Teen Addiction Anonymous Logic Model
MPOWRD Program

Prepared For:

Teen Addiction Anonymous

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Teen Addiction Anonymous MPOWRD Program

Logic Model

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Introduction

Teen Addiction Anonymous (MPOWRD) is a non-profit organization that has created a program for adolescent empowerment called MPOWRD. MPOWRD is a youth-centered program that promotes leadership and prevention skills in adolescents struggling with addictive behaviors. MPOWRD has developed a curriculum for certified facilitators to utilize at sites with adolescents, such as: schools, juvenile corrections and youth outreach facilities.

The MPOWRD curriculum defines addictive behaviors as "any habit that is causing personal harm." Behaviors such as, but not limited to: eating disorders, codependency, anger issues, self-mutilation, gambling, sex addictions, racism, smoking, drugs, and chemical abuse are included in the scope of addictive behaviors. TEEN AA, as the parent organization, provides training and certification in the MPOWRD curriculum to qualified adult facilitators. Certified facilitators then recruit/refer students to MPOWRD groups on site locations which have been licensed as safe and professional environments by Teen AA. A structured, developmental and interactive curriculum is provided for each meeting. The adult facilitators model group facilitation and support student participants to serve as group leaders to further facilitate meetings within the program development.

Adult facilitators may also collect data on the program within the attendance and general demographics of participants at meetings. This is performed on a voluntary basis which they upload to the MPOWRD's data portal. MPOWRD uses this data for program monitoring and other evaluation activities. The curriculum, certification of facilitators, site-based adolescent-led support groups, and program monitoring via the data portal are the strategic components of MPOWRD.

MPOWRD is designed to educate and empower adolescents to reduce/eliminate addictive behaviors. This goal is accomplished directly by: 1) raising adolescent knowledge and awareness regarding human empowerment to address addictive behaviors and other life challenges, 2) introducing Teen AA's 12 edited steps, based on the content of the original 12 Steps as a set of tools to manage addictive behaviors, 3) providing a formal curriculum to support age-appropriate engagement and processing, and 4) utilizing a structured meeting format to promote leadership, peer support and personal accountability for any challenging or self-destructive behaviors.

The program's CEO, Susan Rothery, served as an educator and crisis school counselor for over thirty years, working with teens and their families as they faced the challenges of addictive behavior. MPOWRD, a program originated by students in 2003 was developed and researched over a five year investigate study. This collaboration between a heterogeneous student population and the program CEO created a unique and authentic grounding of the program theory in the lived experiences of the adolescents.

As these teens collaborated and developed the program under the guidance of their TEEN AA co- founder, the CEO reported that the students found many aspects of 12-step programs inspiring, but reported that the lack of peers in 12 Step meetings a deterrent to engagement. In addition, they requested more structure and a plan of action within their meetings as a

methodology in terms of moving forward in a healthy direction. Teens also became highly engaged with the opportunity to lead/facilitate meetings within their peer groups. As an educator, Ms. Rothery valued a written curriculum that could be adaptable to all cultural, economic and social communities. The teens named the first version of the program Teen Addiction Anonymous. Eventually, the leadership and positive growth of teen participants inspired the name MPOWRD, a leadership and prevention opportunity for youth.

The MPOWRD curriculum incorporates certain elements of 12 Step Programs and deviates significantly from others. Critical differences include the following: 1) no one is labeled or self-labels as an addict/alcoholic; 2) the motivation to join is to help oneself and/or to help others; 3) the specific nature of the addictive behavior is never disclosed or discussed, simply identified as an unhealthy choice; 4) the curriculum extends beyond 12 Step Programs in that it includes raising knowledge and awareness on a range of mental health and addictive behaviors.

MPOWRD is not an adaptation nor a version of AA as it exists today in the community. TEEN AA's 12 steps are edited and simplified from the copyrighted 12 step program. AA owns the copyrighted steps but according to documented correspondence, AA has no objections to TEEN AA's 12 steps as used within the context of the program. The curriculum is facilitated in a support group format and retains an 'open' model similar to a 12 step program in that any adolescent who thinks they have a problem is welcome to attend. Similarly, there is no minimum or maximum number of meetings required. The program has a semi-structured format, progressive questioning techniques, readings, self-assessments, content on coping skills and recovery strategies for teens. At the beginning of each meeting, in lieu of stating, "Hi, I'm [name] and I'm an alcoholic or drug addict," each teen states, "Hi, I'm (name) and I'm here to work on my addictive behavior. A positive thing that I did this week was..."

In comparison to other adolescent treatments for drug and alcohol addiction, specifically group therapy, MPOWRD does not engage a licensed therapist or counselor. Although the adult certified facilitators may have advanced education in school psychology, training in counseling is not a requirement for certification. Rather, groups are facilitated by teens with the support of adult facilitators. MPOWRD does not require a fixed number of meetings (dosage) although the curriculum is designed as a full academic year (32) week intervention. MPOWRD has not consciously incorporated evidence-informed practices such as Motivational Enhancement Therapy (MET) or Cognitive Behavioral Therapy (CBT) into its curriculum or activities. Rather, MPOWRD utilizes its curriculum to support a semi-structured, facilitated, context specific, peer-based self-help group with educational components. MPOWRD provides adolescents with education regarding addictive behavior, mental health issues such as depression and anxiety, and introduces their edited 12 steps as a mechanism to manage addictive behaviors. The program is always delivered through facilitated peer support in a setting where adolescents are already engaged for another purpose such as attendance in a school, participation in a community youth center, or assignment through a juvenile detention center.

MPOWRD uses a structured curriculum and is implemented in a tightly controlled setting. Both the physical and emotional safety of the adolescents engaged is enforced. The setting is also physically and emotionally distinct from the home (family and parents). Parents are not permitted to participate in teen MPOWRD meetings to protect the confidentiality of these

students. The specialized setting fosters opportunities for self-expression and peer support. The curriculum is structured to better match the developmental level of the participants. MPOWRD utilizes a facilitator handbook that includes directions to the facilitators for teen engagement, scripts, worksheets, self-assessments, and details the step-by-step protocol for each meeting. Confidentiality and basic rules of discussion and group interaction are reinforced at every meeting with a script. The curriculum is divided into stages and topics.

Early stages and topics raise awareness and introduce the concepts of empowerment and addictive behaviors; the next set of meetings introduces recovery steps based on their 12 Step program. The latter stages support participants to practice the principles outside of meetings: at school, in their families, in relationships, and at work. The handbook concludes with a module designed to promote outreach comparable to AA's 12th step by creating outreach and concern to the communities that surround them. There is a sequential model on "Life Challenges" which is designed to help participants practice on integrating the12 step principles within other areas of their life, such as: dealing with anger management, building self-confidence, identifying abusive situations and stages of grief. Since there is no specific transition module to assist participants to continue to attend MPOWRD meetings after high school, unless utilized within assigned facilities, teens are encouraged to investigate young adult support groups within their communities which follow the same principles of positive healing and unconditional support. Teen Addiction Anonymous is currently extending curriculum into middle schools called "2B MPOWRD", an age-appropriate introductory curriculum to MPOWRD, and has developed a program called M-squared (M^2) which is designed as both a stand-alone and transitional support program for young college-aged students.

The MPOWRD curriculum consists of six modules: 1) Empowerment, 2) Redefining Addictive Behavior, 3) 12 Steps of MPOWRD, 4) Recovery, 5) Life Challenges, and 6) Outreach. The curriculum is designed to be completed in an academic calendar year. The twelve steps are introduced in depth at module 3 and each step is covered week-to-week until all steps have been worked. Following the 12 steps, modules on recovery and how to address life challenges with 12 step tools are introduced. The last module is designed to transition participants from a site-based program to using Teen AA's 12 steps as part of a life skills strategy Teens are able to experience the empowerment gained by acknowledging the importance of healthy decisions and extending efforts to support others. The MPOWRD meetings cycle through the program manual curriculum accordingly and once finished, the meetings start over at module one. Repetition of curriculum at various stages in teen maturation produces an opportunity for continued levels of processing within healthy life decision-making.

The adult facilitators go through an extensive training process of the curriculum with the program CEO and gain professional hours at the end of the two-day educational program and break-out simulation modules. Certification needs to be completed within three months of the training. It is inclusive of the trained facilitator starting meetings with teens, indicating understanding of the protocol, investment in teen inclusion and a transitional opportunity to invest teens in the meeting leadership. The adult facilitators are encouraged to follow the strict ordered protocol as defined in the curriculum; each module stands on its own as a curriculum component. Recordings are sent to the Teen AA organization, where they are reviewed with feedback provided for each trained facilitator. If the above criteria are met, facilitators are sent

certification verifying their competency in the MPOWRD program facilitation. This certification is considered renewed each year as long as the program is run continuously. Consulting and support for facilitators is ongoing and updates are provided on the website portion for MPOWRD facilitators.

The MPOWRD curriculum and the weekly facilitated meetings stand at the heart of the program intervention. There are developmental meeting strategies to support the curriculum and teen engagement, including: 1) specific regular meeting introductions and format explanation (e.g., rules for confidentiality and unconditional respect), 2) the "two person challenge", an activity where participants engage in one-on-one discussion of a related meeting topic with a fellow group member followed by discussions within the entire group, 3) utilizing positive affirmations within interactive support during open group discussions, 4) promoting the development of "sidekicks," a form of adult/peer mentoring outside of the meeting, and 5) supporting participant facilitation/leadership of the meetings. According to the CEO, these activities develop empowerment skills and assist in cognitive, affective and behavioral changes.
The purpose of the MPOWRD Logic Model project is to assist Teen AA to develop a logic model and provide accompanying documentation of that logic model that will describe the articulated program theory of the MPOWRD program. To accomplish this task, four information gathering activities were executed by the evaluators at Arizona State University (ASU):

1. Literature Review: ASU conducted a comprehensive systematic review of peer-reviewed, professional literature and summarized the existing scientific evidence and clinical consensus regarding the efficacy of the 12 steps, peer based support groups, drug education, and evidence-based programs for adolescents with addictive behaviors, substance use, emotional disorders, mental illness, and other related disorders.
2. Review of Facilitator's Manual: A copy of the MPOWRD facilitator's manual that describes the structure, policies and procedures, content and curriculum was provided to ASU. The manual was evaluated for its content, organization, clarity and ease of use by facilitators. The manual was also used to: 1) develop an observation instrument that assessed the observed meetings for their adherence to the program as described in the manual, 2) develop a semi-structured interview instrument for adult facilitators/site administrators, and 3) determine the extent of and adherence to traditional12 step material by comparing manual content to open adult 12 step meetings that evaluators attended within the Arizona community.
3. Implementation Review: Three main methods were utilized to gain an understanding of MPOWRD from program facilitators, administrators and participants: 1) direct observations of the intervention, 2) interviews with facilitators, site administrators and participants, and 3) meetings with the MPOWRD CEO and MPOWRD developer. A structured observation tool was developed to assess compliance with best practice for facilitated groups and compliance with the program manual. Direct observations of three separate MPOWRD groups were conducted at three unique sites by evaluators. A fourth observation was made by program CEO without evaluators present to assess the preliminary validity and usefulness of the meeting observation instrument and feasibility of using such a tool as a quality control tool in assuring program compliance. The fourth observation is documented but not scored. At all three sites, the observation instrument was administered by evaluators during scheduled observations. Semi-

structured interviews were also conducted at the time of the observation at all three sites using an instrument developed specifically for this purpose. In total, 6 adult facilitators were interviewed (4 certified, 2 not certified; 1 student facilitator (uncertified); 58 student participants were interviewed directly by evaluators or indirectly by facilitators with evaluators present using an interview guide developed specifically for that purpose. One school administrator was interviewed. All interview instruments utilized are included as appendices to this report. Over 17 hours of informational meetings with the program developer and CEO, Susan Rothery, were undertaken to gain an understanding of the program, assess the data collection mechanisms available for evaluation, gain specific insight on program theory and implementation, gather published and unpublished information on how the program was developed and review preliminary results. The meetings also provided an opportunity to acquire deep background on the history of the program, specifically how it was developed and why. Also included in the 17 hours was a meeting with MPOWRD program CEO and two adult certified facilitators on June 6, 2016 to facilitate discussion of the logic model.

4. Program Data Review: To assess program data, the evaluators took a three-pronged approach. Evaluators reviewed extant reports that utilized program data, assessed the data portal for content, completeness and comprehensiveness relative to program service, performance and outcome measures, and developed additional instruments to understand outcomes qualitatively as an initial undertaking to build the logic model and determine the feasibility of collecting additional outcome data from program sites. Access to school records required several levels of informed consent including the parents, school and school district mandating a period that was beyond the scope of this review. Therefore, no school records were reviewed.

The program data review comprised the following activities:

- Prior Reviews: MPOWRD has undergone two prior unpublished evaluations that utilized data from a data collection mechanism dating back to program inception. MPOWRD CEO, Susan Rothery, provided unpublished written reports generated from program data prior to 2016. Previous data collected by the program also incorporated numerous service measures such as referrals by school counselors and teachers, GPA, attendance and participant self-reported values of self-concept, social support, willingness to attend meetings, and perceptions of safety while attending meetings.
- Quality and Type of Data Currently Collected: The MPOWRD program strongly encourages, but does not require group facilitators to upload program information to the MPOWRD data portal (for a full discussion of the portal, see data portal below). ASU was also provided with the necessary access to the MPOWRD online portal for data collection to review extant data, assess current gaps and evaluate capacity for further data collection. Current information collected through the portal includes participant information such as: basic demographics, high school start date, graduation date, and number of meetings attended.
- Qualitative Assessment of Outcomes: Several new tools were developed to assess the evaluability of both program implementation and outcomes. A group implementation observation rating scale was created to rate the skill of peer facilitators and the level of

adherence to the program manual via direct observations. This instrument was designed to measure an adult trained group facilitator and its application here to relatively untrained peer facilitators may require further adaptation and testing before it can be validated. The scores reflect how well a peer facilitator performed on 11 domains of group facilitation and program adherence. Several interview instruments were developed to measure facilitators/administrators perceptions of program impact and student participant's perceptions of impact. These instruments are included in Appendix C of this report. ASU was afforded direct access to observe MPOWRD meetings on 3 school campuses through MPOWRD CEO, Susan Rothery, who obtained verbal consent from school administrators for ASU to speak to facilitators, administrators and students directly as part of MPOWRD's normal oversight protocol. MPOWRD CEO Susan Rothery attended two out of the three observations and interviews.

Methods

To develop a logic model for MPOWRD, an evaluability assessment was performed utilizing the information generated through the four information-gathering techniques as described above. The assessment was performed specifically to determine:

- program theory;
- how the program currently collects and utilizes program data;
- what outcomes are identified by the program currently;
- the type, quantity and quality of data available to measure program process and outcomes currently; and
- the feasibility of generating new process/outcome data if needed going forward.

Evaluators utilized the results of the literature review to identify key measures and data that can be directly leveraged to demonstrate MPOWRD as an evidenced-based intervention. Evaluators identified data that has already been collected, is currently being collected or could be collected via various methods and utilized for purposes of assessing program outcomes. Evaluators assessed the feasibility of analyzing existing data to evaluate outcomes and barriers to collecting additional outcome data via the portal. Finally, evaluators piloted several new instruments to assess the feasibility of collecting additional program data not already collected by other methods.

Literature review

A search was made of peer-reviewed journal articles that address areas critical to MPOWRD. The articles were accessed through Library One Search using search terms such as:

- "Adolescent recovery"
- "Mutual help organizations"
- "12 step program for adolescents"
- "Mutual self-help groups for adolescents"

- "Peer support for adolescent recovery"
- "Effectiveness of AA on teen recovery"
- "Adolescent interventions for alcohol"
- "Adolescent interventions for substance abuse"
- "Evidence based practices for adolescent recovery from substance abuse"

Forty-seven initial articles were found and 42 were culled to assure they were published in peer-reviewed journals or if a book chapter, written by a known author in field who has published similar topic areas in peer-reviewed journals. The articles were not culled based on methodology and were not required to meet a methodological standard such as engaging a randomized controlled trial or quasi-experimental design. Overall, 42 articles reported the results of 171 empirical studies. The smallest sample size was 14 and the largest was 3,538. The articles were also reviewed for their references, and applicable references that focused on adolescent recovery models were then incorporated into the literature review. Many individualized treatments such as cognitive behavioral therapy (CBT) were identified, but not included as a model for this logic model because MPOWRD is a group peer-based approach. The literature search revealed several types of interventions: 12-step programs, mutual-help (peer-based) groups, and drug education groups focusing on teens and adolescents. Additional articles were assessed to evaluate the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP) substance use interventions such as: Project MATCH, the Adolescent Community Reinforcement Approach (A-CRA), and the Cannabis Youth Treatment (CYT) series. Specialized programs for specific issues such as steroid abuse, smoking and eating disorders were reviewed for comparison purposes. Other non-peer reviewed articles and tools were utilized to gain a better understanding of the existing literature and to supplement the peer-reviewed articles. A summary of the literature is provided below (see Literature Review section below under Results/Findings). An annotated bibliography of the peer-reviewed journal articles is included as Appendix A.

Direct observation

Approximately sixteen sites (including schools, community centers and juvenile detention facilities) currently have 19 ongoing MPOWRD meetings as of April 2016. Of the meetings, 14 are held at high schools and junior high schools, four meetings are held in the community, and one meeting is held at a juvenile detention facility. For the purposes of this initial assessment and development of a logic model, school sites, which make up the largest proportion of implementing sites were selected as sites for potential observation. Of the 14 meetings held at school sites, evaluators selected three based on the suggestion of the program CEO, as sites that would be inclined to grant ASU access to observe meetings. The CEO also wanted ASU to observe a site where she believed the facilitation to exemplify the teen engagement. Several different sites were approached by the CEO and based on the school's willingness to participate, three meetings at three separate sites were selected. All meetings took place during school hours and all meetings were observed in school-based settings during the months of March and April 2016. Meetings lasted on average one hour and were typically run by a student participant while the adult facilitator(s) observed from an area outside the group.

The observation process started with meeting the adult facilitator (school counselor or other school staff member) at the school site and being introduced to the other facilitators and school administrator. An informal conversational interview was conducted at that time while students entered the room for the meeting (see Facilitator Interviews below). Once students began to arrive for the meeting, the adult facilitator would assist the students in getting settled, answering questions students had for the counselor (unrelated to the meeting) and handing out worksheets for the group meeting. Evaluators utilized a conversational interview approach to create rapport, provide some background on why the effort was being undertaken and answer any questions the facilitators had regarding the evaluation. Evaluators outlined what they would be doing during the observation and showed facilitators a copy of the observational instrument. Evaluators were also able to gather background information (i.e., history of MPOWRD program implementation at the school) and gain an understanding of the facilitators and school's motivation regarding MPOWRD. During the conversational interview, evaluators also inquired about average attendance and specific group context relevant to the observation such as the number and grade of participants in each meeting, and specific community/school demographics regarding the student population of each site. Evaluators also requested information regarding participants typical pathways to group referral, typical issues participants are referred to MPOWRD for and specific issues that arise/counseled at the school (e.g., suicidal ideation, alcohol and drug abuse, violence, bullying). Additionally, the evaluators asked what the specific topic of the group (module/lesson) that the group was working on that day, whether there were student facilitators, the diagnostic variation and severity within the group, and group focus. Evaluators summarized their conversation as part of the observation notes included in Appendix B2.

Once the school bell rang indicating the class should begin, the participants settled in their seats, which were arranged in a circle, and the group facilitator formally opened the meeting. An ASU observer sat in the back of the room with a notepad and observed the group while taking notes. Evaluators also observed and noted their impressions of the group experience and culture of each meeting utilizing to the extent of an open 12 Step meeting as a benchmark. Group participant demographics such as: gender, race, ethnicity, socioeconomic status, family structure, diagnostic severity, and behavioral issues were noted through this method, but confirmed though facilitator interviews. Outcomes and risks were assessed in relation to participant's severity of their addictive behaviors and transition to similar groups upon graduation.

The evaluators rated each group based on the authenticity of the sessions as outlined in the training manual and facilitators were rated on fourteen dimensions in including preparedness, staffing, structure, feedback, attendee management and activities (i.e., group topic, modeling, role play). Each dimension was rated on a four-point interval scale from 0, indicating not present, to 3, indicating full execution. The total possible score of 42 (14 x3) would represent compete adherence to the facilitator manual. It should be noted that this instrument is only piloted for this purpose and not, as yet, validated. Therefore, the results should be interpreted with caution. Although the observation instrument is preliminary and subject to further reliability testing, a rule of thumb regarding scores suggests that scores below 50% would indicate weak compliance in many areas. Scores between 50-75% indicate overall consistency to the facilitator manual, but several critical areas need improvement. Scores of 75-85% indicate modest compliance and a few areas with less than perfect implementation. Scores 85-99% indicate high compliance with perhaps one weak area. These direct observations of MPOWRD meetings gave evaluators an

opportunity to witness the group process first-hand in order to fully understand the ways in which MPOWRD operates in accordance to its facilitator manual. The observation also permitted an assessment of group demographics, self-reported diagnostic severity, behavioral issues raised and mechanisms to manage behavioral issues via the program intervention. The instrument used is included in Appendix B1 and the actual observation summaries are included in Appendix B2.

In each meeting observed, the topic for that meeting was predetermined by the point the group was at in the facilitator manual. If the manual was completed from start to finish, the facilitator starts at chapter one and begins the chapter-by-chapter execution of the program all over again. The chapter-based facilitator manual is designed in self-contained modules to provide ongoing exploration of a topic via open-ended questions, individual reflection and group discussion. The main topic discussed at a given meeting corresponded to the curriculum outlined in the manual for the topic in that chapter. Each facilitator observed for this assessment began the 2015 academic year at the start of the curriculum, empowerment, and followed the manual chapters accordingly each week. Because the program design rests on an open group structure rather than a fixed number of meetings or a specific order of meetings, students may join the group at any point during a semester. Students may attend one week and not the next. There is no minimum number of sessions required per MPOWRD's standards and a student may enter a group at any point in the progression of the program manual. A summary of observations is provided below (see Observation section below under Results/Findings). The group implementation observation rating scale and a detailed summary of the findings from the direct observation of meetings are included as Appendix B1 and Appendix B2 respectively.

Facilitator/Administration interviews

Five facilitators (3 certified, 2 not-certified) and one school administrator were interviewed to assess their capacity and experiences working with the participants, knowledge and perceptions about adolescents and substance use disorders/treatment in general and through MPOWRD, implementation of the program, and to describe successful and unsuccessful clients that have gone through MPOWRD. Adult facilitators were all employees of the schools where the meetings were held. Both informal conversational interviews and formal semi-structured interview were conducted. Only formal semi-structures interviews utilized an interview instrument (see Appendix C). Informal conversational interviews were conducted prior to the start of the group meeting to gain school and facilitator specific background on how the program was started at the school. Formal interviews were conducted at the end of the group meeting to gain an understanding of the program, perceived benefits and barriers of providing MPOWRD meetings to students and what they have learned from MPOWRD.

Facilitators were interviewed following each directly observed MPOWRD meeting for about 35-50 minutes during March and April 2016. The school administrator was interviewed together with the facilitators following the first direct observation of MPOWRD. Each interview was audio-recorded so that it could be reviewed later. Due to time constraints, facilitators and administrators were not asked all questions noted in the instrument. Core questions were taken from the instrument to gain facilitator's perception on the focus, benefits and barriers of MPOWRD within the set time limits. A summary of facilitator interviews is provided below (see Interview section below under Results/Findings). A listing of facilitator/administration interview

questions and a summary of the collective interviews are included as Appendix C1 and Appendix C2 respectively.

Participant interviews

Following each observation, the student participants were informally interviewed to talk about why they have joined MPOWRD and their perspective on the benefits of the meetings. In total, 50 student participants were asked questions in a conversational manner either by the site's facilitator or by an ASU evaluator with the site's facilitators present at each of the three sites observed. Participants were encouraged to talk about their background and experiences in order to provide information on how MPOWRD has aided in their recovery from their addictive behaviors. Participants were also asked their perceived "best" and "worst" part of MPOWRD meetings and what elements of the program that they wish to change.

Participants were asked questions as a group after their MPOWRD meeting for about 10-15 minutes during the directly observed MPOWRD meetings within March and April 2016. A teen facilitator was interviewed informally after the first observation and asked about the benefits of facilitating MPOWRD meetings. Participant responses are summarized below (see Participant Interview section of Result/Findings). A listing of participant interview questions and a summary of the collective interviews are included as Appendix D1 and Appendix D2.

Program data review

The program review consisted of assessing all prior evaluations, review of any reports that the program has generated to date utilizing program data, and data collection mechanisms currently in use. Prior reports and evaluations were utilized to assess how available program data had been utilized to assess program performance and outcomes. These reports also provided important information on feasibility of data collection as well as gaps in service and outcome measures. To date, two separate non-peer-reviewed studies have been completed by other researchers to evaluate this program (Rothery, 2012; Pierce, 2016). One previous MPOWRD study was conducted in school-based settings and analyzed for quantitative data involving grade point average (GPA) and attendance as well as self-reported measures from a student participant survey regarding safety, self-concept and drug use (Rothery, 2012). Additionally, an exploratory study was conducted for MPOWRD in a detention-based setting, which evaluated the incarcerated youth's willingness to participate in the program (Pierce, 2016).

Prior data-based program reviews:
In 2011, quantitative and qualitative data was collected from six high schools with 60 student participants to assess the strengths, weaknesses and effectiveness of MPOWRD. Initial data was collected from the 2011 spring semester and used to compare students in the 2011 fall semester (start of MPOWRD participation) and 2012 spring semester. The simple PRE-POST study did not have a final published report. The study utilized a survey instrument (See Appendix E) to assess impact. The study also utilized data uploaded to the portal, specifically school attendance and student GPA. The study found that two key outcomes, school attendance and academic performance improved for students attending meetings. The research compared the 60 students before and after the intervention but did not have a control group. No specific dosage (number of meetings attended) was assessed; group demographics were reported but not analyzed. The study also concluded the structure of MPOWRD groups was perceived by program participants to be

beneficial to the participants. Specifically, the qualitative assessment found that the program was appropriate to the teens' developmental level and promoted reduced drug use and improved self-concept. The study found that the groups appeared to promote specific cognitive development to support the transition from concrete thoughts to complex thinking processes. Limitations of the study included researcher bias, self-report bias, instrumentation bias due to the instrument utilized for the age group, and small sample bias which limited generalizability.

Recommendations for future research included collecting similar data from school and community based settings to determine whether there are motivational and perceived helpfulness of MPOWRD differences between school, community and detention based settings. A significant risk was identified regarding the implementation of the MPOWRD program because it is dependent upon a trained facilitator. The study found that when a certified facilitator leaves the site, the program might no longer be offered or be offered by a non-certified facilitator.
In 2015, research was undertaken at one juvenile detention center in Arizona assessing the impact of an early version of MPOWRD previously known as TEENAA (Pierce, 2016). Over a one year period from January 2015-December 2015, a researcher in the doctoral program in Counseling Psychology at Argosy University studied XX juveniles (x girls; x boys) who participated in 4 separate groups in a single detention center. The research methods for the study included long term participant observation and interviews of group participants to better understand what benefits participants derived from meeting attendance. The study found that participants identified the leadership skills specifically as directly beneficial and unique in comparison to all other groups they attend voluntarily or by mandate.

Data portal:

Currently, a facilitator online portal can be accessed by facilitators via the MPOWRD website. All newly trained facilitators are provided a username and password to access this online data portal. Using the designated username and password, the online portal allows facilitators to input participant information such as gender, ethnicity, high school start date, high school graduation date, number of meetings attended and where each meeting was held. An ASU evaluator accessed the portal using a designated username and password in order to review the files. In addition to participant data, locations (sites), number of groups implemented at each location, and facilitators of MPOWRD were identified. MPOWRD program data was collected from MPOWRD's online database system portal for facilitators. Quantitative data is easily collected and offered through this database system. Currently the data portal has data on participant demographics and attendance. This portal has the ability to be expanded to include any qualitative data if needed.

Portal Data Screen

Country	State	Type	Facility	Total Teens	Active Teens	Inactive Teens	Male	Female	American Indian or Alaska Native	Black or African American	Hispanic or Latino	Native Hawaiian or Other Pacific Islander	Asian	Middle Eastern	White or Caucasian	Other
US	WY	High School	FUSWY0065 - REACH High	16	13	3	11	5	2	0	3	0	1	0	10	0
US	AZ	Community	FUSAZ0091 - White Mountian Youth Center	25	25	0	14	11	7	0	7	0	2	0	9	0
US	AZ	Community	FUSAZ0066 - Douglas Gov. Center	8	8	0	6	2	0	0	8	0	0	0	0	0
US	AZ	Community	FUSAZ0067 - Tumbleweed	19	14	5	10	9	0	6	9	0	0	0	4	0
US	AZ	Community	FUSAZ0057 - Youth Development Institute-19th Street	10	1	9	10	0	1	1	1	1	0	0	4	2
US	AZ	Community	FUSAZ0055 - YMCA-Maryvale	8	8	0	7	1	2	2	4	0	0	0	0	0
US	AZ	Community	FUSAZ0051 - John F. Long Family Services Center	3	3	0	3	0	0	0	3	0	0	0	0	0
US	AZ	Community	FUSAZ0032 - The Rock at 32nd St	6	0	6	4	2	0	0	3	0	0	0	3	0
US	AZ	High School	FUSAZ0092 - Lake Havasu High School	34	29	5	19	15	1	2	11	0	0	0	20	0

Participant Details

TUSAZ2809 - Male, Black or African American

Status	Created	Modified	Notes	Actions
On	02/02/2016 08:48 am	02/02/2016 08:48 am	8	Edit Meetings Delete

High School Start	High School Graduation
Aug 11th, 2014	May 25th, 2018

Facility ID	State	Country	Facility	Type
FUSAZ0092	AZ	US	(On) Lake Havasu High School	High School

Note: No school records were utilized in this review because access to school records requires permission from the school district and parents of the participants. Redacted case files also require this same permission from the school district and parents of the participants.

Results/Findings

Literature review

The review of available literature was completed to address what evidence supported programs, treatments and therapeutic interventions for adolescents to achieve effective recovery from addictions. Four related research areas were identified: 1) 12 step programs, specifically adolescent 12 step interventions; 2) mutual-help (peer based) groups and group therapies for adolescents; 3) School-based mental health/drug education and treatment for adolescents; and 4) nationally recognized evidence based programs and interventions for adolescents with mental illness, behavioral health disorders, addictions and substance use disorders.

12 Step Programs. Overall, the literature supports group therapy strategies for adolescents struggling with substance use, depression, and anxiety (Hides et al., 2010). Assessments of the impact of 12-step programs on adolescent recovery are almost exclusively based on traditional AA models where the mechanism of AA meetings is utilized in combination with other treatment or as part of aftercare (Pierce, 2016; Kelly and Urbanowski, 2012). In almost all studies assessing the impact of 12 step meetings on adolescents, the percent of age-appropriate peers is low. Researchers agree that the impact from peer-based support is underestimated owing to the lack of age appropriate meetings (Kelly and Urbanowski, 2012; Kelly et al, 2014; Passetti and White, 2008; Passetti and Godley, 2008; Kelly and Myers, 2007; Kelly et al., 2002; Kelly et al., 2008). As a result, the impact oi a 12 step approach may be underestimated in this age group. Much of the research has been done on adolescents discharged from inpatient or residential treatment that were referred to 12-step programs post-treatment and not focused on adolescent 12 step treatment referrals in an outpatient setting (Passetti and White, 2008). Passetti and Godley (2008) found that most clinicians referred adolescents to self-help groups for aftercare that were almost exclusively 12-step oriented and that referrals were given with consideration to the adolescent's severity of substance use, co-occurring disorders and the ability to comprehend and grasp 12-step concepts. Researchers consistently make several recommendations for adaptations of Alcoholics Anonymous' (AA) 12 steps: the use of teen facilitators, increased visibility of programs seen as teens helping teens and more integration of MPOWRD/NA programs into the community and social sphere of teens (Sussman, 2010). Beck and Olivet (1988) recommended specifically that AA's 12 steps should be modified for adolescents and presented at a developmental (psychological and cognitive) level that adolescents can comprehend.

Studies that have reviewed adolescents' experiences in AA or other related 12 step groups in the community are limited to programs that also included a mixed group of adults (Kelly et al., 2002; Kelly and Urbanowski, 2012). Despite this limitation, research has demonstrated the effectiveness of 12 step attendance as part of better outcomes in aftercare for adolescents (Kelly et al., 2008). The primary function of 12 step group meetings is to provide support, identification and a sense of belonging to its members, and sharing experiences with older members may not be as helpful for youth in their own point in recovery (Kelly, et al., 2005). Despite the ongoing dearth of AA meetings outside of adolescent treatment facilities and juvenile detention centers, it has been demonstrated that AA improves aftercare; youth who are more affiliated with 12 step groups are more likely to increase their motivation, coping strategies and self-efficacy against relapse over time (Kelly, et al., 2002). This finding does not currently extend to youth re-entering

after juvenile detention (Pierce, 2016). However, it has been demonstrated that peers and encouragement to attend 12 step programs is associated with improved attendance at meetings; professional encouragement has been shown to have a stronger influence on adolescents than parent attitudes toward AA attendance (Kelly, et al., 2010).

Mutual-help (peer based) support groups:

The literature on peer support in health, wellness, behavioral health and other areas is expansive covering a range of behavioral issues, but almost exclusive to adults (Morris et al., 2015). Peer support has been recognized as valuable to adult recovery from addictions, specifically in terms of aftercare (Boisvert et al., 2008). In adult studies, crucial features of mutual-help/mutual aid groups include individual transformation, sharing of personal experiences, overcoming personal difficulties, and peer direction (Humphreys et al., 2004). Research on the impact of peers on adolescents has largely been undertaken in the context of social psychology and education research (Frank et al., 2008). Frank et al., 2008) suggests that adolescents are highly influenced by peers and that understanding peer networks is critical to demonstrating how positive and negative behaviors in adolescents are reinforced. Adolescent treatment literature has recognized the value of group processes to recovery and it is a common recommendation by clinicians (Gangi and Darling, 2012). The individual experiences of adolescents who have participated in group, peer-based therapies have largely been shown to be successful in treating a wide range of symptomology (Fine et al., 1991).

Attendance at 12 step groups increases abstinence from alcohol and drugs (Kelly et al., 2008). Parental attendance in Al-anon has been linked to increased abstinence for the adolescent (Hsieh and Hollister, 2004). Length of attendance in 12 step groups, gender and group composition specifically impact adolescent outcomes. 12 step approaches have been demonstrated only as an effective supplement to other forms of treatment and aftercare not as an effective treatment in their own Kelly et al., 2008). Researcher has found that adolescents have difficulty engaging in groups as part of aftercare because groups are not age-appropriate (Kelly et al., 2005). The opportunity for adolescents to come together in a group setting to address troubling behaviors and situations they encounter in their everyday lives changes adolescents' perceptions about their lives (Waldron and Kaminer, 2004; Cone et al., 2009). Group treatments have the benefit of mirroring daily experiences and the enhancement of interpersonal learning and trust can be influential (Kaminer and Slesnick, 2005). Building on knowledge and shared experiences learned from group sessions can positively influence adolescents by creating helping relationships with each other in forms of healthy attitudes and protective factors against substance use (Mogro-Wilson et al., 2015). The realization that others share similar problems and issues and the development of socialization techniques can help facilitate affective, behavioral and cognitive changes for adolescents (Burleson et al., 2006). Adolescents that attend meetings with more similar aged peers are most likely to view the meetings as an important component on the road to recovery (Kelly et al., 2005).

School-based Interventions and Substance Abuse Education. Considerable research on school interventions has demonstrated the effectiveness of adolescent treatments in this setting for a range of behaviors including alcohol and drug addiction, suicidal ideation, depression and anxiety (Ritchel, 2011; Strunk et al., 2014; King et al., 2011). School-based therapies are specific to diagnosis or clinical issue such as suicide, depression, anxiety. The treatments studied have

been evidenced-based such as Motivational Enhancement Therapy (MET) psychotherapy, Cognitive Behavioral Theory (CBT), group therapy and the Adolescent Community Reinforcement Approach (A-CRA) (Green et al., 2011; Ritschel, 2011; King et al., 2011; Godley et al., 2014; Dennis et al., 2004). These newer evidenced-based approaches come after decades of drug prevention education in school and community settings that were not effective (e.g., D.A.R.E.) (Tobler and Stratton, 1997). Schools are a practical mechanism to deliver services to at-risk youth (Ritschel, 2011). School-based programs also make good use of the adolescent's natural environment to provide health education (HIV, STD) and health services.

However, school-based alcohol and drug treatment is driven by prevention, which has been historically educational (Tobler and Stratton, 1997). Tobler and Stratton (1997) studied the effectiveness of school based drug prevention programs and found that of 120 school-based programs interactive programs were more effective than non-interactive (didactic) programs. The size of the intervention also limited impact such that larger programs were less effective. Currently, there is a lack of clinical trials and research that verify the effectiveness of what specific therapies used in school, juvenile detention and community settings with adolescents are associated with good outcomes for adolescents without a specific clinical issue or diagnosis. The MPOWRD curriculum covers a wide array of issues relevant to adolescents including addiction, depression, anxiety, suicide, mental illness and co-dependency. Studies have demonstrated that depression and suicide education increases students' knowledge about depression, encourage positive coping skills, and can also change attitudes associated with suicide and depression that help destigmatize the illness and allow adolescents to seek help (Swartz et al., 2010). It has also been shown that adolescents with substance use disorders benefit from embedding psychoeducation modules into group therapy sessions (Burleson et al., 2006). The use of interactive (as opposed to didactic) drug education programs have been found to be most effective because this approach incorporates knowledge, social influence and comprehensive life skills in ways that reinforce knowledge acquisition and social connectedness (Tobler and Stratton, 1997). Traditional drug education programs (i.e., D.A.R.E.) provided knowledge without peer-to-peer support (Tobler and Stratton, 1997).

Evidence-based Treatments and Interventions. SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) lists both treatments and programs with components that are effective in addressing substance use disorders, addiction, depression or other issues for adolescents. The registry also identifies promising practices where the evidence is not yet fully established to support outcomes. These interventions are demonstrated effective by rigorous research utilizing experimental or quasi-experimental research protocol. Critical to determining effect is the dosage (length of treatment), participation requirements, provider credentials (licensed clinician) and embedded core elements of widely recognized evidenced based treatments such as Cognitive Behavioral Therapy (CBT) or Motivational Enhancement Therapy (MET) (e.g., Project MATCH, Cannabis Youth Treatment). Several evidence-based programs address specific clinical conditions and diagnosis such as depression and anxiety in adolescents (Green et al., 2011). Many programs and interventions address issues more broadly within the context of families, e.g., Multidimensional Family Therapy. These approaches are effective in either an individual or group formats (Pierce, 2016). Group formats are the most common modality employed for treatment of adolescent substance use disorder because they leverage peer support to resolve problems and teach adolescents how to relate in a pro-social manner (Sussman et al., 2004). Adolescents are typically "social users" in that they use drugs and alcohol in group

settings and are easily influenced by peers (Kaminer, 2005). Treatment often takes place within the family system and peer-based group therapy is a component of treatment. Holistic, community-based support groups have been utilized primarily to enhance primary treatment outcomes in adolescent recovery models as part of aftercare (Fisk et al., 2006).

MPOWRD does not fall into the class of program interventions that are built directly on an evidence-based intervention such as ADAP (for treating depression) or cognitive behavioral therapy (CBT). MPOWRD instead is derived from an organic and agent-based adolescent model of self-help that is informed by evidence -based approaches such as group therapy as well as the 12 steps of AA and then manualized as a high school curriculum. MPOWRD also reflects psycho-social theories that promote behavior change such as Yalom's (2005) theory supporting the primary factors of the therapeutic experience that promote and social learning theory (Bandura; 1986). Primary factors that promote change via group therapy include university, hope and the acquisition of social skills that can lead to improved relationships. Kelly et al., (2008) asked adolescents their reasons for attending 12 step groups and their responses indicated substantial support for Yalom's dimensions of universality, hope and support from other group members. Social learning has also been linked to good outcomes for adolescents by altering their social networks and increasing the number of peers that encourage recovery (Kelly et al., 2000 Humphreys et al., 2002). Pro-social skill development promoted through group interactions has been linked to positive outcomes in adolescent treatment (Fine, et al., 2011). When researchers compared traditional group therapy to simple social skill building groups for adolescents, they found no difference between the two groups after nine months.

Evidence-based therapeutic interventions designed to address specific diagnosis such as trauma and specific behaviors such as "cutting", "anorexia", "steroid abuse", and "smoking" have also been demonstrated as effective in group settings. However, these programs are typically geared to a target population that is demonstrating the behavior or symptomology. Adolescents who present with co-morbid conditions, however, can also benefit from groups focused predominantly on substance abuse (Kelly et al., 2003). Many programs such as the Adolescent Community Reinforcement Approach (A-CRA) require a licensed therapist with specific certification for this intervention and demonstrated competency within 17 skill areas, a fixed dosage of attendance and often require family members to attend sessions as well (Amodeo, Lundgren, et al., 2011). This treatment intensity and specialization may not be a good fit for school settings. Evidence-based treatments and programs that have been demonstrated as effective and implemented effectively in school settings, specifically treatment of depression and anxiety, still pose challenges in school settings. Costs, program intervention requirements such as fixed dosages, licensed therapists, and the involvement of the family are among some of the more common program elements that may impede implementation in schools. Adolescent perceptions of privacy, safety, stigma, and how their peers might view them can also influence students' decisions to participate in treatment in school settings. Recent research suggests that traditional treatments and therapies that are adapted to school settings can be as effective as traditional treatments in other settings (Ritschel, 2011).

Direct observation

Four separate observations were conducted at four sites during the evaluation period of March-June 2016. The observations captured the participants' engagement with MPOWRD, how adolescents interact in the meeting format; how well the group facilitator executed his/her role

and how closely the meetings followed the curriculum and proposed format in the facilitator manual. Participants were surprisingly open during observations. Teens shared many personal experiences and demonstrated openness about psychiatric diagnoses, mental illness, suicide attempts, family problems and personal struggles. The openness suggested participants were aware of their issues and felt safe to communicate them during the meeting regardless of the research observation. The participants communicated that they were on the road to empowerment based on the issues they raised and how they were choosing to react to them. The changes the students described were profound, going far beyond abstinence from or reducing harm from addictive behavior, including drugs and alcohol. Types of impacts described included: improved self-esteem, cognitive awareness and abilities, the ability to consider the impact of decisions, managing emotions, leadership, not engaging in self-harm or harm to others, improved family relationships, improved relationships with school teachers and administrators, with peers, improved attendance and academic success (going to class, doing homework, taking tests, scoring well on tests, completing assignments, fewer referrals to the school's office, fewer hours in detention, completing assignments on time), less 'partying', graduation from high school, educational attainment past high school, and setting and meeting career goals.

Evaluators observed that each meeting observed adhered to the strict written protocol as described in the facilitator manual for meeting start. Adults serve as facilitators of the group and are credentialed by the program. Each facilitator must meet a minimum number of training hours and be certified as a facilitator. Facilitators range in their professional credentials, typically being school counselors with advanced degrees in education with additional hours/certification in educational psychology. However, advanced degrees are not required for program certification. Adult facilitators observed varied in the extent of their activism. One group was, for the most part, run by the adult facilitator where the teen facilitator served only as an assistant and facilitated only when directly asked by the facilitator to take an action. In another observation, the adult facilitators took a very passive role, acting only to support group management.

As a program of personal empowerment, leadership and social communication, the program encourages groups to be facilitated directly by its participants. Groups observed varied widely on this program dimension although all groups had been in place for the academic year and the observations took place late enough in the school year where leadership skills would have had more than sufficient time to be developed. When asked about the degree of activism by an adult facilitator that is considered ideal, Program CEO and other adult facilitators interviewed indicated that "less is more." A major aspect of the MPOWRD group is modeling leadership and good decision-making by serving as a teen facilitator. Teen facilitators are not required to meet any specific elements such as have any length of sobriety or group attendance to serve as a group facilitator. Adult facilitators do not actively teach or train facilitation; they merely serve as models. For observations reported here, student facilitators were provided the chapter prior to the meeting and adult facilitators remained in the meeting to provide guidance, support, and group management and to assure that any serious mental health or legal concerns raised by students are appropriately addressed by professionals after the meeting. Student facilitators were scored using the observation tool. It should be noted, however that the tool was developed to compare facilitation with adult best practice and not adolescents whose facilitation skills are in development. To the extent that the tool was not designed to assess adolescents and has not been validated in adults, observation findings based on the tool should be interpreted with caution.

The pacing of each meeting began with a serenity pledge (so-called to avoid legal challenges that might arise from infusing prayer in school), a reminder about the group norms and rules and then a check in (how you feel today on a 10-point scale—(optional) if they want to say why, otherwise pass). The next key activity is called the "two-person" challenge. This segment took about 6 minutes to execute. In the "two-person" challenge, a question related to the topic of the meeting was introduced briefly. The facilitator asked group members to match up with a partner and discuss a directed question together. The facilitator stopped each person after 3 minutes to allow the other member to speak. For example, a particular group discussed the topic of power. The "two-person" challenge discussed how people give away their power. The challenge raised a brief discussion question to the group, "How do you give away your power?" After 6 minutes of the two-person discussion, the group members came back into the circle again and another discussion question is asked, but participants were asked to answer this question within the group. After this activity, the heart of the chapter topic or writing activity was engaged. This occurs about 10 minutes into the 50-60 minutes meeting. The facilitator read some educational material from the manual and then participants were asked to take a few minutes to think about additional questions to answer as a group. In this case, the question was asked: "Who has the power in your home?" The facilitator then went around one person at a time and encouraged input. Participants who chose not to share stated, "Pass".

Before the meeting concluded, some groups gave out 'tokens' for various lengths of sobriety and adult facilitators provided positive affirmations such as "great job" and "glad you are here". The tokens were optional for each group. The facilitator then checked in one last time for any additional feedback regarding the meeting and some time is taken for the participants to respond. A confidentiality pledge is then read together reminding everyone about keeping what they said and did at the meetings confidential. ASU evaluators noted that students did not, on average, have extensive lengths of sobriety; participants were given tokens for self-reported lengths of one day, one week, two weeks etc. Evaluators observed that one student received a token for one year of sobriety, but this was anomalous because the student was an original participant (actually case zero) for the group and had been participating in the school program since inception as part of his own aftercare treatment for anger management.

Observation #1: Millennium High School in Goodyear, Arizona. Millennium has one MPOWRD group each Wednesday with 12-20 participants. 2015-2016 was the first year of implementation for the program. Millennium has two certified facilitators and the school is planning to certify one additional facilitator for the next academic year. The two current facilitators are school counselors with advanced degrees and certification in educational psychology. The additional facilitator is a school safety officer. Each participant sat in a circle in the center of the classroom, which is designated for MPOWRD meetings. The participants generally are split 50/50 male/female and the group is designed to meet juniors who would have advising time; one or two freshman and sophomores also participate. No one would be turned away if referred or self-referred. The group is run by students as facilitators with at least one counselor (adult facilitator) in the room. At the observed meeting, three facilitators were present (two credentialed and 1 in training). Typically, only one facilitator is present. Since the students run the group, the program goal of empowerment is modeled more directly and the group follows much closer to a peer-run intervention with facilitated support. The topic of the observed meeting was the "Power of One". The counselors observed from a table in the back of the room and intervened in only a handful

(5) instances—3 times to prompt the student facilitator to keep the group moving along or get tighter control of the group and 2 times to respond to "shares" as "good job" "glad you are here".

The group followed the meeting structure as stated in the manual, starting with the reading of confidentiality, purposes of the meetings, basic rules, introductions and serenity pledge. This group executed the "two-person" challenge as designed in the manual and then reported out to the group in a group discussion. Following this, the topic was brought into the discussion and elaborated upon while each person in the room was able to individually answer the questions posed in the circle. The "pass" option was utilized during this observation by a couple of participants. The meeting ended with some probing of feelings, reflections or feedback of the current meeting followed by the confidentiality pledge that is recited all together.

The participants exhibited a range of self-described diagnostic severity. For example, one participant suffered a severe trauma; two admitted to attempting suicide. One participant admitted to "having crazy thoughts". Despite the severity of the conditions, the participants were for the most part laughing and enjoying the time they had at the meeting.

Several participants had been in jail; at least two students were no longer participating in the group because they had not successfully managed their behavior and were sent to "alternative school"; two students described previous 'in-patient treatment' experiences and had joined the group after they returned from treatment to school. About half the participants were diverted to the group for violating a school rule that would have resulted in suspension. These issues include: drugs, alcohol, smoking anger/fighting, absenteeism or other behavior. All participants discussed family issues although some discussed relationship issues with friends (drama) or partners.

The Millennium group was scored at 31.5 (75%) rating based on the observation instrument. This score reflects moderate adherence to the program manual. Because the instrument is not yet validated, results should be interpreted with caution. Based on the components where Millennium lost some points on the instrument, the moderate adherence can be attributed to a strong understanding of the curriculum and fairly strict implementation of the content in the program manual. However, the student facilitators had no training or certification in the curriculum or its implementation. In addition, student facilitators exhibited difficulty in managing cross talk, individuals with domineering personalities and other group dynamics such as side conversations, and reticent participants. Finally, the size of the group (18 students) was large which precluded the facilitator's ability to provide optimal time and space for participants to become engaged in and benefit from the process.

Observation # 2: Fountain Hills High School in Fountain Hills, Arizona. Fountain Hills has one meeting set every Thursday on a rotating basis so that students would not miss the same class each time they attend a meeting. There are typically 12-20 participants per meeting. There are two credentialed facilitators at this site, one facilitator is the school nurse and the other facilitator is the school counselor with an advanced degree in education. Fountain Hills is currently in its third year of implementation of MPOWRD. A facilitator placed the sign in sheet on a desk near the entrance so that the students can sign in upon entering the room. The classroom utilized is specifically for MPOWRD meetings and space was cleared except for the chairs in the center of the room formed in a circle for the participants to interact with one another. There were rubber

balls in the center of the room for the students to use as a chair or a footrest.

The group consisted of all levels of high school aged participants (ages 14-19, freshman-seniors) and the group had 16 participants. The participants are generally split 50/50 male/female in the group from varying ethnic backgrounds. The students are from different class years, but this does not seem to pose any barriers of participation. The facilitator indicated that there were some students were missing from the group due to a band trip to Disneyland. Two facilitators are typically always present in the back of the room. During this meeting, the adult facilitators had to intervene a number of times (10) to tell the group to stop the side conversations. The counselor facilitator had to intervene a number of times (seven) to probe the students to think more critically about certain areas after some of the questions.

The topic of the observed meeting was "Anger Without Control" from the life challenges curriculum. A teen participant facilitated the meeting while the two adult facilitators sat in the back of the room. The group began following the meeting structure laid out in the manual, starting with reading of rules of confidentiality, purpose of meetings, basic rules, introductions and the serenity pledge. The facilitators gave the participants the option to break out into the "two-person" challenge, but the students decided against it due to the size of the group. The students sat in the circle and discussed the "two-person" challenge questions in a group discussion format where each participant answered the questions in a circle. Following this discussion, the topic was introduced and the teen facilitator read the "Anger Without Control" and "Anxiety and Stress" handouts to the group, followed by the discussion questions. Each participant answered the questions individually and only one participant utilized the "pass" option throughout the whole meeting.

One of the facilitators indicated that many of the students lived in kinship households, where the grandparents are the primary caregivers of the children. Kinship placement was not mentioned specifically during the group, although many of the students described their family dynamics as "frustrating" and directed their hostility toward their mothers. Many students, for example, spoke about ways their anger towards their mothers manifests, particularly when the program participant speaks directly with his/her mother. Several students stated that they do not go to their parents or other family members when they are angry, because these individuals do not listen to them or respect their feelings. They specifically indicated, "Adults just don't listen to what we are feeling, or if they do listen they don't understand." The participants demonstrated frustration and mistrust with adults in their lives. In responding to each question asked by the facilitator, all participants raised family issues.

Fountain Hills High School received a score of 26 (62%) which indicates moderate adherence to the program manual. Because the instrument is not yet validated, results should be interpreted with caution. However, several group meeting implementation areas are in need of improvement. Fountain Hills' adherence score can be attributed to the student facilitator generally following the curriculum as prescribed in the program manual. However, Fountain Hills did not adhere to the curriculum in specific instances deviating without cause. For example, the facilitator did not adhere to the manual in executing the "two-person" challenge. In addition, the facilitator demonstrated difficulty in group management, by being unable to minimize cross-talk, interruptions and side conversations.

Observation #3: Phoenix, Arizona. The administrators in the setting for this observation requested that the name of the setting not be included in this report and that no statements made by adult facilitators, program administrators or participants be included as direct quotes. This setting implemented the first version of MPOWRD, previously known as Teen AA. They offer four different ongoing groups that reflect the various needs of the students at the school such as a gender specific group or group for high risk students. The setting has been engaged in MPOWRD for about four years dating back to 2012. The meetings occur after the regular school day at 3pm. According to the program administrator and based on school policy, the groups have 8-12 participants. The meetings are voluntary; many participants also attend other treatments and group therapy.

The topic of the session was step 3 "higher power." A teen participant facilitated the meeting with the support of an adult facilitator. However, the adult facilitator was highly activist and directive to the student facilitator. The meeting format followed directly from the curriculum. The introduction, serenity pledge, check-in and closure adhered to the facilitator's manual. The two-person challenge was not followed and was instead replaced with open discussion by students taking turns sharing.

The student facilitator demonstrated very good leadership skills, listening attentively to the adult facilitator's questions and prompts; taking initiative to keep the meeting moving and responding/modeling for other group members. However, because the adult facilitator was so active, the student facilitator scored no points for at least 4 items on the tool reducing the total score to 20 (48%). The group demonstrated no group management issues but had a relatively high "pass" rate, i.e., the percent of students who chose to "pass" when asked to check in or share was higher than other observed groups (50%). "Pass" rates in other groups hovered closer to 20%.

Observation #4: Mountain Pointe High School in Phoenix, Arizona. The meetings are set every Thursday and a lead counselor was hired and selected by the school's principal to run the sessions. Only one facilitator is present at the meetings, but the school is planning on certifying one additional facilitator for the next academic year. This is the first year of implementation for the program at this school and there are currently four meetings; all are facilitated at various times during the school week by the same facilitator. According to the current facilitator, participation numbers average up to 16 per meeting. The meetings are voluntary, although there are some participants that must attend because they have been recommended by the school administration.

The topic of the session was step 10 of the 12 steps: "I will continue to evaluate my own actions and admit to myself what choices were wrong". A teen participant facilitated the session with the support of the adult certified facilitator. Very little intervention was needed by the facilitator other than restating the question posed to the group twice to reinforce the topic throughout the meeting. The student facilitator supported the responses given by the other participants appropriately based on samples from the manual such as nodding the head or stating "thank you". Because this was an open discussion format, the group was not as structured as other parts of the curriculum.

The meeting format was based on open discussion of step 10. Each participant went in turn and discussed their understanding of the topic. Many participants of the group expressed feelings of isolation from their family; some participants demonstrated shyness or reticence during the meeting and discussed their extreme introversion. Participants also shared common diagnoses such as depression and anxiety. Participants commented on communication issues with their parents and families.

The time constraints on the group were strict. The facilitator's time was limited with the participants because students had to report immediately back to their classes at the close of the group. Therefore, discussion was abbreviated but it appeared that students had more to talk about and share.

The group consisted of 16 students from all levels of high school students (freshman – senior) and was 50/50 split between male and female from varying ethnic backgrounds. Two participants identified as transgender. According to the adult facilitator, attendance varies between the participants from week to week, but there is overall a committed core group of participants that attend every week.

Mountain Pointe was not scored on the observation rating scale because the instrument was applied as part of instrument validation and MPOWRD CEO, Susan Rothery, was willing to test the instrument to assess its utility as a feedback mechanism for program adherence. Ms. Rothery made the following observations:

- Teens were placed around a table which she found inhibited open discussion.
- Teens did not hold hands during the Serenity Pledge. However, when one participant mentioned it, the group started the pledge over holding hands.
- The adult facilitator was highly directive of the student facilitator, which kept the group more on track; however, the adult facilitator's actions inhibited the teen facilitator's development as a group leader and had an impact on the student facilitator's independence.

Facilitator/Administrator interviews

Interviews were conducted at all four sites. These interviews included six facilitators (4 credentialed, 2 in-training or not yet credentialed) and one school administrator indicated that the primary aims of the MPOWRD program is to provide students with the tools to create change in their own lives. Time restrictions on the adult facilitator and the students from Mountain Pointe High school precluded any interviews other than informal conversational interviews being conducted at that site. The interviews with adult facilitators demonstrated that in addition to the primary aim of creating change, MPOWRD is perceived as helping students and schools increase attendance rates, improve academic performance, lower referrals to the administrative office for school violations and behavioral issues. The program is also viewed as a mechanism to increase school safety by identifying and referring students to a program in school that prevent students from hurting themselves or others. The program is viewed as creating a safer school environment for students with behavioral issues and contributing to an environment for students to learn safely and thrive. The identified factors that help most of the students achieve these aims are: 1) a school environment where they feel safe and comfortable to voice issues and address their

concerns without fear of ridicule or punishment; and 2) the opportunity to develop skills via a curriculum that supports specific behavior change.

As described by facilitators, the recruitment process typically starts with the program CEO making a presentation to the school counselors, teachers and administrators. Based on this presentation, a school then agrees to adopt and seeks the credentials needed to implement the program. Next, the counselors recruit students during an open assembly (depending on the school either all ages or junior/senior). During the recruitment, the adult group facilitators describe the group aims and purpose. Facilitators stated they often refer to MPOWRD as a "student group" to discuss whatever is on the participant's mind. It is not marketed as "self-help", "MPOWRD", "12 steps", or "group counseling". School or site administrators market the group as an opportunity for students to talk about whatever they want. Participants who are not referred through mass recruitment or through administrative action may be invited to participate and explore the group by a teacher or counselor as part of ongoing mentoring. Often, an adolescent who may seek guidance from a school counselor regarding an issue or concern is also referred to the group. MPOWRD is marketed to students as a positive, self-improvement opportunity. A majority of students, however, are referred through administrative action or on advice of the school counselor. Nevertheless, when students are referred through administrative action, they join a group where others are participating voluntarily. The mix of students either self-referred or administratively referred supports the positive branding of the group at school sites. The group is held during (or right before/right after) school hours, usually at a time set aside for study hall, assemblies or upper division counseling of students or on a rotating schedule. As a result, there was no conflict with students attending the group and attending to class or missing too many of the same classes. The intervention is designed to be part of the school curriculum, not separate from it. The students go the meeting just as they would any other class, club or activity, destigmatizing any preconceptions and reducing barriers to participation.

Facilitators identified the program as instrumental in the growth and development of skills necessary to establish changes in behaviors. Key skills identified were leadership skills, communication skills and social skills, all affecting a positive self-concept. Facilitators also expressed their appreciation for the opportunity to have closer relationships with the participants of the group, which keeps school counselors and adult facilitators more connected to students, increasing counselors' perceptions of self-efficacy. Counselors get to see their students more frequently and expressed appreciation for the ability to "check in" with students. The facilitators singled out the more latent empowerment component of the curriculum, which encourages students to take control (facilitate) the meetings and make a difference not only in their own lives but in the lives of their peers. The facilitators recognize that these participants may not have strong communication skills, well-developed social skills or even a voice in their own families. Many do not feel empowered to communicate. Adult facilitators associated the lack of communication and poor social skills with the range and number of the addictive behaviors that have observed in students. Their opinions are reinforced by group discussions where students associate their behaviors to their own self- perceptions, social skills, inability to communicate with family and peers and with family issues such as poor or absent parenting, kinship and relative guardianship, blended households, poor school performance and a lack of family and financial resources.

Certain barriers in implementing the program were identified, such as: gaining support from parents and school district boards; the religiosity of the program, which may offend some or make school boards fearful; the program exceeding the scope of the educational mission of the school by actively implementing a peer group program at school; as well as schools having to manage competing areas of focus with limited resources. Competing areas of focus for schools include: cutting into classroom time, managing a wide range academic with non-academic issues, finding resources to support a non-academic program and prioritizing the issues addressed through MPOWRD over other non-academic needs. Views from site to site were not monolithic; two facilitators mentioned the barriers above, while two facilitators at two other sites indicated that there were no barriers of implementation and that MPOWRD was supported and flowed smoothly into their school.

The facilitators identified that the program would be strengthened if there were more certified facilitators in schools and ways to manage turnover in facilitators. They would also like alternative ways that they could manage the group size because running small groups of 8-12 would create waitlists and prohibit student exposure to MPOWRD. On the other hand, groups larger than 8-12 are very difficult to manage for this age group, especially in a school setting where students are used to talking in classrooms and engaging in side conversations throughout the class period with impunity. A significant amount of effort was observed in attempting to manage group cross-talk at school sites. To manage the issues created by group size, schools must invest in training new facilitators, adding new groups, finding space, and committing additional funding to the program. Evaluators noted that facilitators and school administrators alike recognized the limitations of the group size, but expressed that the experience was typical for current class sizes at their schools, and expressed some hesitation to lowering group size. For example, two facilitators pointed out that there also might be additional considerations when creating a second group at a school. One suggested that participants become very attached to the group and may not appreciate being artificially unlinked from their group to better manage group size. Another suggested that she feared she could not restrict students from attending. One school administrator pointed out that additional resources would be needed to lower group size (a new room, a new facilitator). Although facilitators and administrators alike agreed group size was a concern, and schools interviewed were taking steps to manage size, school commitment to keeping group sizes between 12-15 participants is an ongoing implementation risk.

Participant interviews

Interviews with the participants illustrated the primary and secondary purposes of attending MPOWRD meetings as well as the contrast between initial reasons for attendance and participant reasons for continued attendance. Participants also expressed their feelings regarding their overall connection and attachment to the program. Many participants admitted that they were initially diverted to the program by a behavioral action referral from school administration. Other initial reasons for attending meetings involved being able to skip class, personal desire and motivation to change their lives and in a significant minority of participants, the severity and desperation of their mental health or substance issues.

Participants identified the benefits of attending MPOWRD meetings and the components that kept motivating them to attend. Responses centered on having a safe place to be themselves and

to communicate what is on their mind. Here are some examples of what students described as their ongoing motivations for attendance:

- "I always know that if I have something going on or a bad week, I have someplace to talk about it."
- "At the group I am myself, the self who goes to school and gets good grades."
- "[I] just need to come and talk about the bad things."
- "This is a safe place to talk about things."
- "I attend a lot of groups but in this one I always feel comfortable."

Almost every group of participants mentioned how the group was their own, how teens both run and lead the meeting. The sense of empowerment stemming from leading the meeting was very real. Students highlighted their attachment to members in the group but also to the idea of a student-run group itself:

- "This is our group."
- "Everyone in here is my friend."
- "[Name] is my brother; I brought him in here, now we attend this group together."

Improved self-esteem, a sense of belonging, positive attitudes toward school, and the ability to work with peers to talk through issues in a respectful, supportive way is important to students. Students perceive these elements of the program as the perceived benefits of the program. Participants identified with each other though shared experiences; they gained insight into different perspectives and were better able to reflect upon their own decisions by seeing through the eyes of their classmates; they increased their skills in managing vexing issues; and they realized that they are not alone. Participants perceived they were powerful and could help others and themselves to manage their problems by fostering encouragement and confidence to face challenging situations. One student, for example, described a school situation where she intervened to stop a fight and described how she felt being able to bring calmness to the threatening situation and prevent violence. Many participants felt that MPOWRD also provided support in dealing with academic pressures of school as well as the stress and pressure to graduate. One student described how he utilized his MPOWRD skills at his after-school job.

Elements of the program that they hoped to change differed between the groups. The group at Millennium focused on the confidentiality and privacy component, while the Fountain Hills group mentioned the cross talk and side conversations that were distracting during the group itself. Teens in general asked for the program to be offered to middle school children and that there would be more meetings run each week. Teens were concerned that MPOWRD ended with high school. Their interest continues to drive their CEO to create more opportunities that are age-appropriate for this generation. Regarding the issue of confidentiality, student participants at Millennium High School did not fully understand what was meant by "confidentiality." They presumed that nothing about MPOWRD could be communicated to anyone once the students left the group meeting. CEO Susan Rothery, who was also in attendance at the observation, clarified to this group that confidentiality simply means not discussing or sharing someone's personal story outside the room. The CEO then encouraged students to discuss MPOWRD as an opportunity to find support with friends and anyone whom

they believed could benefit from participation. Time restrictions did not permit student interviews at Mountain Pointe High School.

Prior Evaluations

In 2011, data was collected from six high schools with 60 student participants to assess the strengths, weaknesses and effectiveness of MPOWRD. A mixed-methods design was implemented in order to collect all relevant data. A survey instrument was created by the evaluator in order to collect qualitative data from student participants. The instrument included a 0-10-point scale in which students rated their drug use, addictive behaviors, performance in school, self-concept, plans about their future, friend support systems and how safe they felt during MPOWRD meetings. The students were given the survey at their first MPOWRD meeting and given the survey again at their 7th meeting. Quantitative data, such as attendance rates, referrals to the administration office, and grade point averages (GPA) were collected by each site's certified facilitator (school counselor or other school staff member) for the purposes of this study. Initial data was collected from the 2011 spring semester used in comparison for 2011 fall semester (start of MPOWRD participation) and 2012 spring semester. The Rothery (2012) unpublished study described the following outcomes:

- Self-reports of drug abuse/use of mind altering substances significantly decreased after attending 6 sessions of MPOWRD
- Improvement in/maintenance of GPA (Note: GPA in the subsequent semester following MPOWRD attendance did not improve, but was maintained.)
- Decline in/maintenance of absence totals for participants when compared to the previous semester prior to the start of MPOWRD participation, (Note: absences in the following semester did not continue to improve, but the effect was maintained.)

Both maintenance of and improvement in GPA/absenteeism were treated in prior research as positive outcomes. In addition, the study proposed that students traditionally perform better during the fall semester. Schools often see a decline in grades among seniors that are about to graduate and performing at the minimum in order to graduate. Some students may be taking more difficult classes as result of the program and this could result in a decline in GPA. Finally, it is difficult mathematically to improve cumulative GPA in one semester. Measuring differences in the difficulty of classes taken and change in semester GPA may be more applicable as an outcome measure than change in cumulative GPA. Despite this, the study has shown that students that have participated in MPOWRD have promising outcomes in regards to controlling their drug use as well as improving their performance in school while in the program. Prior recommendations emphasized increasing encouragement for academic performance as well as encouragement for sobriety by adult facilitators.

An exploratory study by Pierce (2016) was conducted in a detention-based setting implementing MPOWRD to incarcerated youth. The purpose of the study was to evaluate the willingness of incarcerated youth to participate in the group. In total, 51 participants (aged 14-17) incarcerated at the Arizona Department of Juvenile Corrections (ADJC) were recruited to the study. All participants were surveyed using an instrument developed by the principal investigator of the study incorporating elements of relevant literature, MPOWRD stakeholder involvement and the research committee. All participants were also administered the Stages of Change Readiness and

Treatment Eagerness Scale (SOCRATES) in order to measure each participant's readiness for change in alcohol and substance use. The SOCRATES also measures participant levels of motivation to make changes in substance use behaviors. In addition to the survey and the SOCRATES, 24 interviews were conducted with participants that volunteered to do so. All interviews were audio-recorded except for four youths that requested not to be recorded. (The MPOWRD survey, SOCRATES, and interview instrument are located in Appendix E1, Appendix E2, and Appendix E3 respectively.) The study yielded the following results:

- More than half of participants viewed MPOWRD as helpful (i.e., reported support from peers, learned new coping skills, discussed personal issues and focus on 12-step material).
- Half of the participants indicated they would rather attend MPOWRD than other groups due to the content that is relevant to them and the group perceived as a safe place to discuss their feelings and experiences.
- Half of the participants reported taking steps toward change in regards to their drug use.
- Half of the participants reported they did not plan to attend MPOWRD after release from detention.

Pierce (2016) found that the structure of MPOWRD groups it was appropriate to their cognitive developmental level and was also beneficial to the participants because it facilitated the transition from concrete thoughts to complex thinking processes. Limitations of the study included researcher bias, self-report bias, instrument validity due to the age group, and generalizability. Recommendations for future research include collecting similar data from school and community based settings to determine whether there are motivational and perceived helpfulness of MPOWRD differences between school, community and detention based settings.

Ongoing Data Collection

Based on the data collected through the online data system portal, 85 schools, community centers, and detention centers in two states have implemented MPOWRD by over 80 facilitators with over 2,500 adolescents participating in the program from 2012 to present. All facilitators are given access to an online data system and asked to voluntarily upload data. The program historically provided a small incentive to collect data at the time of the completion of the 2011 study. Because data upload is voluntary, currently, not all facilitators utilize the system to input any data on their participants. Not all facilitators who are credentialed start a program at their site so there is no data from those sites. A review of the current facilitator data system portal revealed facilitators from schools, community, and detention-based settings have recorded information about participants. Gender, ethnicity, location of meetings, number of meetings attended, high school start date and graduation information about participants were included into the system. Participants from community settings did not have their high school start or graduation date added to the system. Data appeared to meet basic standards of completeness and consistency. For example, attendance data did not contain any missing data. Based on existing data filed by the 80 facilitators trained, the length of attendance per student ranged from 1 to 29 meetings attended, from 1 week to 7 months in length. Further analysis of the current data could be accomplished by downloading the data to a spreadsheet to be analyzed in Excel or SPSS. Additionally, the

online system has the ability to expand so that further values can be collected.

Note: A significant risk identified to the implementation of the MPOWRD program at a particular site arises from the lack of site commitment and the heavy dependency upon certified facilitators to implement the program. Like any non-mandated area in a school, if the facilitator leaves the site, the program is not implemented.

Discussion

The logic model identifies four major components of the MPOWRD program that are instrumental in understanding the program's theory of change: inputs, activities, outputs and outcomes. The logic model also incorporates influences from the setting and external environment that are relevant to consider and underlying assumptions that influence the theory of change.

Assumptions

The assumptions about MPOWRD are indicators of the framework in which meetings are most successful. Evaluators attempt to state all assumptions, to better describe the underlying, often overlooked causes for program success. For example, one assumption in MPOWRD is based on the understanding that adolescents that attend meetings with more similar aged peers will benefit more from meetings than if the adolescents attend adult groups. Another assumption is that the structured program curriculum "fits" a school setting, feels like another class and reduces stigma of attending. Another assumption is that programs tailored to the developmental and emotional level of adolescents will benefit more than those not tailored to their brain development and readiness for change. One critical assumption is that the group process supports normalization of personal growth parallel to the family and non-MPOWRD peers. It is assumed that the group process reinforces changes in life experiences. Additionally, facilitating MPOWRD meetings during school hours is based on the assumption that utilizing a part of the school day for non-academic curriculum makes the program accessible to teens and eliminates transportation barriers.

External Factors

Elements that affect MPOWRD from outside of the program are listed as external factors. MPOWRD cannot control individual site funding and monetary costs toward implementation of the program. This includes, but is not limited to, hiring processes of facilitators at each site, adult facilitator training, school district policies regarding non-academic programming or funding requirements for non-academic programming. For example, if a school is utilizing federal monies to support MPOWRD, the program may have to meet federal requirements for the school to receive the funding.

MPOWRD also cannot control the individual adult facilitator's credentials and experience. MPOWRD specifies that facilitators must have a background check and a professional association with a youth support agency, school, or detention center, but there is no guarantee

that a facilitator will have any advanced professional degrees or the experience necessary to facilitate a group. Additionally, MPOWRD cannot control the variation in time in which the groups are held at each site and that may affect individual and group attendance.

Inputs

MPOWRD's MPOWRD program inputs are the resources that are available to implement the program. Human resource input consists of MPOWRD's participants and adult facilitators. Adult facilitators range in credentials from site to site, but a majority have advanced degrees of education with specializations in educational psychology. Participants vary individually and by site with respect to their background and demographic characteristics. Typically, participants must be between the ages of 13-24 and have some sort of behavioral issue generically defined as any decision that leads to personal harm. For this age group, typical behaviors include underage drinking, school rule violations, violence (fighting), bullying, criminal justice involvement and other interpersonal/relationship issues. Many participants experience substance use, behavioral issues, depression, anxiety, grief and loss, academic challenges, transgender challenges, abusive relationships, difficulties in managing emotions, self-mutilation, suicidal ideation and eating disorders. These behaviors may be characteristics of participants in MPOWRD, but are not mandatory for participation.

Additional inputs include the adult facilitators that run the meetings as the facilitator manual states that at least one adult facilitator must be present during each meeting. Other inputs include school administrators, teachers and counselors that may have referred students to the group and support the implementation of the program. Participant families are not included as inputs because they are not included in the program approach. A student may participate with parent permission, but ongoing parent input is not elicited unless there is reason to break confidentiality. The setting of the group is also characterized as an input, as meetings are conducted in a peer group setting at a site within a school district, community, detention or corrections setting. Each meeting is located in a private, confidential, safe environment, typically a classroom, where chairs are positioned in a circle to facilitate discussion.

The site's support (e.g., the school district and school administration) for non-academic programming is an important input for implementation. No single parent would have the power to change programming to a school, but a motivated group of parents could promote or prevent MPOWRD from coming to a campus. Similarly, the school district's policies and procedures, individual school's policies and procedures, the individual school's academic mission, the individual school administrator's perceptions of MPOWRD, and the Arizona Department of Juvenile Corrections policies and procedures are critical inputs to the program's implementation and sustainability.

Activities

The central activities of the program are 1) engagement and referral of students; 2) execution of the MPOWRD curriculum via facilitated group meetings; and 3) supplemental skill development to support recovery.

Engagement occurs though mass information/recruitment at school assemblies and by individual counselors, staff members and administrators at school sites. Students can self-refer or can be recommended by a counselor or school administrator. Students who are referred for administrative violations must attend for the duration of the administrative penalty. Each school can assign a period (such as two weeks) or minimum number of meetings as the administrative penalty. This is usually offered as an option, where another choice can be implemented as well.

MPOWRD meetings are weekly ranging between 45-60 minutes with a maximum of 16 clients per session. MPOWRD has a highly structured MPOWRD program curriculum, with a written facilitator manual providing a conceptual overview of the program, program goals, and a step-by-step execution of the curriculum and each program module/meeting. The curriculum, which follows either an activity based meeting or a step-by-step scripted structured meeting format, outlines four critical cumulative stages of recovery. Activities are matched to each stage. Stages include:

Stage 1: Empowerment and redefining addictive behaviors
Stage 2: 12 steps of MPOWRD and recovery
Stage 3: Addressing life challenges
Stage 4: Outreach

The stages outlined in the manual correspond to specific activities that facilitates cognitive and behavioral changes. Stage 1 includes curriculum that generates encompassing individual personal power and aids participants to process, explain and redefine their addictive behaviors through personal assessments of self-reflection (made through worksheets that are copied for participants by each site); Stage 2 applies strategic exposure to the 12-steps for participants; Stage 3 includes learning about specific "life challenges" such as: abusive relationships, depression, anxiety and stress, anger, etc., and Stage 4 incorporates a portion of the material in Stage 3 while setting personal goals for the present and future, made through worksheets provided. This stage is inclusive of recognizing the stages of healing and progression through Maslow's Hierarchy of Needs.

During Stage 1, the meetings follow an activity-based meeting format. The group begins with the Confidentiality Pledge, purpose of the meeting and the rules, followed by worksheets or self-assessments that the adult facilitator chooses to review with the participants for discussion. An array of worksheets and self-assessments focused on processing empowerment and addressing addictive behaviors are provided to facilitators through the facilitator manual. These worksheets are read and individually filled out by the participants in order to provide self-reflection. During Stage 2 and on, each meeting is strategically structured to begin as follows:

- Introductions and Serenity Pledge
- A "two-person" challenge
- Group discussion/cohesion on the subject presented that week
- Confidentiality Pledge

Each meeting will have a designated topic area of focus from a stage in the curriculum and educational material is read regarding the topic area of focus before the group discussion. The

"two-person" challenge and group discussion are all focused on the topic at hand and the educational material provided for the topic outlined in the facilitator manual.

Throughout the course of the MPOWRD curriculum, participants are encouraged to facilitate the meetings with the support of the adult facilitator. It is intended that the group be peer-led for most of the meetings. The adult facilitator promotes this leadership position to empower students in their own recovery and contribute to the feelings of safety created by a peer-based recovery support system. Once the meetings are primarily peer-led, the facilitator moves from inside the circle to outside of the circle in order to empower the participants to make the meetings their own. However, adult facilitators should facilitate effective group management of all meetings and provide direction and support to adolescent facilitators when necessary.

In addition to the group sessions, participants are encouraged to develop a support system that will aid them through recovery. Adult facilitators stress the need for participants to find "sidekicks" who might be positive friends, mentors, coaches, counselors, etc. that a participant can trust to be there for them through good and bad times and hold the participant accountable for their addictive behavior(s). Additionally, tokens can be purchased through MPOWRD and utilized to support periods of sobriety. Time spent on the distribution of tokens can occur after the meeting curriculum has been executed. Each participant is invited to state the length of time of their sobriety and be awarded tokens for their accomplishment. The distribution of the tokens is optional and each site can implement the tokens at their own discretion.

Note: There is no official end to the program. At school sites, participants may participate as long as they have not graduated. The groups typically run on an academic calendar and are not offered in the summer months. In a school setting, the groups start fresh at the beginning of the school year in August and end at the end of the school year in May. In other settings, the calendar is based on the setting's own administrative/programming calendar.

ASU Center for Applied Behavioral Health Policy
ARIZONA STATE UNIVERSITY

MPOWRD Logic Model

Inputs

- Participants:
  - Age 13-18
  - Addictive behavior
- Certified adult facilitators
- School administrators, teachers, counselors

Setting

- Peer groups conducted in schools, community pro-social settings, detention and correction facilities.
- Chairs positioned in a circle, protocols used according to facilitator manual
- Private, confidential and safe environment.

Environment

- School district policies and procedures
- School policies and procedures
- School academic mission
- School administrator perceptions of MPOWRD
- Site support of MPOWRD (non-academic programming)
- Arizona Department of Juvenile Corrections policies and procedures

Activities

- **Required**
  - Engagement of adolescents to participate through recruitment
  - Weekly group meetings for 45-60 minutes with maximum 12 participants per session
  - 12-step meeting
    - Introductions, CPR, check-in & Serenity Pledge
    - "Two person" challenge
    - Group discussion/cohesion
    - Confidentiality Pledge
  - Activity-based meeting model: Explaining and redefining addictive behaviors through personal assessments of self-reflection
  - Developing and modeling leadership skills
- **Optional**
  - "Sidekicks" –outside support
  - Distribution of tokens for periods of sobriety

Outputs

Individual:

- Number of meetings individual participants attended
- Number of assessments of self-reflection completed
- Number of tokens for periods of sobriety received (optional)
- Length of time meetings were attended
- "sidekicks"

Group:

- Number of adolescents referred
- Number of participants attending meetings
- Number of adult facilitators certified per site (turnover)
- Number of adolescent facilitators total and per group
- Number of participant led meetings/year
- Percent of curriculum completed by school year end
- Fidelity scores on observation instrument

External Factors

- Funding
- Facilitator credentials, experience and commitment to curriculum
- Variation in sites and times groups are held

Outcomes

Proximal

- Increased knowledge and awareness in 12 steps, addiction & recovery
- Abstinence or reduction in addictive behaviors as measured by length of time of self-report sobriety
- Increase in empathy, perceptions of support, helpfulness, willingness to share, group attachment, and leadership
- Increase in school attendance
- Decrease in behavioral referral

Intermediate

Individual:

- Sustained periods of abstinence or reduction in addictive behaviors
- Improved attendance in school
- Improved academic performance
- Increase in engagement of extracurricular /pro-social activities
- Increase in meeting frequency with "sidekicks"
- Improved interpersonal communication skills
- Increased leadership skills

Distal

Individual:

- Improved communication, empowerment & leadership skills
- Sustained abstinence or reduction of addictive behaviors
- Decreased referral to alternative schools or justice involvement
- Improved decision-making
- Increase graduation rates

Assumptions

- Teens attending meetings with more similar aged peers offers benefits than mixed adult groups
- Programs tailored toward developmental and emotional level of adolescents benefit readiness level and improves engagement
- Meetings during school hours destigmatize attendance, improve access and increase engagement
- 12 step/other curriculum provides age-appropriate information and didactic approach

Outputs

The outputs of MPOWRD's MPOWRD program are specific measurable products of individual (participant) participation, group function and group contribution that are linked to program's activities. As such, outputs are very useful for program monitoring and to establish the robustness of the program outcomes. Outputs also assist in explaining sources of program variation, identifying critical program characteristics that influence outcomes and identifying key facilitator and participant characteristics that influence outcomes. The more that is understood and tested with respect to program outputs, the more valid and reliable are program outcomes. For example, evaluators often ask whether a program outcome varies by the participant's age gender. Determining how demographic and program implementation characteristics change outcomes is a critical component to sound program theory.

Outputs typically represent Individual (participant) outputs of MPOWRD include the number of meetings individual participants attended; number of assessments of self-reflection completed; number of tokens for periods of sobriety received (optional); and length of time meetings were attended. Student participant demographic information should also be collected to better understand how outputs may vary with participant demographics. These individual outputs reflect indicators of participant engagement and participation.

Group outputs include the number of adolescents referred, the number of participant's attending meetings, the number of adult facilitators, number of adolescent facilitators, number of adolescent facilitators per group, number of participant led meetings, number of "sidekicks" per group, and percent of the facilitator manual is completed by the school year end. The number of participants present at each meeting and the number of participants that facilitated each meeting are further measures of overall program involvement.

Outcomes

The ultimate goal of MPOWRD is for adolescents to have improved self-esteem in order to empower themselves to change though a structured curriculum focused on raising awareness and promoting skills that support healthy decision-making. The end point of the program is not defined similarly to 12 Step programs in the community; the meetings may be attended as needed throughout a lifetime. Participants attend for the length of time at their own will while at the site unless mandated by administrative/school order/diversion. Some participants attend though graduation; others drop out after one meeting. There is no minimum length of time to observe proximal benefits. However, the facilitator manual breaks up the program into attendance tiers to match appropriate curriculum to the level of attendance. These tiers can be used to match expected outcomes to attendance levels (program exposure). Tier 1 is defined as 2-4 meetings and appropriate to raising awareness (empowerment, addictive behavior, steps 1-2); Tier 2 is defined as 5-12 meetings and appropriate to a Stage 1 recovery (steps 3-4 and the five challenges); Tier 3 is defined as 13-25 meetings and is matched to Stage 2 recovery (steps 5-12 and the five challenges); meeting attendance that exceeds 25 is defined as Stage 3 (12 plus 12/outreach activities). These are just guidelines. The program should expect, similar to other 12 Step programs, that for some, one meeting may suffice, for others a lifetime of attendance in related programs may not be enough.

The proximal benefits of participation in MPOWRD are intended to be accessible and achievable from the first meeting. The proximal outcomes of MPOWRD are:

- Increased knowledge and awareness in personal empowerment, the healing possibilities within Teen AA's 12 steps, understanding the universality of addictive behavior, coping skills and recovery.
- Abstinence or reduction in addictive behaviors as measured by length of time of self-reported sobriety.
- Increase in empathy, perceptions of support, helpfulness, willingness to share, group attachment, and shared common experiences.
- Openness to group processes.

All proximal outcomes are experienced from an individual (participant) level, which can improve with increased meeting attendance. MPOWRD utilizes a facilitated peer group format to promote the value of shared life experiences to recovery while creating reciprocity among meeting participants, which can be experienced from the initial meeting. The peer group provides support and reinforces skills and healthy decision-making. Individual (participant) level intermediate outcomes include:

- Sustained periods of abstinence or reduction in addictive behaviors.
- Improved attendance in school (semester level).
- Improved academic performance (semester level grades and GPA).
- Increase in engagement of extracurricular activities (semester level).
- Increase in meeting frequency with “sidekicks”.
- Improved family dynamics and communication.
- Improved personal growth and self-confidence.

Site intermediate outcomes include:

- Decrease in behavioral referrals to school administrators (semester level).

The individual intermediate outcomes are intended to be accessible after a Tier 2 level of meetings have been attended. It is intended that continuous participation in weekly group meetings will have individual benefits regarding school performance, risk reductions in social networks (i.e., increase in “low risk” friends and a decrease in “high risk” friends), increased meetings with their established “sidekicks” to ensure sustained accountability, positive relationships and communication at home, and increased self-esteem. As a result, from the individual intermediate outcomes, site intermediate outcomes would see a reduction of behavioral referrals to the school administration.

From a long-term perspective, there are benefits to both individual students who participate and to the sites. Distal outcomes on an individual (participant) level include:

- Improved self-esteem, empowerment, and leadership skills.
- Sustained abstinence or reduction of addictive behaviors.
- Increase in coping skills.
- Sustained improvement in family relationships.

- Transitional support readily available.
- Site distal outcomes:
- Decreased administrative referrals
- Decreased referrals to alternative schools
- Increased school safety
- Lower suicide rates
- Increase in graduation rates.

Defined benefits of program participation will provide adolescents with the opportunity to develop skills that will allow them to continue on a path of personal growth and awareness, while concurrently abstaining from or reducing their addictive behaviors. Once a participant is approaching graduation, it is expected that the participant has transitional support readily available and accessible to them in their community so that the participant can continue on the path of recovery (i.e., locate young adult/adult 12 Step groups in the area, or other peer-led support groups facilitated in the community, etc.). It must be noted that distal outcomes may require full implementation for schools to experience benefit. However, these distal outcomes rest on the relative ratio of students with defined behavioral issues relative to the availability of program groups. Many schools can be described as 'piloting' the intervention and are at an initial exploratory stage of implementation. Therefore, these distal outcomes should not be expected until full implementation

Findings, Recommendations and Next Steps

The purpose of this project was to assist Teen Addiction Anonymous to develop an articulated program theory and accompanying logic model for the MPOWRD program. This assessment would also be the first step in exploring the need for and the feasibility of further process and outcome evaluations including the type of data required for those evaluations. MPOWRD's CEO, Susan Rothery, expressed interest in developing a logic model and program theory specifically to:

- Ensure program consistency across the various school, community, and detention based locations in which MPOWRD is implemented (process improvement); and
- Determine whether a rigorous outcome evaluation to assess program impact is feasible at this time.

According to the MPOWRD CEO, the outcome evaluation should assess the impact that participation in MPOWRD has on adolescents' social, emotional and personal growth and provide necessary evidence so that MPOWRD can apply for "promising practice" status on SAMHSA's National Registry for Evidence-Based Programs and Practices (NREPP).

MPOWRD's program assists adolescents in reducing harm from addictive behaviors and in achieving healthy and productive lifestyles. The curriculum and facilitated peer group intervention format serves to increase knowledge and awareness regarding addictive behaviors, promote personal empowerment and introduce the 12 steps of Alcoholics Anonymous as a recovery paradigm. In addition, the directed activities, self-assessments and intergroup topical discussions promote age appropriate pedagogy, social communication and self-expression to

engage participants, promote peer-based recovery, and build life skills to enhance healthy behaviors. The curriculum promotes strategies for adolescents facing difficulties in order to facilitate cognitive, affective and behavioral changes. As a result of participation in MPOWRD, participants can experience personal growth, empowerment to change, leadership skills, improved coping skills, and improved academic performance. In its simplicity, MPOWRD provides a safe place for teens to talk to each other via a structured curriculum that promote positive change.

As reflected in the Logic Model, core activities facilitated by MPOWRD during each weekly meeting include the use of highly structured and directed meetings focusing on specific topics laid out in the curriculum. The use of scripted exposure to the 12 steps and other activities accomplishes several things. The activities assist teens with processing each step and topic; 2) raise awareness about addictive behaviors; and 3) promote effective communication and social skills. Adult facilitators encourage the group to become autonomous and self-sustaining by encouraging participants to serve as peer facilitators for the weekly meetings. Promoting peer-led groups also encourages accountability and group connectedness by making the meeting their own. Peer support is a critical component of recovery (Collier et al., 2012). Developing and strengthening a support system encourages personal growth. This model can be extended beyond the group to the school, the home and the community by the adolescent learning how to find and utilize peer support strategies as he/she matures. Participation in the meetings allows for the establishment of social connections within the members, review of choices and behaviors, self-assessment, self-reflection, acceptance of life challenges, and goal-setting to manage life challenges.

A number of quantitative indicators (outputs), the program processes, and performance values are identified and include the number of group meetings attended, length of time meetings were attended, number of participants present in each group, number of participant led meetings, number of participants that led meetings, etc. These outputs provide indication of program performance but are limited in what can be said regarding program impact. Program impacts are reflected by the proximal, intermediate and distal outcomes identified in the logic model.

Several outcomes were identified as reflecting the behavioral improvement and changes that program participants should display shortly after their participation in the MPOWRD program. These outcomes reflect both individual success and school success. For individuals, reducing addictive behavior and improving relationships are key outcomes. In a school or detention setting, improved attendance in school, a decrease in behavioral referrals to school administrators, improved academic performance in school and an increase in graduation rates. Regardless of setting, other outcomes could also be derived from MPOWRD such as improving family relationships and reducing criminogenic risk.

The existing online data system portal or the creation of an equivalent user-friendly online document to add key outputs and outcomes currently not collected. Initial input by facilitators for the additional means to assess each of these outcomes can be done during school breaks to provide a baseline measure of the number of classes or credit hours passed/failed or GPA, days absent, and behavioral referrals prior to participation in MPOWRD. These measures can continuously be added throughout the program's duration until completion of meetings or

graduation to measure improvements. Ideally, participants' classes passed or GPA, days absent, and behavioral referrals can be recorded every semester until the participant's graduation from the school and can provide an assessment of the behavioral changes. Additionally, recording participant's graduation rates would allow an assessment of durability after program completion. Ongoing data collection of these measures can serve a monitoring function through periodic reporting in order to manage site variation and promote best practices across sites. Data can be collected regardless of setting and should permit comparison across settings.
Several different information-gathering processes were carried out by the ASU evaluation staff in order to obtain sufficient information to develop a working program logical model and articulated program theory for this program.

Based on these techniques, an evaluability assessment was made to determine the feasibility of collecting outcome data to establish program impact. ASU also facilitated a meeting with program staff to finalize the MPOWRD logic model and develop a formal theory of change. The theory of change documents how the program activities link directly to outcomes. Oftentimes, programs engage in activities that are driven by funding streams, setting requirements, historical legacy (we have always done that) or simply because they "feel good" but these activities do not have the strength of program theory to support expected outcomes. By articulating a theory of change, the program staff becomes aware of how program activities directly support outcomes. The logic model captures this in a snapshot. The logic model and theory of change assist the program in supporting quality outcomes and promoting the importance of program fidelity because facilitators become aware of how their activities directly create outcomes. A theory of change can also identify those activities that clearly inhibit expected outcomes. Thus, programs increase efficiency and effectiveness by focusing on only those activities that promote expected outcomes.

Theory of change (TOC). It has been seen in many studies that adolescents who attend meetings with more similar aged peers are most likely to view the meetings as an important component on the road to recovery (Kelly, Myers, et al., 2005). MPOWRD is an inclusive program to adolescents in their respected age group and provides opportunities for adolescents to form positive social supports that encourage and motivate each other to participate. Because adolescents typically engage in addictive behaviors with others in their peer groups, group treatment can mirror their daily experience. Research suggests that mutual-help groups can help adolescents maintain recovery long term (Kelly and Urbanoski, 2012). Group support groups are associated with various features such as realization that others share similar experiences, development of socialization techniques and peer/facilitator feedback (Burleson et al., 2006). The reciprocity that adolescents receive from their peers is essential to working through challenges and can aid other adolescents to the road of self-realization. The opportunity to address distressing behaviors and situations adolescents encounter in their everyday lives with an adult and peer support appears to be helpful at least in changing adolescents' perceptions about their lives (Cone, Golden, and Hall, 2009). The realization that others share similar problems develops into positive socializing techniques and opportunities to enhance interpersonal learning, which are important skills for relapse prevention (Waldron and Kaminer, 2004). MPOWRD utilizes these strategies through a facilitated meeting and structured curriculum with supplemental activities such as "sidekicks," all of which contribute to improved personal growth and personal awareness. In turn, personal growth translates into sustained periods of abstinence

from addictive behaviors and substances among adolescents served in the program, which allows them to attend school more regularly, focus on academic performance, and reduce risky behavior and graduate.

MPOWRD Theory of Change

MPOWRD has developed the MPOWRD program to empower adolescents who struggle with addictive behavior. Addictive behavior is defined as any behavior that causes personal harm. Settings with an adolescent population age 13-18 who are at risk for addictive behavior utilize MPOWRD to achieve the following outcomes:

Educators, adult facilitators and other site professionals …

- Empower adolescents to make healthy decisions
- Provide an opportunity for at risk adolescents to be successful in the setting/ community
- Provide a mental health intervention that supports healthy decisions
- Support activities that build trust in peers
- Promote pro-social engagement

Facilitated meetings …

- Provide a safe place to explore/learn about addictive behaviors
- Promote the 12 steps to manage addictive behaviors
- Demonstrate to adolescents that they are not alone in their experience
- Demonstrate adolescents can rely on their peers for support
- Promote the development of empathy among adolescents
- Develop leadership skills
- Promote the value of service to others
- Provide an opportunity to model listening, acceptance, respect

Participants …

- Are engaged in an intervention that supports recovery from addictive behavior
- Understand the universal nature of addictive behavior and mitigate their isolation
- Learn to trust and rely on peers for support
- Empower themselves to change
- Acquire specific cognitive/behavior self-regulation skills to make healthy decisions
- Develop pro-social communication strategies and positive leadership skills
- Develop empathy and respect for others
- Support their peers in recovery from addictive behaviors
- Perceive others in the setting care about them so that will engage/remain in the setting

The following setting outcomes are achieved:

- The number of at risk adolescents making unhealthy decisions in the setting decreases

- The number of at risk adolescents who engage/remain in the setting increases
- The number of at risk adolescents who stay in school, achieve academic success, engage in pro-social activities and demonstrate positive leadership increases
- The number of students who are referred to alternative schools, become justice-involved, drop out, disengage, isolate, or engage in negative behavior decreases

The following community outcomes are achieved:

- Community settings that serve adolescents such as schools, clubs, jails and detention centers:
  - remain productive, safe, rehabilitative and educative environments
  - increase pro-social community engagement *for all* adolescents in the community
- The number of at risk students who remain in pro-social community settings and traditional educational settings increases;
- The number of at risk adolescents who become contributing members in the community through community settings increases

Recommendations

The next steps for TEEN AA include the following:

- Developing a data collection protocol which would include data collection procedures, a data map, additional instruments and sampling frame to support ongoing data collection. A data map identifies data needed for process and outcome evaluations and then maps the data to specific collection procedures. Data on program demographics and additional process/outcome data should be collected to support a comprehensive and rigorous evaluation. A brief assessment instrument to assess critical outcomes at baseline and follow-up should be developed to support a rigorous evaluation and supplement outcome data that is not currently collected. The data portal could be utilized to upload all or most key outcome data (with modification).
- Designing an outcome study that is both feasible and meets a level of methodological rigor required to support valid and reliable conclusions. A comprehensive evaluation plan should be drafted to identify the logic model, program theory, data and research design to assess program process and outcomes. To meet the highest standards of scientific rigor needed for the program to become eligible for NREPP registry as a promising practice, the design should reflect an experimental or quasi-experimental approach and sufficient power to draw meaningful and statistically significant conclusions. Specifically, the evaluation design should incorporate at a minimum 80 participants at multiple sites over at least one academic year. The study should also establish a pre-intervention baseline and post-intervention outcomes with valid instruments, use a control or matched comparison group, and methodologies to analyze results that insure valid and reliable conclusions. Current clients and new community partners can play an important role in the program's effort to seek promising practice status by supporting a multi-site outcome evaluation through ongoing data collection.

Appendix A

Annotated Bibliography

The following list of articles was compiled from peer-reviewed journals using the search terms such as *adolescent twelve-step program participation, mutual self-help groups, peer support groups, evidence-based practices on adolescent recovery of substance abuse, effectiveness of AA on teen recovery, adolescent interventions on alcohol, adolescent interventions on substance abuse,* and *drug educational programs.* Of the full body of articles located, those which addressed adolescents and teens directly and which showed evidence of therapeutic success were included in this collection. The articles are listed in alphabetical order by primary author.

Amodeo, M., Lundgren, L., Cohen, A., Rose, D., Chassler, D., Beltrame, C., & D'Ippolito, M. (2011). Barriers to implementing evidence-based practices in addiction treatment programs: Comparing staff reports on motivational interviewing, adolescent community reinforcement approach, assertive community treatment, and cognitive-behavioral therapy. *Evaluation and Program Planning, 34*(4), 382-389. doi:10.1016/j.evalprogplan.2011.02.005

Abstract: This qualitative study explored barriers to implementing evidence-based practices (EBPs) in community-based addiction treatment organizations (CBOs) by comparing staff descriptions of barriers for four EBPs: Motivational Interviewing (MI), Adolescent Community Reinforcement Approach (A-CRA), Assertive Community Treatment (ACT), and Cognitive-behavioral Therapy (CBT). Methods: The CBOs received CSAT/SAMHSA funding from 2003 to 2008 to deliver services using EBPs. Phone interview responses from 172 CBO staff directly involved in EBP implementation were analyzed using content analysis, a method for making inferences and developing themes from the systematic review of participant narratives (Berelson, 1952). Results: Staff described different types of barriers to implementing each EBP. For MI, the majority of barriers involved staff resistance or organizational setting. For A-CRA, the majority of barriers involved specific characteristics of the EBP or client resistance. For CBT, the majority of barriers were associated with client resistance, and for ACT, the majority of barriers were associated with resources. Discussion: EBP designers, policy makers who support EBP dissemination and funders should include explicit strategies to address such barriers. Addiction programs proposing to use specific EBPs must consider whether their programs have the organizational capacity and community capacity to meet the demands of the EBP selected.

Beck, S., & Olivet, D. C. (1988). Adapting the alcoholics anonymous model in adolescent alcohol treatment. *Holistic Nursing Practice*, *2*(4), 28-33. http://journals.lww.com/hnpjournal/Citation/1988/08000/Adapting_the_Alcoholics_Anonymous_model_in.7.aspx

Boisvert, R. A., Martin, L. M., Grosek, M., & Clarie, A. J. (2008). Effectiveness of a peer-support community in addiction recovery: Participation as intervention. *Occupational Therapy International, 15*(4), 205-220. doi:10.1002/oti.257

Abstract: The main purpose of the study was to determine whether a peer-support community program would reduce relapse rates among clients recovering from substance addictions and homelessness and result in increased perceived community affiliation, supportive behaviors, self-determination and quality of life. Mixed methods were utilized including semi-structured interviews, participant observation and a pretest/post-test to evaluate changes on the quality of life rating, the Medical Outcomes Study-Social Support Survey, and the Volitional Questionnaire. Data from the prior year's permanent supportive housing program were used for comparison of relapse rates. Significant reduction of risk of relapse was found in clients who participated in the program. Significant differences were found on three subscales of the Medical Outcomes Study-Social Support Survey. Improvement that did not reach statistical significance was seen on the quality of life rating. Qualitative evidence supported improvements in perceived community affiliation and supportive behaviors. Evidence suggests that a peer-supported community program focused on self-determination can have a significant positive impact on recovery from substance addictions and homelessness. Limitations include a small sample size and lack of a randomized control group.

Burleson, J. A., Kaminer, Y., & Dennis, M. L. (2006). Absence of iatrogenic or contagion effects in adolescent group therapy: Findings from the cannabis youth treatment (CYT) study. *American Journal on Addictions, 15*(S1), 4-15. doi:10.1080/10550490601003656

Abstract: Though widely used and presumed effective in practice, some scholars (Dishion et al., 1999) have raised the concern that group therapy for adolescents with substance use disorder and a range of deviancy has the potential for causing iatrogenic effects (e.g., increased substance use, behavior and legal problems) for those with low deviancy. Using data from 400 youth in the largest adolescent treatment experiment conducted to date (Dennis et al., 2004), this study shows that group composition in terms of conduct disorder symptoms is not associated with worse substance use, psychological, environmental or legal treatment outcomes. The results actually indicated that there was a slight advantage for youth with high conduct disorder to be included in the groups with fewer symptoms. The results appear consistent with recent meta-analyses of delinquency studies (Lipsey, 2006) which have found no evidence of iatrogenic effects. These results support the common clinical belief that group therapy for youths with substance use disorders is a safe and effective treatment modality.

Chi, F. W., Campbell, C. I., Sterling, S., & Weisner, C. (2012). Twelve-step attendance trajectories over seven years among adolescents entering substance use treatment in an integrated health plan. *Addiction (Abingdon, England), 107*(5), 933-942. doi:10.1111/j.1360-0443.2011.03758.x

Summary: This study examines 12-Step attendance trajectories over 7 years, factors associated with the trajectories, and relationships between the trajectories and long-term substance use outcomes among adolescents entering out-patient substance use treatment in a private, non-profit integrated managed-care health plan.

Chi, F. W., Kaskutas, L. A., Sterling, S., Campbell, C. I., & Weisner, C. (2009). Twelve-step affiliation and 3-year substance use outcomes among adolescents: Social support and religious service attendance as potential mediators. *Addiction, 104*(6), 927-939.

Abstract: Twelve-Step affiliation among adolescents is little understood. We examined 12-Step affiliation and its association with substance use outcomes 3 years post-treatment intake among adolescents seeking chemical dependency (CD) treatment in a private, managed-care health plan. We also examined the effects of social support and religious service attendance on the relationship. We analyzed data for 357 adolescents, aged 13-18, who entered treatment at four Kaiser Permanente Northern California CD programs between March 2000 and May 2002 and completed both baseline and 3-year follow-up interviews. Measures at follow-up included alcohol and drug use, 12-Step affiliation, social support and frequency of religious service attendance. At 3 years, 68 adolescents (19%) reported attending any 12-Step meetings, and 49 (14%) reported involvement in at least one of seven 12-Step activities, in the previous 6 months. Multivariate logistic regression analyses indicated that after controlling individual and treatment factors, 12-Step attendance at 1 year was marginally significant, while 12-Step attendance at 3 years was associated with both alcohol and drug abstinence at 3 years [odds ratio (OR) 2.58, $P < 0.05$ and OR 2.53, $P < 0.05$, respectively]. Similarly, 12-Step activity involvement was associated significantly with 30-day alcohol and drug abstinence. There are possible mediating effects of social support and religious service attendance on the relationship between post-treatment 12-Step affiliation and 3-year outcomes. The findings suggest the importance of 12-Step affiliation in maintaining long-term recovery, and help to understand the mechanism through which it works among adolescents.

Collier, C., Simpson, S., Najera, J., & Weiner, L. (2012). Peer influence and recovery. *Prevention Researcher, 19*(5), 6.

Abstract: Research has shown that peer influence can be negative, by increasing the likelihood that a youth will engage in high-risk behaviors and make risky decisions. However, peer influence can also be positive and protect a youth from these same high-risk activities. This article examines the extent of peer influence and then describes the Alternative Peer Group (APG) model. The APG model provides a number of recovery support services, ranging from 12-step meetings, to psychosocial education for youth and their parents. However, the most important component is the use of a positive peer group to promote and support recovery.

Cone, J. C., Golden, J. A., & Hall, C. W. (2009). The effect of short-term cognitive-behavioral group therapy on adolescents with attachment difficulties. *Behavioral Development Bulletin, 15*(1), 29-35. doi:10.1037/h0100511

Abstract: This study was designed to investigate the effect of short-term cognitive-behavioral group therapy on fourteen adolescents with attachment difficulties. All of the participants in this study had a history of child abuse/neglect and have been in foster or adoptive care. Participants were divided

into two male adolescent groups and two female adolescent groups. Each participant completed the Reynolds Adolescent Adjustment Screening Inventory (RAASI; Reynolds, 2001) pre – and post group intervention. A six-week group intervention resulted in a significant change in self-ratings on measures of both externalizing and internalizing adjustment problems. Results of the study are encouraging given that there is a stigma among adolescents, especially males, related to disclosing in groups with peers (Black & Rosenthal, 2005).

Dennis, M., Godley, S. H., Diamond, G., Tims, F. M., Babor, T., Donaldson, J.. . Funk, R. (2004). The cannabis youth treatment (CYT) study: Main findings from two randomized trials. *Journal of Substance Abuse Treatment, 27*(3), 197-213. doi:10.1016/j.jsat.2003.09.005

Abstract: This article presents the main outcome findings from two inter-related randomized trials conducted at four sites to evaluate the effectiveness and cost-effectiveness of five short-term outpatient interventions for adolescents with cannabis use disorders. Trial I compared five sessions of Motivational Enhancement Therapy plus Cognitive Behavioral Therapy (MET/CBT) with a 12-session regimen of MET and CBT (MET/CBT 12) and another that included family education and therapy components (Family Support Network [FSN]). Trial II compared the five-session MET/CBT with the Adolescent Community Reinforcement Approach (ACRA) and Multidimensional Family Therapy (MDFT). The 600 cannabis users predominately were white males, aged 15-16. All five CYT interventions demonstrated significant pre-post treatment improvements during the 12 months after random assignment to a treatment intervention in the two main outcomes: days of abstinence and the percent of adolescents in recovery (no use or abuse/dependence problems and living in the community). Overall, the clinical outcomes were very similar across sites and conditions; however, after controlling for initial severity, the most cost-effective interventions were MET/CBT5 and MET/CBT12 in Trial 1 and ACRA and MET/CBT5 in Trial 2. It is possible that the similar results occurred because outcomes were driven more by general factors beyond the treatment approaches tested in this study; or because of shared, general helping factors across therapies that helped these teens attend to and decrease their connection to cannabis and alcohol.

Fine, S., Forth, A., Gilbert, M., & Haley, G. (1991). Group therapy for adolescent depressive disorder: A comparison of social skills and therapeutic support. *Journal of the American Academy of Child & Adolescent Psychiatry, 30*(1), 79-85. doi:10.1097/00004583-199101000-00012

Abstract: Two forms of short-term group therapy for depressed adolescents are compared. Adolescents were assigned to either a social skills training or therapeutic support group. Treatment outcome was based on self-report and semi-structured clinical interviews for depression, measures of self-concept, and cognitive distortions. After treatment, adolescents in the therapeutic support groups showed significantly greater reductions in clinical depression and

significant increases in self-concept compared with those in the social skills training group. These group differences were no longer evident at 9-month follow-up, as adolescents in the therapeutic support groups maintained their improvement, and adolescents in the social skills training groups caught up.

Frank, K., Muller, C., Schiller, K., Riegle-Crumb, C., Mueller, A., Crosnoe, R., & Pearson, J. (2008). The social dynamics of mathematics coursetaking in high School. *American Journal of Sociology, 113*(6), 1645-1696. doi:10.1086/587153

Summary: This study examines how high school boys' and girls' academic effort, in the form of math coursetaking, is influenced by members of their social contexts. The authors argue that adolescents' social contexts are defined, in part, by clusters of students (termed "local positions") who take courses that differentiate them from others. Using course transcript data from the recent Adolescent Health and Academic Achievement Study, the authors employ a new network algorithm to identify local positions in 78 high schools in the National Longitudinal Study of Adolescent Health. Incorporating the local positions into multilevel models of math coursetaking, the authors find that girls are highly responsive to the social norms in their local positions, which contributes to homogeneity within and heterogeneity between local positions.

Gangi, J., & Darling, C. A. (2012). Adolescent substance-use frequency following self-help group attendance and outpatient substance abuse treatment. *Journal of Child & Adolescent Substance Abuse, 21*(4), 293-309. doi:10.1080/1067828X.2012.702937

Abstract: Despite the heterogeneity of posttreatment outcomes, the likelihood of relapse is often dependent on several factors, including participation in continuing care services such as self-help groups. However, few studies have examined the use of self-help groups among adolescent outpatients. Therefore, in this study, investigators examined self-help group attendance among male and female adolescents during the three-month time period immediately following outpatient substance abuse treatment. Gender differences were found in regard to self-efficacy, coping, and severity of substance-related problems. A path model indicated that environmental risk provided the greatest total effect on substance-use frequency. Implications for research and practice are reviewed.

Godley, S. H., Smith, J. E., Passetti, L. L., & Subramaniam, G. (2014). The adolescent community reinforcement approach (A-CRA) as a model paradigm for the management of adolescents with substance use disorders and co-occurring psychiatric disorders. *Substance Abuse, 35*(4), 352-363. doi:10.1080/08897077.2014.936993

Abstract: Background: Integrated treatment for youth with substance use disorders (SUDs) and co-occurring psychiatric disorders is recommended; however, there are few studies that have evaluated integrated treatment approaches. Methods: This paper includes a brief review of cognitive-behavioral and family therapies, since they have been demonstrated to be effective treatments for the disorders that commonly co-occur with substance use. It also describes how an integrated treatment paradigm has been implemented using

one Empirically Supported Treatment, the Adolescent Community Reinforcement Approach (A-CRA). Results: There is existing research that supports the use of several A-CRA procedures to treat substance use and commonly co-occurring psychiatric disorders. Conclusions: In the absence of further research, it is reasonable in the interim to train clinicians in treatments that incorporate components that have been found to be effective for both substance use and commonly co-occurring psychiatric disorders. These treatments can then be adapted as needed based on an individual youth's set of problems. Further research is needed to test treatments for various combinations of SUDs and psychiatric disorders (i.e., depression, trauma-related problems, conduct disorder/behavior problems, and attention-deficit/hyperactivity disorder [ADHD]).

Green, J. M., Wood, A. J., Kerfoot, M. J., Trainor, G., Roberts, C., Rothwell, J., & Harrington, R. (2011). Group therapy for adolescents with repeated self harm: Randomised controlled trial with economic evaluation. *BMJ (Clinical Research Ed.), 342*(apr01 1), d682-d682. doi:10.1136/bmj.d682

Abstract: To examine the effectiveness and cost-effectiveness of group therapy for self harm in young people. Two arm, single (assessor) blinded parallel randomized allocation trial of a group therapy intervention in addition to routine care, compared with routine care alone. Randomization was by minimization controlling for baseline frequency of self harm, presence of conduct disorder, depressive disorder, and severity of psychosocial stress. Adolescents aged 12-17 years with at least two past episodes of self harm within the previous 12 months. Exclusion criteria were: not speaking English, low weight anorexia nervosa, acute psychosis, substantial learning difficulties (defined by need for specialist school), current containment in secure care. Setting: Eight child and adolescent mental health services in the northwest UK. Manual based developmental group therapy program specifically designed for adolescents who harm themselves, with an acute phase over six weekly sessions followed by a booster phase of weekly groups as long as needed. Details of routine care were gathered from participating centers. Primary outcome was frequency of subsequent repeated episodes of self harm. Secondary outcomes were severity of subsequent self harm, mood disorder, suicidal ideation, and global functioning. Total costs of health, social care, education, and criminal justice sector services, plus family related costs and productivity losses, were recorded. 183 adolescents were allocated to each arm (total n = 366). Loss to follow-up was low (<4%). On all outcomes the trial cohort as a whole showed significant improvement from baseline to follow-up. On the primary outcome of frequency of self harm, proportional odds ratio of group therapy versus routine care adjusting for relevant baseline variables was 0.99 (95% confidence interval 0.68 to 1.44, P = 0.95) at 6 months and 0.88 (0.59 to 1.33, P = 0.52) at 1 year. For severity of subsequent self harm the equivalent odds ratios were 0.81 (0.54 to 1.20, P = 0.29) at 6 months and 0.94 (0.63 to 1.40, P = 0.75) at 1 year. Total 1 year costs were higher in the group therapy arm (£21,781) than for routine care (£15,372) but the difference was not significant (95% CI -1416 to 10782, P = 0.132). The

addition of this targeted group therapy program did not improve self harm outcomes for adolescents who repeatedly self harmed, nor was there evidence of cost effectiveness. The outcomes to end point for the cohort as a whole were better than current clinical expectations.

Hendriks, V., van der Schee, E., & Blanken, P. (2011). Treatment of adolescents with a cannabis use disorder: Main findings of a randomized controlled trial comparing multidimensional family therapy and cognitive behavioral therapy in the Netherlands. *Drug and Alcohol Dependence, 119*(1-2), 64-71. doi:10.1016/j.drugalcdep.2011.05.021

Abstract: To meet the treatment needs of the growing number of adolescents who seek help for cannabis use problems, new or supplementary types of treatment are needed. We investigated whether multidimensional family therapy (MDFT) was more effective than cognitive behavioral therapy (CBT) in treatment-seeking adolescents with a DSM-IV cannabis use disorder in The Netherlands. One hundred and nine adolescents participated in a randomized controlled trial, with study assessments at baseline and at 3, 6, 9 and 12 months following baseline. They were randomly assigned to receive either outpatient MDFT or CBT, both with a planned treatment duration of 5–6 months. Main outcome measures were cannabis use, delinquent behavior, treatment response and recovery at one-year follow-up, and treatment intensity and retention. MDFT was not found to be superior to CBT on any of the outcome measures. Adolescents in both treatments did show significant and clinically meaningful reductions in cannabis use and delinquency from baseline to one-year follow-up, with treatment effects in the moderate range. A substantial percentage of adolescents in both groups met the criteria for treatment response at month 12. Treatment intensity and retention was significantly higher in MDFT than in CBT. Post hoc subgroup analyses suggested that high problem severity subgroups at baseline might benefit more from MDFT than from CBT. The current study indicates that MDFT and CBT are equally effective in reducing cannabis use and delinquent behavior in adolescents with a cannabis use disorder in The Netherlands.

Hides, L., Carroll, S., Catania, L., Cotton, S. M., Baker, A., Scaffidi, A., & Lubman, D. I. (2010). Outcomes of an integrated cognitive behaviour therapy (CBT) treatment program for co-occurring depression and substance misuse in young people. *Journal of Affective Disorders, 121*(1), 169-174. doi:10.1016/j.jad.2009.06.002

Abstract: There are high rates of co-occurring depression among young people with substance use disorders. While there is preliminary evidence for the effectiveness of integrated cognitive behavior therapy (CBT) in combination with antidepressants among alcohol and substance dependent adolescents and adults with co-existing depression, no studies have examined the effectiveness of integrated CBT interventions in the absence of pharmacotherapy. The aim of the current study was to determine the outcomes of an integrated CBT intervention for co-occurring depression and substance misuse in young people

presenting to a mental health setting. Sixty young people (aged 15 to 25), with a DSM-IV diagnosis of Major Depressive Disorder and concurrent substance misuse (at least weekly use in the past month) or disorder were recruited from a public youth mental health service in Melbourne, Australia. Participants received 10 sessions of individual integrated CBT treatment delivered with case management over a 20-week period. The intervention was associated with significant improvements in depression, anxiety, substance use, coping skills, depressive and substance use cognitions and functioning at mid- (10 weeks) and post- (20 weeks) treatment. These changes were maintained at 6 months follow-up (44 weeks). These results provide preliminary evidence for the effectiveness of the integrated CBT intervention in young people with co-occurring depression and substance misuse. Further studies using randomized controlled designs are required to determine its efficacy.

Humphreys, K., Wing, S., McCarty, D., Chappel, J., Gallant, L., Haberle, B.. . Weiss, R. (2004). Self-help organizations for alcohol and drug problems: Toward evidence-based practice and policy. *Journal of Substance Abuse Treatment, 26*(3), 151-158. doi:10.1016/S0740-5472(03)00212-5

Summary: This expert consensus statement reviews evidence on the effectiveness of drug and alcohol self-help groups and presents potential implications for clinicians, treatment program managers and policymakers. Because longitudinal studies associate self-help group involvement with reduced substance use, improved psychosocial functioning, and lessened health care costs, there are humane and practical reasons to develop self-help group supportive policies. Policies described here that could be implemented by clinicians and program managers include making greater use of empirically-validated self-help group referral methods in both specialty and non-specialty treatment settings and developing a menu of locally available self-help group options that are responsive to client's needs, preferences, and cultural background. The workgroup also offered possible self-help supportive policy options (e.g., supporting self-help clearinghouses) for state and federal decision makers. Implementing such policies could strengthen alcohol and drug self-help organizations, and thereby enhance the national response to the serious public health problem of substance abuse.

Kaminer, Y., & Slesnick, N. (2005). *Evidence-based cognitive-behavioral and family therapies for adolescent alcohol and other substance use disorders*. (pp. 383-405). Boston, MA: Springer US.

Kelly, J. F., Brown, S. A., Abrantes, A., Kahler, C., & Myers, M. (2008). Social Recovery Model: An 8-Year Investigation of Adolescent 12-step Group Involvement following Inpatient Treatment. *Alcoholism, Clinical and Experimental Research*, *32*(8), 1468–1478. http://doi.org/10.1111/j.1530-0277.2008.00712.x

Abstract: Despite widespread use of 12-step treatment approaches and referrals to Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) by youth

providers, little is known about the significance of these organizations in youth addiction recovery. Furthermore, existing evidence is based mostly on short-term follow-up and is limited methodologically. Adolescent inpatients (n = 160; mean age = 16, 40% female) were followed at 6-months, and at 1, 2, 4, 6, and 8 years posttreatment. Time-lagged, generalized estimating equations modeled treatment outcome in relation to AA/NA attendance controlling for static and time-varying covariates. Robust regression (locally weighted scatterplot smoothing) explored dose-response thresholds of AA/NA attendance on outcome. The AA/NA attendance was common and intensive early posttreatment, but declined sharply and steadily over the 8-year period. Patients with greater addiction severity and those who believed that they could not use substances in moderation were more likely to attend. Despite declining attendance, the effects related to AA/NA remained significant and consistent. Greater early participation was associated with better long-term outcomes. Even though many youth discontinue AA/NA over time, attendees appear to benefit, and more severely substance-involved youth attend most. Successful early posttreatment engagement of youth in abstinence-supportive social contexts, such as AA/NA, may have long-term implications for alcohol and drug involvement into young adulthood.

Kelly, J. F., Dow, S. J., Yeterian, J. D., & Kahler, C. W. (2010). Can 12-step group participation strengthen and extend the benefits of adolescent addiction treatment? A prospective analysis. *Drug and Alcohol Dependence*, *110*(1), 117-125.

Abstract: Despite advances in the development of treatments for adolescents with substance use disorders (SUD), relapse remains common following an index treatment episode. Community continuing care resources, such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), have been shown to be helpful and cost-effective recovery resources among adults. However, little is known about the clinical utility and effectiveness of AA/NA for adolescents, despite widespread treatment referrals. Method: Adolescents (N=127; 24% female, 87% White, M age=16.7 years) enrolled in a naturalistic, prospective study of community outpatient treatment were assessed at intake, and 3 and 6 months later using a battery of standardized and validated measures. Results: Just over one-quarter of youth attended AA/NA meetings during the first 3 months, which was predicted by a goal of abstinence, prior AA/NA attendance, and prior SUD treatment experiences. Controlled multiple regression analyses revealed an independent effect of AA/NA on abstinence, in both contemporaneous and lagged models, which persisted over and above the effects of pre-treatment AA/NA attendance, prior treatment, self-efficacy, abstinence goal, and concomitant outpatient treatment. Conclusions: Results suggest that, similar to findings comparing adult outpatients to inpatients, AA/NA participation is less common among less severe adolescent outpatients. Nonetheless, attendance appears to strengthen and extend the benefits of typical community outpatient treatment. Given the dramatic increase in rates of substance use among same-aged peers in the population at this life-stage, and the relative dearth of abstainers and recovery-specific supports, these resources may

provide a concentrated cost-effective social recovery resource for young people.

Kelly, J. F., & Myers, M. G. (2007). Adolescents' participation in alcoholics anonymous and narcotics anonymous: Review, implications and future directions. *Journal of Psychoactive Drugs, 39*(3), 259-269. doi:10.1080/02791072.2007.10400612

Abstract: Youth treatment programs frequently employ 12-Step concepts and encourage participation in Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). Since AA/NA groups are easily accessible at no charge and provide flexible support at times of high relapse risk they hold promise as a treatment adjunct in an increasingly cost-constricting economic climate. Yet, due to concerns related to adolescents' developmental status, skepticism exists regarding the utility of AA/NA for youth. This review evaluates the empirical evidence in this regard, identifies and discusses knowledge gaps, and recommends areas for future research. Searches were conducted in PsychINFO, Medline, relevant literature and by personal correspondence. Findings suggest youth may benefit from AA/NA participation following treatment, but conclusions are limited by four important factors: (1) a small number of studies; (2) no studies with outpatients; (3) existing evidence is solely observational; and (4) only partial measurement of the 12-Step construct. While surveys of adolescent SUD treatment programs indicate widespread clinical interest and application of adult-derived 12-Step approaches this level of enthusiasm has not been reflected in the research community. Qualitative research is needed to improve our understanding of youth-specific AA/NA barriers, and efficacy, comparative effectiveness, and process studies are still needed to inform clinical practice guidelines for youth providers.

Kelly, J. F., Myers, M. G., & Brown, S. A. (2002). Do adolescents affiliate with 12-step groups? A multivariate process model of effects. *Journal of Studies on Alcohol, 63*(3), 293.

Abstract: Research with adolescents has revealed salutary effects for 12-step attendance on substance use outcomes, but no studies have examined the effects of 12-step affiliation, or active involvement, beyond simple measures of attendance. Prior research with adults has shown that measures of affiliation are more predictive than measures of attendance. This study (1) assessed attributes that may influence 12-step attendance and affiliation; (2) tested whether 12-step affiliation in the first 3 months posttreatment possessed unique predictive power above that attributable to attendance alone; and (3) examined the extent to which motivation, coping and self-efficacy measured at 3 months mediated the relation between 12-step affiliation and substance use outcome in the ensuing 3 months. Method: Adolescent inpatients (N5= 74, 62% female), who were aged 14-18 years (mean [SD] = 15.9 [1.19] years), were interviewed during treatment and at three and six months post-discharge. Results: More severely substance-involved youth were more motivated for abstinence and more likely to attend and affiliate with 12-step groups. A high degree of collinearity between 12-step attendance and affiliation suggested that those attending were also likely to be those actively involved. Consequently, affiliation did not predict outcome over and

above frequency of attendance. Motivation was found to influence the relationship between 12-step affiliation and future substance use outcome. Conclusions: Given the widespread treatment recommendations for adolescent 12-step involvement, more study is needed to determine what kinds and what aspects of 12-step groups and fellowships are helpful to adolescent change efforts and what alternatives should be developed.

Kelly, J. F., Myers, M. G., & Brown, S. A. (2005). The Effects of Age Composition of 12-Step Groups on Adolescent 12-Step Participation and Substance Use Outcome. *Journal of Child & Adolescent Substance Abuse, 15*(1), 63–72. http://doi.org/10.1300/J029v15n01_05

Abstract: Youth substance use disorder treatment programs frequently advocate integration into 12-Step fellowships to help prevent relapse. However, the effects of the predominantly adult composition of 12-step groups on adolescent involvement and substance use outcome remain unstudied. Greater knowledge could enhance the specificity of treatment recommendations for youth. To this end, adolescents (N = 74; M age = 15.9, 62% female) were recruited during inpatient treatment and followed up 3 and 6 months later. Greater age similarity was found to positively influence attendance rates and the perceived importance of attendance, and was marginally related to increased step-work and less substance use. These preliminary findings suggest locating and directing youth to meetings where other youth are present may improve 12-step attendance, involvement, and substance use outcomes.

Kelly, J., Stout, R., Greene, M., & Slaymaker, V. (2014). Young adults, social networks, and addiction recovery. *Alcoholism-Clinical and Experimental Research, 38*, 323A-323A.

Abstract: Social factors play a key role in addiction recovery. Research with adults indicates individuals with substance use disorder (SUD) benefit from mutual-help organizations (MHOs), such as Alcoholics Anonymous, via their ability to facilitate adaptive network changes. Given the lower prevalence of sobriety-conducive, and sobriety-supportive, social contexts in the general population during the life-stage of young adulthood, however, 12-step MHOs may play an even more crucial recovery-supportive social role for young adults, but have not been investigated. Greater knowledge could enhance understanding of recovery-related change and inform young adults' continuing care recommendations. Methods Emerging adults (N = 302; 18-24 years; 26% female; 95% white) enrolled in a study of residential treatment effectiveness were assessed at intake, 1, 3, 6, and 12 months on 12-step attendance, peer network variables ("high [relapse] risk" and "low [relapse] risk" friends), and treatment outcomes (Percent Days Abstinent; Percent Days Heavy Drinking). Hierarchical linear models tested for change in social risk over time and lagged mediational analyses tested whether 12-step attendance conferred recovery benefits via change in social risk. Results High-risk friends were common at treatment entry, but decreased during follow-up; low-risk friends increased. Contrary to predictions, while substantial recovery-supportive friend network changes were observed, this was unrelated to 12-step participation and, thus, not

found to mediate its positive influence on outcome. Conclusions Young adult 12-step participation confers recovery benefit; yet, while encouraging social network change, 12-step MHOs may be less able to provide social network change directly for young adults, perhaps because similar-aged peers are less common in MHOs. Findings highlight the importance of both social networks and 12-step MHOs and raise further questions as to how young adults benefit from 12-step MHOs.

Kelly, J. F., & Urbanoski, K. (2012). Youth recovery contexts: The incremental effects of 12-Step attendance and involvement on adolescent outpatient outcomes. *Alcoholism: Clinical and Experimental Research, 36*(7), 1219-1229. doi:10.1111/j.1530-0277.2011.01727.x

Abstract: A major barrier to youth recovery is finding suitable sobriety-supportive social contexts. National studies reveal most adolescent addiction treatment programs link youths to community 12-step fellowships to help meet this challenge, but little is known empirically regarding the extent to which adolescents attend and benefit from 12-step meetings or whether they derive additional gains from active involvement in prescribed 12-step activities (e.g., contact with a sponsor and other fellowship members). Greater knowledge in this area would enhance the efficiency of clinical continuing care recommendations. Methods Adolescent outpatients (N = 127; M age 16.7; 75% male; 87% white) enrolled in a naturalistic study of treatment effectiveness were assessed at intake and 3, 6, and 12 months later using standardized assessments. Mixed-effects models, controlling for static and time-varying confounds, examined the concurrent and lagged effects of 12-step attendance and active involvement on abstinence over time. Results The proportion attending 12-step meetings was relatively low across follow-up (24 to 29%), but more frequent attendance was independently associated with greater abstinence in concurrent and, to a lesser extent, lagged models. An 8-item composite measure of 12-step involvement did not enhance outcomes over and above attendance, but separate components did; specifically, greater contact with a 12-step sponsor outside of meetings and more verbal participation during meetings. Conclusions The benefits of 12-step participation observed among adult samples extend to adolescent outpatients. Community 12-step fellowships appear to provide a useful sobriety-supportive social context for youths seeking recovery, but evidence-based youth-specific 12-step facilitation strategies are needed to enhance outpatient attendance rates.

Kelly, J. F., Yeterian, J. D., & Myers, M. G. (2008). Treatment staff referrals, participation expectations, and perceived benefits and barriers to adolescent involvement in twelve-step groups. *Alcoholism Treatment Quarterly, 26*(4), 427-449. doi:10.1080/07347320802347053

Abstract: Adolescents treated for substance use disorders (SUDs) appear to benefit from participation in Alcoholics Anonymous/Narcotics Anonymous (AA/NA). However, as compared with adults, fewer adolescents attend, and those who do attend do so less intensively and discontinue sooner. It is unknown

whether this disparity is due to a lowered expectation for youth participation by the clinicians treating them, as they may adapt the adult-based model to fit a less-dependent cohort, or whether recommendations are similar to those of clinicians who work with adults and other factors are responsible. All clinical staff (N = 114) at 5 adolescent programs (3 residential, 2 outpatient) were surveyed anonymously about referral practices and other beliefs about 12-step groups. Staff rated AA/NA participation as very important and helpful to adolescent recovery and referral rates were uniformly high (M = 86%, SD = 28%). Desired participation frequency was over 3 times per week. The theoretical orientation and level of care of the programs influenced some results. Findings suggest lower adolescent participation in 12-step groups is not due to a lack of clinician enthusiasm or referrals, but appears to be due to other factors.

Kendall, P. C., & Peterman, J. S. (2015). CBT for adolescents with anxiety: Mature yet still developing. *The American Journal of Psychiatry, 172*(6), 519.

Abstract: Anxiety disorders are common in adolescents (ages 12 to 18) and contribute to a range of impairments. There has been speculation that adolescents with anxiety are at risk for being treatment nonresponders. In this review, the authors examine the efficacy of cognitive-behavioral therapy (CBT) for adolescents with anxiety. Outcomes from mixed child and adolescent samples and from adolescent-only samples indicate that approximately two-thirds of youths respond favorably to CBT. CBT produces moderate to large effects and shows superiority over control/comparison conditions. The literature does not support differential outcomes by age: adolescents do not consistently manifest poorer outcomes relative to children. Although extinction paradigms find prolonged fear extinction in adolescent samples, basic research does not fully align with the processes and goals of real-life exposure. Furthermore, CBT is flexible and allows for tailored application in adolescents, and it may be delivered in alternative formats (i.e., brief, computer/Internet, school-based, and transdiagnostic CBT).

King, K. A., Strunk, C. M., & Sorter, M. T. (2011). Preliminary effectiveness of surviving the teens suicide prevention and depression awareness program on adolescents' suicidality and Self-Efficacy in performing Help-Seeking behaviors. *Journal of School Health, 81*(9), 581-590. doi:10.1111/j.1746-1561.2011.00630.x

Abstract: Suicide ranks as the third leading cause of death among youth aged 15-24 years. Schools provide ideal opportunities for suicide prevention efforts. However, research is needed to identify programs that effectively impact youth suicidal ideation and behavior. This study examined the immediate and 3-month effect of Surviving the Teens[R] Suicide Prevention and Depression Awareness Program on students' suicidality and perceived self-efficacy in performing help-seeking behaviors. Methods: High school students in Greater Cincinnati schools were administered a 3-page survey at pretest, immediate posttest, and 3-month follow-up. A total of 1,030 students participated in the program, with 919 completing matched pretests and posttests (89.2%) and 416 completing matched pretests and 3-month follow-ups (40.4%). Results: Students were significantly less likely at 3-month follow-up than at pretest to

be currently considering suicide, to have made a suicidal plan or attempted suicide during the past 3 months, and to have stopped performing usual activities due to feeling sad and hopeless. Students' self-efficacy and behavioral intentions toward help-seeking behaviors increased from pretest to posttest and were maintained at 3-month follow-up. Students were also more likely at 3-month follow-up than at pretest to know an adult in school with whom they felt comfortable discussing their problems. Nine in 10 (87.3%) felt the program should be offered to all high school students. Conclusions: The findings of this study lend support for suicide prevention education in schools. The results may be useful to school professionals interested in implementing effective suicide prevention programming to their students.

Mason, M. J., & Luckey, B. (2003). Young adults in alcohol-other drug treatment: An understudied population. *Alcoholism Treatment Quarterly, 21*(1), 17-32. doi:10.1300/J020v21n01_02

Abstract: A sample of 98 young adults, ages 18-25, was drawn from an alcohol treatment sample of 1,022 from two large metropolitan urban settings and was compared with the remainder of the sample to describe differences and compare outcomes. The findings indicate that the young adults are a unique substance abuse age group with characteristics and needs that differ from the adult treatment population. Systematic differences were revealed between the young adult group and the remainder of the sample on five domains: Education and Employment with the young adults Relationships; Mental Health; Alcohol and Drug Use; and Alcoholics Anonymous Involvement. The results of this study indicate that the young adult age group has unique psychosocial and behavioral needs when compared to those of an adult treatment population, and these needs may be linked to treatment retention and outcome.

Mogro-Wilson, C., Letendre, J., Toi, H., & Bryan, J. (2015). Utilizing mutual aid in reducing adolescent substance use and developing group engagement. *Research on Social Work Practice, 25*(1), 129-138. doi:10.1177/1049731513518080

Abstract: This study assessed the effectiveness of mutual aid groups for high school students. Methods: A quasi-experimental design was applied to 242 adolescents, where every other adolescent was assigned to the intervention or the control condition. The study evaluated the influence of implementing mutual aid groups in decreasing perceived risk of substance use, favorable attitudes toward substance use, and reducing substance use while increasing group engagement. Participants were assessed at baseline, during Sessions 2 and 7, and treatment exit. General linear mixed-effects models were used to detect significant differences between treatment and control conditions. Results: Findings indicated mutual aid groups significantly reduced favorable attitudes toward drug use and decreased alcohol and marijuana usage compared to the control group. In addition, the adolescents in treatment significantly increased their group engagement. Conclusions: Results support mutual-aid group work models for reducing alcohol use and increasing group engagement for high school youth.

Owen, P. L., Slaymaker, V., Tonigan, J. S., McCrady, B. S., Epstein, E. E., Kaskutas, L. A.. . Miller, W. R. (2003). Participation in alcoholics anonymous: Intended and unintended change mechanisms. *Alcoholism: Clinical and Experimental Research, 27*(3), 524-532. doi:10.1097/01.ALC.0000057941.57330.

Summary: This article is a compilation of the information presented at a symposium at the 2001 RSA Meeting in Montreal, Canada. The presentations were: (1) Maintaining change after conjoint behavioral alcohol treatment for men: the role of involvement with Alcoholics Anonymous, by Barbara S. McCrady and Elizabeth E. Epstein; (2) Changing AA practices and outcomes: Project MATCH 3-year follow-up, by J. Scott Tonigan; (3) Life events and patterns of recovery of AA-exposed adults and adolescents, by Patricia L. Owen and Valerie Slaymaker; (4) Social networks and AA involvement as mediators of change, by Lee Ann Kaskutas and Keith Humphreys; and (5) What do we know about Alcoholics Anonymous?

Pagano, M. E., White, W. L., Kelly, J. F., Stout, R. L., & Tonigan, J. S. (2013). The 10-year course of alcoholics anonymous participation and long-term outcomes: A follow-up study of outpatient subjects in project MATCH. *Substance Abuse, 34*(1), 51-59. doi:10.1080/08897077.2012.691450

Abstract: This study investigates the 10-year course and impact of Alcoholics Anonymous (AA)-related helping (AAH), step-work, and meeting attendance on long-term outcomes. Data were derived from 226 treatment-seeking alcoholics recruited from an outpatient site in Project MATCH and followed for 10 years post treatment. Alcohol consumption, AA participation, and other-oriented behavior were assessed at baseline, end of the 3-month treatment period, and 1, 3, and 10 years post treatment. Controlling for explanatory baseline and time-varying variables, results showed significant direct effects of AAH and meeting attendance on reduced alcohol outcomes and a direct effect of AAH on improved other-oriented interest.

Passetti, L. L., & Godley, S. H. (2008). Adolescent substance abuse treatment clinicians' self-help meeting referral practices and adolescent attendance rates. *Journal of Psychoactive Drugs, 40*(1), 29-40. doi:10.1080/02791072.2008.10399759

Abstract: Clinicians in adolescent substance abuse treatment programs often recommend attendance at 12-Step meetings; however, there has been no systematic study of their referral practices or possible influence on attendance rates. Quantitative and qualitative data were used to examine: (a) the self-help referral practices of clinicians employed in adolescent substance abuse treatment programs; and (b) the potential relationship between practices and self-help attendance. Data were analyzed from open-ended interviews with 28 clinicians at eight CSAT-funded SCY sites and from follow-up interviews with over 1,600 adolescents. Results indicated that clinicians referred adolescents almost exclusively to 12-Step groups. Various factors were considered when recommending attendance, including substance use severity and ability to grasp 12-Step concepts. Meeting age composition and availability were common influences when suggesting specific meetings. Clinicians who described their treatment programs as "12-Step based" and actively linked adolescents to groups tended to be employed at sites that had the highest overall rates of self-help

attendance. Findings suggest that if clinicians want to facilitate self-help attendance, they might assess the "fit" between individual adolescents and particular meetings. Additionally, programs may want to develop and train staff in standardized referral procedures. Further research is needed to empirically test referral strategies with adolescents.

Passetti, L. L., & White, W. L. (2008). Recovery support meetings for youths: Considerations when referring young people to 12-step and alternative groups. *Journal of Groups in Addiction & Recovery, 2*(2), 97-121. doi:10.1080/15560350802081280

Summary: Participation of young people in recovery support meetings is a promising yet largely understudied area. This article reviews the history of youth involvement in meetings, summarizes current research, and discusses issues to consider when making referrals. Professionals may want to research local meetings, help young people structure time before and after meetings, become familiar with group customs, investigate a variety of support groups, interact with support group service structures, develop a list of reliable group members to connect youths to the recovering community, and implement assertive referral strategies.

Ritschel, L. A. (2011). School-based group psychotherapy for at-risk adolescents. *International Journal of Group Psychotherapy, 61*(2), 311-317. doi:10.1521/ijgp.2011.61.2.311

Summary: School-based prevention programs capitalize on making use of adolescents' natural environment to provide needed mental health services. This article reviews two randomized controlled studies of school-based group therapy interventions designed to treat at-risk adolescents.

Strunk, C. M., King, K. A., Vidourek, R. A., & Sorter, M. T. (2014). Effectiveness of the surviving the teens® suicide prevention and depression awareness program: An impact evaluation utilizing a comparison group. *Health Education & Behavior, 41*(6), 605-613. doi:10.1177/1090198114531774

Abstract: Youth suicide is a serious public health issue in the United States. It is currently the third leading cause of death for youth aged 10 to 19. School-based prevention programs may be an effective method of educating youth and enhancing their help-seeking. Most school-based suicide prevention programs have not been rigorously evaluated for their effectiveness. This evaluation employs a comparison group to measure whether program group participants differed significantly from comparison group participants on pretest–posttest measures while assessing the immediate impact of the Surviving the Teens® Suicide Prevention and Depression Awareness Program. Findings indicate several positive outcomes in program group students' suicide and depression knowledge, attitudes, confidence, and behavioral intentions compared with the comparison group. Suicide prevention specialists and prevention planners may benefit from study findings.

Sussman, S. (2010). A review of alcoholics anonymous/ narcotics anonymous programs for teens. *Evaluation & the Health Professions*, *33*(1), 26-55.

Abstract: The investigation of the applicability of Alcoholics Anonymous/Narcotics Anonymous (AA/NA) for teens has only been a subject of empirical research investigation since the early 1990s. In the present review, the author describes teen involvement in AA/NA programming, provides an exhaustive review of the outcomes of 19 studies that used an AA/NA model as part of their formal teen substance abuse treatment programs, and provides data on the effects of AA/NA attendance on abstinence at follow-up, on which youth tend to become involved in AA/NA, and on mediation of the benefits of AA/NA participation. In addition, the author suggests the reasons for somewhat limited participation by teens in more informal, community-based 12-step meetings, and makes suggestions for maximizing participation at meetings in the community. The author concludes that AA/ NA participation is a valuable modality of substance abuse treatment for teens and that much can be done to increase teen participation, though more research is needed.

Swartz, K. L., Kastelic, E. A., Hess, S. G., Cox, T. S., Gonzales, L. C., Mink, S. P., & Raymond DePaulo, J. (2010). The effectiveness of a school-based adolescent depression education program. *Health Education & Behavior*, *37*(1), 11-22. doi:10.1177/1090198107303313

Abstract: In an effort to decrease the suicide rate in adolescents, many interventions have focused on school-based suicide prevention programs. Alternatively, depression education in schools might be effective in decreasing the morbidity, mortality, and stigma associated with adolescent depression. The Adolescent Depression Awareness Program (ADAP) developed a 3-hour curriculum to teach high school students about the illness of depression. The purpose of this study was to assess the effectiveness of the ADAP curriculum in improving high school students' knowledge about depression. From 2001 to 2005, 3,538 students were surveyed on their knowledge about depression before and after exposure to the ADAP curriculum. The number of students scoring 80% or higher on the assessment tool more than tripled from pretest to posttest (701 to 2,180), suggesting the effectiveness of the ADAP curriculum. Further study and replication are required to determine if improved knowledge translates into increased treatment-seeking behavior.

Tobler, N. S., & Stratton, H. H. (1997). Effectiveness of school-based drug prevention programs: A meta-analysis of the research. *The Journal of Primary Prevention, 18*(1), 71-128. doi:10.1023/A:1024630205999

Summary: Effectiveness of different types of drug prevention programs was examined in a meta-analysis of 120 school-based programs (5th-12th) that evaluated success on self-reported drug use measures. Hypothesis tests using Weighted Least Squares regressions were conducted of an a priori classification scheme that was based on program content and its method of delivery. Two major types of programs were identified: Interactive and Non-Interactive. Six

factors related to program effectiveness (sample size, targeted drug, type of control group, special populations, type of leader, and attrition) were included as covariates. The superiority of the Interactive programs was both clinically and statistically significant to the Non-Interactive programs for tobacco, alcohol, marijuana and illicit drugs and for all adolescents including minority populations. The larger Interactive programs were less effective, although still significantly superior to the Non-Interactive programs, which suggests implementation failures.

Waldron, H. B., & Kaminer, Y. (2004). On the learning curve: The emerging evidence supporting cognitive-behavioral therapies for adolescent substance abuse. *Addiction*, *99*(2), 93-105. doi:10.1111/j.1360-0443.2004.00857.x

Abstract: Cognitive-behavioral therapy (CBT) approaches to intervention for adolescent substance use disorders has been limited and formal controlled clinical efficacy trials have been rare. Moreover, the early literature on the efficacy of CBT for adolescent substance abuse has been characterized by significant methodological limitations. Recent innovations in the treatment of adolescent substance abuse and the recent completion of several randomized clinical trials have brightened the picture with respect to establishing the empirical support for CBT. The aim of this review is to integrate the findings from controlled trials of CBT for adolescent substance abuse. Studies representing randomized clinical trials were reviewed using criteria provided by Lonigan et al. and Nathan & Gorman as a guide. Despite some prominent differences in design and methodology, the studies reviewed provide consistent empirical evidence that group and individual CBT are associated with significant and clinically meaningful reductions in adolescent substance use. The evidence for the efficacy of group therapy is particularly important, countering the assertion that aggregating problem youths into group treatment settings is associated with iatrogenic effects. The findings from the randomized trials reviewed represent significant developments in treatment outcome research and lay the foundation for validating CBT for adolescent substance use disorders. Future research directions include improving short- and long-term outcomes, enhancing treatment motivation and engagement, and identifying mechanisms and processes associated with positive change, especially for youths with comorbid conditions.

Winters, K. C., Stinchfield, R., Latimer, W. W., & Lee, S. (2007). Long-term outcome of substance-dependent youth following 12-step treatment. *Journal of Substance Abuse Treatment, 33*(1), 61-69. doi:10.1016/j.jsat.2006.12.003

Abstract: The adolescent drug treatment outcome research literature primarily focuses on short-term follow-up periods (e.g., 1 year). This study extends the said literature by describing the pattern of drug use at 1, 4, and 5.5 years in three groups of adolescents: a Treatment group, which underwent a 12-step-based drug treatment program (n = 159); a Waiting List group (n = 62); and a Community Control group (n = 94). The Treatment group consistently showed significantly lower levels of drug involvement than the Waiting List group.

However, at all points, both the Treatment and Waiting List groups showed higher levels of drug use than the Community Controls. Within the Treatment group, completing treatment and involvement in aftercare were positively associated with improved outcomes. The treatment implications of the study are discussed.

Winters, K. C., Stinchfield, R. D., Opland, E., Weller, C., & Latimer, W. W. (2000). The effectiveness of the Minnesota model approach in the treatment of adolescent drug abusers. *Addiction, 95*(4), 601-612. doi:10.1046/j.1360-0443.2000.95460111.x

Abstract: The treatment outcome of drug-abusing adolescents treated with a 12-Step approach. The study compares drug use outcome data at 6 and 12 months post-treatment among three groups of adolescents: those who completed treatment, those who did not and those on a waiting list. Also, among treatment completers, residential and outpatient samples were compared on outcome. The treatment site is located in the Minneapolis/St Paul area of Minnesota. Two hundred and forty-five drug clinic-referred adolescents (12-18 years old), all of whom met at least one DSM-III-R substance dependence disorder. One hundred and seventy-nine subjects received either complete or incomplete 12-Step, Minnesota Model treatment and 66 were waiting list subjects. In addition to demographics and clinical background variables, measures included treatment involvement, treatment setting and drug use frequency at intake and follow-up. Absolute and relative outcome analyses indicated that completing treatment was associated with far superior outcome compared to those who did not complete treatment or receive any at all. The percentage of treatment completers who reported either abstinence or a minor lapse for the 12 months following treatment was 53%, compared to 15 and 28% for the incompleter and waiting list groups, respectively. Favorable treatment outcome for drug abuse was about two to three times more likely if treatment was completed. In addition, there were no outcome differences between residential and outpatient groups. Alcohol was the most common drug used during the follow-up period, despite cannabis being the preferred drug at intake.

Other Non-Peer Reviewed Sources

Comments on)roject MATCH: Matching alcohol treatments to client heterogeneity. (1999). *Addiction, 94*(1), 31-69. doi:10.1080/09652149934152

Fried, A. L. (2007). *The relationship between treatment implementation factors and core CBT goals in adolescent substance abuse treatment*. (Doctoral dissertation). Retrieved from ProQuest Dissertations Publishing.

Morris, C.W., Banning, L.B., Mumby, S.J., & Morris, C.D. (2015). *The DIMENSIONS: Peer Support Program Toolkit. University of Colorado Anschutz Medical Campus, School of Medicine, Behavioral Health and Wellness Program.* Retrieved from https://www.bhwellness.org/toolkits/Peer-Support-Program-Toolkit.pdf

Pierce, B. (2016). *Incarcerated Youth Attending Teen Addiction Anonymous: An Exploratory Study*. (Doctoral dissertation). Argosy University, Phoenix, AZ.

Rothery, T. (2012). MPOWRD evidence-based research study. Unpublished manuscript.

Appendix B

Appendix B1: Group Observation Rating Scale

MPOWRD Group Observation Rating Instructions v.1

	MPOWRD Lesson Organization and Evaluation Plan			
Lesson Units	Date	Module	Evaluation Plan	Notes (Where is the Group in Cycle)
	Credentials of facilitator (if interview instrument is used to supplement this observation, add notation here).			

Adherence Measure Response Option		
Score	Description	Guidelines
0	Facilitator(s) does not cover this at all	The section was not discussed or behavior not observed
1	Facilitator(s) makes cursory reference to this, not fully completed	The section was not adequately covered, behavior attempted but inadequate, or no client inclusion addressed.
2	Facilitator(s) adequately covers the section or behavior	The Facilitator(s) reviewed all the material and engaged the group in the discussion. Tip: If a Facilitator(s) follows questions that elicit collaboration in the "leader tips," questions should be genuinely asked instead of reviewed quickly.
3	Facilitator(s) covers the section thoroughly, beyond adequate.	The section was covered with a good amount of interaction with group, incorporating feedback and reinforcement. This code is available for only some of the session elements that allow for coverage that is more thorough.
9	Not applicable	This code is used when it is not appropriate to code adherence for a particular item.

Group Demographics				
Date:		Time:		Location:
Observations:				
Group/Cycle:	Lesson:	Group Census:	# Attendees:	# facilitators (adult/students)
Group/Cycle Norms and Expectations:				

Observations:		
Facilitator 1:	Facilitator 2:	Observer:
Observations:		

Individual Adherence Coding Guide			
Topic	Criteria for a 2 rating	Criteria for a 3 rating	Rating and Observations
1. Preparedness	Supplements, handouts, and presentation materials are prepared before group. Clinician has read the module before group.	N/A	
2. Staffing	Two facilitators present.	Two facilitators present and actively engaged in facilitation of group conversation and process.	
3. Structure	Facilitator(s) follows manual, completes lesson.	N/A	
4. Feedback	Facilitator(s) provided and maintained objectivity in feedback.	Facilitator(s) provided and maintained objectivity in feedback, providing constructive criticism and further discussion among clients.	
5. Attendee Management	Facilitator(s) address disruptive behavior and noncompliance during group to keep group on target.	Facilitator(s) appropriately address disruptive behavior, noncompliance, and prosocial behavior in group.	
a) Pre-group description of rules and discussion parameters	Facilitator reviews the rules, discussion approach and models methods to share without divulging information that mandates reporting.	Facilitator reviews the rules, discussion approach and models methods to share without divulging information that mandates reporting. Facilitator gives adequate examples and probes for	

		questions from the students	
7. Activity 1: Homework/Last Skill Review *(insert last group's homework topic)*	Facilitator(s) engaged all clients and allowed then to share answers	Facilitator(s) additionally provided experiences after clients shared answers	
8. Activity 2: What is [Group Topic]? *Introduce concepts, definitions, and objectives of module*	Facilitator(s) reviewed all content material and asked clients to share their experiences and answers to the questions.	Facilitator(s) reviewed all of the content material and actively engaged clients in sharing their own experience, encouraged clients to reflect on their own experience to gain insight, and summarized the comments so that apologizing was normalized (e.g., "Everyone in this group has experienced apologizing") and linked to why the clients are attending the group.	
9. Activity 3: Modeling skill	Facilitator(s) model new skill appropriately.	Facilitator(s) model new skill appropriately and engaged clients in active listening.	
10. Activity 4: Discuss Modeling Display	Facilitator(s) reviewed all material and asked questions after each section.	Facilitator(s) reviewed all parts of the practice and engaged clients in exploring their responses to the practice.	
11. Activity 5: Group Members Role Play Skill	Facilitator(s) has student volunteers role play.	Facilitator(s) has student volunteers role play. Facilitator(s) provided feedback that engaged clients in further discussion. *Facilitator(s) should also have checked in with clients about why they did not do their practice (if applicable).*	

12. Activity 6: Discuss Role Play *Feedback is conducted at the end of each session, gathering input from clients about their impressions of the session. While Facilitator(s) may gather feedback throughout the session, this item codes how well they facilitate feedback at the end of the session.*	Facilitator(s) asked group members about what was helpful and what was unhelpful/difficult/ etc.	Facilitator(s) asked these two questions and engaged clients further, using follow-up questions (e.g., Why was that helpful to you?).	
13. Activity 7: Assign additional activities outside group	Each client chooses a situation to apply the new skill and describes the steps for application. *Handouts are addressed and explained if part of the lesson.*	Facilitator(s) checked in with clients about applying new skill and feasibility/appropriateness of the application. Facilitator(s) have clients address how they will complete the homework.	
14. Activity 8: Wrap-up	Facilitator(s) read aloud the key messages and asked for any comments.	N/A	

Appendix B2: Direct Observation Summaries

Three MPOWRD MPOWRD group sessions were observed. The first observation was done at Millennium High School in Goodyear, Arizona on March 30, 2016. The second observation was done at Fountain Hills High School in Fountain Hills, Arizona on April 7, 2016. The third observation was done at Mountain Pointe High School in Phoenix, Arizona on April 21, 2016.

In each observation, the observer sat at the back of the room with the adult facilitators while the students sat in a circle in the middle of the classroom.

Millennium High School, March 30, 2016

MPOWRD Observation and Interview with

- Student participants
- Interview with Facilitators and Principal (adults)
- Teen Facilitator

METHODS

CABHP Director of Research (Dr. Sayrs) agreed to perform a structured observation of an ongoing MPOWRD group at the high school. The group was scheduled at 9:30am during a normal "advisory" time that student use for high school, advisory purposes. Dr. Sayrs observed the group in vivo for 1 hour at the site. Dr. Sayrs introduced herself to the group: "Hi I'm Dr. Sayrs, I work at ASU, and I am here to day to better understand the group." Dr. Sayrs spent 15 minutes with approximately 14/18 students who stayed after the group had finished to answer any questions she had for them. Dr. Sayrs also conducted an interview with the two adult facilitators and the principal after the meeting for about 35 minutes.

While underway, several announcements came on the school announcement system and although the announcements applied to the student participants, the two adult facilitators assured the students they could continue with their group and they would be advised later of whatever he announcement said.

PROGRAM SITE CONTEXT

Background: The group at Millennium High School has been ongoing for at least a year. The two school counselors who have MA's in education with a specialization in education psychology were champions to support some intervention at the school site for kids referred to them for counseling. One of the counselors had some familiarity with the 12 step-programs and after investigation, reached out to Susan Rothery to invite her to make a presentation at the school. The two counselors then advocated for the program to the principal; the principal supported the program and advocated for it at the district level and each school was authorized to implement groups. No limits were placed on the number of groups—all decisions on implementation were left up to the site (principal). Millennium has one group each Wednesday with 12-20 participants. The participants generally are split 50/50 male/female and the group is designed to meet juniors who would have advising time, one or two freshman and sophomores also participate. No one would be turned away if referred or self-referred. A typical referral is as a diversion for suspension for violating a school rule such as "smoking in a bath room." All

students have permission of their parents to participate although about five students were 18 years old.

Attendance: Open group and attendance from week to week varies however, it is maintained on file at each school. Although student may "miss" here and there, overall it is a committed group with high week over week attendance. Therefore, the dosage for individuals who stay in the group is at least a semester, more than likely higher.

Millennium High School and specific group context: This group is actually run by students as facilitators with at least one counselor (adult facilitator) in the room. On the day I observed three facilitators were present (two credentialed and 1 in training). Typically, only one facilitator is present. Since the students run the group, the program goal of empowerment is modeled more directly and the group follows much closer to a peer-run intervention with support. The counselors observed from a table in the back of the room and intervened in only a handful (5) instances; 3 times to prompt the facilitator to keep the group moving along or get tighter control of the group and 2 times to respond to "shares" as "good job" "glad you are here".

Group focus: The group focus is on addictive behaviors as defined as any behavior that is unhealthy. Group is given 'chips' (referred to as tokens by the MPOWRD facilitator manual) by facilitators for periods of self-reported abstinence. Self-reported abstinence when reported (4/18 times is 1 week to 1 year). Not all students offer their period of sobriety and it may not be a critical component to establishing group trust. No one is criticized for not reporting a period of sobriety but those who do report are rewarded.

Note: The facilitator who had been attending the group for a year had reported "two weeks" of sobriety.

Group experience and culture: The group is full of "old-timers" and "new-comers." The group has sub-groups of friends who demonstrated high degrees of interconnectedness based on their interaction dynamics (smiles, fist-pumps, words of support and praise; identifying each other as friends, highlighting how their friends help; how they help their friends). The participants demonstrated high levels of trust in the group =, each other and in the two main facilitators by naming them as reasons for coming, highlighting what the facilitators have done for them, how they have helped. The two facilitators genuinely respect and admire the teens; genuinely care about their well-being. For example, one counselor told a story of how they had to ask one student to not come back (this is appropriate for this intervention to keep the group safe). The counselor was in almost in tears at recounting the story but received support from her principal and the other counselor about how "tough love: is important. The student ended up coming back but following the group norms. Facilitators are white, middle class well-educated women as is the principal.

Why Millennium High School implements MPOWRD: The principal and counselors described the raison-d'etre for the group as "we had nothing to offer the parents when they asked what we could do to help their kids." Students are suspended for breaking the rule but it is not viewed as "rehabilitative" in any way; parents are referred to places to receive help but either do not take the referral, or cannot take the referral because it requires then to take time off from work etc. Students see the diversion as at first a kind of punishment but soon realize that it has value. Other school districts mandate diversion to drug education programs with parents but it is 100% educational awareness and no trauma-informed or treatment approach is incorporated (e.g., Scottsdale School district partners with Scottsdale police).

PARTICIPANT DEMOGRAPHICS

HS Demographics: Middle class, near the Wigwam; newer construction; school size-2400

Socio-economic status: The students who participate in the group appear to reflect lower-middle income families. Most families had two parents working in hourly positions. Participants also worked after school (as waiters, etc.) (e.g., 16/19 students were from single parent or blended families with a "step-dad"; two had two parent families; one had 'a step-mom." One dad took a job in another state. The participants focused some of their talk time on 'money,' what it meant to them, how they related to it, and some indicated financial insecurity or the interaction of limited resources with family dynamics: "my step-father pays for everything, so he has the power." Other statements indicated impacts from financial decisions; "My mom acts differently because my step-dad now works in Texas." The participants indicated how important school and education was to their lives, how they wanted to graduate; some indicating they wanted to go on to college. Although financial resources appeared limited and students worked to help support themselves within the family structure, students were fosses on staying in school and making something for themselves.

Gender/Race/Ethnicity: 50/50 male female? (Possibly one LGBT,based on issues discussed). Of boys, 90% were Hispanic; two brothers attended; females were mostly white, two African American, two Hispanic. Hispanic culture of the school ranges from well-established second and third generation to very recent immigrants but all participants in the class were second generation or older.

Family structure: Besides the family structure (mostly blended), the teens did not describe their families as supportive, well educated, well off, etc. One student indicated her mother refuses to help her get treatment for her depression and anxiety saying: "nothing's wrong with you." Another student described how she "tried to commit suicide" but did not mention her family at all in the discussion. Only one young man mentioned his brother. No one else mentioned siblings or supportive family structures. One student movingly described how he 'was getting into trouble" and couldn't talk with his parents. When he joined the group and then told this parents how we was asked to be a group leader, both his parents told him how proud they were of him. His re-telling demonstrated his attachment to his parents and family, a connectedness he now valued and connected to his experience with the group. Overall, the group demonstrated connectedness to the group and each other. One participant described how one of the group

members was going to fight someone in school and she, along with other group members helped her to avoid the physical confrontation.

Diagnostic severity: The participants exhibited a range of diagnostic severity but almost all towards the more severe end of behavioral disorders. One participant described how his step-dad treats him and his description easily be reported as emotional abuse. (Following up after the meeting with the counselor on mandatory reporting when she hears statements indicating a safety risk, the counselor indicated that they were aware of the family issues and working with them.) However, at least a third, possibly half, of the group appeared to have been diagnosed with a mental illness such as depression, anxiety, and personality disorder. One student suffered a severe trauma; two admitted to attempting suicide. Despite the severity of the conditions, the participants were for the most part laughing and enjoying the time they had at the meeting. (Note at least 3 students were reticent and failed to communicate much during the group except as a check in "I'm a 4=-pass.") One participant admitted to "having crazy thoughts." Several participants had been in jail; past participants had not successfully managed their behavior and were sent to "alternative school"; two had been in 'in-patient treatment"; one described intensive outpatient treatment and Dialectical Behavior Therapy. Participants indicated they were exposed to other treatments such as Narcotics Anonymous as well. Student in the group were also described by adult facilitators as kids who have threatened violence in the school or to teachers or other students. No students had disabilities but facilitators suggested that when they tried to include some students on the autism spectrum disorder, the group setting was not workable for them and they could not engage. Facilitators suggested students with ADHD might be fine.

Behavioral Issues: About half the participants were diverted to the group for violating a school rule that would have resulted in suspension. These issues include drugs, alcohol, smoking anger/fighting, absenteeism or other behavior. All participants discussed family issues. Some discussed relationship issues with friends (drama) or partners.

Note: Following up after the meeting, I asked the counselors if they noted some of the more extreme behavior like lack of participation, or statements like "I am having crazy thoughts." To determine what steps they took in follow up aft eth meeting with those students. Counselors indicated these students were on their radar, in weekly counseling meetings, etc. Conclusion: for this group, severity and issue salience is high. Therefore, even if students run the group, the ideas expressed mandate that a trained facilitator remain in the room if only to document and follow up on statements of self-harm, etc. This also suggests that when training other non-psychologists as facilitators, such as safety officers, training should include learning to listen for cues that need follow up by trained clinicians.

IMPLEMENTATION

Implementation Scores: Millennium received a 75% or 31.5 this score would characterize modest authenticity to the facilitator manual. Overall, this score can be attributed to a lack of tighter in training student facilitators and the size of the group (18 students). As a result, Millennium had low scores (1-1.5) in three areas: group member's ability to role play; feedback and attendee management. Millennium received 1.5 in attendee management because prompts by the adult facilitator and some facilitation skill by the teen facilitator were demonstrated and helped to keep the group on track. However, these efforts were insufficient to establish high consistency with the facilitator manual.

Millennium received scores of 2 in pre-group discussion of rules because rules were discussed but not followed indicating a lack of norming to the rules among the group; and 2.5 in both modeling skill and discussion of modelling skill; Key skills to be acquired during the discussion were not adequately discussed nor modeled to assure that each and every participant understand the needed skill and could demonstrate it.

Note (recommendation): Integrate more role-play exercises into the curriculum and even ask students to demonstrate it voluntarily "Mary, pretend I'm your mom. What would you say to me about why you need a prom dress?"

Together, the group management and cross talk influenced the optimal adherence to the manual and impact of the intervention. Limiting group size to 8-12 and training the student facilitators (TOT's) to better model the desired behavior for a facilitator would bring this group score above 90%. The school is intending to run a second group and they are credentialing the safety officer to support a second group.

Perfect scores were in structure of the meeting and following a plan, preparedness and implementation.

Substandard scores were in attendee management, feedback and group members being able to understand and demonstrate the critical skill (positive affirmation, re-framing, clear communication, emotion management).

Fountain Hills High School, April 7, 2016

MPOWRD Observation and Interview with:

- Student participants
- Interview with adult facilitator

METHODS

ASU Research Technician (Mariel Nellas) agreed to perform a structured observation of an ongoing MPOWRD group at the high school. Two adult facilitators were present at the MPOWRD meeting. The group was scheduled at 10:30 a.m. and lasted for one hour. Mariel sat with one of the two adult facilitators after the group left in her office for about 50 minutes.

PROGRAM SITE CONTEXT

Background: The group at Fountain Hills High School has been ongoing for the current academic school year, but MPOWRD has been implemented in the school for three academic school years. Two facilitators were present at the meeting, a school counselor and the school nurse, the school counselor has an MA while the school nurse is the process of receiving her MBA. Susan Rothery presented to the school and the district to introduce the program. Fountain Hills' principal and the school nurse were highly interested and very instrumental in bringing the program to the school. The principal has had experience in a 12-step program and was a very strong proponent to bring the program to the school, therefore there was very little problems implementing the program into the school. The principal has recently resigned, although the district's superintendent is a strong proponent for the program and MPOWRD is expected to continue at Fountain Hills High School. The school nurse is also instrumental in the transition process for the students that are on track to graduate, she often researches groups in the student's area or new school that the student can continue with and has reached out to Susan Rothery many times to further the program beyond the school and into the community.

Fountain Hills has one group each Thursday at different times each week so that students will not be missing the same class each week. The classes missed rotates every 6 weeks according to this schedule. The participants are generally split 50/50 male/female from all class grades. No one is turned away and some are referred by staff members at the school. This is also a program that is utilized by the school for students who get in trouble with the school, some students are required to attend a certain amount of meetings and have slips signed by the facilitators. Many students that were required to attend continue to attend after the number of required sessions.

Attendance: The group is open to all students. The school nurse mentioned that there were some regular students missing because they are on the school's band trip to Disneyland that week. The school nurse states that attendance is consistent with many of the students in the group. Some students may miss some weeks in a row, but are likely to appear later.

Fountain Hills High School and specific group context: The topic is chosen by the school nurse facilitator and sheets from the facilitator manual according to the topic chosen are printed and stapled for the students. Handouts of the topic are placed on the seats of the students. The group is run by a student facilitator with two adult facilitators in the room. The group is set up in a circle and the two facilitators are outside of the circle. This is the first year in which the adult facilitators are out of the circle. In previous years, the facilitators were either part of the circle or are in the center of the circle. The school nurse facilitator decided that the adult facilitators were to be outside of the circle because she felt like the students looked to the facilitators for the answers instead of figuring the issues out themselves. The counselor facilitator was not supportive of this idea and generally probes the group if there is silence after the teen facilitator asks a question listed in the facilitator manual.

The adult facilitators had to intervene a number of times (10) to tell the group to stop the side conversations. The counselor facilitator had to intervene a number of times (7) to probe the students to think more critically about certain areas after some of the questions.

Group focus: The topic of the meeting was "Anger without Control" from the life challenges

curriculum in the manual. Each member of the group is given a copy of the lesson to follow along.

Group experience and culture: The group has sub-groups of friends who demonstrated high degrees of interconnectedness based on their interaction dynamics (smiles, jokes, identification of each other as friends, seating in the room, etc.) but all members of the group knew each other's names and were familiar with each participant. During the meeting, members outside of the subgroups were supported by various members as demonstrated by words of encouragement and telling others to quiet down while the person spoke.

Why Fountain Hills High School implements MPOWRD: The school nurse facilitator indicated that there was no program prior to MPOWRD that was provided by the school for the kids. She shared that the school had similar experiences that Susan Rothery talks about in her trainings – too many kids at the school were tired of seeing their friends die. There were some students in prior years overdose off school campus and students at the school were devastated.

PARTICIPANT DEMOGRAPHICS

*HS Demographics: M*iddle class, near the Fort McDowell reservation, newer construction, very large campus

Socio-economic status: Students that participate in the group appear to reflect middle-income families. Most participants live with their grandparents because of trust issues by parents. One student mentioned being a part of a blended family with a "step-dad". Three participants lived on the Fort McDowell Reservation. Only one student mentioned having an after school job. The participants indicated that school and education is important in their lives by continuing their schoolwork.

Gender/Race/Ethnicity: There were 16 participants at the meeting, 50/50 male and female. There were 8 Caucasian participants, 3 Native American participants, 3 African-American participants, and 2 Hispanic participants. The school is predominantly Caucasian but has a high proportion of Native American students due to the proximity of the reservation.

Family structure: The school nurse facilitator pointed out that many of the students lived in kinship households, where the grandparents are the primary caregivers of the children. This was not mentioned throughout the group, although many of the students described their family dynamics as "frustrating", but mostly directed this toward their mothers. The school nurse elaborated that many students opt to live with their grandparents because of family issues, citing "my parents don't listen to me" or "my parents don't respect me" and the option to live with their grandparents is better than living under those circumstances with their parents.

Because the topic was on anger without control, many students spoke about ways their anger manifests, which revolved around speaking with their parents, more notably their mothers. Many of the students stated that they do not go to their parents or other family members when they are angry, because these individuals do not properly listen to them and their feelings. They

specifically indicated, “Adults just don’t listen to what we are feeling, or if they do listen they don’t understand and I get grounded. I am coming to them for help, but I get in trouble instead.” There was a distinct level of mistrust towards adults in their lives.

Diagnostic Severity: The participants displayed a range of diagnostic severity from moderate towards the end of behavioral disorders. One participant described an experience with his step-dad abusing his step-mom and he intervened, “I took a baseball bat and hit him across the face”. There is a clear indication of anger issues displayed by many of the participants. Many were in the group for anger related issues. One participant mentioned that in some cases when he gets angry he “hurts animals”. [Following this response, the counselor facilitator informed the participant that if she heard him say anything like this again, she would report him.] Some participants mentioned to have gone through anger management sessions and have counseling sessions with a counselor outside of school.

Behavioral Issues: Many of the participants were referred to the group for violations of school policies. Most of the participants stay beyond the referred session amount. Some reported issues that the participants have reported by the facilitators are alcohol, marijuana, some heroin, anger management, social media addiction, obsessive-compulsive disorder (OCD) and eating disorders. The most reported is anger management, participants that must deal with parental abuse of alcohol, and OCD. All participants discussed family issues and this was the core issue that participants kept reverting to.

IMPLEMENTATION

Implementation Scores: Fountain Hills High School received a 62% or 26 score, which indicates overall preciseness to the facilitator manual, but several areas are in need of critical improvement. Overall, this score can be contributed to not being able to execute the structure in the manual closely and the lack of attendee management.

Fountain Hills received a 1-score in Activity 1 due to the facilitators not enforcing the students to engage in the ‘two-person challenge’ at the beginning of the meeting due to the size of the group. Facilitators mentioned that it has been difficult to manage this and they have tried several ways to get around it (i.e., the group broken up into two) but side conversations would dominate the conversation and this task would ultimately not be completed. The facilitators instead gave the option to the participants if they wanted to break up into groups of two and the participants wanted to have the discussion in a group setting. The participants took turns answering the question and only one participant utilized the “pass” option during this exercise.

Fountain Hills received scores of 2 in feedback, attendee management, group topic, modeling, and role play because rules were discussed but not necessarily followed. Many side conversations occurred due to the size of the group and there were many times when the facilitators had to intervene to minimize the conversation. Many of the quieter students had a harder time responding to the questions asked because of the side conversations and others were unable to hear. The two facilitators had differing opinions on how the group should operate and the counselor facilitator probed the students many times to think critically while the school nurse facilitator did not. The counselor facilitator had not attended an updated training of MPOWRD

and this could have been the cause of the differences of behaviors between the two facilitators. Additionally, participants did not go around the room to address their periods of sobriety or were issued tokens for their lengths of sobriety.

Attendee management and side conversations/cross talk influenced the accuracy to the facilitator manual and impact of the intervention. Limiting the group size and training the student facilitators to better model facilitator behavior in terms of group management of side conversations and skills revolving positive affirmation, clear communication, etc. would bring this group's score above 90%. Scores of 3 were given in terms of preparedness, staffing, structure and pre-group description of rules and discussion parameters.

Mountain Pointe High School, April 21, 2016

MPOWRD Observation and Interview with:

- Student participants
- Interview with facilitator and school psychologist (not a credentialed facilitator)

METHODS

MPOWRD CEO Susan Rothery agreed to conduct this observation and interviews with facilitators and student participants at Mountain Pointe High School. The group was scheduled at 8:45 a.m. and lasted for about one hour. Susan sat with the adult facilitator prior to the start of the MPOWRD meeting due to scheduling conflicts.

PROGRAM SITE CONTEXT

Background: The groups at Mountain Pointe are in the first year of program and meetings have been implemented since September 2015. The school's principal and head counselor selected the lead facilitator. She was hired to run four groups. Participation numbers averaged up to 16 per meeting. More groups will be offered next year, with the school psychologist being trained in the fall. A typical referral is from diversion for suspension for violations of school rules.

Attendance: The groups are open and attendance varies from week to week. A student may be absent every now and then, but is overall committed to the group and has high attendance each week.

Mountain Pointe High School and specific group context: Teen participants run group with the aid of facilitator direction/questions and restatement.

Group experience and culture: Diverse population of participants. Several participants identified as transgender.

Why Mountain Pointe High School implements MPOWRD: MPOWRD fits well with the school mission.

PARTICIPANT DEMOGRAPHICS

HS Demographics: Students are bussed in; high percentage of minorities. School size = 2500 students

Family structure: Participants focused on need for better communication at home.

Diagnostic severity: Participants did not mention mental health issues for attending, other than depression and isolation/extreme introversion.

Note: The facilitator was limited to the time spent with the participants. All participants had to go immediately back to class which limited discussion.

IMPLEMENTATION

Implementation scores: Mountain Pointe was not scored on the observation instrument. This instrument utilized by MPOWRD CEO, Susan Rothery, as part of the instrument validation process and to assess its utility as a feedback mechanism for program adherence. Ms. Rothery provided feedback to the evaluators on the utility of the instrument. Based on that feedback, the evaluators plan to revise the instrument in the following ways:

- Modify the instrument to be more age appropriate, specifically review communication skills, cross-talk, reflective statements and leadership skill demonstrated to reflect that the student participant is learning (beginner, novice, intermediate, expert).
- Better match both types of meetings (12 step and activity);
- Retain the last two sections of the instrument where facilitators generally did not score well because these items indicate how much the skill was simulated (practiced) and how the participant plans to apply the skill in the week ahead. All groups lost points for not engaging in these activities because they are not directly in the program curriculum or certification training. However, Ms. Rothery felt that based on the instrument, these items have value and plans to revise the curriculum and certification accordingly to support these elements of program fidelity going forward.

Unnamed School, June 2, 2016

(This school gave permission for evaluators to observe a meeting but requested that the name of the school and the exact comments of the students be withheld from the report. Only general observations are provided so that the identity of the school can be kept confidential.)

MPOWRD Observation and Interview with:

- Student participants
- Interview with program coordinator not adult facilitator

METHODS

Dr. Sayrs conducted this observation and interview with program coordinator. Coordinator conducted interviews with participants. The group was scheduled at 3:00 p.m. and lasted for about one hour. Dr. Sayrs sat with the adult facilitator prior to the start of the MPOWRD meeting and interviewed her using the facilitator instrument. The site uses MPOWRD as opposed to the revised MPOWRD curriculum.

PROGRAM SITE CONTEXT

Eight students were in attendance at the meeting on the day of the observation. This school limits attendance to 10. Program design permits as many as 12 and other schools typically exceed that number. This is a strength of the site's implementation. In addition, very little cross-talk took place among the student sin the group allowing the adult and student facilitator to keep the group focused on the topic and activities.

PARTICIPANT DEMOGRAPHICS

The demographics of the group cannot be fully reported here. Some key demographics are that the group are: all male; 14-16 years of age; from impoverished backgrounds where they have been exposed to serious neglect or trauma; have been or are currently in dependency court; exposed to gang violence and drugs. Some indicated they struggled academically. According to the program coordinator almost all the participants have drug/alcohol addictions and about one third may also have an additional diagnosis such as oppositional defiance disorder, ADHD, depression/anxiety, inter alia. The cognitive levels in the group ranged from below normal to above normal according to the program coordinator. Participants may also be teen parents.

IMPLEMENTATION

The meeting followed closely to the curriculum. During check-in, The topic for the meeting was "higher power." Participants appeared to struggle with the topic and the concepts. When one activity question was asked which required responses, 4/8 participants "passed." This is a common occurrence according to the program coordinator but appears to be a relative high "pass" rate. It was not clear what the reason was for such a high "pass" rate. When participants did contribute, they more than once demonstrated that they did not understand the question. The adult facilitator had to correct the participant and ask him to respond to the actual question. Students also demonstrated less reflection and processing of the topic during the group than other groups. One or two students demonstrated reflection and processing by their comments. The

majority used one-word phases to respond, if they did not "pass." The student facilitator appeared to gain the most benefit from the group. He interacted with the adult facilitator the most, answered every question posed.

However, the school scored a 20/42 on the observation instrument owing to the role of the adult facilitator, which limited the role of the student facilitator. The instrument is not validated so these scores should be interpreted with caution. The instrument was used to score the student facilitator. The group had an adult facilitator that was more didactic than required by program design. He appeared to run the group as a teaching opportunity. This approach deviates from the program design. In addition, the adult facilitator provided feedback and probed participants about their statements in ways more akin to a standard "process" group, again deviating from program design. Because the student facilitator demonstrated strong leadership skill despite the dominance of the adult facilitator, for areas where the student facilitator led, he received good scores. Some cognitive elements of the curriculum posed a challenge for the group. Several students misunderstood the question and/or the activities. According to the program coordinator, some students may have limited cognitive skills, which may limit their ability to derive sufficient impact from a group meeting. The program has developed written materials for the participants as a supplement to the meeting, which would allow participants to interact with the material on their own but the cost of the materials was prohibitive for the site.

The evaluator interviewed the program coordinator prior to the meeting start using the tool developed for that purpose. The program coordinator demonstrated a high degree of understanding of the program, its goals and its implementation issues in the setting. The program coordinator indicated that the program is popular, has high attendance rates and the setting had about 4 ongoing groups. The intervention was described as helpful by the program coordinator but outcomes have not been assessed for this site. According to the program coordinator, participants have described how much they like learning constructive leadership skills. No follow up after the program or after students leave the school has been done.

Students were interviewed by the program coordinator after the meeting utilizing the interview tool designed for participants. Participants indicated that they enjoyed the group, came voluntarily, felt comfortable and got a lot out of it. They stated that it was a group they run, as opposed to a group someone else runs, a critical reason why they liked it. In addition, they described their experience with the group as one where they feel more comfortable than they do in other groups. The option of "pass" and not having to share were the elements that participants found particularly valuable. All participants came to the group voluntarily. Only one participant indicated that he might continue to attend AA meetings in the community after high school. When participants were asked what they might do after the program ended, they indicated they would like to complete their high school diploma; one student indicated he planned on learning a good skill such as welding and getting a job.

Appendix C

Appendix C1: Facilitator Interview Questions

Do I have your permission to record this interview for documentation and reference only? The recording will not be kept following the completion of this logic model project.

MPOWRD Program Theory Status and Implementation Outcomes

I am interested in your understanding of the MPOWRD program mission and goals now that you have been using it.

1. In your own words, how would you describe MPOWRD? What is the mission? What it does?
2. In your own words, what are the goals and the objectives of MPOWRD? How well do you think MPOWRD has met these goals and objectives?
3. Has there been changes or adaptations made in MPOWRD's mission or goals during your organization's implementation?
    a. What are your thoughts on the program's fit with your organization?
    b. What are your thoughts on the program's fit with services provided?
    c. What are your thoughts on the program's fit with participants/community's needs?
4. Do you think that your experience of MPOWRD aligns well with the program's mission? Do all the components of it fit with the program intent? (e.g., appropriateness, relevance, compatibility, suitability, usefulness, practicability)
    a. Are there specific components that fit or do not fit?
    b. Have there been attempts to revise/adapt the program with the mission/purpose?
5. How would you describe your overall satisfaction with how you have implemented MPOWRD at this site? Is it working?
    a. What areas do you think were implemented well?
    b. What areas are you dissatisfied with?
    c. Have your staff shared their satisfaction or dissatisfaction with the program?
    d. Can you please describe your level of satisfaction with the program?
6. What successes have you seen with MPOWRD? Participants? For teachers, students, facilitators/clinicians? Programmatically? Organizationally?
    a. What components of MPOWRD do you feel are vital to successful outcomes? Organizational success? Client success?
    b. How important do think it is to deliver it in accordance to the manual? Why or why not?
    c. How easy is it to fit it to your organizations target pop and organizational requirements?

7. What barriers during program implementation have you experienced with MPOWRD? Clinically/case-wise? For your organization? For you and your role?
    a. What could be improved? How?
8. Describe some unexpected outcomes for your organization. For the facilitators? The students/participants? If you have any.
9. How do you fund it? Will the program continue going forward? How are you planning to maintain the program? Expand?
    a. Do you have any program partners? What role would your partners plan in maintaining the program going forward?
    b. What role would your organization plan in maintaining the program, moving forward?
10. Are there any policy procedure impacts or system changes you see as a result of implementing this program? Are there any system issues occurring that might impact the program, e.g., the now implemented affordable care act?

Outcomes

I am interested in how successful you think MPOWRD has or has not been, I am also interested in examples of success or dissatisfaction with the program and if this impacts your use going forward with the program in this setting?

1. Sometimes programs have to balance competing interests, for example using school time for a program like this may take away from academic needs. How are these competing interests handled?
    a. Can you please provide a successful example?
    b. Can you please provide an example where the outcome was not a considered a success?
    c. Have any issues arise concerning participant or facilitator privacy? Safety?
2. Do you think the program has been effective? Why, why not?

Now we are going to shift to questions about the impact the program may be having on your organizations, especially if it has changed how you view your setting and other social service settings.

I am interested to hear about your experience and what you have learned by implementing MPOWRD on this client population.

1. What have you learned about MPOWRD?
2. What have you learned about your target population since starting these groups?
3. What have you learned about other treatments, community behavioral health treatment, and other groups since starting these groups?
4. What have you learned about clients that interact with other groups and treatments? Other systems, e.g., detention; child welfare?
5. Have there been any new challenges since you all have started your groups? Please

describe. (Policy and law, perspective, funding)

6. How would you describe the changes in your relationship with your students, if any?
7. Have there been any changes in how you interact with other system members, or other elements of the system that affect your students?
8. Is there anything else I have not asked you about that you feel would be important for me to know?

Appendix C2: Facilitator Interview Summaries

Millennium High School, March 31, 2016

1. ***How does MPOWRD align with the school's mission*?**

   Answer: We need a school-based intervention to help kids. I was exposed to the 12 steps and this looked like a fit. The school did not want to keep trying a lot of different things that didn't work. The 12-steps had some traction. The two counselors became educated on MPOWRD and started advocating to bring it in and assign resources—a room, counselors, time off from advisory, how to refer, parent permission.

2. ***How does MPOWRD do in helping you met your school goals?***

   These were the outcomes described directly by facilitators and the principal:

   "Profound personal change"

   "Attendance"

   "Safer school"

   "Better students"

   "Fewer referrals to the office"

   "Fewer kids going to alternative schools"

   "Kids not hurting themselves or others."

   "Fewer kids getting into trouble"

3. ***Have you revised it or adapted it?***

   Answer: No.

4. ***What are the barriers to implementing?***

   Answer: "We recognize the group size is too big. We are training a third person to be able to facilitate. It takes some time, and a commitment. The right person has to do this."

   Probe: what do you mean by the right person?

   Answer: "It has to be person who the kids relate to and trust, someone who already has a good reputation on campus as somebody who cares and the kids know.

   Probe: what about your safety (police officer?)

   Answer: "Oh "name," he's new but our old officer, "name," was a huge supporter of the program.

   Probe: has this spread throughout your district?

   Answer: "no, some schools have it, some don't. it's up to them. "

Probe: what are the barriers as you see them for other schools implementing?

Answer: "I don't know."

Probe: what is your guess?

Answer: "Other competing areas of focus."

Probe: "Like what?"

Answer: more time in the classroom – academics, parents don't like it, too religious, not the schools job top = be doing this kind of thing.

After about 15 minutes of interviewing the adult facilitators, the interview was interrupted by the group student facilitator. She was invited to join the discussion and an informal conversational interview began with the group student facilitator (no instrument). Susan Rothery asked if I had anything specific I wanted to ask the student. I took the opportunity and asked one question:

5. ***What do you get out of facilitating the meetings?***

   "I have to focus more, I have to be prepared, I have a responsibility. I listen better."

I then allowed the student to have a discussion with Susan Rothery and when she was done, I went back to the group interview.

6. ***What has the program taught you? What have you learned from it?***

   Answers:

   "Oh, I have learned so much by watching these kids get a better understanding their problems and how to manage them."

   "I learned we can help."

   "I learned the program works."

   "I can really help kids."

   "I can offer parents something that works."

Fountain Hills High School, April 7, 2016

1. ***In your own words, how would you describe MPOWRD?***

   "Empowering the kids to do it themselves and run the meetings. These kids have blossomed. Before, they were just little mice we were doing everything and they were just reading along and sitting there. Turning it into the empowered piece is like, I am empowering you, this is your meeting, what do you want to do with it? The student who ran the meeting today was a little mouse that just sat there before, but empowering her has changed her whole demeanor and her whole outlook. At the beginning of the year, they were so quiet and shy and now they have really opened up. There is such a comradery or comfort level in there. They know that what happens in there stays in there. I have seen a number of them come together outside of the group at lunch and talk about

their problems. I hope that they aren't drawn to each other due to the addiction though, that's my hope."

2. ***What are the goals and objectives of MPOWRD?***

"The goals and objectives from my understanding is that the kids understand what is going on around them in terms of understanding what drugs and alcohol can do to them. I give them information from a medically and evidenced-based program as to what is happening to their bodies and brains when they do this. The kids are like, 'really?' It's a thought process that they have that comes along with it and there's so much that it can encompass and there's just not enough time. I would love to have a meeting everyday with these kids. They're like little sponges; they just want to know everything."

3. ***How would you describe your overall satisfaction with your implementation of MPOWRD?***

"There are areas that I would love to know how to tweak—I would love to know how to stop the side conversations, that's a big one. I pick up on the conversations going on and if they would just put it out there and not have to conversation with the people on the side of them, they are so powerful. I hear that and I tell them to put it out there to the group and then the light bulb goes on for some kids and it's like, 'I'm not doing this alone, we are together'. I've had kids come in and say I really don't want to be here or their parents were making them come, but they stay because it changes them. A lot of kids that have come before aren't coming anymore because they're on track to graduate. The principal says to me, 'I don't know what you're doing with some of these kids to make them be on track' and I respond, 'I'm empowering them to be better and I keep telling them. You're the most powerful person in the room and you're the only person that has the power to change and do what you want.'"

3a. ***What areas are you dissatisfied with?***

"It's a parent piece that I would really love to have a program for so they would understand why their kids are doing these behaviors. You heard the kids say that their parents don't listen to them, and when they go to their parents about a problem they have their parents automatically say, 'No, you're grounded' without really listening to them makes them go out and they find a way to feel good about themselves because the parents don't listen to them. That's what I don't know how to change and that's what I feel needs the most help."

4. ***What are some successes you have seen with MPOWRD?***

"We have one student in there currently that is a super senior, and he's finally on track to graduate. He was not close before when he started coming to the meetings. He told me that he's scared to graduate because then he can't come to the meetings. It's like if he doesn't come to the meetings then he slips. I am trying to get this program on the reservation to be at the clinic over the summer. That could help him out.

My measure of success is if the kid is on track to graduate. There are some kids that come in that are nowhere close, but now they are there and they will graduate this year. Some kids have stopped coming because they are on track and they don't want to

miss class to come to the meetings anymore and that's good, they wouldn't have been saying that before. It's their choice to be in the classroom to keep their grades up.

I have had some students realize that the level of dysfunction in their family and took it upon themselves to empower themselves through that situation to change it and make it better. I have had some kids that were doing drugs turn around and start turning in kids that did drugs. I like that the kids get the education and the knowledge from the program and they make their own educated decision on what they want to do.

I have a student that went through this program and he was not on track to graduate, but he finally did and now he is in the nursing program at NAU. He came to me recently to tell me about his achievement. That is something I'm very proud of this program for.

Students are finally taking some ownership to the program, especially when they tell people to stop the side conversations so that they can hear other kids. That's just something else they need to work on more. It's just the dynamics of having the big groups and I understand that it is so tempting. I just don't want to break them up because they have such camaraderie so I'm probably more tolerant to that."

4a. ***What are some participants that were unsuccessful?***

"There was a couple years that a student had to come due to a suspension. He came and sat and I couldn't get through to him. He just came and sat there with his hood up. I didn't realize how far he was gone on drugs because that was his whole demeanor. He came in one day and said, 'I got to get this off' and he had powder on his nose and I don't know if he was on meth. I had to send him out 911 and he did not graduate. I had a young man last year that did not graduate, he was on heroin. If you don't have parents that recognize that this is a problem. I don't know where to go with this, he was arrested, put in jail, he was put in rehab, he walked out. If you have that severe of an addiction, this program does not address it. We don't know how to address it. We did the best we could. Those are the two failures of this program that I can think of."

5. ***What were the biggest barriers of getting MPOWRD to the school? Did you bring it here?***

"No, Susan made a presentation to our principal and a number of us in the room and when she left I went up to the principal and told him that I want this program on the campus. The two of us (counselor and school nurse) went and took the trainings. The principal understood because of his recovery that these kids have issues and problems and they just need guidance and direction. It was easy to put the program here, it was not a struggle.

I've actually tried to get it implemented in the churches in this town. I have promoted it and people are like yes but then they just don't get the training done. Then I had people from the coalition do the training but they didn't get their fingerprints done. They never completed the process but there has to be a real commitment. I have found that a lot of older people just don't want to make that commitment."

6. ***What are some of the unexpected outcomes that have happened that you really weren't expecting?***

"Probably the number of kids that have turned around from a negative life to a positive life. I wasn't sure how long it was going to take to get them there, I was thinking oh maybe this will help them get through high school and they will make a positive difference down the line. I was not anticipating such a quick turnaround in their thought processes and decision-making capabilities and their openness and honesty. Sometimes it is very shocking what they tell us in the meetings and I've followed up with them one on one to make sure that they are getting some counseling.

6a. ***You mentioned the principal just resigned, do you think there are going to be any issues sustaining the program with the new administrator?***

"No my superintendent thinks the program is awesome. So I am anticipating a change in the meeting rooms set up near the cafeteria but the room will solely be dedicated to MPOWRD."

7. ***How is it funded? Will the program continue going forward?***

"We have a gentleman here who is a philanthropist. He is a parent at the school. His son was a junior at the time and probably hanging around kids that he probably shouldn't have been at the time and gave me a gift of money to build the program to decorate the room and buy some chairs."

8. ***What have you learned about other treatments or groups since starting MPOWRD? Do any of the students attend any of these groups?***

"I have had some students attend some AA meetings and they say, 'These people don't relate to us because we are in high school and those are all adults. The adults have different issues and problems than we do.' The juvenile courts mandate them to go to these adult meetings and they tell me that they just go and get their sheets signed with no real interactions. Although one kid did tell me that it showed him that he didn't want to turn into that when he was their age."

9. ***How would you describe the changes in your relationships with the students from the first time they came into the group after say the 6th or 7th meeting?***

"The first time they were very leery like hey what's going on here. I'm an adult and so they don't trust me automatically and they think that they think differently than we do and that we don't understand them. Once they realized that we do understand what is going on in their lives and that we can relate to them at that level and we didn't put them down for their behaviors or punish them, they turned around. The first time they come in they don't know us, so they don't know what to do. It takes a while to build up that rapport so that they can walk in and have a comfort level that is amazing."

Unnamed site June 3 , 2016

1. **In your own words, how would you describe MPOWRD?**

   "Like our other process groups but the kids like it more. It has all the required components of treatment for substance abuse except it doesn't include a family component. The kids go to a lot of groups. Each unit has its own group but the kids like this group the best. They love running the meeting and they love learning leadership skills. It's the only group where they teach leadership skills.

2. **What are the goals and objectives of MPOWRD?**

   "The goals and objectives from my understanding is to empower kids and stay off substances.

3. **How would you describe your overall satisfaction with your implementation of MPOWRD?**

   "We are implementing the old version, MPOWRD not MPOWERD. We can't afford to do MPOWRD but I feel like the basic elements haven't changed too much. We asked for some workbooks and Susan developed them. I thought that if the kids could work the topic areas before or after meetings, it would help them. Susan obliged but the books are too expensive and we can't afford them."

   3a. What areas are you dissatisfied with?

   "The workbooks. We also have had a lot of turnover and so there are only a couple of us left who have been certified. I try to make sure the skills of the adult facilitators stay current and promote the best practice but each adult facilitator has his/her own style. Not every personality is a match for the program."

4. **What are some successes you have seen with MPOWRD?**

   "I don't follow the students once they leave this site; only if they come back. I'll ask them if they went to AA meetings after they left. Most often, they say they did not. Students love the leadership piece. It's the only place they are getting any positive leadership skills."

   4a. What are some participants that were unsuccessful?

   "They come back."

5. **What were the biggest barriers of getting MPOWRD to the school? Did you bring it here?**

   "No barriers. Susan made a presentation and although we had a lot of groups, we didn't have anything specifically for addictions."

6. **What are some of the unexpected outcomes that have happened that you really weren't expecting?**

   "The student leaders and participation levels. Listening to the students share."

7. **How is it funded? Will the program continue going forward?**

   "We have agency support but there are big cutbacks under the new governor. This program is not expensive to implement and because the students participate, we will most likely keep the groups going."

8. **What have you learned about other treatments or groups since starting MPOWRD? Do any of the students attend any of these groups?**

   "Yes, as I said, the students attend a lot of different groups but they attend MPOWRD at higher rates and prefer it to their other groups. They like that they can pass if they don't want to share and that it is student led. "

9. **How would you describe the changes in your relationships with the students from the first time they came into the group after say the 6th or 7th meeting?**

   "The first time they were very confused because they did not understand that it was s student led group. Even by meeting six or seven it was still odd. As students got to see what was happening and student facilitators started leading, the group took off. They feel comfortable right away because it is student-led."

Mountain Pointe High School, April 21, 2016

CEO Susan Rothery conducted this interview with MPOWRD adult facilitator and the school psychologist.

1. **In your own words, how would you describe MPOWRD? What is the mission?**

   "The mission is to provide a safe place for students.

   1a. What are your thoughts on the program's fit with your organization?

   "MPOWRD fits with our organization's mission, our school goals and what we want to do from a mental health perspective on providing that support. This is an outlet for students who are dealing with addictive behaviors. MPOWRD has made an alliance with the objectives of the school program."

2. **How would you describe your overall satisfaction with how you have implemented MPOWRD at this site? Is it working?**

   "I would say yes I would say it's definitely working. I don't think that it is implemented as much as it could be, but it's our first year with it rolling out the first time and we are doing a good job."

   2a. Have your staff shared their satisfaction or dissatisfaction with the program?

   "I think folks appreciate it. I think we definitely need to do more to get the word out there which we are in the process of doing that for the future."

3. **What successes have you seen with MPOWRD?**

   "I think MPOWRD opens the door to have a relationship with the kids. I think I've noticed that I tend to have a closer relationship with my group students versus just students that are in my office. I see them weekly. I get to check in with them more consistently."

   3a. What components of MPOWRD do you feel are vital to successful outcomes?

   "I think the most vital component of it is who facilitates it and who's in the group."

4. **What barriers during program implementation have you experienced with MPOWRD?**

   "One of the biggest challenges is having more people trained as it's a costly program. It's not one of the cheaper ones so that's a barrier. One of the other barriers could depend on families having a 12-step program within a school and what does that mean."

   4a. What could be improved?

   "I'm busy making staff aware (which is something we need to do a better job of in the future) and educating them on the purposes of this group."

5. **Will the program continue going forward? How are you planning to maintain or expand the program?**

   "I would say 100% on how the program is supported at this school. I get a lot of help from the other school counselors. I am the only one implementing it at this time. My peers and other teachers have taken a lead as far as who was referred to the group. The administration is also starting to use us as a resource for intervention. We also use announcements over the intercom."

6. **What have you learned from MPOWRD?**

   "I think that I was surprised, but not for my 12-step program perspective but using a 12-step program within a school for every addiction."
   "I just think it's important for people to start listening as to why we need to start prevention early instead of reacting when it may be too late."

   6a. What have you learned about clients that interact with other groups and treatments?

   "I finally saw that one student in particular made a comment about how her outside psychologist said that she is doing better since she has been part of this group."

7. **Have there been any new challenges since you have started your groups? Please describe.**

   "It's hard to run all the groups in one day. There is a great deal of work just getting kids into the meetings with passes, excuses from kids and teachers and running the general process."

"One of the challenges here is to have enough time to find out why a student is not showing. If a kid doesn't come because they are absent and have a test, I let that go. Where it used to be hard for me to allow kids "not to show", I don't have the option to worry because the school is so big (2,500 students) and I can't keep track of all the kids in my groups as we have over 70 at this time."

Appendix D

Appendix D1: Participant Interview Questions

*Facilitator will ask these questions to the participants – may have to limit questions asked at this time

1) Why did you first start coming to MPOWRD meetings?
2) What do you think about the meetings?
3) What is the best part of the MPOWRD meetings?
4) What is the worst part of the MPOWRD meetings?
5) Do you think you have changed from MPOWRD? In what ways?
6) If you wanted to improve MPOWRD, what would you change?

Others:
Have you attended any other groups before?
How is MPOWRD different from other groups you have attended?

Appendix D2: Participant Interview Summaries

Millennium High School, March 30, 2016

1. ***Tell me about the group, how did you get here?***

   "I was offered this as a diversion when I got caught for smoking"

   "This is sad but I tried to commit suicide last year.

   "I was getting into trouble and I couldn't talk to my parents.

   "I have depression and anxiety and my mom won't listen to me talk about what It's doing to me."

2. ***What do you get out of attending?***

   "At first I just got out of advisory but now I come because it helps me."

   "I like being with my friends."

   "I feel better."

   "I always know if I have something going on or a bad week I have someplace to talk about it."

   "I was so depressed and isolated last year, now I am not."

   "I feel like I can help my friends."

   "I feel connected and supported."

   "I am doing better with my family."

   "I am doing well in school."

   "I can help others"

   "Feeling good"

"Being successful"

"Being myself, the self who goes to school and gets good grades"

"I don't get into trouble"

"I get good grades"

"I have better boundaries and a filter"

"I belong somewhere."

3. ***If you were going to change anything about the group, what would it be?***

"It's not a punishment or a secret. I want to be able to tell other people about it."

All student participants agreed with this response. Susan Rothery took the moment to provide direction. She stated:

- Confidentiality means not talking about things that people say in here;
- Anonymity means you can't divulge who goes but you can certainly share with whomever you would like to your experience.

The issue suggests that the program may want to take a small amount of time to re-draft the materials when training to better describe these features to students since it impacts the issue of stigma and isolation.

4. ***Not all of you have had a chance to speak, what else would you like me to know about the program?***

Two students (with prompting from the counselors) told a little bit of their story.

"I tried to commit suicide last year."

"I didn't think this group was for me at all but then when I got here, it was good and I stayed."

Fountain Hills High School, April 7, 2016

1. ***Why did you first start coming to MPOWRD meetings?***

"It was recommended by my teacher."

"My friend came and said I should start."

"To get out of class, but then it turned into a great thing."

"I wanted to change."

2. ***What is the best part of the MPOWRD meetings?***

"Working out our problems."

"Just need to come and talk about bad things."

"Joining together."

"Getting out of class."

3. ***What is the worst part of the MPOWRD meetings?***

   "Side conversations."

All students agreed with this response due to the distracting nature of side conversations.

4. ***Do you think you have changed from MPOWRD? It what ways?***

   "Yes. My attitude towards school has changed in a good way."

   "Yes! I stopped giving people the power to make me angry. I ignore it now and I keep my power."

   "It's made me more open, like social changes."

5. ***If you wanted to improve MPOWRD, what would you change?***

   "We should be able to eat in meetings!"

The adult facilitator notes that the students were previously offered food during the meetings, but it was too messy and distracting to others around them, so they stopped offering food. The crinkling of the bags and the chewing can be a distraction to other kids who have complained about it before. The school nurse also notes that the school does not offer breakfast and many kids do not come to school properly fed, so they tend to snack during class and want to during the meetings.

Unnamed School, June 2, 2016

(This school gave permission for evaluators to observe a meeting but requested that the name of the school and the exact comments of the students be withheld from the report).

Students were interviewed by the program coordinator after the meeting utilizing the interview tool designed for participants. Participants indicated that they enjoyed the group, came voluntarily, felt comfortable and got a lot out of it. They stated that it was a group they run, as opposed to a group someone else runs, a critical reason why they liked it. In addition, they described their experience with the group as one where they feel more comfortable than they do in other groups. The option of "pass" and not having to share were the elements that participants found particularly valuable. All participants came to the group voluntarily. Only one participant indicated that he might continue to attend AA meetings in the community after high school. When participants were asked what they might do after the program ended, they indicated they would like to complete their high school diploma; one student indicated he planned on learning a good skill such as welding and getting a job.

Mountain Pointe High School, April 21, 2016 (based on interviews completed by CEO Susan Rothery)

Students felt that the group helped them deal with their problems and realized that many people are going through the same things that they are. They gained different perspectives in terms of how to address the issues and found that sometimes there was a better way to look at life.

Many felt that it helped them deal with stress and the pressure with trying to graduate.

Others believe that they have gained a great sense of confidence to face some of the situations that they were in.

Most agreed that they used to feel completely alone and that the people in their group helped them work through some of the problems.

One student felt that the group helped her to understand that other people go through the same things that she was and that there was a better way to look at life.

Appendix E

Appendix E1: Teen Addiction Anonymous Survey

Teen Addiction Anonymous Survey

Please read each question carefully and follow the instructions. Check the boxes that apply to you. If at any time you would like to stop taking the survey, return the survey to the researcher. Thank you for your participation.

Gender: (Circle One) Male Female

Age: (Circle One) 14 15 16 17

Please specify your ethnicity:
_____African American
_____American Indian or Alaska Native
_____Asian
_____Biracial (more than one ethnicity)
_____Caucasian
_____Hispanic
_____Other:_____

What is your drug of choice? (Please Rank top 3)
1=first choice 2=second choice 3=third choice
_____Alcohol
_____Amphetamines
_____Cocaine
_____Hallucinogens (LSD, Mushrooms, Mescaline)
_____Inhalants (Gasoline, Paint, Glue, Air Duster etc.)
_____Marijuana
_____Opioids (Oxycodone, Percocet, Morphine, Codeine, Hydrocodone, etc.)
_____PCP
_____Sedatives. Hypnotics, Anxiolytics (Valium, Librium, Xanax, etc.)
_____Spice
_____Other_____

Have you participated in substance abuse treatment prior to ADJC?
_____ Yes
_____ No

Are you currently or in the past been assigned to a substance abuse treatment unit? (Hope, Freedom, Sunrise)
_____ Yes
_____ No

How severe is your substance use problem (Circle One)?
Very severe

Severe
Undecided
Somewhat severe
Not a problem

Have you attended 12 step meetings (MPOWRD, AA, NA) prior to ADJC?
_____Yes
_____No

If Yes, was it required?
_____Yes
_____No

Why did you choose to attend MPOWRD at ADJC? (Circle all that apply)
_____ Curious what MPOWRD was about
_____To receive support from others
_____A friend was in MPOWRD
_____To learn new coping skills
_____ To discuss personal issues with others
_____ To focus on 12 step material (working 12 steps, spirituality, etc.)
_____ Other _____

How many MPOWRD meetings have you attended while at ADJC?
_____1
_____2-5
_____5-10
_____10+

Rate how helpful you think MPOWRD is to you? (Circle one)
Very Helpful
Somewhat Helpful
Undecided
Not Very Helpful
Not Helpful At All

Is it important to you to attend groups with others of similar age? (Circle one)
Very Important
Somewhat Important
Undecided
Not Very Important
Not Important At All

What do you think is most helpful about MPOWRD? (Rate top 3: 1 being most important, 2 next, 3 next)
_____ I know I am not the only one with a problem
_____Support from the other members

_____Structured format (the way the meetings are run)
_____Having the opportunity to run the meeting (Leadership)
_____Learning how to interact with others in a positive way
_____Hearing stories from other members of their success
_____I am able to discuss my feelings and thoughts with other teens
_____AA-specific content (working the 12 steps, spirituality)
_____Other _____

How is MPOWRD different from other groups you have attended? (Check all that apply)
_____MPOWRD has a more structured format
_____MPOWRD has a less structured format
_____The content discussed is related to issues I experience
_____Group members get to lead the meetings instead of an adult
_____Group members can openly discuss their problems and feelings

Are you more or less motivated to attend MPOWRD compared to other groups?
_____I prefer to attend MPOWRD over other groups
_____I am equally motivated to attend all groups.
_____I prefer to attend groups other than MPOWRD.

MPOWRD also covers "Life Challenges" that address issues teens are faced with. Which do you find to be the most helpful?
_____Listening and letting go of emotions or things we cannot control
_____Recognizing abusive relationships
_____Building healthy relationships
_____Coping with Depression
_____Coping with ADHD/ADD
_____Coping with Anger
_____Coping with Grief
_____Teen and parent relationships
_____ Addictive behaviors

Will you attend MPOWRD meetings after you are released from ADJC?
_____Yes
_____No

If No, Why not? (Check all that apply)
_____ I do not know where MPOWRD meetings are held
_____I do not have a problem with addictive behavior
_____The content of MPOWRD is not relevant to me
_____There are no MPOWRD meetings offered in my area
_____I do not have transportation to get to MPOWRD meetings
_____Other _____

Appendix E2: Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES)

Miller, W.R. & Tonigan, J.S. (1996). *Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES)*. Retrieved from: http://casaa.unm.edu/inst/SOCRATES%208D.pdf

INSTRUCTIONS: Please read the following statements carefully. Each one described a way that you might (or might not) feel about your drug use. For each statement, circle one number from 1 to 5, to indicate how much you agree or disagree with it right now. Please circle only one number for every statement.

	NO! Strongly Disagree	**No** Disagree	**?** Undecided or Unsure	**Yes** Agree	**YES!** Strongly Agree
1. I really want to make changes in my use of drugs.	1	2	3	4	5
2. Sometimes I wonder if I am an addict.	1	2	3	4	5
3. If I don't change my drug use soon, my problems are only going to get worse.	1	2	3	4	5
4. I have already started making some changes in my use of drugs.	1	2	3	4	5
5. I was using drugs too much at one time, but I've managed to change that.	1	2	3	4	5
6. Sometimes I wonder if my drug use is hurting other people.	1	2	3	4	5
7. I have a drug problem.	1	2	3	4	5
8. I'm not just thinking about changing my drug use, I'm already doing something about it.	1	2	3	4	5
9. I have already changed my drug use, and I am looking forward for ways to keep from slipping back into my old pattern.	1	2	3	4	5
10. I have serious problems with drugs.	1	2	3	4	5
11. Sometimes I wonder if I am in control of my drug use.	1	2	3	4	5

12. My drug use is causing a lot of harm.	1	2	3	4	5
13. I am actively doing things now to cut down or stop my use of drugs.	1	2	3	4	5
14. I want help to keep from going back to the drug problems I had before.	1	2	3	4	5
15. I know that I have a drug problem.	1	2	3	4	5
16. There are times when I wonder if I use drugs too much.	1	2	3	4	5
17. I am a drug addict.	1	2	3	4	5
18. I am working hard to change my drug use.	1	2	3	4	5
19. I have made some changes in my drug use, and I want some help to keep from going back to the way I used before.	1	2	3	4	5

Appendix E3: Teen Addiction Anonymous Interview Questions

The following questions were generated from the survey and were used to focus individual interviews.

1. Why did you choose to attend MPOWRD at ADJC?
2. How helpful you think MPOWRD is to you?
3. Why is it important to you to attend groups with others of similar age?
4. What do you think is most helpful about MPOWRD?
5. How is MPOWRD different from other groups you have attended?
6. Are you more or less motivated to attend MPOWRD compared to other groups?
7. Which "Life Challenges" do you find to be the most helpful?
8. Is there anything else you would like to say about your experiences in MPOWRD?

Additional follow-up questions were utilized when applicable:

- Can you tell me more about that?
- Can you explain your answer in more detail?
- Why did you choose that answer?