CYT information packets, business cards, and Rolodex inserts. There was some resistance to referring clients to the project when referral sources discovered that they could not control which intervention their clients would receive. Some were concerned that the five-session intervention would not provide an adequate level of service. After some education about the benefits of brief therapy in general, however, and the need to test such therapies in the substance abuse arena, most were willing to make referrals.

Of 690 adolescents referred to the CYT sites between May 1, 1998, and May 31, 1999, 38.6 percent were referred by criminal justice-affiliated agencies, 24.8 percent by families (7.6 percent of which came from a media promotion of the CYT project), and 15.2 percent by educational community health and human service agencies (Webb & Babor, 1999). An analysis of adolescents admitted to treatment in the CYT study (Tims, Hamilton, Dennis, & Brantley, 1999) revealed that 84.7 percent were age 15 or older, 38.1 percent were nonwhite, and 11.9 percent were female. The low rate of female admissions is attributable to at least two factors. The first involves the use of referral sources such as juvenile probation departments that serve predominantly male clients. The second factor is that, of those females referred to the CYT study, more than one-third presented with comorbid psychiatric disorders severe enough to exclude their participation in the study.

Client engagement was enhanced through five broad strategies. The first was to make the transition between the research staff (the equivalent of the intake staff in most agencies) and the clinical staff as personal as possible. When a therapist was not available to be introduced to the client/family by the research staff, the assigned therapist called the parents or the adolescent before the first appointment to introduce himself or herself, begin alliance building, and clarify any questions about treatment participation. All of the CYT interventions begin with an emphasis on empathy and skillful rapport building to build a strong therapeutic alliance and work through resistance related to the coercive influences that may have brought the adolescent to treatment.

The second strategy was for the therapist to speak for 5 to 10 minutes with any adolescent who had to wait more than 2 weeks to begin service (a delay sometimes caused by randomization and the cycles of starting new groups) to sustain his or her motivation for service involvement.

The third strategy was to remove as many environmental obstacles to treatment participation as possible by using geographically accessible service sites, providing assistance with transportation (that is, cab vouchers, bus tokens, picking adolescents up in the agency van), and providing or arranging child care. Case management, whether provided by therapists, case managers (in the FSN intervention), or even during the screening activities of the research staff, was an essential medium of engagement for those families whose lives were most chaotic at the point of initial contact with the CYT project. Every effort was made to link what could be learned in treatment with what could help the immediate crisis presented by the family. The CYT interventions shared the message, "We have something that could help with some of these problems and improve the quality of life for you and your child."

The fourth and most important strategy was to actively engage the adolescents and families by creating strong therapeutic alliances, expressing interest in their participation (e.g., by weekly phone prompts for participation), finding a goal that the adolescent and family were interested in working on, expressing optimism in their capacity to change, and persisting in family contacts during the earliest signs of disengagement. FSN intervention staff felt that home visits were very important in initiating and sustaining the involvement of the most treatment-resistant families.

The fifth strategy was to provide a warm, collaborative, adolescent- and parent-friendly environment (with informal but respectful hosting, providing pizza and sodas as part of the dinner-hour adolescent and parent meetings) and to provide specific incentives for involvement in treatment (help with very specific problems, fully subsidized treatment, and token prizes for homework completion).

D. Safety Net Procedures. Safety net procedures involve strategies for recognizing and responding to adolescents who before or after entering outpatient care were thought to be in need of a higher level of care or allied services. We anticipated and experienced four scenarios that required such safety net procedures. The first involved emergency situations that might arise related to an adolescent's drug use during the course of the study. All parents were provided a laminated card listing signs of acute intoxication and oriented to procedures that could be used to respond to an emergency. The second scenario occurred when adolescents underreported the frequency and intensity of their drug use at intake but disclosed it after they were randomized and admitted to one of the therapies. The third scenario involved the frequency and intensity of use escalating after the adolescent had been admitted to outpatient treatment. The fourth scenario occurred when an adolescent's mental health status deteriorated following admission, particularly where such deterioration posed the threat of harm to himself or herself or others. Safety net procedures were established at

all four sites that 1) ensured the periodic reassessment of the status of use and the appropriateness of the level of care to which clients were assigned, 2) ensured the availability and use of supervisory supports to formally reevaluate changes in clients' status and care needs, and 3) facilitated, when needed, moving an adolescent to a more structured and intense level of care or the addition of collateral services. Where alternative or additional services were thought to compromise evaluation of the effect of the CYT intervention, the adolescent and family were provided the additional services but the adolescent was no longer included in the study.

E. Concurrent Services. The exclusion of adolescents with severe psychiatric illness from the CYT study does not mean that all adolescents with psychiatric comorbidity were excluded from the CYT study. The majority of adolescents and families admitted to the CYT study presented with multiple problems, and the rate of psychiatric comorbidity of the adolescents admitted to the study was quite high. Forty-two percent met the criteria for attention deficit/hyperactivity disorder, 55 percent met the criteria for conduct disorder, and 29 percent presented with multiple symptoms of traumatic stress (Tims, Hamilton, Dennis, & Brantley, 1999). Those adolescents who were referred for more intense services prior to randomization and who were not included in the CYT study were most likely to be excluded because they presented a high risk of harm to themselves or others. (These risks were identified through the participant screening form completed at intake and through the assessment instrument [GAIN] [Dennis, Webber, White, et al., 1996] and the interviews that were part of the intake process at all of the CYT service sites.)

The multiple problems presented by the CYT adolescents and their families raised an important clinical and research issue: How to respond to the clinical needs they presented without contaminating (through concurrent service involvement) the evaluation of the particular interventions in the CYT study. This problem was complicated further by the referral patterns of the agencies that linked adolescents with the CYT project. Acutely aware of the number and complexity of the problems many of these adolescents presented, many of these referral sources used a shotgun approach—simultaneously referring the adolescent and family to multiple treatments, hoping that the cumulative dose of services would have some positive effect on the child and family. These problems diminished through education of and negotiation with referral sources. It was a policy of the CYT study that adolescents would not be allowed to remain in the study if they were receiving concurrent treatment whose primary focus was the problem of substance abuse or if they were receiving services whose impact was judged by the local staff to inordinately confound the impact of the CYT intervention being provided. However, no adolescent had to be excluded from the study for such concurrent service involvement. Several adolescents who were treated simultaneously for collateral problems (e.g., being medicated for hyperactivity or depression) were allowed to enter and remain in the CYT study because the focus of the concurrent services was not on substance abuse or dependency.

F. Session Management. Efforts were made to ensure that issues related to the management of sessions that were not unique to the particular interventions would be handled in reasonably consistent ways across the sites. Where procedures were not the same, they were reviewed to ensure the differences would not confound outcomes. These discussions included how to respond to lateness, missed sessions, the criteria for dropping cases, intoxication, contraband, disruptive behavior, preexisting relationships between members, and a group session at which only one member is present.

Lateness was handled by degree, by ensuring either that the client got the minimal dose for that session or that the session was rescheduled. Missed sessions were rescheduled or, in the case of group interventions, provided as an abbreviated makeup session prior to the next scheduled session. (All services across the five modalities were expected to be completed within 14 weeks of the time of the first therapy session, with local TCs reviewing and approving any exceptions to this rule.)

All programs made intoxication and possession of contraband grounds for exclusion from that particular session and a flag for reassessment of the appropriateness of the current level of care. (While rare episodes of an intoxicated youth arriving for services did occur, these episodes were clinically managed without excluding the adolescent from continued service.) Only one adolescent per family was included in the CYT study, and preexisting relationships between participants in the group modalities were reviewed to determine whether the prior history would undermine or enhance treatment. A group with only one member present was conducted in a 30- to 45-minute individual format covering the material that was scheduled for presentation. If an adolescent failed to appear for a family session, the session was conducted without the adolescent.

The TCs collectively sought and implemented general strategies that could enhance the effectiveness of sessions for all of the CYT therapies. Strategies that served to minimize problems and enhance session effectiveness included formalizing, posting, and consistently enforcing group/family norms on such issues as dress (banning drug/gang symbols on clothing) and language (profanity, drug argot). In the group interventions, the closed group structure made it particularly important to guard against negative influences within the peer cultures that evolved. A final issue was the appropriate level of contact between therapists and adolescents outside the intervention. The TCs decided that such contact should be minimized so as not to contaminate model fidelity by altering dose. More specifically, it was agreed that all extra-session contact should be responded to within the therapeutic framework of the particular intervention, channeled into upcoming sessions, documented, and brought to supervisors for review.

G. Gender and Cultural Adaptations. While there is significant momentum toward the development of standardized, empirically supported, and manual-based treatments (Wilson, 1998; Carroll, 1997), there is a simultaneous call for the refinement of standardized treatment that includes gender and cultural relevance and effectiveness (Orlandi, 1995). All of the CYT therapists noted making changes in their delivery of the

manual-based treatments that were based on gender, cultural, and socioeconomic status (SES) appropriateness. Therapists in group interventions explicitly noted diversity issues in the group and incorporated respect for diversity into the ground rules established at the beginning of each group. The most frequently mentioned adaptations included:

- Changing the language of the session to reflect cultural or geographical norms
- Adding items to some worksheets to make them more applicable to urban youth
- Providing special writing and reading assistance to address illiteracy
- Slowing the pace and adding repetitions of key ideas to accommodate learning impairments
- Developing examples and illustrations of key points that had greater gender, cultural, and SES relevance.

Therapists emphasized it was not the content of interventions that had changed; there were subtle changes in the way that content was framed or delivered.

H. Case Mix Issues. Therapists involved in the group interventions (MET/CBT5, MET/CBT5 + CBT7, FSN) also decided to monitor closely client mix issues according to gender, ethnicity, and other important dimensions. There was an effort to identify any potential iatrogenic effects of randomization (e.g., harassment, scapegoating, or other predatory targeting of a vulnerable group member by other group members) and to actively manage potential negative effects of group support for antisocial behavior (Dision, McCord, & Poulin, 1999). This was managed primarily by establishing and enforcing norms for group sessions.

I. Mutual Aid and Peer Support Groups. In contrast to Project MATCH, a 12-step facilitation therapy was not included in the CYT study, and there was some variation in the philosophies of the 5 interventions related to the desirability of mutual aid involvement by cannabis-involved adolescents. The ACRA, MDFT, and MET/CBT interventions do not directly encourage affiliation with addiction recovery support groups, but they do frame such involvement positively if the adolescent is already involved in such a group or self-initiates involvement during the course of treatment. FSN, while strongly encouraging parents to participate in Al-Anon, does not directly encourage adolescent clients to affiliate with Narcotics Anonymous (NA) or Alcoholics Anonymous (AA). Information on local mutual support groups is provided simply as one of many community resources. There was more of an emphasis in all the CYT interventions on involvement in drug-free prosocial activities in general than on addiction recovery support group involvement.

J. Ethical Issues. The TC meetings also provided a venue to discuss and formulate responses to some of the complex ethical and legal issues that can arise in the treatment of adolescent substance abuse (White, 1993). Considerable time was spent discussing questions such as:

- What are the boundaries of confidentiality regarding disclosure of information about an adolescent to his or her parents?
- Do parents have a legal/ethical right to the results of their child's urine tests?
- What circumstances would constitute a duty to report or duty to intervene?
- What obligations, if any, do therapists have in responding to an adolescent's disclosures of past or planned criminal activity?
- How should therapists respond to reports of abuse of adolescents by a parent or to failures by child protection agencies to intervene to ensure the safety of the adolescent?

Discussion

Carroll and colleagues (1994, 1996, 1997) are to be commended for helping transfer the technology model of psychotherapy research to addiction treatment outcome studies. The CYT study greatly benefited from the earlier experience of Project MATCH in the use of this model. This paper has described a structure (the interface between a cross-site and cross-intervention TC group and the CYT executive committee) and a process (monthly meetings of all the TCs and monitoring visits at each CYT study site) that were used to control contextual elements surrounding the experimental interventions. Our goal was to hold these contextual elements constant across the interventions in order to enhance our ability to measure the differences the experimental interventions produced on outcome measures. We wanted differences in outcomes to reflect differences in the interventions themselves and not factors incidental to the interventions.

While there were major research design elements (consistency in clinical data collection instruments and procedures, inclusion and exclusion criteria, and followup procedures) that helped control such variance across sites and interventions, we also sought to identify more subtle areas of potential contamination of the study. By generating consistent cross-intervention procedures to respond to lateness, missed sessions, disruptiveness, intoxication, and concurrent participation in other services, we were able to ensure a consistent and a more precise definition of the dose and type of services provided in, and collateral to, each intervention. By developing and monitoring safety net procedures across the sites and interventions, we were able to ensure timely and appropriate responses to the placement of a client in an inappropriate outpatient modality who needed a higher level of care and to respond to acute episodes of clinical deterioration that warranted a similar change in the level of care. We found that the

collaborative work of the TCs helped enhance the methodological rigor of the CYT study and helped establish a sound clinical infrastructure upon which each of the interventions was tested.

There are many aspects of the clinical management of the CYT project other than the efficacy of the particular interventions used that may have wide applicability to the field of adolescent substance abuse treatment. It is our view that many of the procedures to provide overall clinical management of randomized field trials have great clinical utility and are likely to become future baseline clinical practices in the treatment of adult and adolescent substance abuse disorders.

The technology model that, to date, has been used primarily as a means of ensuring methodological rigor in multisite field trials seems to us to have enormous advantages for enhancing the quality of treatment and should be studied for potential adaptation to mainstream clinical practice. Those looking for ways to enhance the quality of adolescent substance abuse treatment would be well served to explore how the elements of this model could become part of the future definition of treatment as usual. Parents seeking help to address the substance abuse-related problems of their son or daughter ought to be able to expect that the theory behind the treatments they are offered can be articulated and that their active ingredients can be defined. They should further be able to expect that these treatments have some degree of scientific support for their effectiveness and that they will be delivered in a manner consistent with procedures whose effectiveness has been validated.

Increased demands for such accountability and fidelity by parents, policy makers, and funding agencies will likely make manual-based therapies the rule in the future, along with the training and adherence measures that accompany them. The technical aspects of cross-site clinical management of the CYT project have much to offer the field as a whole. The use of standardized assessment instruments that are capable of providing comprehensive assessment and treatment planning data should become a requirement of all adolescent treatment programs in the next decade. We further commend the use of central (and booster) training, videotaping and adherence ratings as standard practices in supervision, and cross-site supervision as marvelous tools for training and professional development. Finally, we believe that rigorous followup (monitoring, feedback, and, where indicated, early reintervention) should move from the realm of clinical research to being an expectation, if not a requirement, of mainstream clinical practice. The idea of providing services without measuring outcomes will be incomprehensible in the very near future, and the technology to perform this task is rapidly emerging. Morale among staff working in the CYT project remained high, in part because of the near universal belief in the historical importance of this study and the climate of excitement and discovery that permeated the project. We believe that small field-based experiments to answer critical clinical questions, opportunities for cross-site sharing, and the opportunity to work on papers and presentations can similarly contribute to staff morale within local service organizations. We believe this milieu of curiosity, discovery, and contribution is transferable

and sustainable in natural clinical settings. Routine outcome monitoring and field-based experiments, like the other items in this discussion, must simply be moved from the arena of clinical research to the arena of standard clinical practice. This transfer of technology from the research environment to the clinical practice environment, however, will not be simple.

If there is a single weak link in the current practice of addiction treatment that will slow this technology transfer, we believe it is in the arena of clinical supervision. Comprehensive assessments, science-guided treatment planning, empirically validated and manual-based therapies, regular adherence measurement and monitoring, using clients' response-to-treatment data to individualize and refine standard interventions, and rigorous posttreatment followup (and early reintervention, where called for) all flow from the clinical infrastructure at the core of which is a clinical supervisor. If we can elevate the quality of clinical supervision in the field—the selection, training, and support of clinical supervisors to do true clinical supervision—to that of clinical supervision in controlled clinical trials, we will be able to channel knowledge from clinical research to clinical practice.

Conclusions

Clearly defining the demographic and clinical characteristics of client populations, presenting the active ingredients in a manual format and procedures inherent in particular treatments for those populations, monitoring therapists' adherence to such procedures, controlling contextual influences that can influence treatment outcomes, and conducting rigorous and sustained followup to determine clients' responses to particular interventions collectively hold great promise in moving the treatment of adolescent substance abuse from the status of a folk art to that of a clinical science. The technologies used to build this science may themselves offer great potential in enhancing the quality of adolescent substance abuse treatment programs if they can be adapted for routine use in the clinical setting. The CYT study confirms the importance that these new tools can and will have in the future clinical management of adolescent substance abuse treatment.

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