

# **Intervening With Drug-Involved Youth**

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Issues and Intervention  
Substance Abuse Treatment for Adolescents  
Using a Modified Therapeutic Community Model

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The percentage of America's youth who use drugs has been increasing over the past several years. This upward trend in drug use is documented not only for marijuana use but for harder drugs as well. Research results of the National Institute on Drug Abuse (NIDA) 1994 Monitoring the Future study show that for the third year in a row, a statistically significant increase in marijuana and cocaine use was substantiated in annual use by 8th-grade students. Among 8th graders, 25.7% reported illicit drug use at some point in their lives. When inhalants such as gasoline or glue were included, the percentage rose to 35.1 %. Increases in drug use by 10th and 12th graders were also evidenced (Swan, 1995). Access by teens to alcohol and other drugs (AOD) is easy; 78% of teens have easy access to alcohol, 80% of older teens have easy access to marijuana, and 54% of older teens have easy access to cocaine and heroin.

Adolescents' attitude toward drug use is becoming more accepting. The NIDA survey showed a decline in the percentage of students who think that using marijuana, cocaine, or crack cocaine is harmful. For instance, in 1991, 62.8% of 8th-grade students perceived trying crack cocaine once or twice as risky. In 1994, this percentage decreased to 54.4%. In addition, there was a drop in the number of 8th-, 10th-, and 12th-grade students who said that trying marijuana once or twice, smoking marijuana occasionally, or even smoking marijuana regularly is harmful to one's health.

Although adolescents' attitude toward drug use may be more accepting, results from a survey conducted by the Center on Addiction and Substance Abuse (CASA) showed that 32% of the

400 adolescents surveyed named drugs as the greatest problem that they faced on a daily basis. The adolescents surveyed named crime and violence (13%) as their next biggest problem ("Teens Rate Drugs," 1995). Results from a poll of 504 boys and girls aged 8 to 12 years indicated that 92% thought that people using drugs caused violence (McClain, 1994). Although the estimates of the number of violent crimes committed by drug users vary, there is little argument that drugs and violence go hand in hand. The National Center for Juvenile Justice reported that the number of murders committed by youths under the age of 18 increased by 85% from 1986 to 1991; sexual offenses rose 9% in a 1-year period, 1,990 to 1991 (Ingrassia, Annin, Biddle, & Miller, 1993). Every 15 seconds, an American teen is victimized by a violent crime. The staggering rise in violent crimes committed by juveniles and experienced by juveniles can in part be attributed to the increase in drug use and involvement in the drug culture, the availability and use of guns, an increased level of violence and child abuse within the neighborhood and the home, and the lack of job opportunities and economic empowerment.

The number of street crimes committed by adolescents increased with the onset of the crack cocaine epidemic. Because of the relatively low cost of a "rock," young people could more readily afford the drug. However, the highly addictive nature of crack cocaine also led young people to seek out more of the drug. Without a source of income, adolescent drug users turned to crime and drug dealing as avenues for obtaining money and drugs. With more involvement in criminal activities and the drug trade, the demand for weapons, particularly guns, increased. Guns were needed not only for committing crimes such as robbery and burglary but for protection from those who might want to steal one's money or drugs.

A survey of 1,600 male students in 10 inner-city high schools found that 22% of the students owned at least one gun. Of the youths that owned guns, 82% owned a semiautomatic handgun, 68% a

revolver, 45% a shotgun, 41 % a sawed-off shotgun, 36% a target hunting rifle, 27% a military-style rifle, 18% a single-shot handgun, and 18% owned a homemade handgun. As might be expected, the percent of gun owners among teens who use drugs is higher than it is among those who do not use drugs. Interviews with youths ages 11 to 17 indicate that guns are easy to get and are viewed as a necessity in many schools and neighborhoods. In some cities, teenagers talk about their guns as if they were baseball cards and trade them almost as frequently (McClain & Gaynor, 1994).

Nearly 1 million teenagers are victims of violent crimes each year. The number of teenagers and younger children killed annually by firearms rose by 59% between 1986 and 1991. Arrests of juveniles for murders increased by 128% between 1983 and 1992 (Moyers, 1995). Violence occurs more frequently in poor, urban areas, areas often occupied by minority ethnic groups, including Hispanics and African Americans. Black youth are six times more likely to be homicide victims than are white youth.

Domestic violence accounts for much of the violent crime committed. It is estimated that 35% to 45% of all U.S. homicides in 1995 stemmed from domestic violence. Jaffe, Wilson, and Wolfe (1986) reported that exposure to marital violence is related to greater frequency of child behavior problems. Furthermore, research sponsored by the National Institute on Justice found that childhood abuse increased the odds of future delinquency and adult criminality overall by 40% (Widom, 1992). Children who witness violence also have elevated levels of dysfunctional and violent behavior.

Strong correlations have been uncovered linking violence with psychoactive substances, including alcohol (Roth, 1994). Children who grow up in homes in which violence and drug use are daily activities are at tremendous risk for becoming drug-using, violent adults. The Tucson forensic psychologist Todd Flynn, as quoted in the Tucson Citizen, stated, "The most violent kids I see witness violence and are subjected to violence in the home. They have

parents without any motivation or ability to spend time with them, who use a blend of drugs, and don't help them learn anything" (McClain & Gaynor, 1994, p. 13).

Although the incidence of drug use and violence among American teenagers is high, the rates vary by race, class, educational achievement, job status, and geographic location (urban, suburban, or rural). Thus, although concern exists for the spread of drug use and violence throughout society, additional concern exists for youths growing up in high-density, underprivileged, poverty-stricken areas of the country. Children and adolescents are disproportionately represented among the poor in America. One in every three children in New York City under the age of 19 lives at or below the poverty line (Green, 1993). Also, a disproportionate number of youths living in poverty are minority youths. Whereas Latino and African American families are disproportionately represented in urban areas such as New York, in Arizona 53% of the youths living at or below the poverty line are Native Americans. To these people, the American dream of hard work, job security, safety, and family does not exist. Consequently the drug trade is often alluring. As Currie (1993) pointed out, the decay of economic opportunities combined with an exaltation of consumer values has made the urban drug culture especially attractive and difficult to dislodge. Constricted economic opportunities have weakened the indigenous institutions and traditions of poor communities, and this weakening has helped make possible the rise of a violent and materialistic street culture.

There has been considerable debate concerning how to intervene with drug-involved youth, particularly those who are also involved in criminal activities, violence, and gangs. Some advocate stricter laws, longer juvenile sentences, or even trying juveniles as young as 13 in adult courts. Others advocate treatment-not only drug treatment but the provision of extensive services, including family therapy, job training, academic training, and relapse prevention. Whether removing the youth from the home is more effective than providing intensive treatment services within the home has also

been debated. Although research data on residential versus nonresidential treatment are scarce, both models have demonstrated some success with this population. One promising model of treatment for drug-, violence-, and gang-involved youth is that of the therapeutic community (TC). The TC model of treatment originated with adult heroin addicts in the 1950s. More recently, adolescent TCs have been established in many parts of the country. Adolescent TCs tend to enroll youths whose drug involvement, criminal behavior, and family situations are such that removal from the home is considered a necessary intervention. In addition, many adolescent TCs are set up as "diversion" from adolescent detention centers. Young men and women are given a choice either to complete detention center time or to enroll in treatment or are simply stipulated to treatment by a judge.

In Arizona, Amity, a nonprofit drug treatment, prevention, and research TC, operated several adolescent TCs for youths who were drug involved. Almost all of the youth were involved in criminal behavior, and many were gang members. For the purpose of this chapter, descriptive data collected on participants who entered one of Amity's adolescent TCs in 1993 are provided below. This information includes data from Amity's Pioneer Ranch (PR), an adolescent boys' TC located on an 80-acre ranch northeast of Phoenix, Arizona; Amity's Adobe Mountain (AM) TC, an adolescent boys' TC located at the Adobe Mountain Juvenile Detention Center in Phoenix, Arizona; and Amity's Las Rosas (LR) ranch, an adolescent girls' TC located on a 23-acre ranch outside of Tucson, Arizona. Referrals to all three Amity TCs were almost exclusively from the Arizona Department of Corrections, although there was one private placement at Pioneer Ranch and there were two private placements at Las Rosas.

It is interesting to note that the percentage of Hispanics at Amity's incarcerated TC was much higher (AM = 56%) than at the noninstitutional TCs (PR = 36%; LR = 32%). Moreover, the number of African Americans referred to any of the three TCs was very low

(PR = 3%; AM = 8%; LR = 10%) in comparison to the overall number of eligible incarcerated youths (Table 8. 1).

Age of first police contact (Table 8.2) and the number of times in detention centers (Table 8.3) were similar across TCs, with the overall mean age of first police contact being 11.0 years. The overall mean number of times in a detention center was 8. 1.

All of the participants were polydrug users. There were no substantial differences between boys' and girls' drug use. One difference evidenced, however, was between the number of heroin and crack cocaine users who were referred to the nonincarcerated TC. Eighty-eight percent of those in the incarcerated Adobe Mountain TC had used crack cocaine, compared to 39% of those referred on to the nonincarcerated (PR and LR) TCs. Alternatively, only 2% of those participating in the incarcerated Adobe Mountain TC setting reported using heroin, compared to 20% at PR and 25% at LR (Table 8.4).

Substantial differences existed between boys and girls with regard to family environment and experiences (Table 8.5). More girls reported (a) having a mother with an AOD problem.(LR = 63% vs. PR = 59% and AM = 49%), (b) having a father with an AOD problem (LR = 75% vs. PR = 62% and AM = 59%), (c) having been in a physical fight with a parent (LR = 71 % vs. PR = 37% and AM 31 (d) having been physically abused (LR = 55% vs. PR = 26% and AM = 21%), and (e) having been sexually abused (LR = 73% vs. PR = 17% and AM = 7%). Given these data, it is not surprising that more girls reported having attempted suicide (LR = 55% vs. PR = 30% and AM = 14%) and that More girls reported having run away from home (LR 84% vs. PR = 71 % and AM = 56%; see Table 8.6).

Finally, most of these drug-involved youth were also involved in delinquent acts (Table 8.7). Although differences between boys and girls and between TC placements were in evidence, it appears that the girls were just as involved in delinquency as boys. More girls

than boys reported (a) having stolen a vehicle (LR = 63% vs. PR = 56% and AM = 53%) and (b) having attacked someone with the intent to injure seriously (LR = 63% vs. PR =

61 % and AM = 47%). More boys reported (a) having carried a hidden weapon (PR = 78% and AM = 82% vs. LR = 63%) and (b) having been in a gang fight (PR = 47% and AM = 65% vs. LR = 36%).

Because of these youths' involvement with the police, the number of times they were placed in detention centers, their extensive AOD involvement, their home environment, and their delinquency tendencies, they were stipulated to Amity's long-term residential program, which employs a TC model of treatment.

Many elements in the TC contribute to a distinctive model of treatment. Traditionally, TCs are residential, with the proposed length of stay between 15 and 18 months. According to De Leon (1985), treatment in traditional TCs is broken down into three stages, with the initial stage (0 to 100 days) focusing on assessment of individual needs and orientation and assimilation into the TC. The second phase (4 to 12 months) challenges individuals to do more personal work and to become more psychologically aware and socialized. During the third phase (13 to 18 months), individuals strengthen their skills for autonomous decision making and prepare for reentry into the wider community.

Proponents of the TC model insist that drug use is a symptom of the person's disorder, not the essence of the disorder. A global change in lifestyle is the goal of treatment, not just a reduction or cessation of drug use. The model is one of "self-help"; consequently staff take a limited role. Residents are expected to live publicly; self-disclosure is viewed as essential for one's own recovery process and the recovery process of other community members. The TC is viewed as a microcosm of the wider community and is therefore considered the primary teacher. The majority of the primary treatment staff in traditional TCs are recovering addicts themselves. Because of the staff's background of addiction and their positive change in values and lifestyle, the staff serve as role models for the residents. Interaction with biological family members who often use drugs themselves is limited. Instead, those living in the TC are considered "family" (Stevens, Arbiter, & McGrath, in press).

Services provided at the TC are generally comprehensive, with little need for collaboration with outside agencies. There is an organized structure to each day, with morning and evening meetings anchoring the majority of the activities for the day. Mimicking the wider community, residents engage in a spectrum of activities, including academic education, work/jobs on the property, social events, and exercise, as well as various types of therapeutic groups.

At Amity's adolescent TCs, the traditional TC model has been modified to fit the specific needs of adolescents. Underlying Amity's adolescent TC model is the assumption that most of the teenagers referred to the program come from

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lly and emotionally delayed youth, Amity's treatment philosophy is based on Miller's hypothesis regarding rage and pain. Miller (1983) asserted that repressed rage and pain experienced in childhood must be expressed as it was experienced in childhood. If repressed emotions are not expressed and directed to the source, the individual will continue to be out of control and will act self-destructively and/or compulsively to hurt others. Therefore, although skill building is important, it is essential that underlying psychogenetic material be resolved (Mullen, Arbiter, & Glider, 1991).

With resolution of underlying psychogenetic material being of primary importance, much of the structure of the day and content of the therapeutic curriculum involves the articulation and resolution of emotionally and psychologically charged issues. Following the traditional TC "stage" model, much of this work is done in the second stage, after the individual has been assimilated into the TC and prior to focusing on reentry into the wider community. A variety of groups and retreats are facilitated. Although "peer-facilitated" groups are common in adult TCs, they are not appropriate for adolescents. Mature and understanding leadership, the leadership of a senior staff member, is particularly important for making encounter groups safe for adolescents to discuss sensitive personal matters. Therefore, although the treatment model remains one of self-help, participation, facilitation, and leadership provided by staff are much more prominent in Amity's adolescent TCs.

Perhaps the bulk of deep psychological work is accomplished during participation in retreats. At Amity's adolescent TCs, retreats last from 3 to 4 days and are scheduled several times a year. Retreats are often looked on as an emotional adventure. Although there may be as many as 30 participants, the larger group is divided into groups of 8 to 10 adolescents, each with two staff leaders. Retreats are highly structured, with a specific schedule of activities, including teaching sessions, art activities, field trips, exercise, encounter groups, psychodrama, and ceremonies. The retreat curriculum is built around a specific theme, such as family dynamics, violence, pride and prejudice, sexuality, or relationships. Spending concentrated time together in a small, psychologically safe setting, the adolescents are able to address sensitive issues. Frequently, these retreats are the settings in which adolescents feel safest to talk about their most painful and difficult experiences.

The home life of many of the adolescents lacked a sense of organization and structure and was devoid of ritual and ceremony that are often common in a healthy environment. Because the TC is

viewed as a microcosm of the wider community, it is important that these elements be present. Simple rituals such as the morning meeting, formal dining, the end-of-the-day ceremony, the evening meeting, and the bedtime story give a sense of organization, wholeness, and substance to lives that have been devoid of such formality and repetitiveness. Along with this, the day-to-day structure of formal education and work/jobs intended to build skills for use on reentry into the wider community offers security and a sense of stability that have been lacking in most of these adolescents' lives. The educational curriculum provides not only basic GED preparation but also teaching of skills related to day-to-day living, such as communication and negotiating skills; sex and health education, including HIV prevention; bank accounting; and transportation issues. Work in the TC has two benefits. First, prevocational skills, such as getting to the job on time, learning to get along with coworkers, and responding appropriately to supervisors' directives, are learned. In addition, job skills that increase adolescents' job opportunities on discharge from the program are acquired. Second, the work/job assignment allows for bonding with other coworkers, a sense of responsibility and ownership, and an opportunity to be involved in what has become an adult activity.

Part of the structured activities includes a recreation-exercise program. It is thought that discipline and teamwork can best be taught through physical activities because adolescents' attention span tends to be short for cognitive tasks, particularly at the beginning of the program. Frequently, when adolescents first enter the TC, they have "written off " physical exercise and physical activities as not part of their self-image. At best, the young men engage in weight lifting or basketball. Within a month of participation in Amity's recreation program, almost all of the teenagers admit that they enjoy at least some of the exercise activities. Two reasons seem to account for this change in attitude toward recreation. First, Amity offers a variety of activities in which the youths can engage. These include horseback riding, fishing, hiking, packing with llamas, mountaineering, rock climbing,

baseball, basketball, swimming, jogging, and aerobics. Second, the staff do not just "referee" these activities but rather participate along with the residents. The teenagers seem truly to enjoy being part of a team with staff or competing against staff in a healthy, fun activity.

Unlike traditional adult TCs, in which the biological family is required to take a limited role, most adolescent TCs attempt to engage the family as soon as possible. This is also true of Amity's adolescent TCs. Phone contact, family orientations, family picnics, family groups, family therapy sessions, and family workshops are all part of the regularly scheduled activities. Unfortunately, in many cases the family of origin does not have a functioning, non-drug-using parent who can be involved and supportive of positive behavioral change on the part of the adolescent. Occasionally, a relative, sibling, foster parent, or involved neighbor may be the significant other who becomes involved in the family activities. For those adolescents who are to be reunited with their family members, the period of transition includes a more intensive training for family members willing to participate. Family members go through relapse prevention strategies with the adolescents so that they can identify high-risk situations and relapse triggers. For those adolescents not returning to the family, an emphasis is placed on developing supportive relationship with others in the community, whether peers, former graduates, or staff members (Mullen et al., 1991).

Unfortunately, transition back into the wider community is a difficult challenge. Often the environment, family, and social network are not supportive of the positive changes made by the adolescent. Too often, staff at the TC must concentrate on the new incoming individuals, and those who are transitioned back into the wider community do not receive enough supportive services to continue their positive change of lifestyle. Amity provides aftercare groups and recreational activities for all adolescents who have completed residential treatment. Adolescents are contacted by staff on a regular basis and encouraged to attend not only the aftercare groups and recreational activities but also Amity's Saturday Night

Open House, Community Circle, and other gatherings. In addition, a transitional house was set up and maintained for six to eight adolescents. Although outcome data were not formally obtained, anecdotal data from both Pioneer Ranch and Las Rosas suggest that over 80% of the adolescents remained AOD-free at 6 months post discharge. Regrettably, this percentage progressively decreased thereafter, with many experiencing relapse within a 2-year period. Interestingly, however, some of the relapsing individuals have come back around and are again living sober and productive lives.

In summary, the TC model of treatment provides an excellent intervention for youth who are drug involved. This model, given its residential aspect, extensive length, and intensive therapy, is well suited for adolescents who are not only AOD users but also involved in criminal activity and gangs and who come from families that are dysfunctional and unsupportive of positive change. The traditional adult model needs some modifications to fit the specific needs of adolescents. These modifications include more staff involvement, more structure and organization, a more comprehensive family program, and a more intensive transition period from residential treatment to the wider community. Like adults, however, adolescents need appropriate recovering role models, ceremony and rituals, education, job training, recreation and exercise, therapeutic groups, and retreat settings in which deep psychological work can be accomplished. Structured interviews with participants suggest that adolescents welcome emotional challenge as long as they feel safe and trust those with whom they are working. Once assimilated into the TC, almost all of the participants request to be included in retreats and look forward to them with anticipation and excitement. Many report that the retreat experience was an important component of their treatment process.

Within the treatment field, there is recognition that the transition from the TC back into the wider community must be more extensive and that aftercare services must be more intensive so that these youths can continue to lead productive, responsible, drug-free

lives. Although the TC provides an excellent setting to habilitate youth, the temptations and pressures of their familial and social network on reentry to the wider community are often overwhelming, especially for individuals who are still making the difficult transition into adulthood. Perhaps the TC model needs to be further modified so that the third stage of treatment is extended to include supervised independent living in the wider community. Funding this component up front would allow for more intensive services at the critical juncture of transition.

Longitudinal data on those who participate in TC treatment as adolescents are lacking. Although nonscientific follow-up data from the Amity TCs suggest that most adolescents remain AOD-free for at least 6 months, many of them eventually relapse. Interestingly, many do seek treatment soon after their relapse. It appears that the adolescents who had been in Amity's adolescent TC and who relapsed sought treatment relatively sooner than those who had not been in Amity's adolescent TC or any other long-term adolescent residential treatment program. Treatment entry data from Amity's adult program indicate that those who had participated in long-term treatment as adolescents and subsequently relapsed reentered treatment at a younger age, with fewer total years of AOD use, than those who did not have exposure to treatment as juveniles. Maybe it should not always be terribly disappointing to hear that relapse occurs, or perhaps exposure to treatment as adolescents enables individuals who do relapse to seek treatment sooner, ending the cycle of drugs, violence, and destruction of lives sooner than what might have been possible without the exposure to treatment as juveniles. Consequently it is suggested that longitudinal data need to be collected to clarify fully the true effects of adolescent interventions and treatment.

## References

Currie, E. (1993). *Reckoning: Drugs, the cities, and the American future*. New York: Hill & Wang.

De Leon, G. (1985). The Therapeutic Community: Status and evaluation. *International Journal of Addictions*, 20, 823-844.

Green, M. B. (1993). Chronic exposure to violence and poverty: Interventions that work for youth. *Crime and Delinquency*, 39, 106-124.

Ingrassia, M., Annin, P., Biddle, N. A., & Miller, S. (July 19, 1993). Life means nothing: Is adolescent brutality on the rise? *Newsweek*, pp. 16-17.

Jaffe, P., Wilson, S., & Wolfe, D. (1986). Promoting changes in attitudes and understanding of conflict resolution among child witnesses of family violence. *Canadian Journal of Behavioral Sciences*, 18, 356-366.

McClain, C. (1994, October 3 1). A grim hit parade. *Tucson Citizen*, pp. 25-28.

McClain, C., & Gaynor, G. (1994, October 31). Making a bad kid *Tucson Citizen*, pp. 12-13.

Miller, A. (1983). *For your own good. Hidden cruelty in child-rearing and the roots of violence*. New York: Farrar Straus Giroux.

Moyers, B. (1995, January 8). There is so much that we can do. *Parade*, pp. 4-6.

Mullen, R., Arbiter, N., & Glider, P. (199 1). A comprehensive therapeutic community approach for chronic substance-abusing juvenile offenders: The Amity model. In T. L Armstrong (Ed.),

*Intensive interventions with high risk youths. Promising approaches in juvenile probation and parole* (pp. 211-243). Mousey, NY Criminal Justice Press.

Roth, J. A. (1994, February). Psychoactive substance and violence. *National Institute of Justice, Research in Brief*, pp. 1-8.

Stevens, S. J., Arbiter, N., & McGrath, R. (in press). Women and children: Therapeutic community substance abuse treatment. In G; De Leon (Ed.), *Community as method: Modified therapeutic communities for special populations in special settings*. New York: Greenwood.

Swan, N. (1995). Marijuana, other drug use among teens continues to rise. *NIDA Notes*, 10(2), 8-9.

Teen