Perspectives on Therapeutic Treatment from Adolescent Probationers

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Abstract—Little is known about youths' experiences in residential adolescent treatment programs. To better understand the experiences of youth in such programs, the authors conducted a longitudinal qualitative study of 10 juvenile probationers in an adolescent therapeutic community (TC) treatment setting. Seven boys and three girls were recruited into the study upon their entry into the TC. Ages ranged from 14 to 17 years old; six youths were Hispanic, three were White, and one was African American. Each participant completed between two and six audio-recorded interviews over the course of two years. We report on youth experiences in the TC as well as after discharge or drop out. Three issues were most salient in these interviews—the positive and negative influence of peers, youth appreciation of the family counseling component, and the need for improved methods to prevent running away from the program. Regarding running away, half of the youth in our sample who ran away regretted it, suggesting that with more focused intervention some of them might have been retained in the program.

Keywords—drop out, probation, residential drug treatment, retention, substance use, youth

The primary source of referrals to drug abuse treatment for adolescents in the United States is the criminal justice system. Admissions of adolescents to treatment have risen 65% in the past 10 years, due in large part to the juvenile court's growing reliance on the treatment system to provide rehabilitation services to youth (SAMHSA 2004). Nevertheless, few research studies have rigorously examined the effectiveness of programs implemented in juvenile justice or community settings (Williams & Chang 2000; Henggeler et al. 1997). One recent exception is a Morral, McCaffrey and Ridgeway (2004) study that found that youth entering the Phoenix Academy therapeutic community had superior drug use and psychological functioning outcomes at 12-month follow-up as compared to similar youth in alternative probation programs. However, this report provided no information about how or why the treatment was effective.

The few studies that have examined juvenile substance abuse treatments have shown that program effectiveness depends largely on length of stay (Hser et al. 2001; Jainchill et al. 2000). Recommended length of stay in long-term residential treatment programs is about one year, although for adolescents referred by the justice system, the required length of stay may vary depending on sentence. However, research indicates that among adolescents who enter residential treatment only a small percentage successfully complete the programs (Jainchill et al. 2000; Pompi 1994). One national evaluation found that 26% of adolescents dropped out of treatment within the first month, and only 15%
completed treatment (Pompi 1994). Although the reasons for treatment dropout are poorly understood, identification of the factors involved may be crucial to improving retention and by extension, treatment effectiveness.

One potential source of poor retention is the potentially damaging effects of congregate care. Concerns have been raised about the potential for “delinquency training” (Dishion, McCord & Poulin 1999). Residential treatment settings are a potential venue to study this issue. Unfortunately, little is known about how or what form delinquency training might take in congregate care settings.

Quantitative analyses can be used to address such issues, assuming the important or influential aspects of treatment have been well measured (e.g., Chan et al. 2004; Jaycox, Morral & Juvenen 2003; Orlando, Chan & Morral 2003). Alternatively, qualitative case studies of youths’ own perceptions of the treatment experience and its effective elements within the broader context of their lives offers a rich source of insight into influential aspects of the treatment setting (Currie 2003; Duroy, Schmidt & Perry 2003; Reisinger et al. 2003; Riehman et al. 2003).

Building on the treatment effectiveness findings presented above, this article describes the results of a qualitative case study conducted at Phoenix Academy simultaneously with a quantitative study (Morral, McCaffrey & Ridgeway 2004). Over the course of two years, the authors used repeated, semistructured, open-ended interviewing to elicit youths’ perceptions of their lives before, during and after treatment and the role they perceived this program played in their lives. Our interviews with juveniles in this residential treatment setting provided a unique picture of both the positive and negative aspects of treatment experiences for these youth.

BACKGROUND

Of the roughly 13,000 juveniles arrested in Los Angeles County yearly, some 2,000 are placed in residential community settings for rehabilitation services. These unlocked group placements include foster care and residential group homes such as Phoenix Academy of Lake View Terrace. During the term of the present study (2000 to 2002), Phoenix Academy was one of the principal placements providing long-term residential substance abuse treatment services for the Los Angeles Probation Department.

Phoenix Academy was established in 1987 by Phoenix House, a large nonprofit substance abuse treatment provider. The program model is a modified therapeutic community for adolescents that integrates an onsite public school into the treatment milieu (Morral et al. 2003; Jaycox, Marshall & Morral 2002). It is housed in a large, modern building on a 15-acre site that includes parking and recreational areas. In 2000, the facility could accommodate 150 youth, the majority of whom were juvenile justice placements.

Phoenix Academy has a traditional therapeutic community view of substance abuse as an outward manifestation of a broad set of personal and developmental problems. Therefore, therapeutic change is seen as requiring thoroughgoing changes in virtually all aspects of an adolescent’s life. This holistic view of substance abuse contrasts with other approaches to treatment, which focus more on physiological dependence, behavior, or on identification of cognitive or emotional problems caused by drug abuse.

According to the therapeutic community perspective, therapeutic change requires a commitment to help oneself and others. Opportunities to do so are provided through structured therapeutic experiences, such as encounter groups, family therapy sessions, and meetings with counselors, as well as through informal interactions with staff and other residents. The “self-help” philosophy is intended as a continuous part of the community experience, so even during activities that are not traditionally therapeutic (like school, the performance of house jobs, or recreational activities) residents are expected to be available to help each other recognize and redress behavioral, attitudinal, or other problems.

Each phase of program advancement provides the opportunity to earn additional privileges and promotion in the hierarchy of job functions to more responsible and attractive positions. Contingent privileges include more frequent communication with people outside of the therapeutic community, greater access to personal property (e.g., radios, jewelry), more free time, and enhancements of a resident’s status within the community (for instance, assignment to a more desirable room, invitation to lead seminars, and permission to take special trips). Behavior that deviates from accepted practices of the community is met with disciplinary consequences or “learning experiences.”

Juvenile offenders are placed in Phoenix Academy if they are referred by the Probation Department, are eligible, and there is an available bed. At intake, residents are introduced to the staff member in charge of their family group (consisting of 50 to 60 youth), assigned to a “clan” (consisting of 10 to 15 youth from the family group), a roommate, and a Big Brother or Sister (who is often also their roommate).

The treatment program at Phoenix Academy is divided into four phases. Orientation, which begins at entry, entails integration and exposure to the main components, rules, and philosophy of life in Phoenix Academy. Phase I is designed to stabilize residents within the community. Phase II, called “primary treatment,” is the period when residents are expected to be developing a new social identity as a person in recovery. Phase III, called “reentry,” focuses on preparing residents for return to their families and communities. As residents meet the treatment goals of each phase, they advance through the program, concluding with successful discharge, usually 12 to 15 months after orientation. Specific details on program characteristics are provided elsewhere (Morral et al. 2003; Jaycox, Marshall & Morral 2002).
**STUDY METHODS**

Ten adolescents (ages 14 to 17) were recruited shortly after their admission to Phoenix Academy in 2000. Participants were selected from sequential program admissions referred by the Los Angeles Department of Probation, with the aim of ensuring a racial/ethnic and gender distribution proportional to that of all Phoenix Academy residents. There was one refusal (a 13-year-old White male resident).

All participants were wards of the court, which provided informed consent for their participation. In addition, research participation was contingent upon youths providing voluntary, informed assent to participate in the study. Once this was secured, an initial tape-recorded interview was conducted by one of three interviewers within five days of program entry.

The interviews were conducted by two Ph.D. level sociologists and one doctoral student in sociology. Each interviewer had substantial training and experience in qualitative interviewing techniques using the grounded theory approach (Strauss & Corbin 1990). Further, training was provided on special issues related to interviewing youth and the specific background of the treatment setting. To facilitate frank conversations, interviewers and subjects were matched by sex. Interviews occurred in private one-on-one sessions at Phoenix Academy, juvenile hall, other probationary settings, and/or participants' homes. They typically lasted 45 minutes and were transcribed for analysis. Data presented in this report were drawn from 39 interviews with at least two from each participant.

The semistructured, open-end interview guide was developed by the authors of this article in consultation with operators of the treatment program. At the initial interview, participants were asked about their backgrounds, living arrangements, familial relationships, alcohol and drug use, peer behaviors, school and work experiences, social support, criminal activity and other issues related to pretreatment experiences. Participants were also asked why they were enrolled at the treatment facility and to provide a description of their early treatment experiences. At subsequent interviews during treatment, we attempted to assess treatment readiness, and asked about treatment experiences, impressions of specific treatment activities, social relations and support in treatment, issues related to leaving the program, and interactions with staff. In interviews conducted after treatment, we asked about the circumstances of their program discharges, current living conditions, self-assessment of program impact, future plans, and about their current drug use, work, and school circumstances.

Data reduction and analysis was accomplished using N5 (NUD*ISt) (QSR International, Melbourne, Australia). The initial coding scheme was developed by the first and second authors, who also read and coded the transcribed interviews. Supplemental codes were added as themes emerged. The codes for which results are reported here include family composition, family attributes, drug use, drug use in treatment, criminal activity, violence, running away, treatment readiness, treatment engagement/entry/experience, rules, staff, residents, school, clan, and encounter groups. All data presented were drawn from the interviews; neither case file reviews nor interviews with Phoenix Academy staff were used to supplement the interview data. Where possible, we include verbatim quotations from participants, with some editing for purposes of clarity. In order to protect the confidentiality of participants, after each quotation, we note the participant's sex (male or female) and treatment status (first month, mid [second month to discharge], and after treatment [after discharge]). Within the quotations, sections beginning with "I" indicate statements by the interviewer and "P" indicates statements by the participant.

**RESULTS**

We first describe the demographics of our participants. Then our findings are presented in relations to treatment stage—Pretreatment, Treatment, and Post-treatment. Within these categories, we present findings by theme, such as relations with staff or program component (e.g. encounter group).

The demographic characteristics of study subjects are as follows: seven boys and three girls; six Hispanics, three Whites, and one African American. Participants resided throughout Los Angeles County. The average length of stay in treatment for these participants was approximately 14 weeks, and the median was eight weeks (we approximate the time because participants did not always give exact the date of their discharge or self-termination). Table 1 shows the number of participants and interviews by months in treatment.

Table 2 shows the number of interviews that occurred at each stage of treatment and the number of participants from which these interviews were drawn.
TABLE 2
Number of Participants and Interviews by Treatment Status

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<th>Early Treatment (First Month)</th>
<th>Mid-Treatment (Second Month to Discharge)</th>
<th>After Treatment or Discharge</th>
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<td>5</td>
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<td>Interviews</td>
<td>20</td>
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Pretreatment Background

Family structure and prior living situation. Prior to their involvement with the criminal justice system none of the 10 participants lived with both biological parents, and only one normally resided in a two-parent household. Further, many had lived at home intermittently in recent years: four had spent time in foster care; five had been homeless for a period of time, either because they were kicked out of their homes or ran away from a previous placement. Familial drug use (either parent or sibling) was reported by half of the participants. One participant reported using drugs with a parent shortly before program entry.

Juvenile justice system involvement and previous criminal activity. Despite frequent drug use, only two participants were currently in the juvenile justice system due to drug use at the time of treatment entry. Half of the participants were in the system due to theft, burglary, or shoplifting and three were in for fighting or related offenses.

Although drug use was not the criminal offence for which most of these youths were in the juvenile justice system, their involvement started either while they were under the influence of drugs or for purposes of acquiring money to purchase drugs. Self-reported criminal activities among these youth ranged from shoplifting to auto theft and prostitution.

Participant (P): And then I’d do some [methamphetamine], like if I was just coming down or whatever, wake up the next night. Stay up all night . . . Be up for like three or four days. Going on missions. Like going on a mission with the crimey [crime], like going from each car, going to the cars getting what we could. (Female, early treatment)

Interviewer (I): So, how were you paying for these things [drugs]?

P: You know, stealing. The dealer tell you he wants, you know, something. You go out there. You get it. Bring it back. He’ll bring you some drugs, whatever, you know? (Male, early treatment)

Alcohol and other drug use. Varying levels and kinds of substance use were reported. All participants reported some alcohol use. With one exception, all participants reported daily or near daily marijuana use. Methamphetamine or speed use was reported by three youth. Two others reported regular crack cocaine use, and one reported infrequent heroin use. Among the four youth who reported either methamphetamine or heroin use, half reported drug injection. All of the residents described drug use as a routine part of their lives before treatment entry. Six of the ten felt they were addicted to drugs. Among participants who considered themselves addicted, both mental and physical addiction were reported.

P: Yeah, but I was doing crack a lot. I was addicted to that. I was all messed up and I didn’t like it, because I was all paranoid, so I didn’t really like that. I was all really skinny and I don’t know. It was just messing me up. I was like, “Man, I got to stop doing this.” . . . I always wanted some. (Male, early treatment)

I: Do you feel like you’re addicted to drugs?

P: Physical addiction? No. Mental addiction? Yeah, in a way, because throughout my life it’s been my only way of coping with reality. Coping with situations that make me feel upset or depressed. (Male, early treatment)

A marijuana user, in contrast, described his use as a means of forestalling withdrawal symptoms.

I: So you have physical cravings to smoke marijuana?

P: Yeah, like my body would crave it. I’ve been getting headaches, body aches. My stomach will start turning. And as soon as I start smoking again all that will start going away. I’ll start feeling like normal. (Male, early treatment)

Among those who did not consider themselves addicted, we found evidence of rationalization, denial, and minimization of drug use.

P: I don’t think I need help because like they say this placement’s for drug rehab because you got a drug problem. But it’s not something serious like a lot of minors in here. I just didn’t want to stop smoking weed, and I say I ain’t got a problem with smoking weed. I know I could stop. (Male, early treatment)

Whether participants perceived themselves to be addicted or not, all participants reported that it was difficult to avoid drug use when not in jail or a substance abuse placement.
Treatment readiness. Given their diverse backgrounds and criminal offense records, it is not surprising that participants' treatment intentions varied. Several residents hoped to use the program to become drug-free. Indeed, some specifically requested placement at Phoenix Academy to address their substance abuse problems.

I: So what do you hope to get out of your time here?
P: I’d like to stop doing drugs. That’s one good reason because I’ve seen what the effect do and what they could lead to. So I plan on stop doing drugs in here. (Male, early treatment)

I: What are your expectations regarding starting to use drugs again?
P: I don’t ever want to see a drug in life. And I look down on everybody now that does drugs. I mean not marijuana. I’ll still smoke weed; weed is weed. (Female, early treatment)

Other participants appear to have little interest in succeeding in the program.

I: How long do you think you’re going to end up staying here? Do you think you’re going to run before that amount of time?
P: I don’t know, because I need some shoes. That’s what I need if I’m going to run.

I: If you had some shoes right now, would you run?
P: Yeah, I’d be out and get caught, and go back to jail and just stay there. Go to court, and then go get sentenced to camp. That’s what my PO, that’s what my judge said. If you mess up in placement, then you’ll go to camp. So that’s what I want is to go to camp. (Male, early treatment)

Tensions like these between Big Brother/Sisters and Little Brothers/Sisters are similar to tensions described among residents in the program in general. As with all therapeutic communities, much of the enforcement of community rules is the responsibility of residents. Many behaviors may be seen as transgressions. Such views of a resident’s behaviors can lead others to provide a written report of a resident’s misbehavior, which in turn, can lead to punishment. Similarly, privileges are awarded, in part, based on observations of other residents, which requires residents to understand a rule system where both punishment and rewards are meted out by peers or because of peers’ behavior.

Family/clan and general resident interactions. Family/clan membership is a central feature of the treatment program experience. It is through these relationships that support and caring are provided to residents. Comments from participants indicated that, in general, many felt supported by their family/clan and/or other residents.

I: So what do you think about the place so far?
P: It’s pretty good. I thought it was going to be different. I thought that when I got here everybody was going to be hitting me with, where are you from? And all that. But now everybody came up to me, Hey, what’s your name. They’re all friendly. I was surprised. It’s a good place. … It’s like everybody treats each other with respect. (Male, early treatment)

P: I was like raising my hand like saying stuff and everything because usually I’ll just be quiet even though I have the answer in my head and I know the answer or whatever I won’t say it for fear that I might be wrong. And kids might laugh or something. But I really didn’t care yesterday.

I: What made you not care? Did you feel like the atmosphere was a little more accepting, that the kids were more accepting or?
P: Yeah, it was my family, that’s why. (Female, early treatment)
An important aspect of the therapeutic community is routine reinforcement of positive behavior and punishment of negative behavior. A primary means of delivering positive and negative feedback is the family gatherings. Family gatherings occur twice daily. One resident described the meetings this way:

P: It’s a family gathering. They tell you the weather and they have these things called pull-ups that you roll up in front of the family and you call someone up and you tell them what they’re doing wrong or what they’re doing good. . . . And then they get strokes. They call you up, stand up, and tell them what they’re doing right. (Male, early treatment)

Another mechanism for feedback is through the clan or family group accountability. One participant reported on the consequences of being part of a clan that was not doing well.

P: Well, we could improve, you know, but it’s not like—it’s just not like—probably about five people that mess it up for the whole group, you know? They don’t stop talking and all that. You know, we have to be telling them “be quiet” you know? Be quiet. Some quiet and all that. And it gets everybody frustrating and all, you know. I don’t know . . . We were about to have some free time and everything, and they send us to our room, you know? (Male, early treatment)

Because peers provide supervision as well as support, problems can arise when residents feel that their peers are unfairly exercising authority over them.

I: Talk more about what you do not like about being here.

P: I don’t know, because they were making me clean around and there was this other minor [another resident] who was always behind me looking at me like, “You missed a spot right there.” . . . There was all these minors bossing me around. (Male, early treatment)

Encounter groups. Encounter groups at Phoenix Academy, formed within clans or other group situations (such as girls within a family), are gatherings in which youths can confront each other about misbehavior, ongoing personality conflicts, and performance in the program. Study participants reported valuing the opportunity to confront others over personal slights, attempts to remain sober, and other issues related to successfully completing the program.

P: In our group they talk about how they’ve been doing lately or how they felt about trying to take drugs again or how to stop trying to take drugs. And just clan issues where you could put people down because they say the floor is open for people, and that’s when you could curse at people and let them know how you feel about the person and what’s really the problem with what they’re doing. (Male, early treatment)

I: What are some things about Phoenix Academy that you’ve liked?

P: Being more free to speak about emotions and feeling with cussing and stuff in encounter groups was stuff we couldn’t do in the halls [Juvenile Hall] without getting sprayed [punished]. Being able to pour out emotions whenever and somebody actually come and hold you and be really serious about it, talk to you. (Female, early treatment)

During these sessions, the person being criticized cannot speak. After group members have had their say, the subject of the criticism has five minutes to respond to comments and hear additional feedback on the issue from other group members. Occasionally, youths found encounter group criticism to be excessive or unfair.

I: Did you think the encounter groups are helpful?

P: Yeah sometimes. But sometimes people overdo it and they start talking. And all you’re doing is putting the person down instead of bringing them up. (Female, early treatment)

I: How did it feel the first time you were confronted?

P: Man, I just felt like I was just blamed for everything that was going on around the house. I was like damn, everybody’s going to get on me now. (Male, after treatment)

Staff relations and program rules. As a therapeutic community, Phoenix Academy places emphasis on peer-to-peer relationships. However, staff also contribute significantly to the program. Participants regarded the staff as crucial authority figures, caring adults, and the principal enforcers of program rules. An important source of connection for several study participants was that many staff members had experiences with drugs that were comparable to that of the residents.

I: Do you think the staff care about you?

P: Yeah. I think because half of them, or more than half of them are recovering addicts. So yeah, they care because . . . we’re the future of the world. (Female, early treatment)

Chafing against program rules is a theme that has already emerged in earlier passages. A common concern among participants was their perception that some rules were enforced inequitably by staff. One rule that raised particular objections concerned restricted socializing among residents.
As voiced by one resident:

P: I've seen a lot of kids having problems with just going in other people's room and talking you know, because they feel like talking because their roommate ain't there or something. And they just write a note to a friend's room and they start talking and they get in trouble for that. I seen that every day. That's one of the major problems in here. (Male, early treatment)

**Provisions for education.** Phoenix Academy houses a high school (eighth to twelfth grade) run by the Los Angeles County Office of Education Court School Program. In this school, certified teachers, tutors, and volunteers teach core subjects and electives (e.g., art, dance), enabling residents to earn credits towards a high school diploma. In general, participants reported benefiting from the opportunity to continue their education, although many thought the work should be more demanding. Comments such as the following were echoed by several residents:

I: How did you like going to school there?
P: The teachers, they really help you. They start you at your own pace, wherever you need to go. And then little by little they take you at your step.

I: Do you feel like you learned anything when you were there in school?
P: I'm the type of person that I'll always try to get something out of wherever I'm at. So yeah, I did. I think I caught up on my algebra. (Female, after treatment)

**Family counseling.** Several participants reported benefiting from the family counseling that is provided by Phoenix Academy. In some cases, participants described these sessions as providing them new opportunities to communicate with their parent(s).

P: She [therapist] was real good in the advice she gave to my (inaudible) and my mom. My little sister would be there too... So she [the therapist] got along with my little sister. I don't know how, but she really got along with my little sister good. So that was something good about my therapist that I liked... It brought a lot of connection back to me and my family. (Male, after treatment)

P: I had another counselor. My mom would go on certain days and I would have a meeting with my mom and my counselor, and we would talk and just little by little get to the root of whatever it was. Like talk about any problems and conflicts that we had between us. That helped a lot because before that I never used to talk to her like that. I never opened up to my mom. So that was like the first time I ever actually spoke to my mom. (Female, after treatment)

**Program phases.** Our interviews elicited few comments about the program structure as few participants remained in the program past Phase I. The following comment sums up the opinions expressed by those who did progress past Phase I.

P: ... when you're in orientation you can't do anything. You can't even go out of the house, you can't even go on pass. You could just have your picnic while you're there, and that's about it... When you hit the second phase you get to go out of the house and go to NA [Narcotics Anonymous] classes. Or you can say you're going somewhere else, to the library or to the museum or something. That's what we used to do a lot. When I hit my second phase I was going to NA like twice a week: Tuesday through Thursday. (Male, after treatment)

**Drug use at Phoenix Academy.** Despite being an unlocked facility with substantial movement of residents in and out of the facility (residents go on field trips and receive weekend passes), few participants engaged in or ever heard of episodes of substance use (including cigarettes and alcohol) in the facility. Some participants expressed the belief that drug use was rare, and likely to be reported or detected if it occurred. However, one participant suggested that drug use was widespread.

I: Were you offered drugs when you were there?
P: Yeah.
I: What kind?
P: Cocaine and meth.
I: Did a lot of kids...?
P: Yeah, most of them. No, there were only a couple that had them, but most of them were doing them. (Female, after treatment)

**Sexual activity at Phoenix Academy.** Few of our participants reported sexual activity within the program. Although only two participants reported having sex while in the facility, at least one participant suggested that although he had not had sexual relations while in the facility, he believed sexual behavior was widespread among other residents.

I: Did kids have sex while they were in the program?
P: Yeah. Like with their boyfriends. They used to go in the laundry and do little things. Any chance they had they would do it.
I: Do you think that was the norm there?
P: Not that norm, but here and there. (Female, after treatment)

However, as with perceptions of drug use in the facility, perceptions of sexual behavior varied.

**Running away.** For reasons that ranged from being discharged by the court to running away, none of our
participants completed the entire program. Within the first three months, half of the study participants had dropped out. By nine months, all but two had left the facility. Throughout the interviews, residents described episodes in which either they or other youths ran away from the program. Among study participants, two ran away and returned only to run away eventually for good (a total of seven ran away at some point).

Participants cited various reasons for contemplating running away or actually running away. Some of these reasons were related to program issues, including length of stay, program rules, availability of services, and treatment approach. Personal factors were also cited as reasons for leaving, including being away from home, preferring another placement, stress, depression, and negative peer reinforcement.

P: I just figured that place really wouldn't help me. I don't know. I mean you couldn't go home within like six months. And its like, they didn't give you opportunity to go to NA [Narcotics Anonymous] meetings, AA [Alcohol Anonymous] meetings or anything, for a while . . . I think that if you're able to be there you should be able to talk to one another like human beings, not like trash. And that's one of the reasons I left. (Male, after treatment)

P: . . . And I was on top of the house with other residents that were doing good. A lot of staff really liked me and got along with me. They were cool. But when that happened everything shut down. Everybody's like, "Well, [name] got high. He's out of here." . . . So they tried to get rid of me . . . I guess I was there for over a year. Almost over a year. I guess when you do that and you mess up, they just get rid of you quick. (Male, after treatment)

Other residents cited issues such as missing family and friends or not being able to contact family members as requested. As one resident comments:

P: It's just not a happy environment for me at that time. And I wanted to call my mom, and they said, "Tomorrow you can call your mom." But I knew in my mind that I want to AWOL. I wanted to call my mom and hopefully she would talk me out of it. But they didn't let me call my mom. So I was like, see ya. And then I was talking to someone (another youth) and just opened the door and the alarm went off and someone said, "If you're going to leave you might as well—you should run." (Female, early treatment)

Residents who ran away repeatedly talked about being encouraged to leave by other disgruntled residents. The resident above may not have left were it not for a similarly unhappy resident who was also willing to leave. Quotes like the one below were common among residents who AWOLed.

P: I just told like a person that I was talking to that I was just going to leave and he's like, "I'll go with you." And I was all right. And then he told somebody and then he said, "I'll go too." . . . Like I was thinking of AWOLing, kind of joking around. Like, this place sucks. I don't like this place. I'm going to AWOL and then somebody that I was talking to is like, "You really want to? I'll go with you." And I was like, "All right." And I just left. (Male, early treatment)

Another factor that was critical in the decision to leave the program was, simply, opportunity. Phoenix Academy has attempted to create an intentional community, where residents want to stay to work on their issues. Since it is an unlocked facility located near public transportation, returning home or to a resident's neighborhood is much easier than in more rural or locked facilities.

Efforts to dissuade residents who are running away or thinking of running away are fairly common, though the efforts described were made by other residents, not by staff. For example:

P: And so I started running. And then like about six, seven students came running after me and they like tackled me and kind of blocked me. "You ain't going nowhere. Don't do it. Think about it." And I talked to a girl named [female name] and she told me, "don't worry baby girl, don't trip, all of us went through this. You all want to leave at a certain time. You hate it here kind of at first because it's not normal. You've got to think of this place as your home. Write down and make a list of things you'll need to be more comfortable." (Female, early treatment)

After Treatment

Among our ten participants, seven ran away from the facility (all returned but two ran away again), two were discharged by Phoenix Academy prior to completing the program, and one was lost to follow-up. We were able to interview five of our participants at some point following treatment (two females and three males). Of these, one male and one female reported continued drug use (marijuana and methamphetamine respectively). The other three participants reported no drug use. In terms of living arrangements, two participants (both female) were living at home with a parent, one of the males was living with a relative, another was in foster care, and the last was living with friends on his own. In these interviews that occurred after leaving Phoenix Academy, observations were offered that suggested emotional and social growth by some, and recognition by others that they are responsible for their own behavior.
I: Are you glad you left the program?

P: Well, in a way I was, kind of. Not in the way I left it. I was AWOL'ing. I wish I just left by graduating. But I don’t know, when I left it was like there’s nothing they could do or I could do now. When I thought about it, they did help me a lot in the 10 months I was there. But I thought that I was going to be on my own now. I’m going to be 18 so it’s going to be my time to do what I’ve got to do. So that’s what basically happened. . . . I’d say, the stuff I’d done from before, I changed that. Like going out and missing around. Basically when I used to go out before it was just to go out and do what I want. Get into fights and get faded and get high and just whatever. And now, I don’t see it like that. I don’t even go out. I barely go out with my homies, if we go to a party or something, or if I go out with my girlfriend or something. But I don’t go out and just get drunk and get high and do the same thing as before. That’s the change I’ve seen. (Male, after treatment)

I: So do you think that things are better for you now than about the time you were in Phoenix House?

P: Kind of, but like really just myself. My drug habit is worse when I got out, but I don’t think it’s because of Phoenix House though. . . . It’s [Phoenix Academy] a good place if you make it a good place. You know what I mean? You could get help if you really want to get help. I don’t think at the time I was willing to get the help I needed. I hadn’t accepted yet that I had a drug problem. (Female, after treatment)

DISCUSSION

Therapeutic drug treatment programs are attempting a monumental task: to transform the behaviors of high-risk youth with little familial and community support, within the context of a juvenile justice system that has recently been acknowledged to be failing (CASA 2004; Warren 2004). Understanding youth experiences in court-referred drug treatment programs is complicated by a wide range of factors: youth characteristics, drug treatment program philosophy and operations, correctional official involvement, and the courts. Thus, the experiences of youth within the program are impacted by a wide variety of forces beyond the influence of the drug treatment program or the youth themselves.

Three issues emerged as important for potential program effectiveness and retention from these interviews: the dual nature of peer influences, the importance of family and family counseling, and the need for more systematic responses to running away.

First, the program’s reliance on peer influences results in nearly every program component providing both obstacles and opportunities for behavior change. This issue was perhaps best typified in reactions to the early treatment period, where we obtained most of our interviews. The therapeutic community as described by these youth and based on our own limited observations is a highly structured, highly monitored care setting that relies upon peer influence and enforcement — under the direction of staff — to assist youth in developing personal self-control, maturity, and sobriety. These goals are ambitious and challenging for youth who for the most part are entering the community from family and living circumstances that are characterized by disorder in the form of neighborhood, sibling, and/or parental drug use, homelessness, assignment to the foster care system, and in general, less than ideal parental supervision. In addition, the emphasis in the therapeutic community on personal responsibility and peer accountability are also diametrically opposed to how the youth were previously living. Youth consistently reported confusion regarding rules and distrust of peers and to a lesser extent staff. However, this confusion creates an opportunity for youth to build new relationships and new behaviors as they seek information on (and role models for) how to get along in the program from Big Brothers/Sisters, Clan members, and staff. In some cases, these opportunities appeared to influence youth meaningfully, providing them with a rare experience of caring and concern from others. As indicated by several youths, the program provided an opportunity to share their feelings with their peers and receive support, often cited as contributing to positive program experiences very early in treatment.

However, peers also reinforced negative responses. It is noteworthy, for instance, that youth tended to run away from the facility with at least one other resident. This observation likely reflects both rational planning (it is safer) as well as the capacity of youth to reinforce impulsive, negative behaviors during pivotal crisis moments. While negative peer influence contributed to running away, peers also exerted positive influence in these circumstances by intervening to convince or attempt to convince youth in the process of running away to remain in the program. Although the therapeutic community recognizes and capitalizes on the positive aspects of peer influence in its model, it is possible that greater recognition and attention should be paid to the effects of negative peer influence on program retention.

A variety of psychological and sociological theories and empirical studies have shown significant negative impacts of peer influences on youth for at least 30 years. Ideally, the overall structure and organization of the therapeutic community aims to diminish potential negative peer influences while supporting positive ones. However, these structural elements of the program will have had little time to take hold during the early period in treatment when residents are most apt to run away. Consideration of techniques available to more rapidly integrate new residents into positive aspects of peer influences might be useful for reducing running away during the early treatment period.
A second noteworthy finding relates to the importance placed on the resident’s family and the universal endorsement of the family counseling component within this therapeutic community. As with peer influence, youths’ families provide both positive and negative influences on their behavior. Many youth reported having or wanting closer relationships with at least one of their parents (usually their mothers), and expressed guilt that their behavior affected their relationships with their families. Our interviews indicated that family counseling was valuable to all of the participants who remained in treatment long enough to participate in it, providing the youth with a rare opportunity to communicate with their parent(s) and to develop a new understanding of that relationship. The after treatment interviews suggested that the improved parental communications continued even after youth left the treatment setting. However, the importance of family also made it very difficult for some youths to remain in the program. Several youths reported missing their families even in the very early stages of the program, and one youth reported running away because she missed her family and desired to be with her mother during the holidays. Thus, enhancing family contact during treatment might substantially impact youth retention and completion of the program.

Lastly, among our 10 participants, running away from the program was common. Although several youth were readmitted or returned on their own, identifying youth who are at high risk of running away and providing a more consistent response to running away appears warranted. While acknowledging that some youth will run away regardless of program policies and procedures, we believe that it might be possible to forestall others, particularly youth who had been progressing successfully in the program for a substantial amount of time, but who then engage in some prohibited behavior as well as those who are in despair over the length of their required stay. Our interviews suggest that more aggressive outreach to youth who have done well in general or who are returning for court dates might result in greater retention. In after treatment interviews, several youths reported wishing they had stayed in the program, noting the positive impact that the program had on their individual development.

These findings should be considered in light of the following limitations. First, interviews were conducted with only a small number of youth in the facility; the experiences of these youth may not be representative of those youth attending this drug treatment program or others. Second, data were based entirely upon self-reports and thus subject to socially desirable response bias. However, the possibility of such bias is lessened because the interviewers were trained and experienced in working with youth. Further, an advantage of conducting multiple interviews with youths is that with each interview, the youths appeared to become more comfortable and forthcoming. For instance, one youth reported in the initial interview having used only marijuana, but at the next interview also reported having injected heroin. This increase in sharing might also be attributed to the program itself, which encourages youths to be truthful. Lastly, we relied on our interviews and did not use other methods to observe youths or capture staff opinions and experiences with the program. Such an effort was beyond the scope of this project.

Nonetheless, we have identified several issues that should be addressed, programmatically and in future research. The increasing role of substance abuse treatment in general and of therapeutic communities specifically in addressing juvenile offenders appears promising and has much to recommend it. Advantages include better long-term outcomes than incarceration alone and additional ancillary outcomes such as improved family relations. Clearly, more research into ways to improve retention in therapeutic communities is required, including other qualitative and ethnographic studies that integrate both self-report and observational data on youth, families, and program staff. Based on our findings, we would suggest beginning with interventions that monitor and enhance engagement of new entrants into program philosophy, operations, goals, and likely outcomes. These findings further suggest that earlier involvement of family members in the process might increase the likelihood that youth will remain in residential programs long enough to benefit from the many positive characteristics our participants identified.

REFERENCES


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