

ECONOMIC AND SOCIAL COMMISSION FOR ASIA AND THE PACIFIC

UNITED NATIONS OFFICE ON DRUGS AND CRIME

Adolescent Substance Use: Risk and Protection



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PREFACE

The Asian and Pacific region has some of the toughest laws against drug abuse and drug trafficking. Yet, the region is losing the war on drug abuse. Increasing numbers of young people are joining the ranks of drug users. At the same time, the age of initiation into drug use is declining throughout Asia and the Pacific to as low as 12 years.

ESCAP emphasizes an integrated approach to substance use – prevention, treatment and rehabilitation – and works with diverse partners to build the capacity of youth and health workers to deal more effectively with substance use.

Adolescent Substance Use: Risk and Protection responds to young people's call for action against substance use. This publication provides an insight into planning and delivering effective treatment and rehabilitation programmes for adolescent substance users – in the Greater Mekong Subregion and beyond. It is intended to serve as a reference source for policy and programme personnel concerned with youth, health and social services in the ESCAP region.

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GLOSSARY OF SELECTED ACRONYMS

ATS	Amphetamine-type stimulants
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ESCAP	United Nations Economic and Social Commission for Asia and the Pacific
NIDA	National Institute on Drug Abuse
ODCCP	United Nations Office for Drug Control and Crime Prevention
SAMHSA	Substance Abuse and Mental Health Services Administration
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

INTRODUCTION

Substance abuse has been identified by the World Health Organization (WHO) as one of three major health risks that can lead to devastating health consequences for adolescents. Substance abuse can lead to illness and even death, and it is also related to unsafe sex, accidents, violence and loss of productivity (WHO 2001).

Drug use among youth has increased exponentially in South-East Asia, affecting younger and wider segments of society. Amphetamine-type stimulants (ATS), mainly amphetamines, methamphetamines and ecstasy, are the main problem drugs in the subregion and their use has increased dramatically in recent years. There has been a notable trend of increased ATS use among young people. Overall substance abuse among high school and college students in this region doubled between 1994 and 1998, and it appears to have doubled again in 1999 with ATS being the main substances responsible for the rise (UN ODCCP 2002).

At the same time, medical and psychiatric facilities in the region are inadequate for coping with the increasing number of drug users. Counselling facilities and rehabilitation centres are scarce. The high relapse rate of current drug treatment programmes, most of which are concentrated in urban areas, indicates a need for new approaches to deal with demand and treatment.

Only a few institutions and organizations in Asia have been successful in providing alternative approaches to prevention, treatment and rehabilitation. Furthermore, much of their work has been undertaken at the pilot level. There is potential to scale up these interventions and at the same time to incorporate new approaches, such as the integration of “protective factors”, to reverse or reduce known risk factors that predispose young people to drug use.

Adolescent Substance Use: Risk and Protection focuses on the treatment of illicit substance use among young people, including abuse of amphetamines, opiates, depressants, hallucinogens, cocaine and cannabis.

It presents an analysis of research on the application of risk and protective factors that addresses substance abuse among adolescents aged 12 to 24 years. On the continuum of care from primary prevention, secondary prevention, assessment, intervention, treatment and aftercare, it focuses on the latter three.

Section 1 examines the reasons for drug use among adolescents and illustrates the sequential stages of substance use. This Section also provides an overview of traditional approaches to intervention and treatment and the extent to which each has been proved successful.

Section 2 analyses the risk and protective factors that influence young people's attitudes and behaviours towards substance abuse. Section 2 also examines the framework for risk and protective factors and how these factors have been applied to the development of intervention, treatment and aftercare.

Examples of specific programmes that have applied these factors in developing successful therapeutic responses to adolescent substance abuse are presented in Section 3.

Section 4 discusses the broad implications for programme development and implementation that can be drawn from the experience of these programmes and research findings. An integrated framework is provided, in which the level of substance abuse is matched with corresponding treatment approaches and appropriate settings, and guiding principles of effective treatment for adolescents.



Section

1

TREATMENT
APPROACHES TO
YOUTH DRUG USE

SECTION 1:

TREATMENT APPROACHES TO YOUTH DRUG USE

1.1. Why young people use drugs

Adolescence is a challenging developmental period when young people go through many biological, cognitive, social and psychological transitions. This is a period of rapid change marked by the onset of puberty, a growth spurt and the development of secondary sex characteristics.

Cognitive thinking during adolescence changes from concrete operational thinking to abstract thinking. Socially, adolescents spend more time with their peers and move away from their family and home environment or try to develop their identity while living in the same household with parents and grandparents. Psychologically, adolescents develop a sense of identity and a self-concept.

Adolescents tend to be risk takers, as they feel invulnerable and experience stress associated with these transitions. Thus, adolescence is a time when most substance abuse is initiated. Substance abuse is one of many interrelated risk behaviours, including unprotected sexual intercourse, eating disorders, delinquency and conduct disorders that have similar causes. Whereas experimentation and infrequent drug use tend to be more related to peer and social factors, substance abuse or dependence tends to be more associated with biological and psychological factors (Spooner, Hall and Lynskey 2001).

Young people use substances for functional reasons, such as rebellion, sensation-seeking, pleasure, curiosity, social bonding, attaining peer status, alleviating boredom, escaping or coping with reality. Young people may also use substances for symbolic reasons, such as expression of solidarity or to demarcate social boundaries (Paglia and Room 1998). Youth workers in Australia report that young people abuse substances for the following reasons: adolescent risk-taking behaviour, low self-esteem, pain suppressant (e.g., from sexual/emotional/physical abuse or parental disapproval/rejection), recreational use and peer approval, and stress and anger management (Department of Human Services 1998).

Research consistently indicates that family factors and peer associations are the most important contributors to substance use in adolescence. Inadequate social support, stressful life events, societal pressures, and physical or sexual abuse have been increasingly associated with heavy substance use by adolescents, especially young women. Adolescent substance abusers often have co-existing problems – with family, school or job; medical or emotional issues; social relationships; or leisure – which may have existed before substance abuse or may have arisen from substance abuse (Roberts and Osborne 1999). Different substances tend to be used for different reasons by young people. For example, young illicit substance users reported that they drank alcohol for fun but used heroin to deal with problems (Spooner, Mattick and Howard 1996).

1.2. Progressive nature of substance use and treatment options

Substance use habits develop over time and are marked by sequential stages. As individuals continue to use substances, they increase the chances of progressing through each stage and developing a chemical dependency. It is important to note that this progression can be stopped at any stage, if proper support is available.

Pandina described in *Drug Dependency*, a 1986 course offered at the Rutgers Summer School of Alcohol Studies, Rutgers University, New Jersey, United States, a longitudinal study

of 6 to 24 year-olds, that he had conducted. In that study, he had identified a progressive model for the acquisition and maintenance of drug use. In the model, he identified six common stages for substance use: (1) priming, (2) initiation, (3) experimentation, (4) habit formation, (5) dependency, and (6) obsessive-compulsive use (Figure 1, page 5).

Acquisition begins with priming – which most people are exposed to at a very young age – when the young person learns about the existence of substances through friends, family, media, or other means and acquires early notions about the acceptability or unacceptability of substance abuse.

Initiation follows when the young person tries a substance for the first time. The manner in which this initiation takes place, together with the early childhood priming, is significant in defining a future relationship with drugs.

For many, a stage of experimentation occurs in which a young person willingly uses substances occasionally as an end in itself. At this stage, the user generally regards substance use as an enjoyable experience with no significant negative consequences.

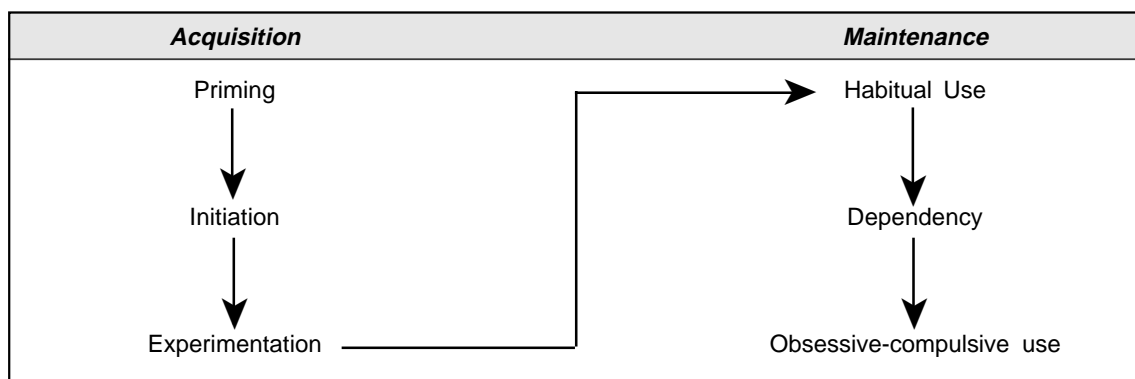
If use continues, which is especially the case if the individual feels incapable of getting a desired mood change in other ways, the individual can progress from acquisition to maintenance – from wilful use to a problem behaviour that is beyond wilful control. The first stage during maintenance is habitual use, marked by repeated use of a favoured substance. The user has come to believe that substance use can reduce stress, provide excitement, or facilitate social acceptance. These effects have become a means that enables the user to cope with life's problems or better experience life's joys. At this stage, the individual tends to switch from a peer group of casual users to one of habitual substance abusers.

If substance use continues, it leads inevitably to dependency when brain functions have changed and call for continued use. At this stage, the individual has lost control over the substance use and experiences a series of grave physical and psychological problems.

This individual is most likely encountering difficulties with finances, relationships, and job or school performance. This may lead to obsessive-compulsive use, in which the individual is driven by pursuing substance use behaviour as the dominant activity in his or her life, even if it no longer produces the desired effects.

This model has implications for adolescent substance abuse treatment approaches. The need for treatment, and its type and intensity, depend on the stage of involvement and the degree of impairment caused by substance use. Rossi (1978) discussed a progressive continuum of care developed by Loeb (1969) that is still applicable.

Figure 1. Progressive stages of substance use



This model has different levels of treatment that are appropriate for different levels of substance use. Levels 1 and 2 address ways in which substance users can be identified and referred to treatment, such as through family and friends (Level 1) or through case finders such as clergy, doctors, supervisors, social workers, bartenders or policemen (Level 2). Entry into the treatment system at Level 3 includes outpatient diagnosis and treatment, such as at a drug information centre or outpatient clinic. Level 4 describes a semi-protective treatment environment, such as a day care centre, group care, or detoxification programme. Level 5 refers to total institutionalization. Individuals may enter this continuum at any level, depending on their level of substance use. If intervention is successful, individuals may proceed to any stage at Levels 6 to 9 that refers to rehabilitation, including rehabilitation centres, out-patient follow-up, and return to their families.

As observed by Pandina and others, young people move through phases on the path to substance abuse. It has also been suggested that they move through a continuum of stages that determines their readiness for treatment. This can be represented by the theory of change (Prochaska and DiClemente 1982; Prochaska, DiClemente and Norcross 1997). The objective is to help the young person move from one stage to another to quit substance abuse or reach a lower level of use. Treatment strategies will be most effective if matched to the user's stage of change, described in Figure 2, page 6.

Figure 2. Stages of change

<i>Stage of change</i>	<i>Substance abuser</i>	<i>Treatment personnel</i>
<i>Pre-contemplation</i>	User is not thinking about quitting in the foreseeable future.	Form a relationship with the user. Try to raise user's awareness of substance abuse and its consequences.
<i>Contemplation</i>	User is aware that a problem exists and is seriously thinking about doing something about it.	Evoke reasons for change. Strengthen self-efficacy for change.
<i>Preparation</i>	User is determined to make a change and intends to take action within the next 30 days.	Undertake a full assessment of user's substance use and help to determine the best course of action for change.
<i>Action</i>	User changes his or her behaviour and/or environment to quit, or at least seriously reduce, the intake of substances.	Help the user learn skills and develop strategies to live substance-free. Support is necessary during this stage.
<i>Maintenance</i>	The person is abstinent and wants to remain that way.	Help the individual develop a healthy lifestyle and help identify and use strategies to prevent relapse.
Relapse	After trying to abstain, user may resume taking substances. This can occur at any time and move the person back to an earlier stage in the cycle.	Prepare the user in advance to expect the possibility of this stage. Help figure out what causes relapse and help renew contemplation and work out a more effective plan of action.

Sources: ESCAP 2000; Swadi 2000.

In treatment, adolescents must be approached differently from adults because adolescents face unique developmental issues, strong peer influence, and have different value and belief systems. Treatment must address each adolescent's experience, including cognitive, emotional, physical, social and moral development and the reason for substance abuse (Winters 1999). Further-

more, the effective treatment of adolescents will depend in large part on the degree to which programmes can match the phase of substance use (Pandina Model, see Figure 1, page 5), the readiness for change (Stages of Change Model, see Figure 2, page 6), and the proper treatment approach and modality. The following chapter examines a variety of treatment approaches and modalities. Section 4 presents a perspective on how to effectively choose treatment options based on the nature of a young person's involvement with substances.

1.3. Overview of traditional approaches to substance use intervention and treatment for adolescents

Substance use can lead to addiction or dependency, which is a treatable disorder. While the ultimate goal of treatment is to achieve lasting abstinence, the immediate goals are to reduce substance abuse, improve the patient's ability to function, and minimize the medical and social consequences (NIDA 2002).

There are different types of substance abuse treatment programmes. The World Drug Report 2000 distinguishes five main approaches of treatment: biophysical, pharmacological, psychological, therapeutic community, and traditional healing. Treatment is followed by social integration and aftercare (ODCCP 2000). Treatment should address the adolescent's complex personal and environmental needs, including concurrent psychiatric illnesses, social skills, educational deficits, physical health, and family problems (Swadi 2000). Short-term treatment methods last less than six months and include residential therapy, medication therapy, and drug-free outpatient therapy. Long-term treatment may include methadone maintenance outpatient treatment for opiate abusers and residential therapeutic community treatment (NIDA 2002).

Principles of effective treatment

Three decades of scientific research and clinical practice have yielded a variety of effective approaches to drug abuse treatment. The U.S. National Institute on Drug Abuse identified the following principles of effective treatment:

- No single treatment is appropriate for all individuals.
- Treatment must be readily available.
- Effective treatment attends to the multiple needs of the individual, not just to substance abuse.
- An individual's treatment and service plan must be assessed continuously and modified as necessary to ensure it meets the person's changing needs.
- Remaining in treatment for an adequate time is critical.
- Counselling (individual and/or group) and other behavioural therapies are critical.
- Medication is an important element of treatment for many, especially when combined with counselling and other behavioural therapies.
- Substance dependent or abusing individuals, with co-existing mental disorders, should have both disorders treated in an integrated way.
- Medical detoxification is only the first stage of treatment and by itself does little to change long-term substance abuse.
- Treatment does not need to be voluntary to be effective.
- Possible substance use during treatment must be monitored continuously.

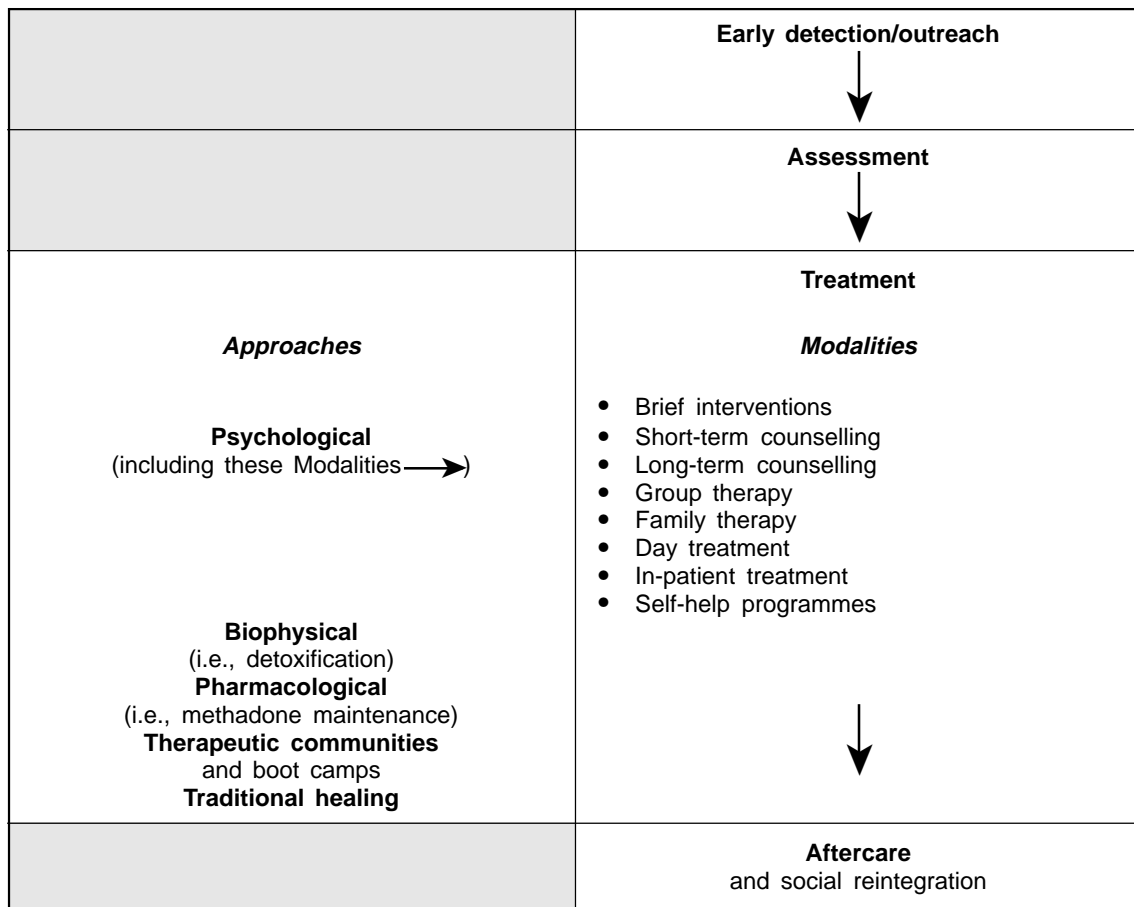
- Treatment programmes should include assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, as well as counselling to help change behaviours that place individuals or others at risk of infection.
- Recovery from drug dependency can be a long-term process and frequently requires multiple episodes of treatment (NIDA 1999).

Continuum of care

The literature suggests a continuum of care that starts with early detection and outreach programmes to identify those in need of treatment. This is followed by an assessment that helps determine which type of treatment programme, or combination thereof, would be most suitable for the client. Treatment programmes usually combine a psychological approach with one or more other approaches, such as biophysical, pharmacological, therapeutic communities, or traditional healing, depending on the stage of substance use and the options available. Aftercare then follows treatment.

Figure 3, page 8 presents the key elements of the continuum of care for substance abuse treatment, as well as the major treatment approaches that have been utilized by programmes to treat adolescent substance abuse.

Figure 3. Continuum of care for substance use treatment



Early detection and outreach

- **Early detection** and access to services are crucial for individuals at high risk. This is best accomplished through primary health care settings (UNODC 2002). Those who detect substance use in young people may include family, friends, peers or neighbours, as well as case finders in public settings, such as clergy, doctors, nurses, social workers, supervisors, police officers, judges, lawyers or bartenders (Rossi 1978).
- **Outreach** programmes are necessary to reach the many substance users who are not in contact with any medical or substance abuse treatment institutions. Flexible, unconventional approaches outside the formal health and social environments aim to access, motivate and support substance abusers, reach out-of-treatment substance abusers, increase substance treatment referrals, and reduce illicit substance use behaviour (UNODC 2002). In Australia, an evaluation of youth alcohol and drug outreach services identified four main models: (1) satellite outreach models located in a range of youth-friendly settings; (2) detached and mobile models situated in a community health centre, alcohol and drug service, or hospital; (3) street work models where there is no other youth work presence on the streets; and (4) assertive community outreach as a feature of outreach services belonging to an organization with specialist alcohol and drug, mental health and medical services (Pead, Virins and Morton 1999).

Assessment

- A thorough **assessment** helps determine the young person's readiness to change and ensure the most appropriate treatment. Since substance use in young people is a multidimensional problem, a comprehensive assessment needs to include not only quantity and frequency of use but also consequences, contexts, and function in which use occurs and the co-occurrence of other problem behaviours (Department of Human Services 1998; Marsden et al. 2000). An assessment may draw from multiple sources, including parents, teachers, social workers, and observations (Swadi 2000).

It is important to assess the following: what substances are being used, how much, how frequently, what method of administration, the stage of use (see section 1.2), prior attempts to give up or cut back, the functions of substance use, the support the user receives, how substances are paid for, the setting for substance use (alone or with others) (ESCAP 2000), as well as family history, problem history, and physical and mental needs.

Treatment approaches

This Section discusses the treatment approaches outlined in Figure 3, page 8. During treatment, it is also important to consider the role of a **parent programme** and **education**. Recently, the World Health Organization, the United Nations International Drug Control Programme, and the European Monitoring Centre for Drugs and Drug Addiction developed a logic model for youth service programmes. This model includes a parent programme to teach appropriate parenting skills, to provide a forum for the exchange of mutual support, and to educate parents about the consequences of substance use on the youth and the family. Education is essential to teaching risk avoidance and to providing information about the consequences of substance use (Marsden et al. 2000). Education is also vital to teaching life skills (see section 2.3).

Psychological

- **Brief interventions** at an early stage can prevent development of serious substance-related problems. Brief interventions recognize that many people can benefit from receiving appropriate information at the right time and in a suitable manner. People who can benefit from this type of intervention can be identified during an assessment. Interventions emphasize people managing their own problems and monitoring their own substance abuse. Usually, people are given information to take with them, such as a self-help manual on reducing or stopping substance use (Australian Drug Foundation 2002). They may also receive brief motivational counselling and one to three sessions of motivational feedback and advice based on individualized assessment (Roberts and Ogborne 1999). However, brief interventions are used less often with illegal substances, as users are generally unwilling to identify themselves (Australian Drug Foundation 2002).
- **Counselling** is a very important component of the treatment. Many different forms of counselling – individual and group, out-patient and residential, and short- and long-term – are available. The overall goals of counselling relate to changes in substance use behaviours and improvements in several areas of personal and social functioning, including family and social relationships, employment and crime (ODCCP 2000).

Randomized controlled trials provide moderate evidence that cognitive-behavioural therapy is effective in treating substance abuse of psycho-stimulants and cannabis. Cognitive-behavioural therapy emphasizes the important role of thinking in determining how we feel and act. This therapy is more effective at moderating cocaine use than equivalent time in non-therapeutic activities. Findings in relation to a 12-step approach have been equivocal. The effects of cognitive-behavioural therapy may be more durable in preventing relapse (Gowing et al. 2001). General out-patient abstinence-oriented counselling programmes in the United States showed reductions in substance use and crime involvement as well as improvements in health and well-being. Brief motivational therapy has been used successfully with opiate users in oral methadone maintenance treatment. Psychotherapies that are focussed, time-limited, and that incorporate behavioural elements, notably contingency reinforcement therapy, have also produced encouraging results (ODCCP 2000).

Short-term, individualized drug counselling focuses directly on reducing or stopping illicit substance abuse. It also addresses related areas of impaired functioning. Through its emphasis on short-term behavioural goals, individualized drug counselling helps develop coping strategies and tools for abstaining from substance use and maintaining abstinence. Participation in a 12-step programme, originally designed to treat alcohol problems, is encouraged for most cases (NIDA 1999).

Long-term behavioural therapy for adolescents incorporates the principle that unwanted behaviour can be changed by clear demonstration of the desired behaviour and consistent reward of incremental steps toward achieving it. The therapy aims to equip the patient to gain three types of control: stimulus control, urge control, and social control (NIDA 1999). Long-term behavioural therapy can be provided in out-patient and in-patient settings over months or years.

Group therapy that is non-substance use-oriented deals with social skills, relationships, and an element of education and catharsis. Group therapy, particularly that which involves peer confrontation, seems to be effective for adolescents, at least in the short term. (Swadi 2000).

Multidimensional family therapy for adolescents is an outpatient, family-based treatment for substance use that views adolescent substance use within a network of influences (individual, family, peer and community). During the sessions, the adolescent acquires skills such as decision-making, negotiation, problem-solving, and communicating thoughts and feelings to deal better with developmental tasks and life stressors. Parallel sessions with family members focus on parenting style, learning to distinguish influence from control, and having a positive and developmentally appropriate influence on their adolescent offspring (NIDA 1999). Adolescent clients benefit when the treatment team works in conjunction with family therapists (Winters 1999).

Day treatment offers any of the counselling forms described above, possibly combined with other treatment approaches, in a setting where the individual spends full days in a protected environment but returns to his or her own residence overnight.

In-patient treatment refers to a hospital or other health-care setting that provides the care described in day treatment, plus overnight care. This might be utilized for several weeks or a few months.

- **Self-help programmes** are often vital to recovery. These programmes are run and controlled by people who are directly affected by a particular type of substance abuse problem, rather than by professionals.

One of the great advantages of self-help is the deep insight and understanding of problems that groups can offer their members. Many self-help groups can also provide valuable support services in intervention, treatment and aftercare (Australian Drug Foundation 2002). Alcoholics Anonymous and Narcotics Anonymous (based on a 12-step model, see Figure 4, page 12), are two widely known examples of this type of treatment. Friends-helping-friends groups and other types of adolescent peer support programmes can also be found in a wide variety of settings throughout the world.

A combination of professional treatment and participation in a self-help group often provides the most effective recovery programme (NIDA n.d.). Besides potentially improving programme effectiveness, self-help programmes can also prove to be a very cost-effective intervention. In addition, as the true nature and extent of drug problems among young people and their families are often discovered in self-help groups, these groups can serve as a vital link in the assessment, intervention and referral process. Finally, it has been suggested that self-help groups may be effective in reducing relapse; however, there is little evidence at present to support this claim. Further research in this area is needed (Gowing et al. 2001).

**Figure 4. One example of a self-help group approach to substance use:
12 Steps of Narcotics Anonymous**

1. We admitted that we were powerless over our addiction, that our lives had become unmanageable.
2. We came to believe that a Power greater than ourselves could restore us to sanity.
3. We made a decision to turn our will and our lives over to the care of God *as we understood Him*.
4. We made a searching and fearless moral inventory of ourselves.
5. We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. We were entirely ready to have God remove all these defects of character.
7. We humbly asked Him to remove our shortcomings.
8. We made a list of all persons we had harmed, and became willing to make amends to them all.
9. We made direct amends to such people wherever possible, except when to do so would injure them or others.
10. We continued to take personal inventory and when we were wrong promptly admitted it.
11. We sought through prayer and meditation to improve our conscious contact with God *as we understood Him*, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as a result of these steps, we tried to carry this message to addicts, and to practise these principles in all our affairs.

Source: *Narcotics Anonymous World Services 1983.*

Biophysical

- **Detoxification** (“Detox”) or drug withdrawal is the systematic elimination of toxic levels of drugs from the body, typically under the care of a physician. It is a precursor of treatment and is not designed to address the psychological, social and behavioural problems associated with drug abuse and does not typically produce lasting behavioural change (NIDA 1999). Adolescents are less likely to have developed a dependence requiring detoxification by the time they are referred to treatment. However, if the assessment does confirm the presence of dependence, then detoxification along the lines used in adults is indicated (Swadi 2000).

Multiple observational studies showed some effectiveness of detoxification from opioids such as heroin, but little evidence for the effectiveness of detoxification from psychostimulants and cannabis (Gowing et al. 2001).

Pharmacological

- **Prescription of substitutes such as methadone treatment** for opiate users is usually conducted in out-patient settings. These programmes use long-acting synthetic opiate medication administered orally for a sustained period. Patients stabilized on adequate and sustained dosages of methadone can function normally (NIDA 1999).

Internationally, there is strong evidence of the effectiveness of substitution treatment for heroin and opioid dependence. With adequate doses of methadone, treatment has been effective in reducing illicit opioid use, criminal behaviour, mortality, and improving health status. Effectiveness is improved when combined with treatment addressing psychological and social issues (Gowing et al. 2001; UN 2000).

Therapeutic communities and alternatives

- **Therapeutic communities or long-term residential treatment** provide care 24 hours per day, generally in a non-hospital setting (NIDA 1999). Usually the patient becomes a live-in member of a community for several months or years. The main aim is to encourage personal growth by changing an individual's lifestyle through a community of concerned people working together to help themselves and each other (Australian Drug Foundation 2002). Therapeutic communities focus on the "re-socialization" of the individual and use the programme's entire "community" as active components of treatment (NIDA 1999). For the treatment of adolescents, there are generally modifications made in the therapeutic community model.

For instance, the stay is shorter than for adults; programmes are less confrontational but reflect developmental progress and provide more supervision and evaluation; there is less emphasis on work and more on education; and family involvement is enhanced (Winters 1999).

There is ample research evidence from several countries on the positive benefits of residential rehabilitation. The majority of studies that evaluated therapeutic communities point to considerable success in post-discharge reductions of illicit substance abuse (ODCCP 2000). For adolescents, the community may be even more crucial than for adults since therapeutic communities function as families (Winters 1999). A review of research evidence in Australia pointed to high rates of drop-out, particularly in the early stages. For those who completed treatment, outcomes were good in terms of reduced substance abuse, reduced criminal behaviour, and increased employment (Gowing et al. 2001).

- **Boot camps** have been used as an alternative to traditional facilities for juvenile substance use treatment and juvenile offenders. These programmes are modelled after basic military training that includes drills, strenuous physical activities and hard labour, as well as required academic education (MacKenzie et al. 2001; MacKenzie and Hebert 1996). Reviews about their effectiveness, available mainly from the United States, are controversial.

The limited information available on boot camps for substance use treatment and aftercare suggests that existing programming in correctional boot camps is likely not to result in reduced recidivism or drug dependence (Cowles, Castellano and Gransky 1995). For instance, an evaluation of the Los Angeles County Juvenile Drug Treatment Boot Camp found it difficult to attribute any of the progress in a few outcome measures on self-reported data to the boot camp programme. The study concluded that "juvenile boot camps as a treatment model are probably not any more effective than existing juvenile programmes" (Zhang 2000). A U.S.-based evaluation identified a need for greater emphasis in five areas to make boot camps more effective:

- (1) Facility-specific programming and greater use of therapeutic community models.
- (2) Individualized treatment programming.
- (3) Qualified professional substance abuse treatment personnel.
- (4) After-care programmes that link the imprisonment and community release phases of the boot camp sanction.
- (5) Evaluation to determine the effectiveness of treatment strategies (Cowles, Castellano and Gransky 1995).

Traditional healing

- **Traditional healing** involves the use of practices based on indigenous cultural treatments that operate outside of official health-care systems. Common elements of these programmes include rituals and other ceremonies – cleansings, confessions, pledges and sacrifices – conducted by traditional healers who use sacred objects and images. Substance abusers, their families, and members of the community are frequently invited to participate in healing ceremonies to strengthen the will of the drug dependent to overcome the substance abuse and to facilitate social reintegration thereafter. In many developing countries, traditional healing is the only source of help available for substance abuse (ODCCP 2000).

Most traditional healing programmes have not been rigorously evaluated, but there is much anecdotal evidence of their effectiveness (ODCCP 2000). In Thailand, Buddhist treatment centres have shown post-discharge abstinence rates comparable to those for modern medical institutions (Poshyachinda 1992). In Malaysia, herbal medicines effectively reduced the craving for opiates (Spencer, Heggenhougen and Navaratnam 1980). The major advantages of traditional healing methods are their low cost and high levels of acceptability (ODCCP 2000).

Aftercare

- **Aftercare** is a phase that follows the completion of a time-limited treatment programme in which the individual may have been isolated from the larger community. The objective is to facilitate the user's return to the community by maintaining recovery, preventing relapse, and improving social and psychological functioning by, for example, helping the young person build a social network that supports a drug-free lifestyle (ODCCP 2000; NIDA 1995). Aftercare ranges from telephone contact with a therapist or case manager to regular individual or group meetings to self-help groups (ODCCP 2000).

Research suggests that aftercare services for adolescents must address the same basic tasks as those for adults. For example, functioning effectively at school or work and staying there, engaging in non-drug-related leisure activities, establishing friendships with non-drug-using adolescents, and having effective coping strategies facilitate effective functioning in the larger community. If the adolescent's home environment exposes him or her to substance abuse, frequent family conflict, and poor communication, the risk of relapse is high unless the home environment changes or the adolescent relates to the environment in new ways (NIDA 1995).

Several early studies have shown positive relationships between involvement in continuing care and improved functioning of people treated for drug and alcohol problems (ODCCP 2000). Cognitive-behavioural therapy has been particularly promising in relapse prevention, especially if it helps the adolescent develop coping strategies to deal with social pressure (Swadi 2000; NIDA 1995). Additional post-treatment strategies that are promising include skills training, problem-solving, assertiveness, time management, family interventions, and case management (NIDA 1995).

- **Social reintegration** entails working with individuals, their families, and communities to help the adolescents to re-establish themselves in their community. Skills training facilitates the re-entry of former abusers into school or the workforce (UNODC 2002). The establishment and maintenance of a support network is critical to social reintegration and aftercare (Health Canada 2002).

These different treatment approaches are strengthened if they address risk and protective factors, discussed in Section 2. Case studies of successful interventions are sampled in Section 3. Section 4 addresses the implications for developing appropriate treatment programmes while considering the models and approaches outlined here.

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Section **2**

**ANALYSIS OF
RISK AND
PROTECTIVE FACTORS**

SECTION 2:

ANALYSIS OF RISK AND PROTECTIVE FACTORS

Various risk and protective factors influence young people's attitudes and behaviours with regard to substance use. These factors are also related to the success of treatment programmes.

A *risk factor* is any factor associated with the increased likelihood of a behaviour that usually has negative consequences. A *protective factor* is any factor that reduces the impact of a risk behaviour, helps individuals not to engage in potentially harmful behaviour, and/or promotes an alternative pathway (Spooner, Hall and Lynskey 2001). A growing body of cross-cultural evidence indicates that various psychological, social, and behavioural factors are protective of health, especially during adolescence (WHO 2002). Consequently, treatment programmes that incorporate protective factors provide greater opportunities for clients to maintain drug-free lives.

2.1. Review of key research related to risk and protective factors

Research has shown that there are many risk factors that increase the chances of adolescents developing health and behaviour problems. Research has also identified protective factors that can decrease the likelihood of young people developing problems such as substance use.

Hawkins, Catalano and Miller (1992) identified 17 risk factors that are associated with alcohol, tobacco, and other substance use among adolescents and categorized them as "contextual factors", which are related to culture and the structure of society, and "individual and interpersonal factors". These factors and those identified by other researchers are included in Figure 5, page 21. The more risk factors are present, the greater the likelihood of young people engaging in alcohol, tobacco, and substance use. The authors also identified protective factors that can reduce this likelihood. Protective factors are based on the **social development model**, which emphasizes the role of bonding with family, school, church and peers. Recent studies have confirmed that adolescents who feel bonded or connected to schools are less likely to use substances or engage in violence and other risk behaviours (Hawkins et al. 1999; McNeely, Nonnemaker and Blum 2002).

Jason and Rhodes developed a **social stress model** in 1988 that illustrates the need to consider the balance of risk and protective factors, for an individual or a community, when planning interventions. Risk factors include *stress*, *normalization* and *experience* with a substance. These risk factors are weighed against protective factors, which include *attachments*, *skills* and *resources*. While the problem with this model is that many of these factors are not just associated with risk or protection, it is useful to look at the full range of factors and to consider their balance (Spooner, Hall and Lynskey 2001).

The World Health Organization's Programme on Substance Abuse modified the model developed by Jason and Rhodes to include the effects of substances, the personal response of the individual to the substances, and additional environmental, social, and cultural variables. The **modified social stress model** is an approach to better understand vulnerability to risk behaviour by looking at risk factors that can increase vulnerability and protective factors that can decrease vulnerability. Each component in the model can have positive and negative aspects that function as risk or protective factors. The model includes the following six components that influence vulnerability:

- *Stress*: major life events, enduring life strains, everyday problems, life transitions, and adolescent developmental changes.
- *Normalization of substance use*: legality and law enforcement, availability, price, advertising, sponsorship and promotion, media presentation, and cultural role.
- *Experience of substance use*: depends on the user, the substance, and the setting.
- *Attachments*: positive attachments are personal connections to people, animals, objects and institutions; negative attachments are connections to people or institutions that are associated with substance use.
- *Skills*: physical and performance capabilities that help people succeed in life, and coping strategies, including internal, behavioural, and social abilities, which help a person manage stress.
- *Resources*: internal resources such as willingness to work hard, and environmental resources such as schools, money, and people who care (ESCAP 2000).

Jessor (1998) developed **interrelated conceptual domains of risk and protective factors** for adolescent risk behaviour: biology/genetics, social environment, perceived environment, personality, and behaviour. For instance, risk factors include family history of substance use, poverty, models for deviant behaviour, low perceived life chances, and poor school work. Protective factors include high intelligence, quality schools, models for conventional behaviour, value on achievement and health, and being part of a religious organization. The interrelation of these factors influences adolescent risk behaviour and lifestyles such as problem behaviour, health-related behaviour, and school behaviour. These behaviours, in turn, are related to outcomes that foster health or are life-compromising. For example, risk behaviours such as illicit substance use, unhealthy eating, or truancy may lead to disease or illness, school failure, inadequate self-concept, and difficulty in gaining employment (Spooner, Hall and Lynskey 2001).

Jessor and colleagues also developed the **problem-behaviour theory**, which recognizes that adolescent behaviour, including risk and protective behaviour, is the product of complex interactions between people and their environment.

This theory is based on the relationships among three psychosocial variables:

- (1) The personality system, which includes values, personal beliefs, expectations, attitudes, and orientations toward self and society.
- (2) The perceived environment system, which addresses perceptions of parents' and friends' attitudes toward behaviours.
- (3) The behaviour system that concerns problem behaviour such as illicit substance abuse as well as "conventional" (protective) behaviours such as church attendance and health behaviour.

The interrelations of these variables represent either instigations or controls that result in proneness: the likelihood that a risk (or protective) behaviour will occur (Jessor, Donovan and Costa 1991). Weakening instigators or strengthening controls helps decrease a child's overall proneness for problem behaviours (that is, the likelihood that the child will engage in problem or unhealthy behaviours) (Mangrulkar, Whitman and Posner 2001). A longitudinal study by Jessor and colleagues established risk and protective factors related to personality system, perceived environment, and behaviour that influence adolescent problem behaviour. This study confirmed a significant inverse relationship between protective and risk factors: the greater the protection, the less the problem behaviour (Jessor et al. 1995).

Benard (1991) challenged research that focused on problem behaviours and risk factors and instead proposed a model that focuses on protective factors that can help young people develop “**resiliency**” to resist alcohol and other drug use. Benard identified four major areas in which protective factors operate: individual, family, school, and community. The characteristics that positively set young people apart in these areas are social competence, problem-solving skills, autonomy, and a sense of purpose. Protective factors within the family, school, and community include caring and support, high expectations, and encouraging children’s participation.

Shene (1999) defines resiliency as “a balancing of protective factors against risk factors, and the gradual accumulation of emotional strength as children respond successfully to challenges in their families, schools and communities”. This balance changes over time and is determined by the frequency, duration, and severity of risk and protective factors present and the developmental stage at which they occur (Global Youth Network 2002). There is a notion that children who are more resilient and socially competent are more likely to withstand peer pressure that lures them into substance abuse (Department of Human Services 1998).

Resilience has also been defined as “the ability to be well adjusted and interpersonally effective in the face of an adverse environment” (Spooner, Hall and Lynskey 2001). Davis (1999) reviewed the literature on resilience and grouped the characteristics of resilient individuals into physical, social, cognitive, emotional, moral, and spiritual competence. The goal of effective treatment programmes is to increase the protective factors and resilience of youth.

2.2. Risk and protective factors for adolescent substance use

The World Health Organization (2001) analyzed research findings on risk and protective factors from more than 50 countries and concluded the following as risk factors for adolescent substance use in Asia:

- Conflict in the family.
- Friends who use substances.

It also concluded the following as protective factors:

- A positive relationship with parents.
- Parents who provide structure and boundaries.
- A positive school environment.
- Having spiritual beliefs.

Risk and protective factors exist on several levels:

- At an *individual level*, life experiences play a more significant role in substance use than genetic traits. Important factors are the level of support and care from a parent or other adult at an early age, the quality of a child’s school experience, and general personal and social competence, such as feeling in control and feelings about the future. Furthermore, adolescents who have spiritual beliefs and who do not believe their friends use substances are less likely to use substances themselves.

- At the *peer level*, the selection of peers with whom young people associate and the nature of peer support are crucial. For example, associating with a problem behaviour peer or a conventional behaviour peer makes a difference.
- At the *family level*, factors include a history or lack of substance use; the effectiveness of family management, including communication and discipline; the structure of coping strategies; the level of attachment between parents and children; the nature of rules and parental expectations; and the strength of the extended family network. Adolescents who have a positive relationship with their parents and whose parents provide structure and boundaries are less likely to use substances. However, adolescents in families where there is conflict are more likely to use substances.
- At the *societal and community level*, factors include the prevailing social norms and attitudes toward substance use. Social-competency skills, communication, and resistance skills also play important roles.
- At the *school level*, adolescents who have a positive relationship with teachers, attend school regularly and do well are less likely to use substances. (Global Youth Network 2002; NIDA 1997; WHO 2001)

Research in various countries and the case studies cited in Section 3 have identified the risk and protective factors presented in Figure 5, page 21. Research on protective factors is not as established as that on risk factors.

Treatment programmes should be designed to enhance protective factors and reverse or reduce risk factors. It is also important to note that many social and health issues are linked by the same root factors. Thus, an integration of strategies may help to economize resources (Global Youth Network 2002).

Figure 5. Risk and protective factors for adolescent substance use

Sector	Risk factors	Protective factors
Individual/Peers	<ul style="list-style-type: none"> • Association with friends/peers who model problem behaviour, e.g., use drugs (Hawkins, Catalano and Miller 1992; Jessor et al. 1995; NIDA 1997; Marsh 1996; Lane et al. 2001) • Attitudes favourable to substance use, knowledge about drugs (Hawkins, Catalano and Miller 1992; Spooner, Hall and Lynskey 2001) • Delinquency such as shoplifting and gang fighting (Lane et al. 2001) • Early and persistent problem behaviours, e.g., early age at first drug use (Hawkins, Catalano and Miller 1992; Spooner, Hall and Lynskey 2001) • General sense of hopelessness about life (Jessor et al. 1995) 	<ul style="list-style-type: none"> • Affiliation with friends who model conventional behaviour and adoption of conventional norms about substance use/positive peer support (Jessor et al. 1995; NIDA 1997) • Good coping styles, including empathy, problem-solving, internal locus of control (Spooner, Hall and Lynskey 2001) • Intolerance of attitudes toward deviance (Jessor et al. 1995) • Moral beliefs and values (Spooner, Hall and Lynskey 2001) • Optimism and positive orientation toward health (Jessor et al. 1995; Spooner, Hall and Lynskey 2001) • Perception of risk of substance use (Lane et al. 2001)

Figure 5 (continued)

Sector	Risk factors	Protective factors
	<ul style="list-style-type: none"> • Genetic predisposition: behavioural under-control (Spooner, Hall and Lynskey 2001) • Low expectations of success (Jessor et al. 1995) • Low self-esteem (Jessor et al. 1995) • Perceptions of peer approval of drug-using behaviours (NIDA 1997; Lane et al. 2001) • Personality: lack of social bonding, alienation, rebelliousness, resistance to authority (Hawkins, Catalano and Miller 1992; Spooner, Hall and Lynskey 2001) • Physiological factors, e.g., sensation-seeking, curiosity, boredom, poor impulse control (Hawkins, Catalano and Miller 1992; Marsh 1996) • Poor social adjustment (Jessor 1991) • Poor coping skills (NIDA 1997; Spooner, Hall and Lynskey 2001) 	<ul style="list-style-type: none"> • Perception of strong anti-drug attitudes and behaviour among peers (Lane et al. 2001) • Perception of strong social controls or sanctions against transgressions (Jessor et al. 1995) • Positive relations with adults (Jessor et al. 1995) • Religious beliefs and practices (Lane et al. 2001) • Social competence skills, e.g., social interaction skills and values (Hawkins, Catalano and Miller 1992; Spooner, Hall and Lynskey 2001)
Family	<ul style="list-style-type: none"> • Chaotic home environments (NIDA 1997) • Family conflict (Hawkins, Catalano and Miller 1992; Lane et al. 2001) • Low bonding, lack of mutual attachment and nurturing, and poor family relationships (Hawkins, Catalano and Miller 1992; NIDA 1997, Marsh 1996; Spooner, Hall and Lynskey 2001) • Parents and/or other family members use substances or have an attitude that favours substance use (NIDA 1997; Hawkins, Catalano and Miller 1992; Marsh 1996) • Poor and inconsistent parenting skills, e.g., ineffective parenting, and negative communication patterns (Hawkins, Catalano and Miller 1992; NIDA 1997; Spooner, Hall and Lynskey 2001) • Unrealistically high expectations (see E's Up case study, page 35) 	<ul style="list-style-type: none"> • Educational opportunities and social support for parents, e.g., teaching parents how to discipline children and handle conflict (Hawkins, Catalano and Miller 1992) • Parental monitoring with clear rules of conduct and parental involvement in their children's lives (NIDA 1997) • Secure and stable family (Spooner, Hall and Lynskey 2001) • Strong bonds/attachments between children and their families (NIDA 1997; Spooner, Hall and Lynskey 2001; Lane et al. 2001) • Strong family norms and morality (Spooner, Hall and Lynskey 2001) • Supportive, caring parents; family harmony (Spooner, Hall and Lynskey 2001)

(Continued)

Figure 5 (continued)

Sector	Risk factors	Protective factors
Community	<ul style="list-style-type: none"> • Availability of substances (Hawkins, Catalano and Miller 1992; Spooner, Hall and Lynskey 2001; Lane et al. 2001) • Exposure to violence (see DASA and Essex case studies, page 38 and page 39) • Extreme economic deprivation (Hawkins, Catalano and Miller 1992; Spooner, Hall and Lynskey 2001) • Lack of legislation and law enforcement (Spooner, Hall and Lynskey 2001) • Lenient laws and norms about drug and alcohol use (Hawkins, Catalano and Miller 1992) • Neighbourhood disorganization, including war and refugee camp (Hawkins, Catalano and Miller 1992; Spooner, Hall and Lynskey 2001) • Perceptions of approval of substance-using behaviours in community environments (NIDA 1997) 	<ul style="list-style-type: none"> • Access to support services (Spooner, Hall and Lynskey 2001) • Community/cultural norms against violence and substance use (Spooner, Hall and Lynskey 2001) • Community networking (Spooner, Hall and Lynskey 2001) • Healthy leisure activities (see AADC case study, page 37) • Strong bonds with pro-social institutions such as religious organizations or other community groups (NIDA 1997; Spooner, Hall and Lynskey 2001) • Strong cultural identity and ethnic pride (Spooner, Hall and Lynskey 2001)
School	<ul style="list-style-type: none"> • Academic failure, poor school achievement (Hawkins, Catalano and Miller 1992; Jessor et al. 1995; NIDA 1997) • Low degree of commitment to school (Hawkins, Catalano and Miller 1992) • Peer rejection in elementary grades (Hawkins, Catalano and Miller 1992) • Poor academic adjustment and commitment (Jessor 1991; Spooner, Hall and Lynskey 2001) • Unrealistically high expectations (see E's Up case study, page 35) 	<ul style="list-style-type: none"> • Organizational changes in schools, e.g., tutoring, improved school-faculty-community relationship, changed discipline procedures (Hawkins, Catalano and Miller 1992) • Positive orientation toward school, sense of belonging, bonding (Jessor et al. 1995; Spooner, Hall and Lynskey 2001; Lane et al. 2001) • Positive school climate (Spooner, Hall and Lynskey 2001) • Pro-social peer group (Spooner, Hall and Lynskey 2001) • School norms that discourage violence and substance use (Spooner, Hall and Lynskey 2001) • Successful school performance and recognition of achievement (NIDA 1997; Spooner, Hall and Lynskey 2001)

2.3. The role of life skills as protective factors

Life skills are abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life (WHO 1994). As stated in Section 1, the World Health Organization, the United Nations Office on Drugs and Crime and the European Monitoring Centre for Drugs and Drug Addiction recently developed a logic model for youth treatment services. This model includes education in risk avoidance and **consequences** of substance abuse, and teaching basic life skills as a technique for stabilization (Marsden et al. 2000).

Evaluations of school interventions for substance use in various countries suggest that prevention efforts based on life skills are the most effective approaches (United Nations 2000). Life skills can also strengthen protective factors in treatment and aftercare, including relapse prevention.

Life skills applied to substance use prevention facilitate the practice and reinforcement of psychosocial skills that promote personal and social development. These skills include self-awareness, empathy, communication, interpersonal relations, decision-making, problem-solving, creative and critical thinking, and coping with emotions and stress. Within treatment programmes, this means imparting skills in drug resistance/refusal and critical thinking, social competence, and communication to explain and reinforce personal anti-drug commitments (United Nations 2000). Examples of life skills to prevent substance abuse are provided in Figure 6, page 24.

Life skills are best taught in a participatory manner (United Nations 2000) with goals and objectives that are relevant to the issue at hand, such as substance use. Participatory teaching strategies include brainstorming, demonstration and guided practice, role play, small group discussions, educational games and simulations, case studies, story telling, debates, practising life skills specific to a particular context with others, and audio and visual activities, e.g., arts, music, theatre, dance, decision-mapping, or problem tree analysis. Figure 7, page 26 describes a model of skills development that can serve as a guide for structuring skill-building sessions.

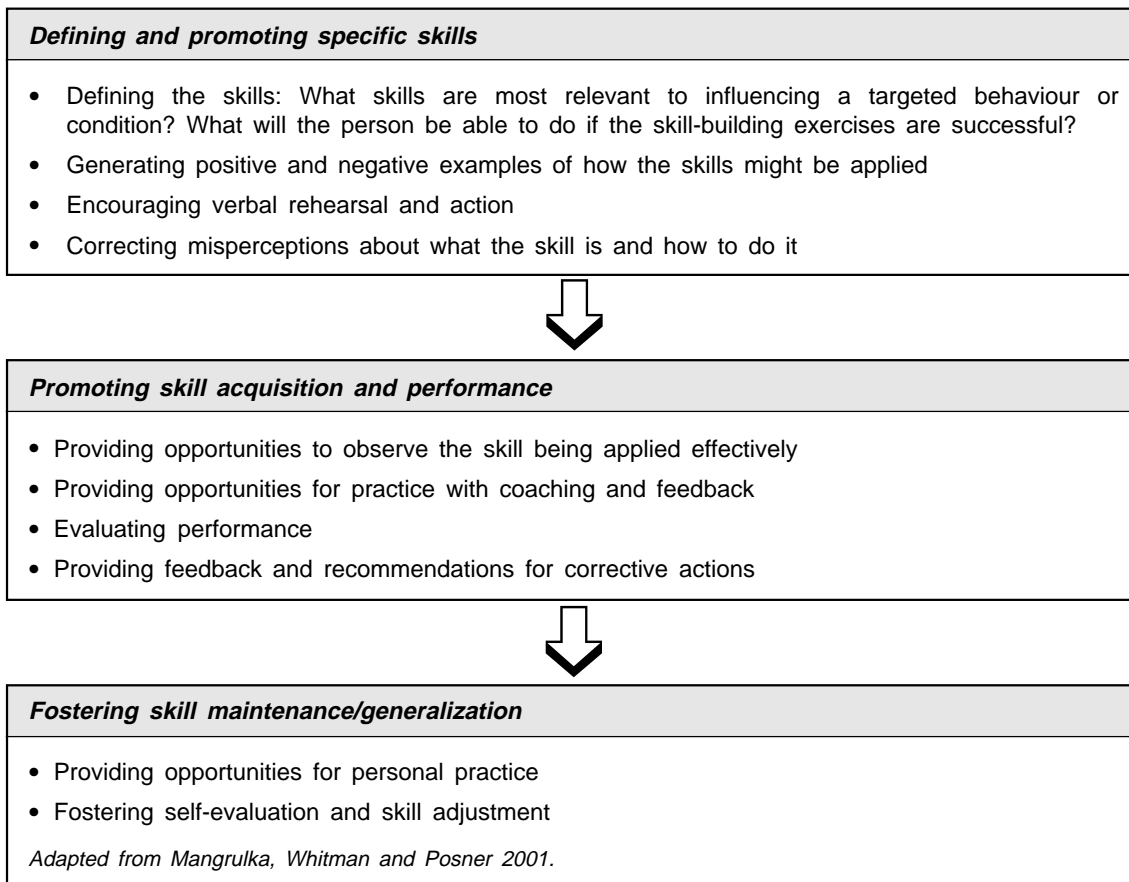
Figure 6. Specific life skills applied to substance use

Communication and interpersonal skills	Decision-making and critical thinking skills	Coping and self-management skills
<p>Communication skills: <i>Participants can observe and practise ways to:</i></p> <ul style="list-style-type: none"> • Inform others of the negative health and social consequences and personal reasons for refraining from substance use • Ask friends and family members not to use substances around them 	<p>Decision-making skills: <i>Participants can observe and practise ways to:</i></p> <ul style="list-style-type: none"> • Gather information about consequences of substance use • Weigh the consequences against common reasons young people give for using substances • Identify their own reasons for not using drugs and explain those reasons to others • Suggest a decision not to use substances in an environment wherein substances are offered • Make and sustain a decision to stop using drugs and seek help to do so 	<p>Skills for managing stress: <i>Participants can observe and practise ways to:</i></p> <ul style="list-style-type: none"> • Analyze what contributes to stress • Reduce stress through activities such as exercise, meditation, and time management • Make friends with people who provide support and relaxation

Figure 6 (continued)

Communication and interpersonal skills	Decision-making and critical thinking skills	Coping and self-management skills
<p>Empathy skills: <i>Participants can observe and practise ways to:</i></p> <ul style="list-style-type: none"> • Listen to and show understanding of the reasons a friend may choose to use drugs • Suggest alternatives in an appealing and convincing manner <p>Advocacy skills: <i>Participants can observe and practise ways to:</i></p> <ul style="list-style-type: none"> • Persuade their communities to adopt and enforce a policy for drug-free zones • Generate local support for drug-free communities <p>Negotiation/refusal skills: <i>Participants can observe and practise ways to:</i></p> <ul style="list-style-type: none"> • Resist a friend's repeated requests to use substances, without losing face or friends <p>Interpersonal skills: <i>Participants can observe and practise ways to:</i></p> <ul style="list-style-type: none"> • Support persons who are trying to stop using substances • Express intolerance of a friend's use of substances 	<p>Critical thinking skills: <i>Participants can observe and practise ways to:</i></p> <ul style="list-style-type: none"> • Analyze offers directed toward young people to use substances and see how they are playing on the need to seem "cool", appeal to girls, or be attractive to boys • Develop counter-messages that include the cost of buying substances and how else that money could be used • Assess how substance use takes advantage of poor people • Analyze what may be driving them to use substances and aim to find a healthy alternative 	<p>Skills for increasing personal confidence and abilities to assume control, take responsibility, make a difference, or create change: <i>Participants can observe and practise ways to:</i></p> <ul style="list-style-type: none"> • Build self-esteem/confidence • Create self-awareness skills, including values and attitudes against substance use and awareness of personal strengths and weaknesses that support those beliefs • Set goals for a life free of substance use and for making positive contributions to one's community • Self-assessment/self-monitoring skills in regard to achieving those goals
<p><i>Adapted from Aldinger and Vince Whitman 2003.</i></p>		

Figure 7. Cycle of life skills development



A recent publication and global survey, developed for WHO and UNICEF on life skills programmes and skills-based health education, confirmed the following factors as critical for successful programmes (Aldinger and Vince Whitman 2003):

- Gaining commitment from stakeholders: Intense advocacy is required from the earliest planning stages to influence key leadership.
- Theoretical underpinnings: Effective programmes are based on theoretical approaches that have demonstrated effectiveness in influencing health-related risk behaviours.
- Coordination between agencies and strategies: Programmes must be coordinated over time with other strategies, such as policies, health and community services, community development, and media approaches.
- Participatory methods: Effective programmes utilize a variety of participatory teaching or training methods that actively involve students or trainees and target particular health issues.
- Training of teachers or trainers and professional development: Teachers, trainers or peer leaders of effective programmes believe in the programme and receive adequate training.

- Content addresses knowledge, attitudes and skills: Programme content should be selected for its relevance to specific health-related risk and protective behaviour.
- Developmental appropriateness and relevance: Interventions must be relevant to the reality and developmental levels of young people and must address risks that have the potential to cause most harm to the individual and society.
- Participation: Mechanisms should be developed to facilitate the involvement of students, youth, parents, and the wider community at all stages.
- Evaluation and follow-up: Evaluation is important and should be considered from the outset and throughout the programme.

The survey also identified the following case study, the *Lions-Quest* programme, which can be applied to substance abuse treatment and prevention initiatives.

Case Study: Lions-Quest Programme

Thanks to partnerships with Lions Clubs International, the American Association of School Administrators, the National Association of Secondary School Principals, the National Association of Elementary School Principals, the National Parent-Teacher-Association (PTA), the National Council of Juvenile and Family Court Judges, and the National Youth Leadership Council (*coordination between agencies*), Lions-Quest programmes for positive youth development have reached more than 4 million young people throughout the world. Over 250,000 teachers in more than 30 countries teach the programme. These programmes engage families, schools, and community members in working together to increase protective factors that promote young people's healthy development and reduce factors that put children at risk of problem behaviours (*commitment from stakeholders*). The programme addresses ways of strengthening the bonds between young people and their families, peers, school, and community and provides meaningful ways for youth participation and contribution (*participation*). Lions-Quest programmes provide a framework (*theoretical underpinnings*) for positive school change through workshops and materials that help school staff, parents, and community members plan and carry out activities to improve their school.

In Lions-Quest workshops, teachers learn classroom organization and management strategies for establishing clear standards for behaviour (*teacher training*). Students help develop classroom rules, practise handling negative pressures, and carry out school-wide campaigns against substance use, bullying, and violence. Shared homework assignments encourage parent-child discussion on drug- and violence-related issues (*participation*). These are supplemented by skill-building parent meetings and information on ways parents can help children grow up safe and drug-free (*coordinated strategies*). Lions-Quest programmes provide sequentially designed, grade-specific classroom materials (*relevance*) that teach competencies such as self-discipline, communication, problem-solving, resistance, and conflict management skills (*content addresses knowledge, attitudes and skills*). The lessons are highly interactive and through guided skill practice, discussions, and service-learning, students practise and apply these skills (*participatory methods*).

In evaluation results from more than 60 research studies, Lions-Quest comprehensive life skills programmes – *Skills for Growing* (grades K-5) and *Skills for Adolescence* (grades 6-8) – have demonstrated effectiveness in changing knowledge, attitudes, and beliefs that lead to violence and substance use, and in strengthening factors that protect young people from harmful high-risk behaviours (*evaluation*).

Source: Quest International n.d.

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Section

3

**SUCCESSFUL INTERVENTION,
TREATMENT AND
AFTERCARE PROGRAMMES**



SECTION 3:

SUCCESSFUL INTERVENTION, TREATMENT AND AFTERCARE PROGRAMMES

The following case studies represent examples of successful programmes for adolescent substance abuse treatment in Canada, Indonesia, the United Kingdom, and the United States. They address the various treatment approaches and modalities outlined in Section 1 and the risk and protective factors addressed in Section 2 (identified as *RF* = risk factor or *PF* = protective factor). Most of the programmes rely on holistic, comprehensive approaches in which family involvement is crucial, as is individualizing treatment plans to meet clients' needs and personalities.

This Section includes selected examples of international programmes to illustrate how the principles from the previous Sections can be applied. These case studies reflect strategies that can be adapted to the Greater Mekong Subregion.

3.1. Hawari and Associates, Jakarta

Hawari and Associates is a private treatment service located in Jakarta. Established in 1997, the agency focuses on drug treatment among adolescents.

Services

Hawari and Associates provides detoxification, counselling, and therapeutic communities for young people. The approach is based on integrating medical, psychological and religious therapy, starting with psycho-pharmacological therapies and lasting three weeks.

During the first week, the patient stays in the hospital for detoxification. The agency employs a method of detoxification that does not use anaesthesia or substitution. The patient is prevented from using illicit drugs and tobacco but receives medical treatment that includes tranquilisers, antidepressants, pain killers, and nutritive elements. The patient sleeps most of the time and undergoes examinations and tests. Only family members may stay with the patient. At the end of the week, the patient is guided through religious rituals, prayers and remembrance of God.

In the second and third weeks, the patient continues ambulatory therapy and stays in a halfway or transit house. During the second week the patient receives psychotherapy to strengthen his or her personality, for example, to increase self-esteem, to develop a mature personality, to support the ego, and to develop a healthier defence.

During the third week, the psychotherapy is combined with psycho-religious therapy, which encourages the patient to seek repentance. The patient asks for God's pardon, promises not to repeat previous behaviour, and asks for the strength to refrain from drugs.

If the patient does not consume drugs for two years, the therapy is considered successful and the patient is considered cured.

Treatment approach

Most of the young patients who come to Hawari and Associates are addicted to heroin. Family referral and urine tests are the most common ways to identify those who need treatment. An assessment of the patient is then conducted through interviews, the examination of evidence, and urine tests. The treatment process is similar for all patients, but the religious psychotherapy is conducted according to the patient's individual belief system.

Hawari and Associates addresses all of the important risk and protective factors by providing individual psychotherapy, and family, religious and psycho-pharmacological therapy. A study by Dadang Hawari (n.d.) concluded that a combination of medical and psychiatric treatment (psycho-pharmacological therapy and psychotherapy), as well as prayer and remembrance of God (psycho-religious therapy), is essential. Studies found that medical and psychiatric treatment without prayer and remembrance of God is not complete; however, prayer and remembrance of God without medical and psychiatric treatment is also not effective.

Risk and protective factors

Most young clients display antisocial behaviour (psychopathic personality) (*RF: lack of social bonding*) and come from unhappy families (*RF: family conflict*). Those who successfully complete treatment follow the programme regularly and are inspired by religious beliefs that forbid drug use (*PF: religious beliefs and practices*). Those who do not complete the treatment generally experience peer pressure from friends who still use drugs (*RF: association with friends and peers who model risk behaviour*). They lack religious beliefs and participate irregularly in the programmes.

Hawari and Associates considers as its biggest success its ability to motivate adolescents through an adequate programme (*PF: optimism, positive orientation*), and provide family support (*PF: supportive and caring parents or family*). Hawari also recognizes the importance of spiritual beliefs as a protective factor (*PR: religious beliefs and practices*). The greatest challenges that adolescents face are ignorant parents (*RF: poor family relationships*), lack of reduction efforts, and lack of law enforcement (*RF: lack of law enforcement and legislation*).

Lack of resources to tackle drug abuse, weak government policies, and a societal misperception of the drug user as criminal are the agency's major barriers to success. Furthermore, the general public shows little interest in literature on substance use and treatment. The roles played by NGOs, Parent-Teacher Associations (PTAs), religious organizations, and the media are important in creating opportunities for adolescent substance use treatment.

3.2. Yayasan Harapan Permata Hati Kita (Yayasan KITA/YAKITA), Bogor, Indonesia

YAKITA is a private foundation in Indonesia that began its substance use treatment programme for young people in 1996. All programme-related staff are recovered clients who were trained through YAKITA.

Services

The YAKITA programme provides young people with the following combination of treatment services:

- *Pre-admission* which includes counselling, and a 24-hour hotline service. Families usually visit the centre to see the facilities and meet the facilitators. There is no pre-admission programme available outside the centre.
- *Treatment Planning*: Three modules (a six-month residential basic programme, a six-month residential peer counselling training programme, and a six-month staff training programme). Treatment planning varies to accommodate individual differences.
- *Counselling* is always provided to the patient and the family.
- *Medical detoxification*, as needed.
- *Non-medical detoxification*, e.g., frequently from prescribed medicines.
- *Rehabilitation/recovery* is the main activity.
- *Aftercare* meetings, twice weekly.
- *Relapse intervention* for those who relapse. Relapse prevention is part of the basic programme module.
- *Outreach* to schools, communities and families.
- *Crisis intervention* teams are often sent to subdue crisis situations in the home, to get clients out of jail once the parents have been counselled and reintegrate abusers to the centre.

Treatment approach

Most young people are referred to YAKITA by community members, psychologists, doctors, non-governmental organizations or other centres, or by those who have had previous contact with YAKITA.

The first contact is often through the Hotline Service. Centre staff, whenever possible, invite the parent, family member, or concerned person to visit and participate in a counselling session. YAKITA assesses the situation – including drug-use history, problem history, family history and other relevant history – with the family and/or potential patient. The counsellors then share information about the programme, rules and regulations. If the substance user and his/her family decide to enter the programme, they sign up for the programme and centre staff explain what is expected from the participant and the family. However, in a crisis situation, the intake is done after the situation has calmed down.

The standard treatment process – including living and facility conditions, meals, job function, household chores, sessions, and free time – is essentially the same for all clients. It differs only by programme (basic, peer, or relapse). The treatment plan varies according to each person's personality, attitude/temperament, habits/patterns, and special physical or mental needs or problems. YAKITA uses the following treatment approaches: psychological, biophysical (detoxification), and therapeutic communities. In addition, YAKITA provides a 12-step Narcotics Anonymous programme, a harm reduction continuum, a four-fold path to recovery (physical, mental, emotional and spiritual), and transpersonal psychology. The following treatment modalities are used:

- Brief interventions for relapse intervention.
- Short-term counselling for those whose problems are not severe.

- Long-term counselling, including lay counselling in aftercare, support group programmes, and professional counselling when needed.
- Group therapy, family therapy, day treatment, and in-patient treatment.

After the intake process, clients enter the centre for detoxification in a safe, supervised "isolation room". Peer counsellors and staff are in charge of the detoxification. They watch over the clients, talk with them while they go through the process, provide food, give massages to soothe aching withdrawal symptoms, and take care of their needs. This always helps to calm clients and they feel supported and safe. Violence is not tolerated. When ready, usually after three to six days, clients are moved to another section where they begin to take an active part in the programme.

Sessions begin in the morning with the encounter group. Clients air their feelings and search for something to be grateful for that day. Each client is assigned a household function such as making his/her own bed or cleaning the living environment and the unit/house. The next morning session addresses psychology, substance abuse, problem-solving techniques, issues surrounding health, family, and relationships, and is personalized for the particular programme. Personal counselling is provided during lunch and rest time. The afternoon session blends lectures and experiential practice of psychology and therapy: The afternoon also includes free time for sports, chatting and relaxing. After dinner, there are Narcotics Anonymous meetings, or time to relax, listen to music, sing, or write. This schedule extends over six days. Sundays are "visiting days" and "resting days".

Sessions address self-acceptance by providing lectures and discussions about developmental psychology that help young people understand that it is natural to want to be accepted and to fit in. Sessions also address the "inner healer", which is about knowing oneself, helping oneself, and being able to reason and think in order to solve one's own problems.

YAKITA's basic programme is a 1,500-hour educational module. It covers the entire process from substance use and abuse to recovery and aftercare, including risk and protective factors. The peer counsellor programme is a more evolved and experiential programme. It also includes 1,500 hours of psychodynamics on the recovery process and on-the-job-training.

YAKITA has high hopes and expectations for its graduates. Clients who leave the programme are expected to help themselves and their family and community. This will begin the process of helping others. Helping those who cannot afford to enter the programme can instil pride and a sense of involvement in the former clients and motivate them to stay clean and sober.

Aftercare for families is done twice weekly. One programme is for families whose children have completed the programme; the other is a "newcomers' meeting". Aftercare for a client includes meetings, located adjacent to the family aftercare meetings, which provide opportunities to share with parents and friends. There is an expanding aftercare community recovery fellowship network throughout Indonesia. The availability of Narcotics Anonymous meetings is increasing and aftercare is also offered to HIV-infected people. Aftercare meetings are open to the general public and not just those from YAKITA. Often, aftercare meetings are the first place parents will ask advice from other parents.

After the six-month basic programme, clients are discharged to their homes. If they want to continue with the YAKITA programme, they can take the six-month peer counselling training programme. Once this programme has been completed, they can take the YAKITA staff training programme. At the end of this process, if they have proven to themselves and

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and think efficiently and effectively. Others have grown up in an overprotected environment, with servants, and do not know how to take care of themselves. Another challenge is working with drug users who have HIV. A significant number of clients who test positive for HIV are also co-infected with hepatitis C and feel “fatalistic”. YAKITA does not have a hospital or clinic on the premises to assist these patients.

The centre does not receive money to subsidize those with insufficient funds to enter the programme. Other problems include the limited number of skilled substance use professionals and the medical community’s lack of understanding about drug use, which results in overmedication and lack of counselling. Moreover, the public sector has little information on substance use, addiction, HIV, hepatitis C, and other sexually transmitted infections.

Some of the lessons learned at YAKITA include the following:

- *Parent/family involvement* with young people is crucial when attempting successful long-term recovery.
- When young people begin using drugs at an early age, they experience *drug-induced retardation*. This is a level of immaturity and “childishness” that makes them act younger than their chronological age. For example, if a person starts using drugs at the age of 15 and continues until 25, the user will not think or act like a 25-year-old. Treatment must take this into consideration.
- When drug use becomes a full-blown addiction, a *drug-induced split personality* develops – the original personality and the addicted personality. When addressing the client, one must know which personality is dominant.
- *When a patient experiences confusion*, this means that she/he is beginning to think for herself/himself and must start to make choices between recovery and relapse. This is a step on the road to recovery.
- *Relapse* may occur once or many times. This is often accepted as a recovery paradox.
- *Medical practitioners* often overmedicate drug users. This may lead to permanent brain dysfunction or damage.
- Programmes must be *well-organized and cohesive*.
- *Violent and abusive* programmes will not work.
- *Behaviour modification* must go hand-in-hand with a change in thinking.
- *Therapeutic communities* must be more than just a set of rules. They must be therapeutic in nature and offer truly solid community.
- Without *aftercare*, almost all recovery programmes fail. With no support upon return to the home setting, people will return to old friends and habits.

3.3. E’s Up, Portsmouth City, United Kingdom

E’s Up is a new, community-based treatment service exclusively for young people under the age of 18. It works alongside other providers of services for this age group and offers a confidential, non-judgmental approach to young people experiencing difficulties associated with alcohol and other drugs or solvents.

Services

The services most frequently used for youth include brief solution-focused therapy, motivational interviewing, short- and long-term counselling – including cognitive therapy and addressing low self-esteem – group and family therapy, relapse prevention therapy, controlled-use packages (bupropione), and non-medical detoxification. When planning care and treatment, E's Up works in a systematic manner involving the interventions of other agencies, both statutory and non-statutory, especially in addressing low self-esteem.

Treatment approach

E's Up accepts various source and forms of referrals, including self-referral and referrals made through the telephone. All assessments and treatments are conducted in the young person's home or another appropriate, friendly location. The assessment covers substance use, social history, family relationships, peer relationships, education/employment, finance, criminal activities, mental health, physical health, self-worth, and future hopes and dreams. Assessments also include a risk assessment. E's Up emphasizes the engagement of young people, as young people often have difficulty trusting authority.

E's Up believes there needs to be a holistic approach to substance use that systematically addresses young people's needs. Following assessment, all clients are discussed in a multidisciplinary review. A key worker is allocated and a medical assessment is arranged, if needed. E's Up develops an individual treatment plan for each client, and the key worker is involved in delivering or coordinating all treatments, including the interventions of other agencies. Treatment is not time-limited. E's Up provides aftercare with on-going support and also refers the client to other support agencies.

One of the biggest E's Up successes in treatment has been using a self-assessment tool every six weeks that asks clients to look at improvements made: in living arrangements, education/employment, alcohol use, drug use, legal and financial issues, relationships, prescribed use, mental health, and physical health. In addition, working to engage clients and building a trust-based working relationship has been successful.

Risk and protective factors

All of the adolescent clients of E's Up face additional issues. Their substance misuse is often an inappropriate method of dealing with these other problems (*RF: poor social coping skills*). Young people who successfully complete the programme have addressed not only their substance abuse but other issues such as low self-worth (*PF: healthy self-esteem*), family problems (*PF: secure and stable family; strong family norms and morality*), and education (*PF: positive orientation toward school, successful school performance*). Others, who do not successfully complete treatment, do not recognize the other issues or face high expectations of others that lead to frustration (*RF: unrealistically high expectations*), breakdown in family relationships (*RF: family conflict, chaotic home environment*), and pressures from external sources such as education (*RF: unrealistically high school expectations*).

E's Up addresses risk and protective factors by working in conjunction with the young person and other individuals that are important in the person's life, such as parents, educators, those working in juvenile justice, and agencies that can make a positive contribution. Its challenges include unfavourable attitudes from other agencies and constrictions within which it may have to work, non-cooperation of parents and others, and the young person's lack of motivation to address his or her needs. Also lacking are resources, particularly accommodation, and the resources of other agencies.

3.4. Alberta Alcohol and Drug Abuse Commission (AADAC), Calgary, Canada

AADAC Youth Services is a programme of the Alberta Alcohol and Drug Abuse Commission. AADAC has two specialized youth centres offering 16 young people a 12-week residential supported day treatment. The programme serves approximately 200 youth per year.

Services

The services most frequently used include pre-admission, treatment planning, individual counselling, family counselling, intensive day treatment programme, relapse prevention, experiential learning, outdoor pursuits, problem-solving skills training, aftercare, and outreach through a prevention team and mobile service team. The greatest number of youth accessing the service receives out-patient individual and/or family counselling.

Treatment approach

AADAC receives referrals from many sources, including self-referral, and referrals from Child Welfare, the Youth Justice System, the Board of Education, family physicians, family/friends, and other AADAC offices within Alberta. In some situations, AADAC may work with an out-of-province or out-of-country referral on a fee-for-service basis.

All young people referred to AADAC see an out-patient counsellor on site or at one of the field offices throughout the province. Clients can book an appointment or drop in during specified times. All counselling and treatment planning is assessment-based. Before admission to the AADAC's Day Treatment programme, clients receive a comprehensive substance use assessment that includes the Personal Experience Screening Questionnaire (PESQ), the Adolescent Problem Severity Index (APSI), the Personal Experience Inventory (PEI), the Adolescent Problem Gambling Screen, and the Treatment Goals Checklist.

AADAC has two treatment processes: Out-patient Treatment Programme and Intensive Day Treatment Programme. The Out-patient Treatment Programme starts assessment with referral to day treatment and assessment with ongoing individual or family counselling, followed by an ongoing parent support group, and a parent information series and adolescents information series that each lasts four weeks. The Intensive Day Treatment Programme begins with a 3-week orientation consisting of engagement with the client, goal-setting, and development of a treatment plan. The orientation phase is followed by a 6-week personal powers phase that includes exploring the impact of substance use on key life areas such as peers, school, leisure, communication, family, self-esteem, relationships, and emotions. Then follows a 3-week transition focusing on reconnecting with community supports such as school, ongoing counselling and leisure. AADAC also provides aftercare that involves weekly aftercare group, out-patient counselling, a weekly parent support group, and ongoing family counselling. However, having young people commit to ongoing aftercare has been one of the greatest challenges.

AADAC's 12-week day treatment programme conducts group intake every three weeks, with each client setting personal treatment goals. AADAC makes every effort to accommodate a client's needs. There are situations in which programmes are individualized for clients for whom an intense 12-week programme is not a fit. Within the out-patient component, each client also sets treatment goals.

One of AADAC's biggest successes involves using an experiential approach to learning and treatment. This has helped young people be more open to learning new concepts and trying new strategies for dealing with difficult situations. AADAC recognizes clearly the strong influence that risk and protective factors play on a young person's use or non-use of drugs. Another important lesson learned is that one must be prepared to deal with complex problems and work collaboratively with other systems, including education, mental health services, and child welfare.

Risks and protective factors

AADAC deals with a wide variety of youth and families. Family backgrounds may include parents with substance use problems (*RF: parents abuse substances*) and youth in child welfare placements. They also include financially stable and intact families who can offer full support to their young person. Most young people seeking the services have a significant adult in their circle of support (*PF: supportive, caring family*). The factors that help the client to successfully complete the treatment services include a personal commitment to change (*PF: internal locus of control, positive orientation*), family and community supports during and after treatment (*PF: supportive parents*), participation in healthy leisure activities (*PF: healthy leisure activities*), and having friends who do not use drugs (*PF: friends who model conventional behaviour*). Family involvement in the treatment process is a key ingredient of success (*PF: supportive parents*). In contrast, those patients who do not successfully complete the treatment services are not ready to make changes in their lifestyle (*Stage of change: pre-contemplation*) and lack support from family and friends (*RF: poor family relationships*).

AADAC focuses on schools, family and peers. Every effort is made to keep the clients connected with their schools (*PF: sense of belonging to school*) or make connections with alternative education programmes. Involvement and support of the family (*PF: supportive parents*) throughout treatment is a priority. Peers (*PF: affiliation with friends who model conventional behaviour*) is the topic of a theme week, as are opportunities to plan and follow through on positive leisure activities (*PF: healthy leisure activities*).

AADAC has observed several barriers such as reluctance of families to engage in the treatment process, significant mental health issues, and clients with severe foetal alcohol syndrome or cognitive limitations. Dealing with street youth is another challenge, as they do not feel a "fit" with the other treatment clients.

3.5. Division of Alcohol and Substance Abuse (DASA), State of Washington, United States

The Division of Alcohol and Substance Abuse (DASA) of the Washington State Department of Social and Health Services in the United States treats individuals who are low-income or indigent, with little or minimal health insurance, and who are assessed as chemically dependent. Treatment services are designed to maintain a cost-effective quality continuum of care for rehabilitating alcoholics and drug users.

Services

The services most frequently used with youth include abstinence-based out-patient and residential treatment. DASA provides out-patient assessment, family counselling and aftercare, and in-patient treatment at different levels of acuity, including work with youth and families with co-occurring disorders. It also provides acute and sub-acute youth detoxification and recovery house services for youth leaving residential treatment.

Treatment approaches

DASA receives referrals from parents, social workers, schools, juvenile justice courts, and probation departments. A limited number are self-referrals. Most patients' assessments are conducted in out-patient settings or upon admission to in-patient treatment by using the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC-II R). DASA mostly designs an individualized treatment plan, with a variable length of stay. A typical treatment process involves the patient's assessment and engagement, treatment planning, orientation, and support intervention. DASA also provides aftercare services by trying to connect youth and families with local community services, if available and convenient to the youth and families.

Early engagement in the treatment is an important factor for helping the adolescents successfully complete the treatment. DASA has also been successful in treating adolescents using the Dialectical Behaviour Therapy (DBT) and Cognitive Behavioural Therapy (CBT) within an abstinence-based in-patient model.

Risk and protective factors

Most of the people/adolescents who receive services from the agency have problems with criminal justice (*RF: exposure to violence*), school (*RF: academic failure, low commitment to school*), running away and abuse. Those who do not successfully complete the treatment are mainly hindered by more complicated life problems (*multiple RF*), including severe mental health conditions and family dysfunction (*RF: chaotic home environment, family conflict*).

Addressing risk and protective factors is the cornerstone of DASA's prevention programmes. While also addressed in treatment, especially during assessment and in treatment planning, these factors play a lesser role than in DASA's prevention efforts.

DASA's challenges include lack of beds in treatment facilities, long waiting lists, and lack of support from mental health and social services to support recovery. One of DASA's lessons learned is that youth programmes require intense supervision, coordination, safety, support, and technical help. Understanding youth development is also critical.

3.6. Essex Young People's Drug and Alcohol Service, Essex, United Kingdom

The Essex Young People's Drug and Alcohol Service in the United Kingdom is a fully integrated young people's service that serves those under the age of 19.

Services

The programme offers crisis intervention, counselling (primarily cognitive behavioural and person-centred approaches), group work, a structured day programme that includes life skills, outreach and street work, work with young offenders, training, prevention and education. Detoxification and methadone treatment are also offered, as necessary, with detoxification showing best results when it is community-based. The programme does not offer in-patient treatment.

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Section

4

IMPLICATIONS FOR PROGRAMME DEVELOPMENT AND IMPLEMENTATION



SECTION 4:

IMPLICATIONS FOR PROGRAMME DEVELOPMENT AND IMPLEMENTATION

Sections 1 to 3 provide an analysis of the progressive nature of substance use among young people and review treatment options and case studies of programmes that effectively addressed this issue. In addition, the extent to which risk and protective factors can further enhance intervention and treatment programmes to better serve the needs of young people have also been considered.

To effectively use this information, it will be necessary to consider an integrated framework that matches specific stages of substance use with indicated treatment options. It will also be important to identify and strengthen the protective factors that would increase positive treatment outcomes. In addition, consideration must be given to creating the conditions for developing and implementing effective programmes that benefit young people. These key issues will be elaborated on in this Section.

4.1. An integrated framework for stages of use, treatment options and indicated protective factors

As described in Section 1, there is a range of treatment options for young people, including different modalities of psychological treatment, as well as biophysical, pharmacological, and traditional treatment. Furthermore, drug users usually go through progressive phases of substance use. The effectiveness of the range of treatment options is determined, in part, by how well the treatment matches the progression of substance abuse (for a discussion of progression of substance use, see section 1.2).

Depending on the particular level of substance abuse, different types of treatments and settings are indicated. Matching the level of use with the appropriate treatment option will increase the chances of a successful outcome. Furthermore, while risk factors increase young people's susceptibility to substance use, protective factors can help prevent young people from using substances. In treating adolescent substance use, it is crucial to reduce risk factors and strengthen protective factors as early as possible so that young people are less likely to progress into deeper levels of dependency or relapse.

Figure 8, page 43 provides an integrated framework in which stages of use are matched with corresponding treatment approaches and appropriate settings. In addition, Figure 8 provides examples of protective factors that, if strengthened during the treatment process, could contribute to improved performance and sustained behaviour changes once the intervention is completed. Skills development that helps strengthen these protective factors can be utilized as an effective component during the treatment process and as part of an aftercare programme.

As Figure 8 suggests, based on the results of a thorough assessment of the nature and stage of an individual's substance use, the appropriate entry point for treatment can be determined. Once this entry point is determined, the treatment process can begin. Depending on the treatment option, or combination of options chosen, there are several pathways on which young people can proceed through this process.

Figure 8. An integrated framework for matching stages of drug use with appropriate responses

Stage of substance use	Recommended intervention	Appropriate setting	Applicable protective factors *
Priming	<ul style="list-style-type: none"> • Prevention 	<ul style="list-style-type: none"> • Schools • Community-based service providers 	
Initiation	<ul style="list-style-type: none"> • Prevention • Outreach 	<ul style="list-style-type: none"> • Schools • Community-based service providers 	
Experimentation	<ul style="list-style-type: none"> • Early detection and outreach • Assessment • Counselling (short-term) 	<ul style="list-style-type: none"> • Schools • Community-based service providers • Out-patient clinics 	<p>Individual factors</p> <ul style="list-style-type: none"> • Social competence skills • Optimism, positive views • Intolerance of attitudes toward deviance • Positive relations with adults • Affiliation with friends who model positive behaviour • Moral beliefs and values • Religious beliefs • Strong anti-drug attitudes <p>Family Factors</p> <ul style="list-style-type: none"> • Supportive parents, family harmony • Educational opportunities and support • Strong bonds/attachments between children and their families • Secure and stable family <p>School factors</p> <ul style="list-style-type: none"> • Successful performance • Pro-social peer group • Positive orientation toward school
Habit formation	<ul style="list-style-type: none"> • Counselling (long-term) • Day treatment programmes (when indicated) • Self-help programmes 	<ul style="list-style-type: none"> • Community-based treatment programmes • Out-patient clinics • Day treatment programmes 	<p>Individual factors</p> <ul style="list-style-type: none"> • Perception of strong social control • Good coping styles • Perception of risk of use <p>Family factors</p> <ul style="list-style-type: none"> • Parental monitoring and rules of conduct • Strong family norms and morality <p>Community factors</p> <ul style="list-style-type: none"> • Strong bonds with pro-social institutions such as religious organizations • Strong cultural identity and ethnic pride • Community/cultural norms against substance use <p>School factors</p> <ul style="list-style-type: none"> • Positive school climate

Figure 8 (continued)

Stage of substance use	Recommended intervention	Appropriate setting	Applicable protective factors*
Dependency and obsessive-compulsive use	<ul style="list-style-type: none"> • Detoxification (when indicated) • Pharmacological (longer term prescription of substitutes) • Counselling (long-term) • Group therapy • Family therapy • Rehabilitation services 	<ul style="list-style-type: none"> • Hospitals (or similar setting for pharmacological treatment) • Rehabilitation centres • Long-term in-patient treatment programmes • Therapeutic communities 	<p>Community factors</p> <ul style="list-style-type: none"> • Community networking • Access to support services <p>School factors</p> <ul style="list-style-type: none"> • Create and foster school norms that discourage violence and substance abuse • Organizational changes in schools
<p>* Matched only with the stages of experimentation, habit formation, dependency and obsessive-compulsive use.</p>			

For example, in one instance, a young person may be assigned to short-term counselling. In another more severe situation, it may be detoxification. In each situation, the path to recovery and reintegration will be different. When a young person enters short-term counselling, he or she may, upon completion of the prescribed number of treatment sessions, proceed directly to reintegration into family and school. On the other hand, if an individual is assessed to need a more intensive form of treatment such as day treatment, in-patient, or a therapeutic community, the person will most likely need to move through rehabilitation and aftercare as essential steps toward the ultimate goal of reintegration with family and society. Figure 9, page 45 illustrates a continuum of treatment and the various pathways that would be associated with various points of entry to the treatment process.

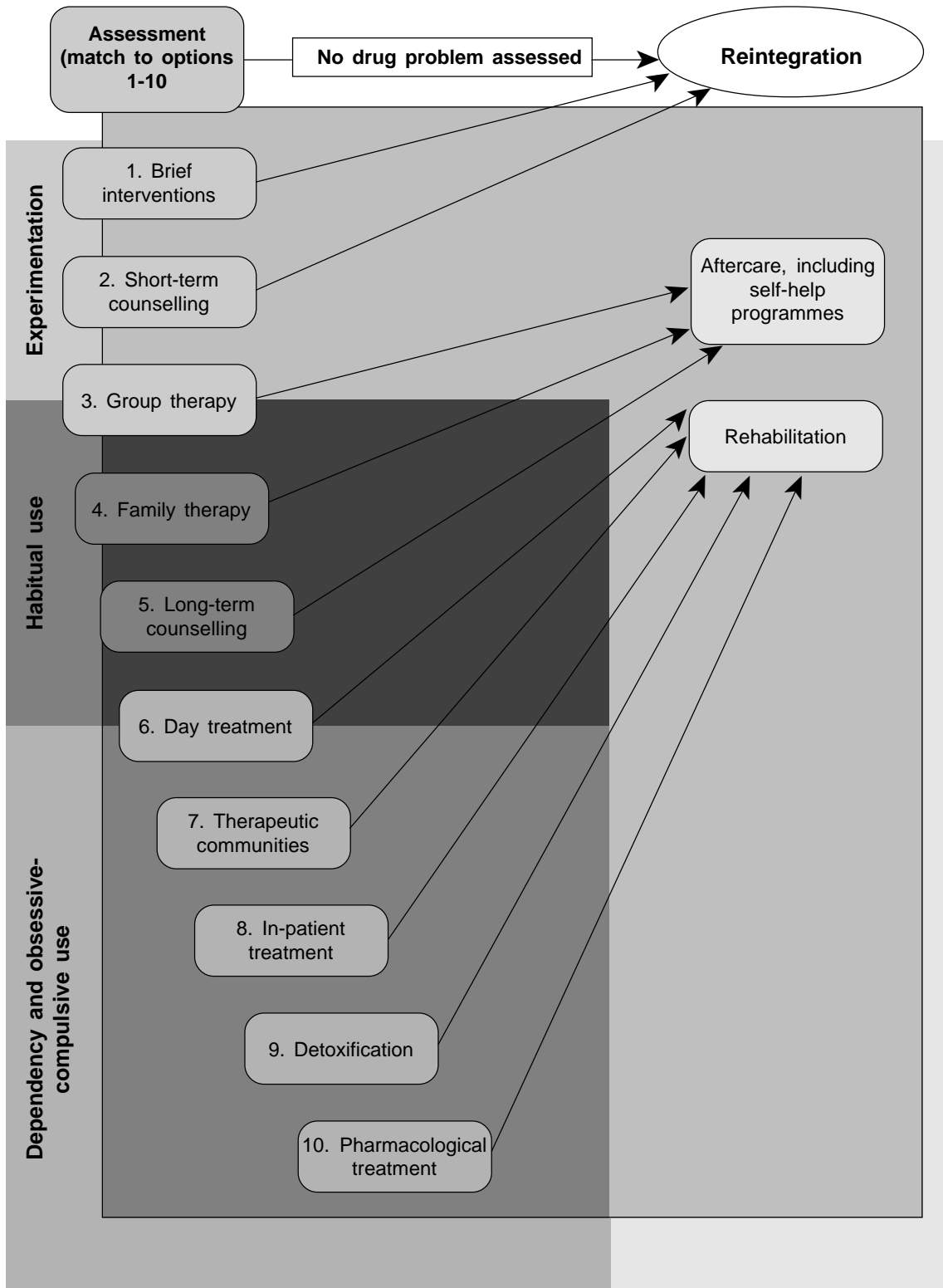
4.2. Additional considerations for effective adolescent treatment programmes

In addition to matching treatment options with levels of abuse and addressing protective factors in treatment programmes, further recommendations for adolescent substance use treatment have been identified by research over the years.

Guiding principles of effective treatment for young people

Treating adolescents for substance use requires special consideration of the adolescent's individual experience and how it affects the nature and severity of drug use. Understanding the special needs of adolescents will help explain why drugs are used and how they became integral to the user's identity. This will provide valuable insights into developing effective treatment programmes (SAMHSA n.d.).

Figure 9. Continuum of treatment options and pathways to reintegration



An analysis of young people and drugs in Australia came to the following conclusions about adolescent treatment (Department of Human Services 1998):

- Specific and unique characteristics of adolescent use and abuse must be taken into account when designing intervention services and treatment models.
- Services must be designed to be accessible, non-stigmatizing, and confidential. The staff required to work in services for these young people must be flexible and non-judgmental, with the knowledge and skills to deal with substance use.
- Treatment approaches must take into account the developmental delays that may have occurred in the substance use process and provide remedial programmes.
- Multiple, intertwining issues are inseparable and must be addressed concurrently with the substance use, as the young person may have other priorities, such as housing and income, to consider before drug treatment.
- Abstinence may be an unrealistic goal; harm minimization may be more achievable.
- Services must be adolescent-specific and based on a model that adopts a holistic approach incorporating: assessment, case management, individual counselling, group work, skills training, education, family work, accommodation and vocational assistance, links with supports, recreation, outreach, and aftercare. Two essential components appear to be life skills training and interventions that incorporate family members who work in combination with staff teams who have expertise in substance use patterns and treatment models.

In addition to reviewing the recommendations of expert researchers and practitioners, it is also important to consider the views of young people. In Chiang Mai, Thailand, in April 2003, at an international conference on the reduction of drug-related harm, young people suggested service providers consider the importance of early intervention including outreach services designed to educate and motivate young drug users.

For example, they recommended developing programmes that help young people learn the risks associated with drug use and the steps one must take to quit. In addition, the young people made the following recommendations (Rosati 2003):

- Programmes must find ways to encourage voluntary entrance to treatment and have varied courses of treatment depending on an individual's drug use.
- Programmes should require family participation.
- Service providers must stop judging young people and treat them professionally and compassionately. Given that most young drug users distrust and resent service providers in general, it is all the more important to create supportive environments for treatment and rehabilitation.
- Due to the gap between need and treatment services, alternatives to rehabilitation centres, such as family and community-based programmes, should be considered.

Figure 10, page 47 provides the specific recommendations advanced by South-East Asian youth at that conference.

Figure 10. Young people's recommendations on how to develop effective drug treatment programmes

General

- Communities should avoid alienating and discriminating against young people who use drugs.
- Community-based programmes that are supported by local authorities must be put in place and communities must be open to developing such programmes.
- See drug users as good persons of value to society.
- "Talk to us and understand the reason we use drugs."
- Develop alternative activities to help youth use free time productively.
- Provide training programmes in occupational and other skills.
- Programmes must move beyond using scare tactics to approaches such as teaching/training life skills.
- Use positive peer pressure and allow young people to participate in programme development.
- Provide constructive, alternative options for youth (parks, community centres).

How to motivate young people to stop using drugs

- Help young substance users see the problem they are creating for themselves and how unmanageable their lives have become.
- Highlight problems associated with drug use, i.e., health and age-related issues and risks.
- Help young substance users look to the future.
- Help young people learn problem-solving skills.

Treatment

- As an alternative to rehabilitation centres, develop community-based programmes.
- Society must accept and reintegrate those who have recovered from drug addiction.
- Parents should be supportive of their children and encourage them to reintegrate.
- Move beyond simple messages such as "To use drugs is not good."
- Have varied periods of time for the course of treatment, per individual need.
- Professionalism in dealing with addiction is critical.
- Young people feel there is a huge gap between their needs and the services provided.
- Young drug users need to feel understood and respected.
- Harsh and discriminative treatment will not motivate young people to stop using drugs.
- Develop youth camps as opposed to boot camps, that emphasise nature, arts and sports; provide opportunities in these camps for young people to learn how to make decisions, exchange views, and learn to engage in activities other than drug use.

Source: Rosati 2003.

Core components of adolescent treatment programmes

Effective treatment programmes for adolescents must be tailored to the specific needs of young people. To meet these needs, a number of key areas and services must be considered. The core components of many adolescent treatment programmes, regardless of their therapeutic orientation, should include the following:

- *Orientation, the first step*, clarifies to the adolescent what treatment is, his or her role in treatment, and the programme's expectations. Orientation should be conducted in a non-confrontational style and tone that does not raise the adolescent's anxiety, which may already be heightened.
- *Daily scheduled activities* (in the case of day treatment and in-patient settings) of school, chores, homework, and positive recreation can help adolescents learn new skills, provide an alternative to substance-using behaviour, and help ensure they remain sober after treatment.

- *Peer monitoring* in a group setting can help the client build the strength to override peer pressure and harness the influence of peers in a positive manner.
- *Client contracts* (e.g., behavioural contracts, including substance-free contracts) are negotiated and signed by both the adolescent and primary counsellor; they lay out concrete treatment goals, expectations, time frames, and consequences (if the contract is not followed).
- *Schooling*, which generally focuses on substance use and basic education, is one of the most important factors in recovery. Whether the schooling is provided on or off site, it should be fully integrated into the programme. Teaching staff/trainers should be considered part of the treatment team. For adolescents who attend public schools, a liaison between the school and programme should be designated.
- *Vocational training* is an important intervention. Appropriate interventions include pre-vocational training, career planning, and job-finding skills training. Without these skills, many young people may be more likely to support themselves through illegal activity (Winters 1999).

Establishing the conditions for effective treatment

In addition to adapting the lessons learned from other programmes, it is critically important to create the social context that supports effective treatment. This context must be created at key levels including the programme, family, community and society.

Programme

Young people live in a world that is increasingly complex. Threats to their health abound, and they often lack relationships with trusted adults who could provide needed advice and guidance. For those who choose to work with young drug users, it is necessary to develop an accurate understanding of how drugs affect adolescents and the factors and conditions that will increase the likelihood of successful treatment.

For example, in working with young people, it is important to consider how to create motivation for treatment. When assigned to a treatment setting after arrest or by referral from parents, young people often lack a sense of investment in the treatment process. As a result they simply create the appearance of complying with treatment and then upon completion return to drug use. It is necessary to help young people become active participants in their treatment programme, otherwise it will be difficult to achieve positive treatment outcomes.

To create that motivation, several factors must be considered:

- *The role of the family* as an active participant during intervention and referral. By giving families information and support, treatment providers can work with them to facilitate a smooth entry into treatment and ensure that parents are active in both treatment and aftercare.
- *The possibility of co-existing mental disorders*. Adolescent substance users are more likely than their abstinent peers to have co-existing problems such as anxiety disorders, attention deficit-hyperactivity disorder, depression, delusion, and other schizophrenic and psychotic disorders. Substance use may disguise, exacerbate, or be used to “self-medicate” psychiatric symptoms. Without tailored treatment, these disorders could interfere with the ability and motivation to participate in treatment

and could increase the potential for relapse (SAMHSA n.d.). It is important for programmes to either employ or form linkages with mental health professionals and programmes.

- *Compassionate, considerate attitudes and practices*, in addition to developing a keen understanding of young people and the specific nature of adolescent drug use. Young people often report encountering what they perceive as harsh and uncaring service providers (Rosati 2003). Regardless of what one may think about adolescents who use drugs, harsh and judgmental treatment has not been shown as effective (Cowles, Castellano and Gransky 1995; Zhang 2000). To increase the degree to which young people may see the value of treatment, it is important to communicate a sense of personal worth, and hope that the treatment can and will be successful.

Families

As mentioned in the previous Sections, families can play a key role in referring a young person to treatment, participating in the treatment process, and providing support in aftercare. In most cases, the family has played an essential role in the origin of the drug abuse. Treatment should take into account family factors that increase risk for substance abuse problems in youth, such as a family history of substance use; domestic violence, physical, sexual or emotional abuse and neglect (SAMHSA n.d.).

To facilitate effective interventions and referrals, and to ensure active participation in treatment, it is important to educate the young person's family about substance use problems. Research has demonstrated that working with families in a collaborative approach optimizes treatment outcomes. There is a need to support not only young people but the parents and family by providing parent/family support groups during rehabilitation. In addition, in cases where parents are not involved in the referral process, service providers must make contact with families and engage them at the beginning of the treatment process (McDougall 2001).

Communities

While policy and norms can be developed at the national level, it is in fact the community, guided by the religious community and other local leaders, that has the moral authority to define a set of values for the common good and to utilize human resources in efforts to address drug use by young people. Communities in many ways have the greatest role to play. Through examining and adjusting the practices of formal and informal systems, communities can significantly change the extent to which an environment can support or undermine the individual's ability to act in a healthy way.

To create communities that support young people and their families in addressing drug issues, it is important to eliminate the stigma that is attached to drug use. Until a community can accept drug use as a treatable medical illness, it will be difficult for young people and their families to seek the help they need, and it will be difficult to gain support for allocating resources to developing effective treatment programmes. The lack of available and effective treatment is the one barrier between many young people and recovery. Yet in countries throughout the world, it has been documented that the desire and demand for treatment far outweighs the availability of programmes (Her Majesty's Stationary Office 1998; Gerstein and Harwood 1990; Epstein and Gfroerer 1998). This is especially true in the case of young people.

In addition to creating adequate levels of treatment services, it is also critical to consider how systems for aftercare can be developed for young people and their families. Young people in East Asia have reported that lack of aftercare support is a major reason for relapse (Rosati 2003). To address this very important need, it will be necessary to explore what new resources may be allocated for such services. It will also be important to examine how existing services can be adjusted to accommodate this need. The following are examples:

- A recreational sports league could hold a programme for young people who have recently been released from treatment.
- A local hospital could conduct weekly family support groups.
- A school could provide a weekend tutoring programme to help ensure that young people who have recently completed treatment are successfully integrated back into the school setting.

Society

At the societal level, it is necessary to ensure that clear norms which support healthy behaviours are adopted. These norms will provide all citizens, and young people in particular, with a sense of what it means to be part of civil society in which individuals seek ways to work together to create safe and healthy environment. Drug use needs to be considered in the context of this broader set of social values. This is not a function of developing punitive policies but is the process of creating a social compact in which citizens participate in establishing shared beliefs that protect the health and interests of an entire society, including its young members.

The following are ways in which a society, through its government structure, can support the development of effective treatment systems:

- Key ministries (such as education, health, and social welfare) must come together to develop policies, allocate resources, and support school- and community-based early intervention and treatment services for adolescent drug use and a range of related health issues.
- Public communication campaigns and direct advocacy at the national level can create supportive attitudes and beliefs.
- Government and other key national organizations should develop information management systems to track the effectiveness of treatment programmes and develop a country-specific data set on evidence-based approaches and strategies.
- Dissemination systems must make this information available to treatment providers and the general public.
- The criminal justice system and other points of referral can work with diversionary settings, such as community-based programmes, to provide alternatives to incarceration or government-managed rehabilitation centres. Evidence suggests that diversionary programmes, which assign individuals to community-based programmes, as opposed to incarceration, are cost-effective alternatives that can have a very strong success rate when managed properly. One study that compared the cost of community diversionary treatment to incarceration determined that the cost of the community-based treatment was approximately 3 per cent that of sending a drug user to a prison (Briefing Report 1995).

4.3. The process of effective programme adaptation

This analysis has attempted to provide an overview of the literature on effective treatment for adolescents and an integrated framework for matching stages of use with appropriate and effective responses. It is important to note, however, that the ultimate value of this information will be determined by the degree to which it is not merely replicated, but in fact, adapted for use in a thoughtful and scientific manner.

Reading this publication, and similar publications, is a first step in that process. It is important to learn what others have done and to what extent research and evaluation data supports specific approaches. As promising approaches are identified, it then becomes essential to adapt these programme models to the specific circumstances of each country and community. This adaptation should take into account cultural values, customs and traditions, as well as the scope and nature of current service delivery systems.

In addition, it is important to consider other factors that will contribute to successful adaptation. For example, it will be important to balance the need to adapt programme elements with the importance of preserving the major components that are critical to successful, sustained implementation of research-based substance use programmes (Backer 2001). There will be greater likelihood of effectiveness when a programme retains the core elements of the original intervention including: basic programme structure (e.g., number of sessions, setting), content (e.g., inclusion of certain types of skill-building activities), and delivery (e.g., facilitated family counselling sessions) (United States Department of Health and Human Services 1997).

Adapting existing programmes and materials

It is often possible to work with existing programmes rather than designing new and appropriate materials and activities for skills-based early intervention and counselling programmes. The adaptation of programme approaches and materials developed by others can be beneficial. For example, if the materials have been proved effective, it may increase the likelihood of effectiveness in other settings. Financially, adaptation typically reduces the development costs associated with a programme.

If you do choose to adapt approaches and materials, you should consider the following:

- Is the programme approach relevant to the needs of youth target groups?
- Does the programme approach have intervention and treatment goals that describe conditions that can be influenced to impact programme goals?
- Has the programme been evaluated? By what audience and in which setting? What is the evidence of effectiveness? What is the similarity between the “proven programme” and the intended audience and cultural setting?
- How appropriate are the methods for achieving the programme’s objectives?
- How easily can staff adapt and implement the interventions?
- How relevant and up to date is the research on which the programme is based?
- How relevant is the intervention to the behaviours that are intended to be influenced?

- Is the programme gender-sensitive in content, intervention and language?
- What time investment is suggested (number and length of sessions)?

Adapted from Aldinger and Vince Whitman 2003

The role of on-going evaluation and refinement

Once an adapted programme approach is developed, it should be applied in a pilot setting where its effectiveness can be measured. Through this process of evaluation, two important results will hopefully occur. First, information will be gathered on ways the programme can be improved and conducted more efficiently. Secondly, policy and programme developers and decision-makers will have an opportunity to judge the adapted programme's effectiveness. Assuming the evaluation process can demonstrate positive results, the programme can be disseminated to additional sites with the confidence that the recommended approach has not only been thoughtfully adapted to reflect an understanding of local culture and values, but has also demonstrated positive outcomes in a scientifically conducted evaluation study.

In developing plans to take effective pilot programmes to scale, it will be important to ensure that the issues discussed in Section 4.2 – the guiding principles of effective treatment for young people, core components of adolescent treatment programmes, and conditions for effective treatment with regard to individuals, families, communities and society – have been addressed. In addition, it may be helpful to conduct an assessment analysis, such as the SWOT process (strengths, weaknesses, opportunities and threats). Analysis of this nature can provide valuable insights into what resources are already in place to support the development of an enhanced treatment system and identify what needs exist for new resources. In addition, this analysis will give policymakers and programme developers a clear sense of where the support and potential challenges may lie in developing a national treatment system designed to effectively meet the needs of young people.

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