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Adolescent substance abuse treatment: Organizational change and quality of care

Traci Rieckmann, Ph.D.,
Research Assistant Professor in the Department of Public Health & Preventive Medicine at Oregon Health & Science University

Holly Fussell, Ph.D.,
Senior Research Associate in the Department of Public Health & Preventive Medicine at Oregon Health & Science University

Kevin Doyle, Ed.D.,
Vice-President for Enhancement and Chief Enhancement Officer for Vanguard Services Unlimited and an adjunct professor at the University of Virginia

Jay Ford, Ph.D.,
Director of Research for NIATx at the University of Wisconsin, Madison

Katherine Riley, Ed.D., and
Assistant Professor in the Department of Public Health & Preventive Medicine at OHSU

Stuart Henderson, Ph.D.
Research associate at the Philip R. Lee Institute for Health Policy Studies, University of California San Francisco

Abstract

Substance abuse treatment agencies serving youth face unique barriers to providing quality care. Interviews with 17 adolescent programs found that family engagement, community involvement, and gender and diversity issues impacted treatment delivery. Programs report organizational change efforts with implications for future process improvement initiatives.

Keywords

Adolescent; substance abuse treatment; organizational change; quality of care; diversity; barriers

Adolescent substance abuse is an emotional and challenging issue for youth, their families, schools, and the community at large. According to the National Survey on Drug Use and Health, 9.8% of youth aged 12 to 17 years use illicit substances (SAMSHA, 2008). Although overall rates of use declined between 2002 and 2007, more recently adolescent use of illicit substances and alcohol has remained stable. Between 2007 and 2008 adolescent substance abuse or dependence displayed minimal change, with a rate of 7.7% in 2007 and 7.6% in 2008 (SAMHSA, 2008). In terms of treatment needs, current national data reports that 23.1 million people aged 12 or older (9.2 % of the population) report needing treatment for substance related problems (SAMSHA, 2008). Unfortunately, only 2.3 million of these individuals actually received treatment, leaving 20.8 million people who need treatment

Contact: Traci Rieckmann, Ph.D., Research Assistant Professor, Department of Public Health and Preventive Medicine, Oregon Health & Science University, 3181 SW Sam Jackson Park Rd CSB 669, Portland, OR 97329. rieckman@ohsu.edu, phone: 503-494-6739.

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which in turn impacts their families and the rising cost of health care, as the severity of the abuse is likely to increase in the absence of treatment. A similar pattern exists for adolescents, with as few as 10% of the youth who need help for substance use disorders actually receiving services (Join Together Report, 2006).

Overall there is a significant need to improve treatment for youth with substance disorders including increasing engagement, retention and the quality of care. One initial step is examination of the characteristics and service utilization patterns of youth who are treated for substance use disorders. Based upon N-SSATS and TEDS data, the majority of adolescents treated within the United States receive addiction services in publicly funded programs and many are referred by the criminal justice system (Godley & White, 2005). Youth often access substance abuse treatment services through multiple referral sources, such as the school system, juvenile court, family interventions, physicians, and social service programs (Brannigan, Schackman, Falco, & Millman, 2004). This myriad of referral sources may contribute to conflicting policies, practices, and paperwork within youth treatment programs, which serve as barriers to providing effective and efficient services.

Similar to the challenges in adult services, youth treatment providers also face programmatic "business process" barriers, such as overbooked staff, poorly designed phone systems, burdensome intake procedures, and repetitive paperwork (Ford, et al., 2007). When adults were asked about their experiences seeking alcohol and drug treatment services, 51% stated that organizational barriers interfered with their ability to engage in treatment (Ebener & Kilmer, 2003). Another study reported that over 50% of adults who contact a clinic to schedule an appointment did not attend this first intake session, and the rates are likely higher for youth (Farabee, Leukefeld, & Hays, 1998). Complicated family and guardianship dynamics also create additional communication challenges and time intensive documentation. Finally, most youth in need of substance abuse treatment services have yet to recognize the impact of their use and rarely seek treatment on their own. In fact, the National Survey on Drug Use and Health reported that the number one reason why persons aged 12 and older have not received treatment is because they are not ready to stop using, and have not yet recognized the need for assistance (SAMSHA, 2008).

In spite of increases in admissions between 1987 and 2003, only one-third of substance abuse treatment centers contain adolescent specialty programs (Godley & White, 2005). Thus, youth may find themselves in programs that are not prepared for the unique and often complicated needs of adolescents who are abusing or dependent on alcohol and/or other drugs. For example, enlisting the family in treatment can be extremely valuable; however, successfully engaging family members in treatment may not always be feasible. Parental incarceration, addiction, indifference, and/or termination of parental rights serve as barriers to optimal family engagement. Along with unique family issues for adolescent treatment providers, effective services for adolescents must also address other population specific differences such as greater frequency of binge or opportunistic use and high frequency of co-occurring disorders (Brannigan et al., 2004). In addition, adolescents are more susceptible to influence by peers and are at a vulnerable stage of development given the multitude of changes they experience at this time, such as moving away from their family and identity development (Mark et al., 2006).

Race, ethnicity, sexual orientation, and language are also significant considerations in adolescent treatment design and delivery (Nissen, 2006; Mark et al., 2006). While matching race and ethnicity of youth and counselors improves treatment retention and success (Flicker, Waldron, Turner, Brody, & Hops, 2008), low wages, along with poor and complicated funding for substance abuse treatment deters this matching possibility for every program (McCarty & Rieckmann, in press). Furthermore, adolescent treatment programs

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primarily replicate or make slight adaptations to existing adult models (Dennis, Dawud-Noursi, Muck & McDermeit, 2002; Kraft, Schubert, Pond & Aguirre-Molina, 2006), and it remains unclear which evidence-based treatments are the most effective for youth (Waldron & Turner, 2008). Thus, providing quality services for youth requires many adaptations including age appropriate, culturally relevant interventions, additional case management, interaction with families and referral sources, and unique organizational policies and procedures.

Organizational Change

Over the past decade, applications of process improvement strategies are reported to have enhanced performance outcomes in business and health care organizations (Pearson et al., 2005; Kaynak, 2003). Broadly defined, process improvement is a continuous quality improvement method (Weick & Quinn, 1999) that applies Plan-Do-Study-Act (PDSA) cycles (Berwick, 2007) to improve organizational processes. Over the past five years, addiction treatment agencies across the country have participated in the Network for the Improvement of Addiction Treatment (NIATx). These agencies used process improvement techniques to identify barriers to treatment and implement rapid cycle changes to improve access to care and retention in treatment (Cappoccia et al., 2007). Participation in process improvement led to decreased time to treatment and improved retention in substance abuse treatment (McCarty et al., 2007).. While good news for the field of substance abuse treatment overall, there is a paucity of research about process improvement and adolescent services.

Adolescent substance abuse treatment programs face unique challenges as they work to implement process improvement strategies designed to decrease time to treatment (including addressing problems with referrals) and increasing engagement in care (including addressing family involvement). Building on the promising results from quality improvement efforts aimed at adult treatment programs (McCarty, et al., 2007), this manuscript assesses how perceived and practical problems unique to serving youth with alcohol and drug disorders impacts possibilities for process improvement. Results inform future quality improvement efforts that organizations serving youth may wish to consider.

Methods

This section describes the participants, measures, procedures, and analyses used to explore the challenges faced by treatment programs that are trying to increase adolescent substance abuse treatment and improve the quality of care. The study received Institutional Review Board approval at Oregon Health & Science University.

Participants

The Network for Addictions Treatment (NIATx) collaborative involves multiple organizations (e.g., universities and substance abuse treatment programs) working in partnership to improve time to treatment and retention. At the treatment program level, one or more individuals volunteer to lead efforts to identify and change organizational practices that may impede ideal time to treatment and client retention. This “change leader” works with a “change team” made up of other program personnel to conduct rapid process improvement cycles and assess outcomes.

For this study, multiple data sources were used including 1) an in-depth phone interview with change leaders or clinical/agency directors who had been involved in process improvement at a NIATx adolescent treatment program (n =17), 2) researchers’ field notes recorded after each interview, and 3) electronic follow-up interviews to clarify points and

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obtain additional information. Participants were asked about the unique challenges in working with youth and process improvement strategies employed within their adolescent treatment unit. Participant eligibility requirements included familiarity with process improvement and occupying a key role in the adolescent program(s). Representative from 17 agencies (n=19 –two respondents within two participating agencies) participated in interviews for this study. Interview participants were agency directors, directors of adolescent treatment services, and change leaders, and the sample reflected that national workforce with 13 female interviewees (out of 19). Agencies ranged in size from 206 to 9401 total patients served each year. Each agency had a program or treatment unit specifically for youth, and the percent of adolescent clients ranged from 7 to 100 of the total clients served. Residential and outpatient programs were included and the agencies were located throughout the United States in both rural and urban areas. For purposes of maintaining agency confidentiality, specific identifiers (e.g., city and state) are not included. In accordance with our approved protocols, we do not identify any specific individuals, programs, or clinics that participated in this research.

Instrument and Procedures

The interview guide for this project was designed to assess a broad range of concepts related to adolescent treatment and organizational change initiatives. Interview questions addressed unique challenges encountered in treating youth with substance abuse disorders, organizational and/or clinical change efforts, how the agency dealt with the needs of diverse youth, and the process the agency used to implement NIATx process improvement strategies to enhance adolescent services. The guide included questions and prompts to illicit detailed experiences and perspectives from participants in order to begin documenting this relatively unexplored topic. Qualitative methodologies, such as the semi-structured interview guides used in this study are particularly well suited for preliminary investigations and discovery (Ambert, Adler, Adler & Detzner, 1995; Miles & Huberman, 1994). A research team with training in interviewing and qualitative methods completed the 60 to 90 minute telephone interviews. Two of the researchers are also clinicians and each of the investigators was familiar with the NIATx initiative. The researchers recorded detailed notes and direct quotes during the interviews. After each phone call, summaries and comments were also completed to generate individual notes and narrative reports for each interview.

Analysis

All narrative notes were categorized and analyzed for themes using Atlas.ti v5.6.1®, a qualitative data management program. The research team generated a list of codes reflective of overarching topics in the narratives. To do this, each team member provided a list of recurring trends they noted in the narrative material. The research team then engaged in dialogue and agreed on a single set of constructs or codes. The single set of codes was then used to categorize the narrative material in Atlas.ti v5.6.1®. A “check-coder,” provided external auditing of the data by reviewing the narrative material for accurate application of the codes and providing input on improving and fine-tuning the codes and their relevance to the data (Lincoln & Guba, 1985). Next, an iterative process with all coders and investigators was employed to identify themes or specific recurring and compelling points made across the material (Lofland, Lofland, Snow, & Anderson, 2006; Luborsky, 1994). Finally, illustrative quotations were identified for each theme and incorporated into descriptions of findings.

Results

Analysis of interviews revealed three major areas of concern specific to improving services for adolescents seeking drug and alcohol treatment: family engagement, community

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involvement, and gender and/or diversity issues. For each category of concern, respondents also noted process improvement or change efforts their agencies conducted in attempts to improve access, retention, and the overall quality of care.

Family Engagement

Treatment directors and change team leaders consistently reported difficulties in balancing the multiple challenges presented by mandatory guardian involvement in adolescent treatment. Parental or guardian involvement was deemed essential by most providers as one respondent noted, "If parents don't engage in the process, within six weeks everything unravels." However, initiating and maintaining their involvement could create complications for the youth and the providers as noted by one treatment manager, "Parents can be helpful or sometimes add an extra burden or challenge." According to respondents, specific family involvement issues include 1) scheduling and transportation issues, 2) parents disengaging after the initial stages of treatment (i.e., adopting a "crisis mentality"), 3) parents who are ambivalent about their child's treatment, and 4) language and communication differences between treatment staff, family members, and adolescent clients from multi-lingual families.

For clients who are not legally mandated to attend treatment, the necessity that parents or guardians agree to have adolescents enter treatment is a critical challenge. Unlike adult programs, the parents or guardians as well as the minor client must agree that treatment is required, and frequently consent must be obtained before any services can begin. Providers participating in this study suggested that in early stages of treatment it is difficult to get parents/guardians to complete necessary paperwork. In addition, after successfully entering the youth in treatment, families often struggle with transportation, scheduling conflicts, alternative family obligations, or minimal funds for treatment. A program manager noted, "Parents who work a lot have a hard time making it to treatment. Even when we offer to meet with them in the evenings or at their convenience—it is often not convenient because they are so exhausted from work."

Participants in this study also reported that a more substantial challenge is keeping parents/ guardians engaged throughout the treatment process. Respondents described negative outcomes associated with families that allow youth to enter treatment but later disengage. A program director suggested that when parents don't support the treatment process, it is frequently related to viewing substance abuse as episodic rather than chronic, noting, "Parental perception is that once the crisis is over, why would the adolescent need more services? Convincing them of the importance of follow up is critical [for continuing engagement]." Ambivalent family attitudes toward treatment may also contribute to a reluctance to support ongoing monitoring of behaviors. Parental addiction or mental health problems and denial of the role the family plays in adolescent behavior could also result in a lack of positive support for treatment. For instance, a program director suggested that for some of his adolescent clients, "home life is so bad that mom wants to pull the child from treatment so that she doesn't reveal [family] addiction problems to counselors." Another respondent indicated that although their center has family counseling sessions, "only about 9% of parents participate in the sessions." Commenting on this rate of participation the director noted that, "The notion is that it is the kid's problem or fault. Parents deny they have anything to do with it." Reflecting on this common challenge, a program manager tied the issue to broader societal views of alcohol and drug use, saying, "Social acceptance of teen drinking and drug use as a right of passage prevents a lot of parents from recognizing that their child is in pain and needs help." Many adolescents in treatment often face more than one of these family related challenges, a circumstance that only adds complexity to alleviating any one of the problems.

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Change Efforts—Study participants identified several critical change efforts aimed at addressing parent/family involvement: 1) extensive outreach to families through public information campaigns, treatment in the home, transportation assistance, evening appointments, and community outreach and education; 2) decreasing wait times for entry into treatment through streamlining referrals and improving efficiency of documentation; and 3) ensuring multilingual staff are present for improved family and youth communication.

Respondents reported that one of the barriers that limits engagement and retention of youth was a lack of understanding by the family about what treatment entails. To educate the public at large, but more specifically parents with youth dealing with substance abuse, one program began airing public service announcements (PSA) on local radio programming. "We have a radio show that we do as a PSA, and we try to do it two times a month to put a face on recovery, and lots of people want to be on the show and talk." Other programs instituted changes that would allow counselors more time to educate and incorporate families into the treatment processes by decreasing or rearranging existing caseloads or changing schedules.

For families with transportation problems, removing the need for multiple visits prior to entry into treatment eased some logistical burdens. Several organizations addressed transportation challenges by going to the client's home or school. This was especially important in rural communities with no public transportation or when parents or other involved adults were not completing and returning paperwork. Home visits also provided opportunities to identify family members' substance abuse or mental health related complexities that informed treatment for the adolescent.

In instances when parents were responding to a crisis that brought the adolescent to treatment, avoiding long waits allowed parents to make rapid arrangements. In order to reduce wait times, programs shifted caseloads to allow for more afternoon and evening intakes. In order to streamline referrals, respondents reported improving communication with schools and probation officers and continued communication and education for parents about the need for treatment. Finally, programs found it was crucial that counselors not rely solely on bi- or multilingual adolescents for translation between staff and family members. Key information can get lost or be miscommunicated if professional staff members are not involved in treatment dialogue involving the client's family.

Community Involvement

In addition to identifying the importance and challenges of gaining parent/guardian involvement in adolescent treatment, providers also noted the necessity of enlisting the community in comprehensive and successful treatment. Three key difficulties within this domain surfaced, including lack of referrals, inconsistent and unclear communication with community partners to support youth in treatment, and confidentiality issues.

Treatment programs rely heavily on a wide variety of community partners to help identify youth with substance abuse disorders. Directors and managers of treatment programs noted two interconnected challenges related to community referrals. First, individuals in community organizations often struggled to identify and respond to adolescents' treatment needs, and second, they had difficulty maintaining linkages and follow-up between community organizations and the treatment program.

Treatment providers cited problems with community members (e.g., teachers, probation officers, primary care providers) failing to identify adolescents' treatment needs. Some providers suggested that the adults who most commonly interface with these adolescents,

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and therefore have a first-hand opportunity to refer them to treatment, often don't want to "interfere" with minors who are legally their parents' responsibilities. Describing the situation, one provider stated, "Certain community partners don't want to tell parents that their child needs treatment—so they avoid doing anything while the child suffers… [The] problem is that people are afraid to, or don't know how to talk to youths or their parents about substance use."

Legally mandated clients comprise a significant number of referrals to adolescent treatment programs, yet several program administrators suggested that legal referral sources had insufficient knowledge of or "forgot" about treatment programs. A treatment program administrator commented, "I believe there are a significant number of kids who have problems that are not being referred. Everybody from school systems to probation officers and parents are not referring…. I think educators and some other referents don't realize how problematic it is, and they are overwhelmed with other issues, and they are not going to refer someone unless they are public [openly using]."

For court ordered youth, the referral process could take several months, and as one respondent noted, "by the time the youth gets into treatment, they're frustrated because they were already punished months ago." Follow-up was also noted as a problem by some providers. One respondent commented that the "Department of Corrections makes referrals; however, no officer ever follows up, and there is no established system in place [for follow-up]."

Communication breakdowns also interfered with continued support for youth working to engage in treatment. Limited resources and time pull community agencies in different directions as they each focus on their own priorities and agendas. One respondent noted, "Educating everyone about what is up – is a constant relationship building task. [It's] challenging to always maintain our link to the other youth services." Another respondent suggested that communication issues were amplified because the lack of "consistency of outside staff agencies we work with… Clinicians constantly change, and the new one may not know anything about the case. Turnover in youth work is very high. The complexity of treatment of adolescents is high, as well, given the difficulty of adolescent development. When you add substance abuse to that, it is an array of challenges."

Finally, confidentiality laws increase complexities of treating youth. For example, one treatment provider stated, "Probation wants to know what the kids say, but they really can't know for therapeutic reasons and because of confidentiality. It's difficult because everyone wants to know what they say." Further complicating issues of confidentiality were "different standards of confidentiality between schools, the legal system, mental and physical health, and addiction programs." Residential programs also noted specific challenges when interfacing with the public school system. A provider of a residential program described: "A huge issue … or problem is complying with compulsory school attendance laws. Huge regulatory issues … standards of learning, No Child Left Behind, and special education issues. It's a nightmare. You can quote me on that one. Kids have to be in school 27 and ½ hours a week, and if the treatment programs were to comply with that, they [the youth] couldn't complete treatment."

Change Efforts—Adolescent treatment programs primarily used education and communication to increase community involvement and referrals from outside sources. Educational efforts were aimed at school officials, the criminal justice system, tribal leaders, community centers, and resources such as hospitals, churches, and clubs. Programs made efforts to promote general dialogue, demystify the substance abuse treatment process, and share ways of talking to adolescents that were consistent with motivational interviewing. In

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addition, some programs noted that they decided to conduct “assertive outreach,” which combined traditional community education approaches with active outreach strategies, such as “free screenings for substance abuse issues” and “free training and consultation” regarding adolescent addiction issues.

Web-based referral systems and simplification of paperwork also improved the referral process and communication links with community. One respondent reported that web-based referrals eliminated gaps in communication, saying, “We have started a website as a place where people can get information and participate in the program from their own home in a confidential manner.” Programs also noted that reducing the amount of paperwork and increasing access “engaged community partners in the referral process.” From this feedback one agency was able to streamline referrals, noting, “All we want is the youth’s contact information, the referrer’s contact information, and a one sentence reason for the referral. Youth can be referred through mail, fax, phone, or the secure website.”

Gender and Diversity Dynamics

Gender dynamics and issues related to diversity emerged as the third theme that impacts organizational change efforts in adolescent substance abuse treatment. Consistent with literature suggesting that counselor to client ethnic/racial matching plays a critical role in successful outcomes with youth (Waldron & Turner, 2008), directors and change leaders articulated concerted efforts to hire treatment staff that adequately mirror the demographics of the clients. Treatment programs also noted how geography influences interpersonal dynamics between ethnically and racially diverse clients. For example, a residential program reported frequent discussions with clients about differences between being an African-American male from a rural setting versus being a white youth from an urban environment.

Interestingly, and possibly due to ongoing treatment matching efforts, interviews also revealed a rather simplified view of the impact of ethnic/racial diversity on treatment. Participants frequently indicated that the clinic population was most often characterized by one or two predominant ethnic/racial categories, therefore concluding that ethnic/racial diversity was not a problem. To illustrate, one treatment program noted that the majority of their clients are Hispanic and then explained further that diversity was not a major factor in clinical services or process improvement efforts. Thus, study participants tended to de-emphasize the potential importance of varied clinical practices and organizational factors that may improve the quality of care for racially or ethnically diverse clientele.

Interview participants also discussed challenges related to blending criminal justice/publicly funded youth with privately funded individuals from other referral sources. In discussing how criminal justice clients differed from other populations, some treatment programs indicated that the criminal justice youth were actually be easier, rather than more difficult to deal with, and these adjudicated youth tended to drop out less frequently than voluntary clients. Program leaders attributed this seemingly counterintuitive trend to mandated clients acquiescing to the requirement of attending treatment and therefore engaging in the process. Participants reported that non-mandated, privately funded youth tended to demonstrate more resistance and often terminated services before completing treatment.

Challenges in responding to real and/or perceived differences in criminal justice and non-criminal justice youth were linked to dilemmas of differences in socio-economic status. Programs reported that socio-economic status factors create subcultures within treatment programs. One program stated that identity development means that programs must deal with everything from “country bumpkin meth heads to urban gang bangers,” and that these youth differ demographically and economically, requiring different responses and treatment. One study participant noted that parental bias extends the challenge of balancing services to

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different geographic and socio-economic profiles, stating, "Parents of the privately funded youth don't feel comfortable with the publicly funded criminal justice side of the divide." In addition, this respondent commented that the physical facility is not necessarily "luxurious," hence parents have to feel comfortable leaving their children in a place that is "not the Betty Ford Clinic."

Many of the participants were concerned with gender dynamics, including issues of male aggression and/or "posturing." Such posturing can affect female clients who have experienced sexual and physical abuse. Participants struggled with how to effectively approach such problems in mixed gender groups. Urban programs reported that combining males and females during group sessions often resulted in inhibited participation, primarily by the female members. One individual stated that, "98% of Level II youth tend to be males, and when we do get females into the program, they become uncomfortable with the aggressive male population." Programs reported that when some female participants experience a "therapeutic breakthrough," they tend toward more emotionally expressive behaviors, such as crying, which are often followed by male taunting or posturing. This type of interaction results in the female client withdrawing, which serves as an interruption to her experience and potential healing. A representative from another treatment program made the observation that mixed-gender group sessions can inadvertently initiate female youth re-experiencing sexual or physical trauma given the physical presence of a past male perpetrator. This scenario then removes any sense of "safety" in group treatment for the female client.

Change Efforts—Participating treatment programs indicated that they had taken measures to hire staff representative of their client population, including staff with the ability to effectively communicate with multilingual families. Programs reported sending staff to diversity trainings and other efforts aimed at education on ethnicity related topics. In a discussion addressing challenges with diversity, one respondent noted that, "We have mandatory trainings on diversity for all staff, encourage professional development in these areas, (and) actively recruit a staff that reflects the characteristics of the populations we serve to the extent possible."

Research examining ethnic matching between clients and counselors suggests that cultural specificities that affect substance use and recovery are best understood by a clinician with similar ethnically specific experiences and knowledge (Waldron & Turner, 2008). In fact, programs reported that they actively sought to address stereotypes about their clients, including their different socio-economic experiences, by supporting the alliance between youth and their families when this relationship was healthy and appropriate. Respondents also suggested that counselors must be prepared to address economic status, and gender and cultural issues as they surface in therapy and influence progress. Finally, each program that cited problems with male/female adolescent dynamics separates female from male populations for some or all of the treatment processes. Additionally, programs "offer(ed) individual counseling sessions for those adolescents who have difficulty adjusting or seem inappropriate for groups."

Discussion

This paper describes several unique challenges adolescent substance abuse treatment programs face and their attempts to address these issues with process improvement efforts. These obstacles and change efforts likely apply to many, if not most, adolescent treatment programs. Findings, therefore, can inform both informal and more structured (i.e., NIATx) individual and organizational initiatives for increasing quality of care for youth with substance use disorders.

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Family involvement serves as an ongoing struggle for treatment programs seeking to improve adolescent service. Barriers associated with engaging family members in adolescent treatment ranged from logistics (e.g., transportation) to complex psycho-social concerns such as family members with substance abuse and co-morbid disorders. These barriers need to be addressed, as research has shown that engaging the adolescent's family is often the key to long-term success (Nissen, 2006). One study in particular found that at four years post-treatment, those adolescents engaged in family therapy had significantly lower drug related arrests when compared to their counterparts who received only individual counseling (Henggeler, Borduin, Melton, Mann, Smith, et al, 1991). Process improvement efforts may be beneficial as providers work to improve family engagement and treatment outcomes for youth.

Results also demonstrate a marked concern about insufficient engagement from community organizations that refer adolescents to substance abuse treatment programs. A lack of initiative from teachers, parole officers, or case workers who could be talking with youth and their parents about substance abuse was cited as an ongoing problem for the programs that participated in this study. Further, adolescent substance abusers are less internally motivated to seek treatment as compared with adults and thus are more likely to enter treatment programs as a result of external influences such as schools or the legal system (Battjes, Gordon, O'Grady, Kinlock, & Carswell, 2003). Therefore, community members, families, and teachers play a critical role in referring youth to treatment. Once adolescents enter treatment, retaining support from these community organizations and educational institutions is essential. Outreach work by proactive treatment staff willing to provide education, assessments, and treatment outside the program facility produced satisfying results in alleviating referral and engagement concerns.

Surprisingly, respondents reported that gender diversity was a greater concern for treatment programs than providing adequate and culturally appropriate services for ethnically diverse clients. Gender dynamics complicated delivery of treatment services when overlapped with socio-economic and demographic dynamics such as gang-involvement. Male posturing and aggression toward females, as well as basic "love" dynamics, provided the impetus for programs to separate females from males for at least a select portion of treatment (often group sessions). The need for gender specific services creates infrastructure and staffing challenges that programs must address to ensure quality care. Most programs that engaged in some form of gender-separated treatment reported satisfaction with the effects on client outcomes.

This study found that parental bias toward publicly funded and criminal justice-involved adolescents provides barriers to successful integration of youth in treatment. Ameliorating parental concerns commonly occurred through straightforward and ongoing communication with the adults. This type of challenge in clinical services could be addressed with process improvement efforts aimed at educating parents about services, monitoring outcomes, offering split services for youth, emphasizing the importance of committing to treatment, and offering the best quality of services available.

Finally, respondents commented on their satisfaction with participation in NIATx and learning the associated approaches to organizational change. Individuals noted that engagement in structured process improvement enhanced their observational and management skills, which in turn allowed for better identification of organizational problems and solutions. The commentary and results presented in this paper illustrate the utility of applying process improvement and the skills it develops to future efforts toward increasing quality of care for adolescent substance abuse treatment.

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