

## **Substance Abuse: Personal Construct Processes and Psychotherapy with Children and Adolescents**

Deborah Truneckova and Linda L. Viney

Deborah Truneckova, University of Wollongong, Australia

Linda L Viney, Professor, University of Wollongong, Australia

### **Abstract**

The effects of substance abuse on children and adolescents, their families and other significant people in their lives, is profound, and possibly life-threatening. In response to these concerns, there has been increased research emphasis on establishing evidence for the benefits of psychological treatment for children and adolescents substance abuse. Many options for psychological interventions have included pharmacologic treatment, as well as individual, family or group therapy in an inpatient or outpatient setting. As well, there has been a need to establish which treatment methods are most useful while also investigating what factors might facilitate these processes of change. In response to these challenges, we will present a personal construct model of treatment for child and adolescent substance abuse that adopts a truly listening approach. Personal construct theory views substance abuse as a way of developing meaning in a social world. Our model explores, with children and adolescents, the significance of the substance-abuse to them, the self-perceptions and identity-defining nature of abuse, and then creates with them personal solutions to their problems. The factors in this approach which, we believe facilitate the psychological processes of change in children and adolescents, will also be explored.

### **Introduction**

#### **The Many Issues Involved in Substance Abuse**

At a recent interdisciplinary forum to discuss ‘Substance Abuse’, the Oxford Round Table (March, 2008), diverse perspectives and opinions were offered. The complexity of this contemporary issue, substance abuse, and the impact it is having across all areas of human engagement, was confronting to all participants. With no universally accepted definition of ‘addiction’ (Zollweg, 2008), the forum was often reminded of the disconnect between research, education and practice (Alausa, 2008; Mann, 2008; Ponder, 2008; Weems, 2008), between public policy and law enforcement (Henning, 2008; Leowy, 2008; Nicholson, 2008), and between health, welfare and criminal law (Bonnelli, 2008; Jojwana, 2008; Leggat, 2008; Ovens, 2008).

As the forum progressed, a body of knowledge and opinions was being collected. There were discussions on treatments, of counseling (Pawlukewicz, 2008; Truneckova, 2008), the application of the law (Arlebrink, 2008; Burks, 2008; Hill, 2008; Redford, 2008; Trump, 2008; Zollweg, 2008), and treatment measurements to be used (Hall-Flavin, 2008). Conversations were also held on the essence of social living as community, and how understanding relationships between self and others (Truneckova, 2008) strengthens the protective factors

against substance abuse (Tsey, 2008). It became apparent as the forum continued that as disciplines interface, there is a connection, a more comprehensive body of knowledge and opinions evolves.

With this evolution, understandings were developing, forming a body of knowledge more creative and useful than the knowledge based on the previously distinct and separate disciplines available before the forum. While this paper presents one perspective or part in the substance debate, it will be argued that it seeks to embrace the ‘whole’, the collective knowledge, by focusing on the essence of relationships, the glue that enables us to come together to talk, understand, and make connections with research, education, practice, public policy, law enforcement, health, welfare, and criminal law.

### **Prevalence and Impact of Substance Abuse by Children and Adolescents**

According to national surveys conducted across the world, substance abuse among children and adolescents is increasing, and alcohol has become the most abused drug (AIHW, 2007b). This alcohol abuse has been recently highlighted by recent research that has reported approximately 10% of 12 to 17 year olds, are binge drinking, or drinking at harmful levels (ANCD, 2008).

Tobacco smoking continues to be a substance of use by young people, and while there appears to be a decline in smoking prevalence, with 4% of 12 to 15 year olds, and 11% of 16 to 17 year olds reporting they were committed smokers (ASSAD, 2005), it continues to be an abused drug. Young people who use both tobacco and alcohol, are twice as likely to use illicit drugs (AIHW, 2007b; SAMHSA, 2007). In Australia, the use of illicit substances by 12 to 17 year olds was found to have either declined, or remained stable between 1999 and 2005, with the largest decrease occurring in marijuana, 29% in 1999 to a decline of 18% in 2005. Polysubstance use was also found to have decreased from 32% in 1999, to 20% in 2005 (AIHW, 2007b). The data on Aboriginal and Torres Strait Islander young people (NATSIHS, 2004-05), 15 years and over, collected 2004 to 2005, describe higher levels of substance abuse by the Indigenous youth, when compared with other young Australians. Almost 23% of young Indigenous Australians compared to 10% of other young Australians, reported drinking alcohol at levels considered risky to highly risky in the long term. Tobacco smoking was reported by 52% of young Indigenous Australians, while 28% reported using illicit substances (AIHW, 2007b).

The worrying trend in child and adolescent substance abuse is that the age of initiation has decreased (AIHW, 2007b), with younger people more often abusing drugs.

Emotional problems predispose young people to abuse drugs rather than frequent substance use causing emotional problems (Nicholson, Duncan, and White, 2002). There is general evidence that mental health problems and substance abuse appear to have increased (AIHW, 2007b), with approximately 20% of young people (age 12-24 years) in Australia, experiencing mental health or substance use disorders (Patel, Flisher, Hetrick, and McGorry, 2007). A significant proportion of these young people will be affected by more than one disorder (Teesson, Hall, Lynskey, and Degenhardt, 2000; Wade et al., 2006). Mental and substance use disorders account for greater

than 60% of the non-fatal burden of disease, and 50% of the total disease burden (disability-adjusted life years) (AIHW, 2007a).

The impact of substance abuse on the life trajectory of children and adolescents is profound. In the USA, \$66.9 billion has been spent dealing with drug-related illness, death and crime (National Drug Control Strategy, 1997). However, with children and adolescents, there are also the negative impacts of substance abuse on the developmental processes. Substance abuse can make it difficult for children and adolescents to maintain relationships, and to retain a connection with school, employment or family, protective factors against escalating substance use, crime, and homelessness (NYARS, 2004). The detrimental impact is further compounded by the elevated risk of developing a coexisting mental illness, and of suicide (NSWHD, 2000). Youth suicide remains the cause of the highest number of deaths among young people (AIHW, 2007a), with approximately 53% of young people who suicide having a substance abuse problem (APA, 2005).

### **Personal Construct Theory and the Psychological Development of Children and Adolescents**

Personal construct theory does not have stages or phases, but rather provides a developmental psychology (Agnew, 1985), by which to understand the transition of the individual through childhood and adolescence. Children and adolescents are continually searching for meaning in their interpersonal relationships, by anticipating, facilitating and participating in processes of creative change.

In personal construct theory, the self-concept is determined by the social roles the child and adolescent plays, and by the constructions, or understandings, others have of the individual. The notion of self is constructed, and elaborated over time. There is no concept of self, rather the individual has a bipolar construct of self-not self and self-others. It is the construction of “self versus others” which will influence how the child and adolescent construes experiences and emotions.

When forming friendships, children rely mostly on commonality of family experience. Children will generally describe people in terms of appearance, social roles, and behaviour, while during adolescence, there is a greater “individuation” and “differentiation” of people as persons (Adams-Webber, 1979). During childhood and adolescence, there is a gradual increase in the capacity to differentiate between self and others. With the transition from childhood to adolescence, the self constructs increasingly become organized within various social roles, so there is a number of ‘selves’ comprising one’s self-identity. The person’s constructs about self are termed core constructs, and it is these constructs which maintain the person as unique.

### **Personal Construct Psychotherapeutic Approach and Processes to Psychological Changes**

Personal construct theory, developed by Kelly (1991a; 1991b), embraces the concept of constructive alternativism, that there is a multiplicity of ways of understanding any given event.

These understandings are constructions which provide meaning and order to the series of events which confront children and adolescents. These constructs make their world meaningful, and guide their interactions with it. Children and adolescents create meaning by posing questions, carrying out experiments and evaluating their outcome. Personality development is the outcome of how children and adolescents respond to validation or invalidation by others or events of their self constructs. Changes or extensions to the child's or adolescent's system of constructs occur when experience either confirms or disconfirms prior anticipations. In personal construct theory, negative emotions are not viewed as either right or wrong, but as a constructive part of the process of change. The behaviour of the children and adolescents is considered experimental, and their emotional states, a measure of actual or impending change in their construct systems. Emotions are inseparable from cognitions as major players in behaviour, and as such both constitute principle components in change processes (Sewell, 1995).

### **Etiology of Child and Adolescent Substance Abuse**

Unlike adult referrals for substance abuse, child and adolescent referrals are made by parents and other adults (Yeh, and Weisz, 2001). When the referrals are made, they tend to be prompted by usually high levels of youth dysfunction often with high levels of comorbidity (Angold, Costello, and Erkanli, 1999). Anxiety and depression (Dadds, 2001; Social Exclusion Unit, 2005), conduct disorder (Dadds, 2001; Ketterlinas, and Lamb, 1994), along with attention deficit hyperactivity disorder, cutting and learning disorders, are common (Greydanus, 2005). A longitudinal study following a cohort of 101 subjects from the age of 3 until age 18 years, with assessments at ages 3, 4, 5, 7, 11, 14, and 18, found frequent drug users at 18 years, were 'relatively insecure, unable to form healthy relationships, and emotionally distressed as children' (Shedler, and Block, 1990, p. 624).

Youth who were strongly attached to fathers in households where parents frequently use drugs, are more likely to use both licit and illicit drugs than adolescents strongly bonded to non-drug using parents (Drapela, and Mosher, 2007). Adolescent misuse was reported to be associated with maternal binge drinking, parenting, peers, school characteristics, and adolescent's own behaviour. Results of the study showed mother's binge drinking, peer drinking, and an early age of onset predicted higher levels of alcohol misuse in youths 14 to 16 years of age. In youth, 16 to 18 years of age, maternal binge drinking was no longer significant, however, maternal attachment, school attachment, peer drinking, and early age of onset were found to significantly predict adolescent alcohol abuse (Tyler, Torres Stone, and Bersani, 2006).

### **Current Approaches to Psychological Treatment**

When considering psychological treatment of substance abuse, the central question becomes:

"Which kinds of individuals, with what kinds of alcohol/other addiction problems, are likely to respond to what kinds of treatments by achieving what kinds of goals when delivered by which kinds of practitioners" (Hall-Flavin, 2008).

With children and adolescents, it is also important to acknowledge their developmental needs, the variations in the emotional, cognitive and behavioural abilities of these young people presenting for treatment. Cultural sensitivity is essential, particularly for young people from an Indigenous (Westerman, 2004), or culturally and linguistically diverse background (Howard, Stubbs, and Arcuri, 2007), for example, the different beliefs to understanding shame, guilt, threat, and isolation. While consideration of cultural and ethnic differences is essential, it is also important that contextual factors such as family, peer group, and school setting are considered during treatment planning (Zarb, 1992).

In a review of the literature on treatment, the Commission on Adolescent Substance and Alcohol Abuse (2005) concluded that young people who remain in treatment have better outcomes than those who do not finish the intervention programme (Lyons, and Rawal, 2005). It is therefore imperative that treatment be meaningful to the child or adolescent. This requires establishing a robust and effective alliance (Carey, and Oxman, 2007), creating a safe environment in which to engage the young person, while identifying stage of change (Prochaska, DiClemente, and Norcross, 1992) in the substance abuse and dependence contexts, and finally providing appropriate interventions.

Recovery from substance abuse by children and adolescents is a process, and not an event (Howard, Stubbs, and Arcuri, 2007). It is the norm rather than the exception that treatment will be long-term (Pringle, and Flanzer, 2005), and support and monitoring are essential during this time to identify possible relapse, and reduce the risk of secondary psychological problems, social upheaval and chronic disability (Kendall, and Kessler, 2002; Vos et al, 2004). Measures of relapse could offer a useful way of determining the effectiveness of the intervention (Mann, 2008).

Psychological treatments of substance abuse in children and adolescents have included pharmacologic treatments as well as individual, family or group therapies in an inpatient or out-patient setting. Of the pharmacological treatments for nicotine addiction, nicotine replacement and bupropion are usually provided. While currently not approved for young people, medications for alcoholic addiction include naltrexone, and acamprostate.

Individual therapies range from problem-focused psychological interventions, to treatments that are primarily client-centred. *Cognitive behavior therapy* teaches children and adolescents to reflect on how their thoughts affect their behaviour. Generally, these therapies regard substance abuse as an acquired behaviour, which begins and continues within the framework of an individual's environment (Allen, Hetrick, Simmons, and Hickie, 2007; Waldron, and Kaminer, 2004). *Behavior modification therapy* is based on rewards and consequences (Carrol, and Onken, 2005). *Constructivist Rational Emotive Behaviour Therapy (REBT)* encourages the adolescent to look at underlying premises behind their feelings, beliefs and actions (Adelman, 2006). *Motivational interviewing* utilizes the principles and practices of client-centred counseling to encourage the child or adolescent to move through the stages of change, and to make personal choices along the way. The core assumptions of motivational interviewing (Miller, and Rollnick, 2002) includes the idea that motivation for behaviour change is the result

of interpersonal interactions, not an inherent character trait, and that ambivalence to change is normal and acceptable (Carrol, and Onken, 2005). *Constructivist therapies* suggest that to understand the child or adolescent's experiences with, and relationships to, the drugs of dependence, it is necessary to consider how others construe them (Burrell, 2002; Klion and Pfenninger, 1997).

The goal of family-directed therapy is to treat the child or adolescent within his/her social and family network (Carrol and Onken, 2005; Pringle and Flanzer, 2005), the psycho-social environment contributing to the establishment of the conditions associated with the substance abuse (Kaminer and Slesnick, 2006). Family therapy is increasingly considered successful (Sexton, Alexander, and Mease, 2004), because of its ability to engage and retain children and adolescents and their families (*functional family therapy*: Elliott, 1998; Sexton, and Alexander, 2002/ *multisystemic therapy*: Henggeler, Pickrel, and Brondino, 1999; Henggeler, Melton, Brondino, Scherer, and Hanley, 1997). Research has also found that family-directed therapies lead to lower drug use after treatment (Stanton, and Shadish, 1997; Smith, Hall, Williams, An, and Gotman, 2006).

The predominant group work treatment used is *cognitive behavior group therapy*, which primarily focuses on skills-training, problem-solving and role-playing to achieve behaviour changes (Kaminer, 2005; Kaminer, Blitz, Bursleson, Kadden, and Rounsaville, 1998). Research has found the intervention efficacious, resulting in significant symptom remission or abstinence (Smith, Hall, Williams, An, and Gotman, 2006).

### **Personal Construct Theory and Substance Abuse**

Personal construct theory views substance abuse as a meaningful and goal-directed action, while focusing on understanding drug use from the personal to the social, with an emphasis on personal agency and personal meaning (Burrell, 2002). Substance abuse can best be understood as a problem involving the process of construing self and others (Klion, 1993). As the chemical dependency becomes a predominant focus for the person, the role of addict becomes well-elaborated and developed into defining his or herself and others. Concurrently, the development of roles which are not involved in substance abuse become increasingly difficult, as the construction of alternative self constructions in other roles and contexts diminishes (Klion, 1993), while 'the addict' is often explicitly and implicitly elaborated and extended (Dawes, 1985). Role relationships are relationships between people in which each participant tries to take the perspective of the other (Fransella, 2003; Viney, 1996). As the role of "addict" becomes central to the person's self-identity, other roles, potential sources of social validation and experience decrease.

Due to their biochemical properties, drugs of abuse are inherently reinforcing, and drug use can provide a form of 'gratification' and 'emotional validation' as well as a means for coping with invalidation (Klion, 1993). Substance abuse can reduce the impact of invalidation experiences which may be reflected by negative emotions such as sadness and guilt, or generate

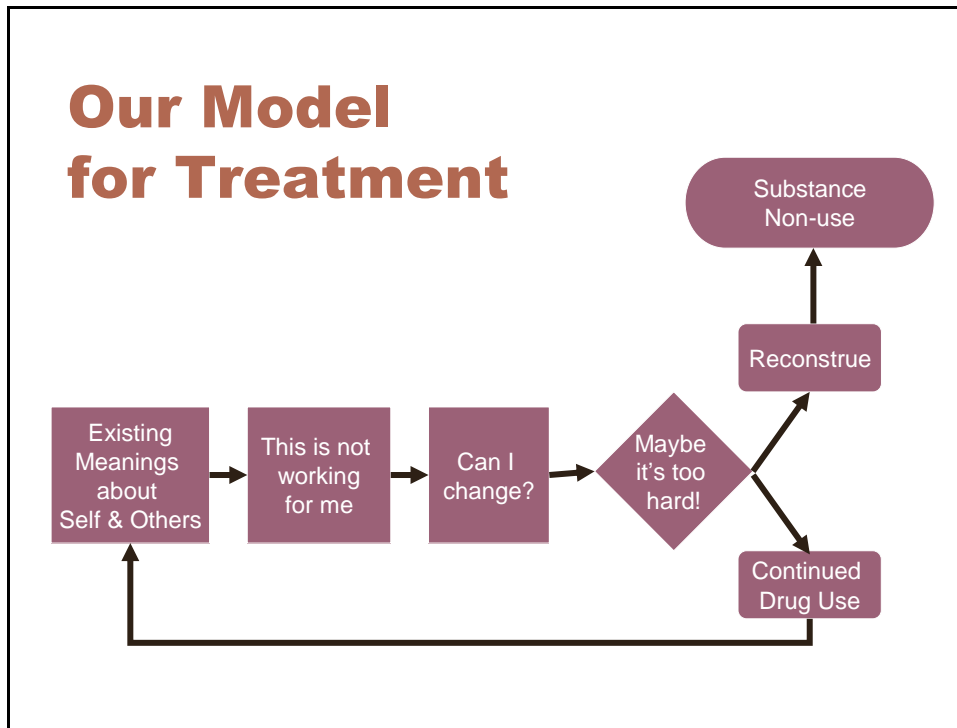
experiences of validation felt in emotions such as joy (Klion, 1993; Klion, and Pfenninger, 1997).

However, to construe oneself as an “addict” and therefore “needing to fix the problem” can be very threatening, because this may require the seemingly impossible undertaking of self-reconstruction (Klion, 1993). Their development of other identities has been restricted, as they have focused more and more on their drug dependency. The addict may ‘slot rattle’, or move back and forth between the poles of their construct system, between the “addicted” and “not addicted” sides of the system. Such confusion may lead the substance abusers to leave treatment, moving quickly from feelings of guilt and expressions of remorse, to minimizing or refusing to acknowledge their addiction problem. Substantial feelings of guilt and threat are experienced by addicts as their construing is frequently invalidated, and there appears to be no apparent means of self change. Guilt is defined as the awareness that one’s actions do not fit with one’s central constructs about oneself (Fransella, 2003; Viney, 1996). Threat is experienced by people when they recognize the imminent possibility of major changes to their most central understandings about themselves (Fransella, 2003; Viney, 1996).

The substance abuse increases to quiet the emotional experiences of invalidation, but in turn, these experiences only get greater as the person’s ability to reconstrue is compromised. The endgame is a self-perpetuating cycle of threat, guilt, and substance abuse (Klion, 1993).

### Our Model of Substance Abuse for Treating Children and Adolescents

Figure 1.



Our model (refer Figure 1) adapted from Klion (1993), is grounded in Personal Construct Theory, viewing meaning-making as psychologically directed by the way children and adolescents anticipate events (Fundamental Postulate, Kelly, 1991a). Our model also sees children, adolescents, and parents and significant adults, as having distinctive understandings and experiences of their worlds (Individual Corollary, Kelly, 1991a). These understandings and experiences can be shared, that children and adolescents can construe their experiences in similar ways to their parents and significant adults (Commonality Corollary, Kelly, 1991a). While, it is not necessary for children and adolescents to share the same attitudes and experiences in order to be in a relationship with their parents and significant adults, there needs to be an attempt to understand each other's perspectives (Sociality Corollary, Kelly, 1991a).

Construct systems are composed of several relatively independent and sometimes incompatible subsystems which may seem to be in conflict with each other (Fragmentation Corollary, Kelly, 1991a). These inconsistencies or conflicts in construct systems have been described as implicative dilemmas (Hinkle, 1965). When core constructs are invalidated by events, feelings of guilt and of hopelessness are experienced. When the child or adolescent sees the self as experiencing a drug problem, feelings of threat are often experienced, creating a dilemma that will require them to undertake major self-reconstruction for its solution. Threat, can be the most important impediment for the child or adolescent construing themselves as drug dependent. The implications of developing a new self role are too great and no other options seem available (Klion, 1993).

Our personal construct model of treatment for child or adolescent substance abuse, begins with adopting a credulous attitude with the therapist, setting out to engage the child or adolescent in a process of collaborative experimentation. Together, the therapist and child or adolescent investigate their own distinctive meanings. They are shared, and attempts are made to understand each other's meanings. An important initial step, is for the therapist to develop a working alliance with the child or adolescent. Most clients are not self referred and they might feel they have been coerced into treatment by more 'powerful' people such as parents and teachers. There will be feelings of anger and confusion, because while others have decided there is a problem, the child or adolescent may not be seeing they have an issue with substance use. The child or adolescent with an acknowledged substance abuse problem, may also be feeling guilty, threatened and out of control. It is important for the therapist to develop early in the treatment, a therapeutic alliance in order to reduce any possible resistance to treatment, and to engage, and maintain the child or adolescent in treatment. Within the working alliance, the therapist encourages the child or adolescent to take part in collaborative experiments, a creative cycle of hypothesis testing, experimentation, reevaluating, and reconstruing on the basis of the results of the experimenting (Stewart, and Birdsall, 2001).

One of the therapist's roles in this collaborative experimentation with the child or adolescent, is to understand their perspective or construing of the substance abuse, and just as importantly how the client understands themselves and others. The other role for the therapist is to help the child or adolescent more adequately understand themselves, to empower them, to

clarify how substance use may or may not be a problem from the child or adolescent's perspective, and to facilitate the growth of the child or adolescent's construct system (Klion, 1993).

In our personal construct model of treatment for substance abuse, the therapist is facilitating the child or adolescent to elaborate their understanding of themselves by searching for meaning through their interpersonal relationships. There is a broadening and deepening of the therapeutic focus on the relationships between substance use, self organization, and social contexts (Burrell, 2002). The child and adolescent are encouraged to develop their social roles, and their understandings they have of themselves, within these various relationships. For children, the therapist will help to develop a sense of mastery, of competency in tasks, and a willingness to take part in mutual activities with peers, develop personal and social skills. The therapist particularly helps adolescent's more fully understand themselves through the lenses of others, to understand who they are by what they are not, to individuate and differentiate people as persons. The therapist also encourages the adolescent to experiment with relationships and intimacy.

By developing a greater understanding of their self-constructions, and the consequent broadening of their social roles, the therapist actively encourages the creation of more viable non-substance centred selves (Burrell, 2002). The goal of our model of treatment is that the child or adolescent's self-definition is not narrowly bound up in enacting or avoiding the role of "addict" but rather moving forward with a more comprehensive understanding of self, others, and the world (Klion, 1993).

### **Criteria Needed to be Met by Our Model**

Considerable research over the last decade has been investigating those factors that lead to successful therapy outcomes. In order to be able to provide effective psychological treatment for child and adolescent substance abuse, our model will need to meet the criteria identified as leading to effective outcomes. The single best predictor, is the engagement of the child and adolescent with the treatment (Hawley, and Weisz, 2005; McLeod, and Weisz, 2005; Orlinsky, Grawe, and Parks, 1994; Shirk, and Karver, 2003; Weisz, Jensen-Doss, and Hawley, 2006). High on the list of factors mediating the link between participation, is the quality of the therapeutic relationship (Bachelor, and Horvath, 1999; Orlinsky, Grawe, and Parks, 1994; Shirk, and Karver, 2003), and the child or adolescent's subjective experience early in the therapy (Brown, Dreis, and Race, 1999; Duncan, Miller, and Sparks, 2004).

A number of empirical studies, along with meta-analysis using several thousand cases, found that retention rates and outcome of treatments improved, when the therapies incorporated formal ongoing feedback on the client, regarding process and outcome of treatment (Lambert, Whipple, Smart, Vermeersch, Nielsen, and Hawkins, 2001; Lambert, Whipple, Bishop, Vermeersch, Gray, and Finch, 2002; Whipple, Lambert, Vermeersch, Smart, Nielsen, and Hawkins, 2003; Lambert, Whipple, Hawkins, Vermeersch, Nielsen, and Smart, 2003). These improvements doubled for clients with substance abuse problems (Miller, Mee-Lee, Plum, and

Hubble, 2005). The collaborative, credulous nature of our approach, suggests that there is a high probability that personal construct psychotherapy can engage child and adolescent clients, and provide a positive therapeutic relationship, along with feedback of processes and outcomes.

Research has also investigated behavioural changes in children and adolescents following effective therapy. When therapy focuses on improving the self-efficacy (Burlison and Kaminer, 2005) or self-concept (Weiss, Watson, and McGuire, 2003) of the child or adolescent, greater evidence of abstinence was found. The core assumption of our model is that the child or adolescent understand themselves and others. With this greater knowledge, they begin to appreciate their uniqueness, and experience more positive self-esteem.

The impact of the strength of the alliance between parent and child or adolescent on treatment outcome, was found to predict treatment retention and drug abstinence (Hogue, Dauber, Stambaugh, Cecero, and Liddle, 2006). In our model, we facilitate exploration and elaboration by the child or adolescent, of interpersonal relationships, and as this occurs, alliances with family and friends are strengthened.

Our model does not require the child or adolescent to work within prescribed structures or techniques, but rather the personal construct approach credulously listens, enhancing outcomes, as the therapist prioritizes the child or adolescent's beliefs, resources, and preferences throughout the course of the therapy (Murphy, 1999). Our approach also is non-blaming and non-judgemental, factors identified as leading to successful outcomes in family-based interventions (Stanton and Shadish, 1997).

Studies into specific treatments when the above factors are controlled, have found that the current approaches to treatment are equally effective (Burlison and Kaminer, 2005), in child and adolescent substance abuse treatment. Personal construct psychotherapy has been found to be effective, providing improvements similar to other treatments (Viney, Metcalfe, and Winter, 2005; Winter, 2003), suggesting that our personal construct model of treatment for child and adolescent substance abuse is potentially an effective psychological intervention.

### **The Functions of Our Model for the Psychotherapist**

Our model grounded in personal construct theory, provides a set of conceptual propositions (Viney, 2006). These propositions assist the psychotherapist to better understand substance use by children and adolescents. The psychotherapist is then able to act on this psychological knowledge to generate hypotheses that can provide information, and further knowledge and skills that can lead to effective treatment (Viney, 2006). The usefulness of models of treatment can be determined by seeing if they meet six functions proposed by Viney (2006). The first function, concerns the ability of our model to assist the psychotherapist to focus on the relevant aspects of personal construct theory, and also on the events pertaining to substance abuse and children and adolescents. This assists the psychotherapist to make sense of very complex concepts and events in the treatment of substance use/non-use by children and adolescents. The second function identified, is how our model we believe, is able to make accountable and available for the psychotherapist, personal construct theory.

Another function of models discussed by Viney (2006), is how models can provide new ideas for the psychotherapist in treatment. While not lost in the complexity of the theory, the simplicity of our model, encourages psychotherapists to creatively generate different perspectives and understandings. Our model, we believe also meets the fourth function (Viney, 2006), that of clarity and specificity. The theoretical concepts are represented by definition and understandings that easily translate into treatment practice. Models also need to provide psychotherapists with better skills or techniques by which they can determine if the information being collected is appropriate to the theoretical assumptions of the model. Our model undertakes this function by having the child or adolescent understand their changing perspectives of themselves and others during treatment. The final function proposed is the capacity of the model to enable psychotherapists to make predictions about their practice. The clarity and specificity in our model allows for the creative generation of hypotheses by the psychotherapist. These hypotheses can be tested. The results of these experiments become important information invalidating or validating material that can be used to promote psychological change.

### **Conclusions**

Our model of treatment for child and adolescent substance use/non-use provides the psychotherapist with a useful and effective approach to practice. It attempts to place therapy within the broader contexts of human engagement, by working within the relationships the child or adolescent experiences in their communities. It also sets out to account for the developmental needs of children and adolescents, and to encourage exploration, elaboration and sharing of self-perceptions and the identity-defining nature of substance abuse. Pivotal to our model of treatment, is the establishment of a therapeutic alliance to reduce negative feelings of threat or guilt, and to build more effective relationships with others. The goal of treatment in our model is for the child or adolescent to develop a more comprehensive understanding of themselves, others, and the world. The outcome of our model is the creation of more viable non-substance centred selves.

### **References**

- Adams-Webber, J. (1979). Construing persons in social contexts. In *Constructs of sociality and individuality*, ed. P. Stringer and D. Bannister, 195-220. New York: Academic Press.
- Adelman, R.W. (2006). The angry adolescent and constructivist REBT. In *Working with anger. A Constructivist approach*, ed. P.Cummins, 99-114. Chichester, UK: John Wiley & Sons.
- Agnew, J. (1985). Childhood disorders or the venture of children. In *Personal construct theory and mental health*, ed. E. Button, 224-245. London: Croom Helm.
- Alausa, O. 2008. The role of health education in combating the high prevalence of substance abuse in tertiary educational institutions in Nigeria. Paper presented at the Round Table, Substance Abuse: Exploring consequences and remedies, March 9-14, in Oxford, England.

- Allen, N.B., Hetrick, S.E., Simmons, J.G., and Hickie, I.B. 2007. Early intervention for depressive disorders in young people: The opportunity and the (lack of) evidence. *Medical Journal of Australia* 187: S15-S17.
- American Psychiatric Association (APA) (2005). *Let's talk about teen suicide*. Arlington, VA: APA.
- Angold, A., Costello, E.J., and Erkanli, A. (1999). Comorbidity. *The Journal of Child Psychology and Psychiatry and Allied Disciplines* 40: 57-87.
- Arlebrink, J. 2008. The moral question and the existential suffering-how an alcohol abuser experiences compulsory treatment and reacts to it. Paper presented at the Round Table, Substance Abuse: Exploring consequences and remedies, March 9-14, in Oxford, England.
- Australian Institute of Health and Welfare (AIHW) (2007a). *Young Australians: Their health and wellbeing, 2007*. (AIHW Cat. No.PHE 87). Canberra: AIHW.
- Australian Institute of Health and Welfare (AIHW) (2007b). *Statistics on drug use in Australia 2006*. Drug Statistics Series No. 18. Cat.no. PHE 80. Canberra: AIHW.
- Australian National Council on Drugs (2008). *Families in need of support*. (2008, February 25). <http://www.ancd.org.au/publications/pdf/rp15supportingfamilies.pdf>. (Accessed February 28, 2008).
- Australian Secondary Student's Alcohol and Drug Survey (ASSAD), (2005). Cited in: Australian Institute of Health and Welfare 2007. *Statistics on drug use in Australia 2006*. Drug Statistics Series No. 18. Cat.no. PHE 80. Canberra: AIHW.
- Bachelor, A., and Horvath, A. (1999). The therapeutic relationship. In *The heart and soul of change: What works in therapy*, ed. M.A. Hubble, B.L. Duncan, and S.D. Miller, 133-178. Washington, DC: American Psychological Association Press.
- Bonnelli, G.W. 2008. Construction challenges for useful models that impact substance abuse policy. Paper presented at the Round Table, Substance Abuse: Exploring consequences and remedies, March 9-14, in Oxford, England.
- Brown, J., Dreis, S., and Race, D.K. (1999). What really makes a difference in psychotherapy outcomes? Why does managed care want to know? In *The heart and soul of change: What works in therapy*, ed. M.A. Hubble, B.L. Duncan, and S.D. Miller, 389-406. Washington, DC: American Psychological Association Press.
- Burleson, J.A., and Kaminer, Y. (2005). Self-efficacy as a predictor of treatment outcome in adolescent substance use disorders. *Addictive Behaviors* 30: 1751-1764.
- Burks, I.F. 2008. Substance abuse and American law enforcement-It's killing us! Paper presented at the Round Table, Substance Abuse: Exploring consequences and remedies, March 9-14, in Oxford, England.
- Burrell, M. (2002). Deconstructing and reconstructing substance use and "addiction": Constructivist perspectives. In *Advances in personal construct psychology. New directions and perspectives*, ed. R.A. Neimeyer and G.J. Neimeyer, 203-232. Westport, CT: Praeger.
- Burton, D., Sussman, S., Hansen, W., Johnson, C., and Flay, B.R. (1989). Image attributions and smoking: Intentions among seventh grade students. *Journal of Applied Social Psychology* 19: 656-666.
- Carey, T.A., and Oxman, L.N. 2007. Adolescents and mental health treatments: Reviewing the evidence to discern common themes for clinicians and areas for future research. *Clinical Psychologist* 11, 3: 76-87.

- Carrol, K.M., and Onken, L.S. (2005). Behavioral therapies for drug abuse. *American Journal of Psychiatry* 2005; 162: 1452-1460.
- Cheek, J.M., and Hogan, R. (1983). Self-concepts, self-presentations, and moral judgements. In *Psychological perspectives on the self*, ed. J. Suls and A.M. Grennwald, Vol.2, 249-275. Hillsdale, NJ: Lawrence Erlbaum.
- Commission on Adolescent Substance and Alcohol Abuse. 2005. Treatment of substance use disorders. In *Treating and preventing adolescent mental health disorders*, ed. D.L. Evans, E.B. Foa, R.E. Gur, H.Hendin, C.P. O'Brien, M.E.P. Seligman, et al., 392-410. Oxford: Oxford University Press.
- Dadds, M. (2001). Potential for innovative prevention strategies. In *National Comorbidity Project. National Drug Strategy and Mental Health Strategy*, ed. M. Teeson, and L. Burns, 42-59. Canberra, Australia: Commonwealth Department of Health and Aged Care.
- Dawes, A. (1985). Construing drug dependence. In *Personal construct theory and mental health*, ed. E Button, 182-194. London: Croom Helm.
- Department of Health and Human Services (SAMHSA) (2007). *Youth and substance abuse*. (2007, December 3). <http://www.oas.samhsa.gov/youthDrugs.htm> (Accessed January 20, 2008).
- Drapela, L.A., and Mosher, C., (2007). The conditional effect of parental drug use on parental attachment and adolescent drug use: Social control and social development model perspectives. *Journal of Child and Adolescent Substance Abuse* 16: 63-87.
- Duncan, B.L., Miller, S.D., and Sparks, J. (2004). *The heroic client: Principles of client-directed, outcome-informed therapy (revised)*. San Francisco: Jossey-Bass.
- Elliott, D.S. (1998). Editor's introduction: In *Book Three: Blue prints for violence prevention*, ed. D. Elliott. Golden, CO: Venture Publishing and Denver, Co: C & M Press.
- Fransella, F. (2003). Appendix 1. Theoretical definitions. In *International handbook of personal construct psychology*, ed. F. Fransella, 455-457. Chichester, England: John Wiley & Sons.
- Galliher, R.V., Evans, C.M., & Weiser, D. (2007). Social and individual predictors of substance use for native American youth. *Journal of Child and Adolescent Substance Abuse* 16: 1-16.
- Greydanus, D.E. (2005). The adolescent and substance abuse: Current concepts. *Dis Mon* 51: 392-431.
- Hall-Flavin, D. 2008. Current concepts in the treatment of addictive disorders: What is successful treatment in the era of transnational medicine? Paper presented at the Round Table, Substance Abuse: Exploring consequences and remedies, March 9-14, in Oxford, England.
- Hawley, K.M., and Weisz, J.R. (2005). Youth versus parent working alliance in usual clinical care: Distinctive associations with retention, satisfaction, and treatment outcome. *Journal of Clinical Child and Adolescent Psychology* 34: 117-128.
- Henggeler, S.W., Melton, G.B., Brondino, M.J., Scherer, D.G., and Hanley, J.H. (1997). Multisystemic therapy with violent and chronic juvenile offenders and their families: The role of treatment fidelity in successful dissemination. *Journal of Consulting and Clinical Psychology* 65: 821-833.

- Henggeler, S.W., Pickrel, S.G., and Brondino, M.J. (1999). Multisystemic treatment of substance abusing and dependent delinquents: Outcomes, treatment fidelity, and transportability. *Mental Health Services Research* 1: 171-184.
- Henning, T. 2008. The criminal justice response to drug abuse-ambivalence and confusion. Paper presented at the Round Table, Substance Abuse: Exploring consequences and remedies, March 9-14, in Oxford, England.
- Hill, F. 2008. Developing comprehensive drug treatment, prevention and interdiction strategies. Paper presented at the Round Table, Substance Abuse: Exploring consequences and remedies, March 9-14, in Oxford, England.
- Hinkle, D.N. (1965). *The change of personal constructs from the viewpoint of a theory of implications*. PhD diss., Ohio State University.
- Hogue, A., Dauber, S., Stambaugh, L.F., Cecero, J.J., and Liddle, H.A. (2006). Early therapeutic alliance and treatment outcome in individual and family therapy for adolescent behavior problems. *Journal of Consulting & Clinical Psychology* 74: 121-129.
- Howard, J., Stubbs, M., and Arcuri, A. (2007). Comorbidity: Coexisting substance use and mental disorders in young people. *Clinical Psychologist* 11, 3: 88-97.
- Jojwana, G. 2008. Substance abuse in the South African workplace. Paper presented at the Round Table, Substance Abuse: Exploring consequences and remedies, March 9-14, in Oxford, England.
- Kaminer, Y. (2005). Challenges and opportunities of group therapy for adolescent substance abuse: A critical review. *Addictive Behaviors* 30: 1765-1774.
- Kaminer, Y., Blitz, C., Bureson, J.A., Kadden, R.M., and Rounsaville, B.J. (1998). Measuring treatment process in cognitive behavioral and interactional group therapies for adolescent substance abusers. *Journal of Nervous Mental Disorder* 186: 407-413.
- Kaminer, Y., and Slesnick, N. 2006. Evidence-based cognitive-behavioral and family therapies for adolescent alcohol and other substance use disorders. In *Alcohol problems in adolescents and young adults: Epidemiology, neurobiology, prevention, and treatment*, ed. M. Galanter, 383-405. New York: Springer.
- Kazdin, A.E. (1996). Dropping out of child psychotherapy: Issues for research and implications for practice. *Clinical Child Psychology and Psychiatry* 1: 133-136.
- Kelly, G.A. (1991a). *The psychology of personal constructs: Volume 1. A theory of personality*. London: Routledge. (Original work published in 1955).
- Kelly, G.A. (1991b). *The psychology of personal constructs: Volume 2. Clinical diagnosis and psychotherapy*. London: Routledge. (Original work published in 1955).
- Kendall, P.C., and Kessler, R.C. 2002. The impact of childhood psychopathology interventions on subsequent substance abuse: Policy implications, comments, and recommendations. *Journal of Consulting and Clinical Psychology* 70: 1303-1306.
- Ketterlinas, R.D., and Lamb, M.E. ed., (1994). *Adolescent problem behaviors: Issues and research*. Hillsdale, NJ: Erlbaum.
- Klion, R.E. (1993). Chemical dependency: A personal construct theory approach. In *Critical issues in personal construct psychotherapy*, ed. L.M. Leitner, and N.G.M. Dunnett, 279-301. Malabar, FL: Kreiger Publishing Company.
- Klion, R.E., and Pfenninger, D.T. (1997). Personal construct psychotherapy of addictions. *Journal of Substance Abuse Treatment* 14: 37-43.

- Lambert, M.J., Whipple, J.L., Smart, D.W., Vermeersch, D.A., Nielsen, S.L., and Hawkins, E.J. (2001). The effects of providing therapists with feedback on patient progress during psychotherapy: Are outcomes enhanced? *Psychotherapy research* 11: 49-68.
- Lambert, M.J., Whipple, J.L., Bishop, M.J., Vermeersch, D.A., Gray, G.V., and Finch, E. (2002). Comparison of empirically derived and rationally derived methods for identifying clients at risk for treatment failure. *Clinical Psychology and Psychotherapy* 9: 149-164.
- Lambert, M.J., Whipple, J.L., Hawkins, E.J., Vermeersch, D.A., Nielsen, S.L., and Smart, D.W. (2003). Is it time for clinicians routinely to track patient outcome? A meta-analysis. *Clinical Psychology* 10: 288-301.
- Leggat, P. 2008. Alcohol consumption by occupation: Public health policy needs to target alcohol screening and brief interventions in the workplace. Substance abuse in the South African workplace. Paper presented at the Round Table, Substance Abuse: Exploring consequences and remedies, March 9-14, in Oxford, England.
- Leowy, A.H. 2008. Substance abuse and the criminal law. Paper presented at the Round Table, Substance Abuse: Exploring consequences and remedies, March 9-14, in Oxford, England.
- Lyons, J.S., and Rawal, P.H. 2005. Evidence-based treatments for children and adolescents. In *The evidence-based practice: Methods, models, and tools for mental health professionals*, ed. C.E. Stout and R.A. Hayes, 177-198. Hoboken, NK: Wiley.
- McLeod, B.D., and Weisz, J.R. (2005). The Therapy Process Observational Coding System-Alliance Scale: Measure characteristics and prediction of outcome in usual clinical practice. *Journal of Consulting and Clinical Psychology* 73: 323-333.
- Mann, J. 2008. Substance abuse control: How do we measure success? Paper presented at the Round Table, Substance Abuse: Exploring consequences and remedies, March 9-14, in Oxford, England.
- Miller, S.D., Mee-Lee, D., Plum, B., and Hubble, M.A. (2005). Making treatment count: Client-directed, outcome-informed clinical work with problem drinkers. *Psychotherapy in Australia*, 11, 4: 42-56.
- Miller, W.R., and Rollnick, S. (2002). *Motivational interviewing: Preparing people for change*. (2<sup>nd</sup> Edition). New York: Guilford Press.
- Murphy, J.J. (1999). Common factors of school-based change. In *The heart and soul of change. What works in therapy*, ed. M.A. Hubble, B.L. Duncan, and S.D. Miller, 361-386. Washington, DC: American Psychological Association.
- National Aboriginal and Torres Strait Islander Health Survey (NATSIHS, 2004-2005). Cited in Australian Institute of Health and Welfare 2007. *Statistics on drug use in Australia 2006*. Drug Statistics Series No. 18. Cat.no. PHE 80. Canberra: AIHW.
- National Drug Control Strategy*, (February, 1997). Office of National Drug Control Policy. Washington D.C.: U.S. Government Printing Office.
- National Youth Affairs Research Scheme (NYARS, 2004). *Barriers to service provision for young people with presenting substance misuse and mental health problems*. NYARS, Canberra, Australia.
- Nicholson, T. 2008. Focusing on addictive disorders rather than drug use. Paper presented at the Round Table, Substance Abuse: Exploring consequences and remedies, March 9-14, in Oxford, England.
- Nicholson, T. Duncan, D.F., and White, J.B. (2002). Is recreational drug use normal? *Journal of Substance Use* 7: 116-123.

- NSW Health Department (NSWHD, 2000). *Mental health and substance use disorders: A discussion paper*, NSW Health Department. North Sydney, Australia: NSW Health.
- Orlinsky, D.E., Grawe, K., and Parks, B.K. (1994). Process and outcome in psychotherapy—noch einmal. In *Handbook of psychotherapy and behavior change*, ed. A.E. Bergin and S.L. Garfield 4<sup>th</sup> ed., 270-378. New York: Wiley.
- Ovens, M. 2008. Maternal substance abuse. Paper presented at the Round Table, Substance Abuse: Exploring consequences and remedies, March 9-14, in Oxford, England.
- Patel, V., Flisher, A.J., Hetrick, S., and McGorry, P. (2007). Mental health of young children: A global public-health challenge. *Lancet* 369: 1302-1313.
- Pawlukewicz, J. 2008. Addictive and recovery thinking: Separated or divorced? Paper presented at the Round Table, Substance Abuse: Exploring consequences and remedies, March 9-14, in Oxford, England.
- Ponder, F. 2008. A study of family origin addiction patterns affecting Masters Level Counseling and Psychologists. Paper presented at the Round Table, Substance Abuse: Exploring consequences and remedies, March 9-14, in Oxford, England.
- Pringle, B., and Flanzer, J. 2005. Treatment services for adolescent substance abuse. In *Handbook of mental health services for children, adolescents, and families*, ed. B. Pringle, and J. Flanzer, 181-200. New York: Kluwer Academic/Plenum.
- Prochaska, J., DiClemente, C., and Norcross, J.C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist* 47: 1102-1114.
- Redford, D. 2008. The little county that could. Paper presented at the Round Table, Substance Abuse: Exploring consequences and remedies, March 9-14, in Oxford, England.
- Sewell, K. W. (1995). Personal and construct therapy and the relation between cognition and affect. In *Cognitive and constructive psychotherapies: Theory, research, and practice*, ed. M.J. Mahoney, 121-138. New York: Springer.
- Sexton, T.L., and Alexander, J.F. (2002). Functional Family Therapy for at-risk adolescents and their families. In *Handbook of family therapy: The science and practice of working with families and couples*, ed. T.L. Sexton, G.R Weeks, and M.S. Robbins, 117-140. New York: Brunner-Routledge.
- Sexton, T.L., Alexander, J.F., and Mease, A.L. (2004). Levels of evidence for the models and mechanisms of therapeutic change in family and couple therapy. In *Bergin and Garfield's Handbook of psychotherapy and behavior change*, ed. M.J. Lambert, 590-646. USA: John Wiley & Sons.
- Shadel, W.G., Mermelstein, R., and Borrelli, B. (1996). Self-concept changes over time in cognitive-behavioral treatment for smoking cessation. *Addictive Behaviors* 21: 659-663.
- Shedler, J., and Block, J. (1990). Adolescent drug use and psychological health: a longitudinal inquiry. *American Psychologist* 45: 612-630.
- Shirk, S.R., and Karver, M. (2003). Prediction of treatment outcome from relationship variables in child and adolescent therapy: A meta-analytic review. *Journal of Consulting and Clinical Psychology* 71: 452-464.
- Smith, D.C., Hall, J.A., Williams, J.K., An, H., and Gotman, N. (2006). Comparative efficacy of family and group treatment for adolescent substance abuse. *American Journal on Addictions* 15 (Suppl.1): 131-136.
- Social Exclusion Unit, (2005). *Transitions: Young adults with complex needs*. London, UK, Office of the Deputy Prime Minister. [http:// www.socialexclusionunit.gov.uk](http://www.socialexclusionunit.gov.uk) (Accessed February 28<sup>th</sup>, 2008)

- Stanton, M.D., and Shadish, W.R. (1997). Outcome, attrition, and family-couples treatment for drug abuse: A meta-analysis and review of the controlled, comparative studies. *Psychological Bulletin* 122(2): 170-191.
- Stewart, T. and Birdsall, M. (2001). A review of the contribution of personal construct psychology to stammering therapy. *Journal of Constructivist Psychology* 14: 215-226.
- Teesson, M., Hall, W., Lynskey, M., and Degenhardt, I. (2000). Alcohol and drug-use disorders in Australia: Implications of the National Survey of Mental Health and Wellbeing. *Australian and New Zealand Journal of Psychiatry* 34: 206-213.
- Titus, J.C., Godley, S.H., and White, M.K. (2006). A post-treatment examination of adolescents' reasons for starting, quitting, and continuing the use of drugs and alcohol. *Journal of Child and Adolescent Substance Abuse* 16: 31-49.
- Trump, M. 2008. An analysis of the effectiveness of the Four Pillars strategy in the City of Vancouver. Paper presented at the Round Table, Substance Abuse: Exploring consequences and remedies, March 9-14, in Oxford, England.
- Truneckova, D. 2008. Substance abuse: Personal construct processes and psychotherapy with children and adolescents. Paper presented at the Round Table, Substance Abuse: Exploring consequences and remedies, March 9-14, in Oxford, England.
- Tsey, K. 2008. Community development and empowerment research in rural Ghana and Aboriginal Australia: Some implications for substance misuse and violence preventative policies and programs. Paper presented at the Round Table, Substance Abuse: Exploring consequences and remedies, March 9-14, in Oxford, England.
- Tyler, K.A., Torres Stone, R., and Bersani, B. (2006). Examining the changing influence of predictors on adolescent alcohol misuse. *Journal of Child and Adolescent Substance Abuse* 16: 95-114.
- Viney, L.L. (1996). Glossary. In L.L. Viney, *Personal construct therapy: A handbook* (pp. 237-243). Norwood, NJ: Ablex Publishing Corporation.
- Viney, L.L. (2006). Applying personal construct models to work with people. In *Personal construct psychology: New Ideas*, ed. P. Caputi, H. Foster, and L.L. Viney, 3-15. Chichester, UK: John Wiley & Sons.
- Viney, L.L., Metcalfe, C., and Winter, D.A. (2005). The effectiveness of personal construct psychotherapy: A meta-analysis. In *Personal construct psychotherapy. Advances in theory, practice and research*, ed. D.A. Winter and L.L. Viney, 347-364. London: Whurr Publishers.
- Voss, T., Haby, M.M., Barendregt, J.J., Kruijshaar, M., Corry, J., and Andrews, G. 2004. The burden of major depression avoidable by long-term treatment strategies. *Archives of General Psychiatry* 61: 1097-1103.
- Wade, D., Harrigan, S., Edwards, J., Burgess, P.M., Whelan, G., and McGorry, P.D. (2006). Substance misuse in first-episode psychosis: 15 month prospective follow-up study. *British Journal of Psychiatry* 189: 229-234.
- Waldron, H.B., and Kaminer, Y. (2004). On the learning curve: The emerging evidence supporting cognitive-behavioral therapies for adolescent substance abuse. *Addiction* 2004 99(Suppl 2): 93-105.
- Weems, M. 2008. Innovative instruction: Preparing Social Workers for careers in the field of addiction. Paper presented at the Round Table, Substance Abuse: Exploring consequences and remedies, March 9-14, in Oxford, England.

- Weisz, J.R., Southam-Gerow, M., Gordis, E.B., and Connor-Smith, J. (2003). Primary and secondary control enhancement training for youth depression: Applying the deployment-focused model of treatment development and training. In *Evidence-based psychotherapies for children and adolescents*, ed. A.E. Kazdin and J.R. Weisz, 165-183. New York: Guilford Press.
- Weisz, P.A., Watson, N., and McGuire, H. (2003). Smoking and self-concept in young adults: An idiographic method of measurement. *Journal of Constructivist Psychology* 16: 323-334.
- Weisz, J.R., Jensen-Doss, A., and Hawley, K.M. (2006). Evidence-based youth psychotherapies versus usual clinical care. A meta-analysis of direct comparisons. *American Psychologist* 61: 671-689.
- Westerman, T.G. (2004). Engagement of Indigenous clients in mental health services: What role do cultural differences play? *Australian e-Journal for the Advancement of Mental Health* (3). [www.auseinet.com/journal/vol3iss/westermaneditorial.pdf](http://www.auseinet.com/journal/vol3iss/westermaneditorial.pdf). (Accessed February 12<sup>th</sup>, 2007).
- Whipple, J.L., Lambert, M.J., Vermeersch, D.A., Smart, D.W., Nielsen, S.L., and Hawkins, E.J. (2003). Improving the effects of psychotherapy: The use of early identification of treatment and problem-solving strategies in routine practice. *Journal of Counselling Psychology* 50: 59-68.
- Winter, D.A. (2003). The evidence base for personal construct psychotherapy. In *International handbook of personal construct psychology*, ed. F. Fransella, 265-272. London: Wiley.
- Yeh, M., and Weisz, J.R. (2001). Why are we here at the clinic? Parent-child (dis)agreement on referral problems at treatment entry. *Journal of Consulting and Clinical Psychology* 69: 1018-1025.
- Zarb, J.M. 1992. *Cognitive-behavioral assessment and therapy with adolescents*. New York: Brunner/Mazel.
- Zollweg, B. The Drug Court model of addiction recovery. Paper presented at the Round Table, Substance Abuse: Exploring consequences and remedies, March 9-14, in Oxford, England.

Published by the Forum on Public Policy

Copyright © The Forum on Public Policy. All Rights Reserved. 2009.