

---

The Stacie Mathewson Foundation



Youth Recovery, Transformed

---

## **Title**

*Below please list the title of this resource.*

---

Adolescent Treatment: Its History and Current Renaissance

## **Author**

*Below please list the author(s) of this resource.*

---

William L. White, Michael Dennis, and Frank M. Tims

## **Citation**

*Below please cite this resource in APA style. For guidance on citation format, please visit <http://owl.english.purdue.edu/owl/resource/560/01/>*

---

White, W.L., Dennis, M., Tims, F.M. (2002). Adolescent treatment: Its history and current renaissance. *Counselor*, 3(2), 20-23. Retrieved from <http://imap.williamwhitepapers.com/pr/2002HistoryofAdolescentTreatment.pdf>

## **Summary**

*Below please provide a brief summary of this resource. If an abstract is available, feel free to copy and paste it here.*

---

It is anticipated that adolescent treatment in the coming decades will make major advances in such areas as early intervention strategies, clinical engagement and retention techniques, and the ability to match particular interventions to particular subpopulations of clients. Perhaps most significantly, we anticipate that the treatment of adolescent substance use disorders will shift (for those adolescents presenting patterns of high problem severity and complexity) from sequential, self-encapsulated episodes of acute care (assess, admit, treat, discharge) to a more time-sustained, community support model of recovery management. This will integrate existing clinical approaches within a deeper understanding of the social and cultural ecology of adolescent recovery. The treatment of adolescent substance use disorders is moving from the status of a folk art to that of a science-guided endeavor.

White, W., Dennis, M. and Tims, F. (2002) Adolescent treatment: Its history and current renaissance. *Counselor*, 3(2), 20-23.

## **Adolescent Treatment: Its History and Current Renaissance**

By William L. White, M.A., Michael Dennis, Ph.D., & Frank M. Tims, Ph.D.

The United States experienced a number of troubling drug trends during the past decade. Most prominent among these trends was a surge in youthful polydrug (cannabis, stimulant, hallucinogen, sedative) use, a rise in juvenile opiate addiction, and changing patterns of youthful binge drinking. The 1990s witnessed shifts in drug tastes and availability that brought old and new drugs onto the psychoactive drug menu: LSD, methamphetamine, "club drugs" (MDMA/"ecstasy", GHB, rohypnol), and dissociative anesthetics (PCP, ketamine). Respondents in the latest national school survey reported particularly high rates of binge drinking (consuming five or more drinks in a row in the past thirty days): 15% of 10th graders, 26 percent of 10th graders, and 31% of 12th graders ([www.MonitoringTheFuture.org](http://www.MonitoringTheFuture.org)). The most disturbing and historically significant of these trends was the lowered age of regular onset of alcohol and other drug use.

Shifting patterns of youthful drug consumption were evident in a number of data sources: alcohol- and drug-related deaths, emergency room admissions, arrest and incarceration rates and treatment admissions. Particularly important for the addiction counselor was the fact that, between 1994 and 1999, the number of persons aged 12 to 17 admitted to addiction treatment in the U.S. increased 20%. (SAMHSA, Treatment Episode Data Set Report). Today's addiction counselor is more likely to see adolescents within his or her caseload and see adults whose relationship with alcohol and other drugs began before or during early adolescence. The resurgence in adolescent illicit drug use and binge drinking has sparked renewed calls for evidence-based intervention programs for substance-involved youth and their families. This article reviews the history and future of such interventions.

### **Drunkard children (1780-1900)**

Children regularly consumed (diluted) alcohol in Colonial America, and youth in some Native American tribes experienced shaman-guided, drug-facilitated rights of passage into adulthood. What did not occur in the seventeenth and eighteenth centuries was widespread misuse of alcohol or other drugs by young people. As per capita alcohol consumption skyrocketed among all Americans

between 1780 and 1820, concern grew about youthful alcohol misuse, particularly among orphaned children. An emerging temperance movement responded by:

- lobbying for minimum drinking age and temperance education laws,
- publishing youth temperance literature,
- including young people in temperance society activities, and
- suppressing drinking on college campuses (Mosher, 1980).

Nineteenth century recovery-support societies sponsored “cadet” branches for young inebriates and launched “youth rescue” crusades. Many of the recovered alcoholics who led these efforts had themselves started their downfall as youth. One even became known on the temperance lecture circuit as the “saved drunkard boy” (Foltz, 1891). Young people were also included within America’s first addiction treatment institutions. Alcoholics between the ages of 15-20 constituted nearly ten percent of admissions to nineteenth century inebriate homes and inebriate asylums. By the 1890s, patients as young as 12 were being admitted for hospital detoxification even as adolescent alcohol use was dramatically declining (White, 1998). By the end of the 19th century, most American youth were protected from significant exposure to alcohol and other drugs, and youth in large numbers were enlisted in the movement to legally prohibit alcohol and other drugs.

### **Treating juvenile narcotic addiction (1910-1950)**

Two trends sparked interest in the treatment of drug- and alcohol-involved youth in the early 20th century. The first was the advent of opiate use among disaffiliated urban youth (Musto, 1974). This trend spurred rising juvenile arrests and the rejection in thousands of World War I draftees due to heroin addiction (Terry and Pellens, 1921). The second trend was the reversal of the decline of alcohol consumption among children and adolescents. Prohibition (1920-1933) produced a decrease in most alcohol-related problems through the mid-1920s, but generated an unintended interest in alcohol among young people. By the end of the 1920s, drinking and smoking had become symbols of youthful liberation and rebelliousness.

Efforts to treat adolescent addicts occurred in several settings. Juveniles were represented among the clientele of the morphine maintenance clinics that operated in the U.S. between 1919 and 1924. Of the more than 7,500 addicts registered at the Worth Street Clinic in New York City, 743 were under the age of 19 (Hubbard, 1920). New York City also established Riverside Hospital as a specialized facility for treating narcotic addiction, but it was closed after it was discovered that most addicts quickly relapsed following their release (Copeland,

1920).

By the mid-1920s, most juvenile addicts were “treated” in municipal correctional institutions, their incarceration a testament to the growing belief in the incurability of addiction. By the time two “narcotic hospitals” were opened in Lexington, Kentucky (1935) and Fort Worth, Texas (1938), the earlier epidemic of juvenile narcotic addiction had abated.

What occurred between 1900 and 1950 was first the inclusion of adolescents within new approaches to the treatment of narcotic addiction and then the collapse of nearly all such treatment. From the closing of Riverside Hospital to the channeling of most addicts to the two federal prison-hospitals, adolescent addicts entering treatment were viewed as miniature versions of adult addicts and were mainstreamed via the indiscriminate application of adult treatment methods.

### **Early community-based adolescent treatment (1950-1990)**

Following two decades of abeyance, juvenile narcotic addiction rose dramatically in the early 1950s, particularly within urban African-American and Puerto Rican neighborhoods. Admissions of persons under age 21 to the two U.S. Public Health Hospitals rose from 22 in 1947 to 440 in 1950. Juveniles were seeking help at local hospitals in many communities, particularly in New York City, where two city hospitals admitted 340 teenage narcotic users between January and October, 1951 (Conferences, 1953). The lack of community resources to help young addicts spurred the opening of addiction wards within some urban hospitals. Churches also became involved in youth addiction ministries during the 1950s, creating such programs as St. Mark’s Clinic in Chicago, the Addicts Rehabilitation Center in Manhattan, the Astoria Consultation Service in Queens, and Exodus House in East Harlem. These were followed by other religiously affiliated programs like Teen Challenge and the Samaritan Halfway House Society in the early 1960s (White, 1998).

Most of the treatment programs of the 1950s mixed juveniles with adults. The exception to this rule — the re-opening of Riverside Hospital in July 1952 as a treatment facility exclusively for juvenile addicts — marks the birth of specialized adolescent treatment. This 140-bed facility and its multidisciplinary staff offered detoxification; psychiatric and medical evaluations; psychological testing; individualized programs of therapeutic, educational, vocational and recreational activities; and outpatient follow-up via community clinics following three-to-six months of inpatient treatment. In spite of its “state-of-the-art” status, Riverside was closed in 1961 after a follow-up study of 247 former patients documented that 97 percent of the juveniles treated at Riverside returned to heroin use following their

discharge (Gonso and Mason, 1958).

Other mid-century events that influenced the future evolution of adolescent treatment included the development of “young peoples’ meetings” within Alcoholics Anonymous and Narcotics Anonymous, the development of modified therapeutic communities for adolescents, and the appearance of adolescent chemical dependency programs based on the “Minnesota Model.”

Through the 1960s, 70s and 80s, the treatment of adolescent substance use disorders continued to be provided primarily in adult substance use units using adult models. These programs were often developmentally inappropriate and were not adapted to adolescent patterns of substance use, particularly the high rates of co-occurring problems. Not surprisingly, treatment outcomes for adolescents revealed less success than those achieved by adults (Craddock, Bray, and Hubbard, 1985; Dennis, Dwaud-Noursi, Muck and McDermeit, in press; OAS, 1995; Sells and Simpson, 1979).

## **The Modern Era**

Starting slowly in the 1980s and early 1990s, several scattered groups of clinical programs, state funding agencies and addiction researchers started modifying treatment models to be more developmentally appropriate for adolescents by:

- using youth-oriented, multi-dimensional assessment instruments
- developing youth-focused family and group treatment modalities
- using younger and more educated staff
- dealing more flexibly with rule violations
- shifting from confrontation to motivation/engagement
- coordinating care with schools and the juvenile justice systems
- defining clinical subpopulations requiring special approaches of engagement and treatment (e.g., ethnic minorities, runaways, and adolescents with conduct disorder, ADHD, depression, HIV/AIDS and other co-occurring disorders)
- refining the use of pharmacological adjuncts in the treatment of co-morbid conditions.

The Center for Substance Abuse Treatment (CSAT) sought to spread these innovations through a series of widely distributed Treatment Improvement Protocols.

The rate of clinical and research advances in the field of adolescent treatment accelerated rapidly at the end of the 20th century. Of the 36 empirical studies of adolescent treatment published by the end of 2001, 22 were published after 1997. The total number of such studies will be more than double in the next few years. Table 1 projects the release of the major findings and treatment manuals, and other materials from the studies currently underway.

<b>Table 1. Timeline for Releasing Adolescent Study Results</b>	
Year	Study
2001	The National Institute on Drug Abuse (NIDA) started releasing the results of its Drug Abuse Treatment Outcome Study of Adolescents (DATOS-A) longitudinal study of 1,785 adolescents treated in outpatient, short-term residential and long-term residential treatment programs (Grella et al., 2001; Hser et al., 2001). DATOS-A is also the focus of a special issue of the <i>Journal of Adolescent Treatment Research</i> and has an online bibliography of findings at <a href="http://www.datos.org">www.datos.org</a>
2001	The Center for Substance Abuse Treatment (CSAT) started releasing the results of its Cannabis Youth Treatment (CYT) multi-site experiment of 600 adolescents from four sites randomly assigned to five types of outpatient treatment (Dennis, Titus et al., in press). CSAT has released the CYT treatment manuals through the National Clearinghouse on Alcohol and Drug Information (1-800-729-6686 or <a href="http://www.health.org">www.health.org</a> ) and CYT has an online bibliography of findings at <a href="http://www.chestnut.org/li/cyt">www.chestnut.org/li/cyt</a> .
2002	CSAT will start releasing the results of its 10 Adolescent Treatment Model (ATM; Stevens & Morral, in press) grants to manualize outpatient, short-term residential and therapeutic community programs and evaluate their effectiveness with over 1800 adolescents. The individual grantees will be responsible for distributing their own model. A list of current publications can be obtained from Randy Muck ( <a href="mailto:rmuch@samsha.gov">rmuch@samsha.gov</a> )
2002	CSAT will start releasing the results of its Persistent Effects of Treatment Study of Adolescents (PETSA) with 1200 adolescents from CYT outpatient programs and ATM residential programs followed up at 24, 30 and 42 months. Some of the early results will appear in a special issue of <i>Evaluation in Program Planning</i> due out in late 2002, and PETSA maintains an on-line bibliography at <a href="http://www.samhsa.gov/centers/csat/csat.html">www.samhsa.gov/centers/csat/csat.html</a> (then select PETS from program resources)
2002	The National Institute on Alcohol Abuse and Alcoholism (NIAAA) and

	CSAT have collaborated to fund over a dozen independent grants to develop and evaluate new approaches to adolescent treatment that are expected to start publishing their findings in 2002.
--	---

## **The Emerging Renaissance of Adolescent Treatment**

This emerging renaissance of adolescent treatment promises to continue for many years. In addition to the studies already in the field, there are several major initiatives just getting underway. CSAT is funding several five-year studies to develop and evaluate community-based efforts to create continuum of care models for adolescents that include linkage to schools and juvenile justice agencies. CSAT and NIDA are collaborating on studies of continuing care after adolescent residential treatment. The Robert Wood Johnson Foundation is funding a guide to adolescent treatment and several demonstrations linking treatment with the juvenile justice system. NIDA/NIAAA are also continuing to fund several individual grants related to individual aftercare. Within the next five years, we expect the development of several dozen, evidence. It is expected that elements of the infrastructure of such studies will also be increasingly mainstreamed, e.g., standardized assessment, competency-based training, treatment manuals, and model fidelity instruments/procedures, and rigorous clinical supervision.

In addition, it is anticipated that adolescent treatment in the coming decades will make major advances in such areas as early intervention strategies, clinical engagement and retention techniques, and the ability to match particular interventions to particular subpopulations of clients. Perhaps most significantly, we anticipate that the treatment of adolescent substance use disorders will shift (for those adolescents presenting patterns of high problem severity and complexity) from sequential, self-encapsulated episodes of acute care (assess, admit, treat, discharge) to a more time-sustained, community support model of recovery management. This will integrate existing clinical approaches within a deeper understanding of the social and cultural ecology of adolescent recovery. The treatment of adolescent substance use disorders is moving from the status of a folk art to that of a science-guided endeavor.

## **References**

- Conferences on Drug Addiction Among Adolescents.* (The New York Academy of Medicine) (1953). New York: The Blakiston Company.
- Copeland, S. (1920). The narcotic drug evil and the New York City Health Department. *American Medicine*, 15:17-23.

- Craddock, S. G., Bray, R. M., & Hubbard, R. L. (1985). *Drug use before and during drug abuse treatment: 1979-1981 TOPS admission cohorts* [DHHS Publication No. (ADM) 85-1387]. Rockville, MD: National Institute on Drug Abuse.
- Dennis, M. L., Dawud-Noursi, S., Muck, R., & McDermeit, M. (in press). The need for developing and evaluating adolescent treatment models. In S. J. Stevens, & A. R. Morral (Eds.), *Adolescent Substance Abuse Treatment in the United States: Exemplary Models from a National Evaluation Study*. Binghamton, NY: Haworth Press.
- Dennis, M. L., Titus, J. C., Diamond, G., Donaldson, J., Godley, S. H., Tims, F., Webb, C., Kaminer, Y., Babor, T., French, M., Godley, M. D., Hamilton, N., Liddle, H., & Scott, C. (in press). The Cannabis Youth Treatment (CYT) experiment: Rationale, study design, and analysis plans. *Addiction*.
- Gamso, R. and Mason, P. (1958). A hospital for adolescent drug addicts. *Psychiatric Quarterly, Supplement*, 32:99-109.
- Grella, C. E., Hser, Y. I., Joshi, V., & Rounds-Bryant, J. (2001). Drug treatment outcomes for adolescents with comorbid mental and substance use disorders. *Journal of Nervous and Mental Disease*, 189(6), 384-392.
- Foltz, A. Rev. (1891) *From Hell to Heaven and How I got There: Being the Life History of a Saved Bar Keeper, with Stirring Addresses on the Temperance Question*. Lincoln, Nebraska: The Hunter Printing House.
- Hser, Y. I., Grella, C. E., Hubbard, R. L., Hsieh, S., Fletcher, B. W., Brown, B. S., & Anglin, M. D. (2001). An evaluation of drug treatments for adolescents in 4 U.S. cities. *Archives of General Psychiatry*, 58, 689-695.
- Hubbard, S. (1920). The New York City Narcotic Clinic and different points of view on narcotic addiction. *Monthly Bulletin of the Department of Health of New York*, 10(2):33-47.
- Mosher, J. (1980). The history of youthful-drinking laws: Implications for current policy. In: Wechsler, H. *Minimum-Drinking Age Laws*. Lexington, Massachusetts: Lexington Books.
- Musto, D. (1973). *The American Disease: Origins of Narcotic Controls*. New Haven: Yale University Press.
- Office of Applied Studies. (1995). *Services Research Outcomes Study*. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from <http://www.samhsa.gov/oas/sros/sros8022-8033.htm>.
- Sells, S. B., & Simpson, D. D. (1979). Evaluation of treatment outcome for youths in the Drug Abuse Reporting Program (DARP): A follow-up study. In G. M. Beschner, & A. S. Friedman (Eds.), *Youth drug abuse: Problems, issues, and treatment* (pp. 571-628). Lexington, MA: DC Heath.

Stevens, S. J., & Morral, A. R. (Eds.) (in press). *Adolescent Substance Abuse Treatment in the United States: Exemplary Models from a National Evaluation Study*. Binghamton, NY: Haworth Press.

Terry, C. E. and Pellens, M. (1928). *The Opium Problem*, Montclair, New Jersey: Patterson Smith.

White, W. (1998). *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Bloomington, IL: Chestnut Health Systems.

**Acknowledgement:** This article was produced with support from the Persistent Effects of Treatment Study of Adolescents (CSAT contract # 270-97-7011). The opinions expressed here are those of the authors and do not reflect official positions of the government.

**William White, MA**, is a Senior Research Consultant at Chestnut Health Systems (CHS) and was the Cross-site Therapist Coordinator of CSAT's Cannabis Youth Treatment (CYT) Study. **Michael Dennis, PhD**, is a Senior Research Psychologist at CHS and was Principal Investigator (PI) of the CYT Coordinating Center. **Frank Tims, PhD**, is a senior researcher at Operation PAR and was PI of its CYT site.