

Final Progress Report for Research Projects Funded by Health Research Grants

Instructions: Please complete all of the items as instructed. Do not delete instructions. Do not leave any items blank; responses must be provided for all items. If your response to an item is “None”, please specify “None” as your response. “Not applicable” is not an acceptable response for any of the items. There is no limit to the length of your response to any question. Responses should be single-spaced, no smaller than 12-point type. The report **must be completed using MS Word**. Submitted reports must be Word documents; they should not be converted to pdf format. Questions? Contact Health Research Program staff at 717-783-2548.

1. **Grantee Institution:** Treatment Research Institute (TRI)
2. **Reporting Period (start and end date of grant award period):** 01/01/2009 - 12/31/2010
3. **Grant Contact Person (First Name, M.I., Last Name, Degrees):** Rosalyn L. Weinstein, MCAT
4. **Grant Contact Person’s Telephone Number:** 215-399-0980, ext. 108
5. **Grant SAP Number:** 4100047653
6. **Project Number and Title of Research Project:** 1- Program Quality Measures for a Consumer Guide to Adolescent Addiction Treatment
7. **Start and End Date of Research Project:** 01/01/2009 - 12/31/2010
8. **Name of Principal Investigator for the Research Project:** John S. Cacciola, PhD
9. **Research Project Expenses.**

9(A) Please provide the amount of health research grant funds spent on this project for the entire duration of the grant, including any interest earned that was spent:

\$ 159,587

9(B) Provide the last names (include first initial if multiple individuals with the same last name are listed) of **all** persons who worked on this research project and were supported with health research funds. Include position titles (Principal Investigator, Graduate Assistant, Post-doctoral Fellow, etc.), percent of effort on project and total health research funds expended for the position. For multiple year projects, if percent of effort varied from year to year, report in the % of Effort column the effort by year 1, 2, 3, etc. of the project (x% Yr 1; z% Yr 2-3).

Last Name	Position Title	% of Effort on Project	Cost
Cacciola	Principal Investigator	13%	16,924
Rosenwasser	Project Coordinator	15%	11,374
Bates	Research Assistant	100%	38,234
Dugosh	Data Analyst	2%	1,680

9(C) Provide the names of **all** persons who worked on this research project, but who *were not* supported with health research funds. Include position titles (Research Assistant, Administrative Assistant, etc.) and percent of effort on project. For multiple year projects, if percent of effort varied from year to year, report in the % of Effort column the effort by year 1, 2, 3, etc. of the project (x% Yr 1; z% Yr 2-3).

Last Name	Position Title	% of Effort on Project
Meyers	Senior Scientist	1%

9(D) Provide a list of **all** scientific equipment purchased as part of this research grant, a short description of the value (benefit) derived by the institution from this equipment, and the cost of the equipment.

Type of Scientific Equipment	Value Derived	Cost
None.		

10. Co-funding of Research Project during Health Research Grant Award Period. Did this research project receive funding from any other source during the project period when it was supported by the health research grant?

Yes X No _____

If yes, please indicate the source and amount of other funds:

Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment (SAMHSA/CSAT) Amount of other funds: \$42,971

National Institute on Drug Abuse Amount of other funds: \$37,237

11. Leveraging of Additional Funds

11(A) As a result of the health research funds provided for this research project, were you able to apply for and/or obtain funding from other sources to continue or expand the research?

Yes X No _____

If yes, please list the applications submitted (column A), the funding agency (National Institutes of Health—NIH, or other source in column B), the month and year when the

application was submitted (column C), and the amount of funds requested (column D). If you have received a notice that the grant will be funded, please indicate the amount of funds to be awarded (column E). If the grant was not funded, insert “not funded” in column E.

Do not include funding from your own institution or from CURE (tobacco settlement funds). Do not include grants submitted prior to the start date of the grant as shown in Question 2. If you list grants submitted within 1-6 months of the start date of this grant, add a statement below the table indicating how the data/results from this project were used to secure that grant.

A. Title of research project on grant application	B. Funding agency (check those that apply)	C. Month and Year Submitted	D. Amount of funds requested:	E. Amount of funds to be awarded:
Parents Translational Research Center – Project 2 - Developing a Consumer Guide to Adolescent Drug Treatment	<input checked="" type="checkbox"/> NIH <input type="checkbox"/> Other federal (specify: _____) <input type="checkbox"/> Nonfederal source (specify: _____)	02/2009	\$1,849,863	\$1,799,499

11(B) Are you planning to apply for additional funding in the future to continue or expand the research?

Yes _____ No X

If yes, please describe your plans:

12. Future of Research Project. What are the future plans for this research project?

We have obtained funding from the National Institute on Drug Abuse (NIDA) to further develop the DSI-D and DSI-P, test short- and long- term reliability of the DSI-D and DSI-P, and use the resulting data to create and beta-test an online Consumer Guide to Adolescent Substance Abuse Treatment Programs for programs in the greater Philadelphia area.

13. New Investigator Training and Development. Did students participate in project supported internships or graduate or post-graduate training for at least one semester or one summer?

Yes _____ No X

If yes, how many students? Please specify in the tables below:

	Undergraduate	Masters	Pre-doc	Post-doc
Male				
Female				
Unknown				
Total				

	Undergraduate	Masters	Pre-doc	Post-doc
Hispanic				
Non-Hispanic				
Unknown				
Total				

	Undergraduate	Masters	Pre-doc	Post-doc
White				
Black				
Asian				
Other				
Unknown				
Total				

14. Recruitment of Out-of-State Researchers. Did you bring researchers into Pennsylvania to carry out this research project?

Yes _____ No X*

If yes, please list the name and degree of each researcher and his/her previous affiliation:

*Funds from the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA) allowed out-of-state researchers to provide consultation on the project and participate in the Scientific Advisory Panel Meeting on 11/11/09.

15. Impact on Research Capacity and Quality. Did the health research project enhance the quality and/or capacity of research at your institution?

Yes X No _____

If yes, describe how improvements in infrastructure, the addition of new investigators, and other resources have led to more and better research.

Kathleen Meyers, PhD, an adolescent expert who developed the Comprehensive Adolescent Severity Inventory (CASI) joined TRI as a Senior Scientist on October 25, 2010 after serving on this project's Scientific Advisory Panel. Her extensive knowledge of the field of adolescent substance abuse treatment has been of great benefit to this project and has

enriched TRI as a whole. Dr. Meyers' further involvement in the new NIDA grant has been invaluable thus far to the quality of our research.

16. Collaboration, business and community involvement.

16(A) Did the health research funds lead to collaboration with research partners outside of your institution (e.g., entire university, entire hospital system)?

Yes _____ No X

If yes, please describe the collaborations:

16(B) Did the research project result in commercial development of any research products?

Yes _____ No X

If yes, please describe commercial development activities that resulted from the research project:

16(C) Did the research lead to new involvement with the community?

Yes X No _____

If yes, please describe involvement with community groups that resulted from the research project:

As a result of the work undertaken with this funding: 1) we are now members of Philadelphia's Office of Addiction Services (OAS) Advisory Board; and 2) an OAS-sponsored Outpatient Treatment Workgroup.

17. Progress in Achieving Research Goals, Objectives and Aims.

List the project goals, objectives and specific aims (as contained in the grant application's strategic plan). Summarize the progress made in achieving these goals, objectives and aims for the entire grant award period. Indicate whether or not each goal/objective/aim was achieved; if something was not achieved, note the reasons why. Describe the methods used. If changes were made to the research goals/objectives/aims, methods, design or timeline since the original grant application was submitted, please describe the changes. Provide detailed results of the project. Include evidence of the data that was generated and analyzed, and provide tables, graphs, and figures of the data. List published abstracts, poster presentations and scientific meeting presentations at the end of the summary of progress; peer-reviewed publications should be listed under item 20.

This response should be a DETAILED report of the methods and findings. It is not sufficient to state that the work was completed. Insufficient information may result in an unfavorable performance review, which may jeopardize future funding. If research findings are pending

publication you must still include enough detail for the expert peer reviewers to evaluate the progress during the course of the project.

Health research grants funded under the Tobacco Settlement Act will be evaluated via a performance review by an expert panel of researchers and clinicians who will assess project work using this Final Progress Report, all project Annual Reports and the project's strategic plan. After the final performance review of each project is complete, approximately 12-16 months after the end of the grant, this Final Progress Report, as well as the Final Performance Review Report containing the comments of the expert review panel, and the grantee's written response to the Final Performance Review Report, will be posted on the CURE Web site.

There is no limit to the length of your response. Responses must be single-spaced below, no smaller than 12-point type. If you cut and paste text from a publication, be sure symbols print properly, e.g., the Greek symbol for alpha (α) and beta (β) should not print as boxes (\square) and include the appropriate citation(s). DO NOT DELETE THESE INSTRUCTIONS.

Summary of Research Completed

Funding for *Program Quality Measures for a Consumer Guide to Adolescent Addiction Treatment* was made available on May 27th, 2009, leaving approximately 7 months for project execution (i.e., until December 31st 2009). Because of this abbreviated cycle, we proactively applied for and were granted a no-cost extension to December 31st, 2010.

Research activities during the project period included: 1) Institutional Review Board Approval of the Program Quality Measures Project; 2) consultation with the original researchers who authored Drug Strategies organization's *Treating Teens: A Guide to Adolescent Drug Programs* as well as with adolescent substance abuse treatment experts for guidance on new treatment principles and practices and the design and adaptation of the original Drug Strategies Interview for Directors (DSI-D); 3) completion of a systematic literature review focused on empirically supported treatment practices for adolescent substance abuse treatment published since those used to develop the *Treating Teens* guide; 4) hosting a daylong Scientific Advisory Panel Meeting on 11/11/09, which provided feedback on the draft Key Elements, Components, and measures; 5) completion of final Drug Strategies Interview-Director (DSI-D) and Key Elements/Components drafts using further expert consultation on 4/23/10 and 5/13/10; 6) identification of adolescent outpatient drug and alcohol treatment programs in Philadelphia and surrounding counties and gathering of relevant program information; 7) random selection of adolescent treatment programs for project participation; 8) Stage 1 initial stability testing of the DSI-D; 9) creation and cognitive testing of the Drug Strategies Interview-Patient (DSI-P) which includes core treatment service items negating the need for a separate Adolescent Treatment Services Review (TSR-A).

IRB Review: While IRB approval of concept was secured from the Treatment Research Institute (TRI) prior to the receipt of the grant award, a total of 13 consent/assent documents, related HIPAA and recruitment materials, as well as a draft Parent Needs Interview were

subsequently developed and approved by our primary IRB (TRI). Because at least some study interviews would take place at treatment centers within Philadelphia, these materials were also submitted for approval from the City of Philadelphia’s Health Department IRB. Minor amendments to the protocol and consent forms were requested and approved by both TRI’s and the Philadelphia Health Department’s IRBs.

Consultation with Original Researchers and Other National Experts: Since this project builds on prior work and aims to guide the field, periodic consultation at key stages of progress were an integral part of this process. Table 1 highlights those experts recruited to provide consultation on: 1) the scope of the literature review; 2) improvements in the design and adaptation of the original Key Elements and Components (KEs/Cs), and the Drug Strategies Interview for Directors (DSI-D); and 3) the scope and expansion of the search for KEs/Cs of evidence-based practices (EBPs) and ways to code for integrity and fidelity of their implementation. Experts were also asked to review, provide detailed feedback on, and craft additional items for: 1) the revised KEs/Cs list; 2) the revised DSI-D; 3) the newly proposed DSI-P; and 4) details of a standardized quality treatment measurement protocol capable of national dissemination.

Table 1: Adolescent Substance Abuse Treatment Experts By Task Completed					
	Literature Review, Coding, and Synthesis,	Initial Revisions to KEs/Cs, DSI-D and Approach	KEs/Cs and DSI-D Scoring Schema	Scientific Advisory Board Meeting 11/11/09	Document Review and Feedback 4/23/10 & 5/13/10
Content Experts					
Amelia Arria			X	X	X
Doreen Cavanaugh				X	
Gayle Dakof				X	X
Michael Dennis					X
Michael Mason	X	X			X
A. T. McLellan		X	X		
Kathleen Meyers				X	X
Ken Winters		X		X	X
Treating Teens Researchers					
Jeremy Gans		X			
Mathea Falco, Esq	X	X		X	X
Bruce R. Schackman		X			
Internal Experts					
Arthur Alterman		X			
John Cacciola	X	X	X	X	X
Constance Pechura		X	X	X	
Beth Rosenwasser	X	X	X	X	X

Stage 1: Development and Testing of the Directors Interview

Stage 1A. Incorporate new evidence based principles and practices into the format and structure of a previously used Directors Interview.

Systematic Literature Review and Element/Component Analysis: In order to discover additional empirically-based practices (EBPs) recommended in the literature since the original *Treating Teens* Guide, we searched PsycINFO using four exploded terms: treatment, substance abuse, empirically-based, and review in combination with adolescent as an age category between the years 2002 and June, 2009. After co-coding and conferring using the first 30 titles and abstracts of 176 records, Drs. Cacciola and Rosenwasser developed the following rules for inclusion: 1) eliminate those focused solely on prevention, tobacco use, or a topic or primary focus other than substance use (e.g., a review of the treatment of violent behavior where substance use is discussed as a risk-factor); and 2) eliminate case studies, individual clinical studies or surveys, book reviews, handbooks and handbook chapters, and those that were primarily opinion/not empirically-based. The remainder were coded for inclusion with twenty percent additionally co-rated for reliability (90% agreement) resulting in 46 records. The selected references were read and coded using a qualitative narrative that determined both support for the original 9 KEs of effective care (e.g., Assessment and Treatment Matching, Efforts at Engagement, Gender and Cultural Competence, etc.) and identified new or updated KEs/Cs. Special attention was given to the abundant literature on the prevalence, assessment and integrated treatment of co-occurring disorders.

The literature review was enhanced with other sources such as state-determined evidence-based treatments, National Registry of Evidence-based Programs and Practices (NREPP), Principles of Drug Addiction Treatment (PODAT), PODAT: Criminal Justice, and National Quality Forum (NQF). Additional searches using similar search terms were conducted using PubMed Plus and Embase and turned up no new relevant citations. In order to clarify intervention principles and practices discussed in 11 large empirically-based *review* articles (of the 46 systematically selected references), we also reviewed an additional 42 key *primary* articles. Furthermore, some principles/practices (e.g., trauma assessment and treatment, developmentally and culturally-informed treatment) warranted review of the more general adolescent behavioral healthcare literature as there were few studies and no reviews with adolescent substance-abusing populations.

Based upon the literature review, Drs. Cacciola and Rosenwasser completed a draft revision of the KEs/Cs. As listed in Table 1, additional guidance for the KEs/Cs as well as for early drafts of measures and their scoring was provided iteratively from a variety of experts in person, over the phone and electronically prior to the Scientific Advisory Board Meeting held on 11/11/09.

Stage 1B. Meet with an expert panel of up to 8 scientist experts to: a) review edits to that Directors Interview; and b) identify and gain input on additional items.

11/11/09 Scientific Advisory Panel Meeting: A Scientific Advisory Panel of six identified experts in adolescent drug and alcohol treatment participated in a full-day, face-to-face meeting on 11/11/09. The Scientific Advisory Panel included as planned, Drs. Doreen Cavanaugh, Gayle Dakof, and Ken Winters. Since three of our expert panelists were unable to attend after initial confirmation (Drs. Richard Clayton, Michael Dennis, and Nancy Jainchill), we invited Dr. Kathy Meyers, who developed the Comprehensive Adolescent Severity Inventory (CASI/CASI-A), and Mathea Falco, J.D. In-house participants included Dr. Constance Pechura, Dr. John Cacciola, Dr. Amelia Arria, Dr. Beth Rosenwasser, and Suzanne Bates. Prior to the meeting, expert panel members individually reviewed the updated KEs/Cs, draft DSI-D (and DSI-P discussed below), and proposed scoring schema. Participants attended the meeting with written feedback prepared for discussion. During the meeting, expert panel members crafted additional items aimed at providing more information about the integrity and fidelity of recommended practices. The group also discussed the details of a standardized quality treatment measurement protocol capable of national dissemination and associated web features. After the meeting, feedback was synthesized, revisions made, and the KEs/Cs and DSI-D distributed for a final review by expert panel members and Dr. Michael Dennis on 4/23/10 and again on 5/13/10. All feedback has been incorporated into updated drafts of the currently established 10 KEs and 59 Cs (see Table 2) with corresponding revisions made to the DSI-D. The final DSI-D draft includes a self-report component (questionnaire) which can be completed electronically or on paper, and an interview component which can be completed in-person or over the phone.

Table 2: Updated Key Elements and Components

The Key Elements of quality adolescent substance abuse treatment and their Components have been updated from the originals used in *Treating Teens: A Guide to Adolescent Substance Abuse Treatment* (2003). Letters next to each Key Element (KE) and related component indicate that: the original item and wording have been retained (**O**), an original item has been revised (**R**), or a new KE or Component has been added (**N**).

KE1: Assessment and Treatment Matching (O)

1. In its screening and assessment process, does the program use either a standardized substance abuse instrument or a structured clinical interview? **O**
2. Does the program have criteria to determine treatment eligibility and level of care? **N**
3. Does the program conduct a comprehensive initial assessment? **N**
4. Does the program have procedures to ensure rapid service provision? **N**
5. Does the program reassess clients throughout the course of treatment to monitor progress and guide treatment? **R**

KE 1a: Assessment and Treatment of Mental Health Problems (N)

6. In its screening and assessment process, does the program use a standardized mental health instrument(s) that covers common co-occurring disorders? **R/moved from KE1**
7. Does the program specify that the treatment plan addresses mental health issues? **O/moved from KE1**
8. Does the program provide clients with mental health services onsite or coordinate their care with community mental health providers? **R/moved from KE2**
9. Does the program reassess clients' mental health status and treatment compliance throughout the course of treatment to monitor progress and guide treatment? **N**
10. Does the program assess and continue to monitor clients for serious stressors (e.g., family/residential instability, victimization, crime, grief and loss) and address their impact throughout the course of treatment? **N**

KE 2: Comprehensive Integrated Treatment (R)

11. Does the program address physical health issues by providing medical services either onsite or by referral? **O**
12. Does the program provide testing, counseling, and education for infectious diseases and sexual health either onsite or by referral? **R**
13. Does the program address educational/vocational needs by coordinating care with the client's home school system and providing educational/vocational services either onsite or by referral? **R**
14. For clients involved with the juvenile justice system, does the program maintain contact and coordinating care with juvenile justice officials, have policies in place to protect the rights of clients, and offer specialized services? **R**
15. Does the program facilitate connections with prosocial, recovery oriented community organizations, mentors, activities and peer groups during treatment? **N**
16. Does the program address 'other' addictive behaviors (e.g., gambling, sex/pornography, gaming, shopping) including tobacco use? **N**

KE 3: Family Involvement in Treatment (O)

17. Does the program conduct a family assessment(s)? **R**
18. Does the program refer parents with alcohol or other drug problems, serious mental health problems, or domestic violence issues to treatment? **R**
19. Does the program provide family based therapy or treatment? **R**
20. Does the program maintain contact with the family for the duration of the client's treatment? **O**
21. Does the program have procedures in place to keep the family engaged and to help the family keep the client engaged in treatment? **R/moved from KE5**
22. Does the program involve family members of adolescent substance abusers in programming or planning (e.g., through Board of Director Involvement, Family Advisory Panel, Consumer Satisfaction Surveys)? **N**

KE 4: Developmentally Appropriate Programming (R)

- 23. Are adolescent clients treated only with other adolescents, as opposed to being integrated with adult clients? **R**
- 24. Does the program vary treatment approach and services based on the age, maturity, and developmental level of the client? **R**
- 25. Does the program employ interactive activities for practicing relevant new skills (e.g., social skills, general communication, emotional management, etc.)? **R**
- 26. Does the program provide and support developmentally appropriate opportunities for clients to have input in decisions regarding their treatment, recovery and personal goals? **N**
- 27. Does the program have policies and procedures to address disruptive, non-compliant, or other problematic behavior in a therapeutic manner? **N**

KE 5: Engage and Retain Adolescents in Treatment (R)

- 28. Does the program have procedures to reduce practical barriers to attendance? **N**
- 29. Does the program emphasize building a therapeutic alliance between staff and clients to engage and retain the client? **O**
- 30. Does the program utilize motivational enhancement techniques initially and throughout the course of treatment? **R**
- 31. Does the program incorporate contingent positive reinforcement or other incentives to engage adolescents to attend and participate in treatment? **R**
- 32. Does the program have special recreational programming, courses, or other features of particular interest to adolescents to engage and retain clients? **R**
- 33. Does the program have outreach and reengagement procedures for missed treatment sessions and poor attendance? **N**

KE 6: Staff Qualifications and Training (R)

- 34. Do all clinical staff have training in adolescent or developmental psychology? **N**
- 35. Do all clinical supervisors possess at least a master's degree? **O**
- 36. Does your program provide direct service staff with ongoing supervision, feedback and evaluation regarding their clinical skills? **R**
- 37. Does the program provide ongoing in-service training, and reimbursement or paid leave for direct service staff and supervisors to obtain training? **N**
- 38. Does the program train counselors in case management or have at least one designated case manager? **N**
- 39. Does the program have at least one master's degreed direct service staff trained in mental health and co-occurring disorders? **R**
- 40. Does the program have at least one master's degreed direct service staff trained in family therapy? **R**
- 41. Does the program have a psychiatrist/physician, nurse practitioner, or physician assistant on-site? **N**

KE 7: Cultural and Gender Competence (R)

- 42. Does the program assess gender, sexual identity, racial/ethnic/cultural, linguistic, learning, and religious issues to inform treatment planning? **N**
- 43. Does the program provide clients with separate gender-specific group sessions and curricula for some topics? **R/combined components 2 & 3 from KE7**
- 44. Is the program designed to meet the needs of lesbian, gay, bisexual, transgendered, and questioning youth (LGBTQ)? **R**
- 45. Does the program provide culturally aware treatment to meet the needs of minority (e.g., racial, ethnic, cultural) youth? **N**
- 46. Does the program facilitate community connections to support minority clients and their families? **N**
- 47. Does the program have policies and procedures to ensure clients' emotional and physical safety, and prevent intimidation and victimization from other clients and staff? **R**
- 48. Does the program provide diversity and cultural competence training to their staff? **N**

KE 8: Continuing Care Services and Supports (R)

- 49. Does the program address relapse prevention? **O**
- 50. Does the program educate the clients and family about and focus on continuing care throughout the course of treatment? **N**
- 51. Does the program provide an individualized transition period of tapered care to support post discharge recovery? **N**
- 52. Does the program create a comprehensive continuing care plan covering an extended period of time post discharge? **R/combined components 1 & 2 from KE8**
- 53. Does the program link clients with relevant community services upon discharge to promote ongoing recovery (e.g., adolescent 12 Step meetings, other peer-to-peer support, mentoring resources)? **R**
- 54. Following discharge, does the program monitor clients with periodic clinical checkups and maintain an ongoing connection with clients (e.g., phone calls, texting, email)? **R**

KE 9: Program Evaluation (R)

- 55. Does the program have a comprehensive electronic medical record? **N**
- 56. Does the program analyze its internal program performance data (e.g., time in treatment, type of discharge, and during treatment substance use) to measure the effectiveness of its treatment services? **R**
- 57. Does the program collect and analyze its own data related to client post-discharge outcomes for internal or external reports? **R**
- 58. Has the program had others independently conduct formal treatment effectiveness or outcomes evaluations? **R**
- 59. Has the program used program performance or outcomes data to improve treatment delivery? **N**

In summary, we retained or revised all 9 Key Elements and added 1. Regarding the Original Components, we retained 7, revised 30 and deleted 8; 24 new Components were added.

Stage 1C. Test the updated Directors Interview with 5 directors for item stability (test-retest) over a 3-day period using a telephone interview format.

Adolescent Program Identification: As summarized below (Table 3), 145 unique outpatient substance abuse treatment (SAT) programs in 4 PA counties (Philadelphia and three within a 50 mile radius) were identified using the PA Department of Health’s (DoH) and SAMHSA’s program registries. Of these 145 programs, we were able to contact and briefly interview 134 (92%) regarding their basic descriptive characteristics and population they serve. Of those contacted, 55 programs (41%) served adolescents. We eliminated 15 of those adolescent programs for further work given that they typically treated fewer than 5 adolescents per month. Thus, through this process, a total of 40 potentially eligible adolescent programs were identified within the four counties (Philadelphia, n=17; Montgomery, n=10; Delaware, n=7; Bucks, n=6).

Table 3: Number of SAT Programs by County & by Project Viability					
	Philadelphia	Montgomery	Delaware	Bucks	Total
# of programs on PA DoH	114	31	20	24	189
# eliminated b/c residential	36	6	2	4	48
# eliminated b/c private practice	1	0	0	0	1
# of programs left on PA DoH	77	25	18	20	140
# added with reference to SAMHSA listing	0	1	1	1	3
# programs added via conversation with other programs	1	1	0	0	2
total # of unique programs	78	27	19	21	145
# programs we were able to successfully contact	74	27	16	17	134
# that treat adolescents for SA	21	15	11	8	55
# that treat fewer than 5 adolescents per month	4	5	4	2	15
# programs eligible for participation	17	10	7	6	40

Recruiting of Programs and Directors: An alphabetical listing of the 17 programs in Philadelphia that treated more than 5 adolescents per month was placed in random order using *Statistical Analysis Software* v. 9.2. This process was repeated with the list of the suburban programs. The first 6 randomly selected programs (i.e., directors and their senior directors/administrators) from the city and from the suburbs were contacted by phone, email, and/or United States Postal Service (as necessary) in order to explain the project and extend an invitation to participate. Seven directors agreed to participate with 5 actually completing the entire test/re-test portion of the work. Three programs were

located in Philadelphia County, one in Bucks County, and one in Delaware County. Table 4 summarizes the demographic characteristics of the participating directors.

Table 4: Participating Program Director Demographics			
Gender	Age Range	Race	Hispanic / Latino
Female	31-40	White	No
Female	41-50	White	No
Female	61-70	White	No
Male	31-40	White	No
Female	31-40	Black or African American	No

DSI-D Results: Overall, there was excellent agreement in DSI-D responses at Time 1 and Time 2 (T1/T2). In over 90% of the items, there was 100% agreement between T1/T2. There were areas however where agreement was consistently low with endorsement of items at T2 higher than endorsement of items at T1. It may be that the directors verified their initial answers with their staff with increases in endorsement representing that they were unaware that clinical staff had recently adopted an approach/service for which they were unfamiliar (e.g., do we do contingency management?) or it may be that directors provided more socially desirable responses (e.g., realized that their programs would look better if certain items were endorsed). Our future work now includes one-day site visits where program “audits” take place to further assess the fidelity of the measures (e.g., Can you show me an intake packet?, Can I see a program schedule of sessions, groups, and activities?, Can I review charts of 5 adolescent study participants?). We are further considering conducting discrepancy interviews wherein items with poor agreement are discussed following the T2 interview. Table 5 highlights areas where there was either 100% agreement across all questions or where Time 1/Time 2 correspondence was low with arrows indicating the direction of the lack of agreement [i.e., more/better services (T1↑), more/better services (T2↑)].

Table 5: Time 1/Time 2 correspondence	
n=5 T1/T2 Director Interviews	100% Agreement or Direction of Discrepancy
Program Information: Treatment Approach	
Family Therapies (e.g., Brief Strategic Family Therapy, Family Support Network, Functional Family Therapy)	T2↑
Contingency Management	T2↑
Motivational Enhancement Therapy (MET)	T2↑
Assessment	100% agreement
Mental Health	
Diagnostic Areas Covered	T2↑
Comprehensive Treatment	
Sexual Health Services	T2↑
Sexual and Non-Sexual Trauma Services	T2↑
Family Involvement in Treatment	
Number and Type of Family-Focused Services Offered	T2↑
Developmentally Appropriate Programming	
Special or Adaptive Programming Based Upon Ages/Maturity Levels	T2↑
Engage and Retain	
Types of Incentives	T2↑
Special Programming of Particular Interest to Engage and Retain	T2↑
Staff Qualifications and Training	100% agreement
Cultural And Gender Competence	
Types of Client Diversity Identified (those not identified at T1 - ethnic/cultural identity, English as a second language, special educational needs)	T2↑
Continuing Care and Supports	100% agreement
Program Evaluation	100% agreement

Stage 2: Development of the DSI-P, Recruiting Parents of Adolescents to Request Permission for their Adolescent's Study Participation in Testing of the DSI-P, and Inviting Parents to Participate in a Brief Informational Interview

DSI-P Development: Based upon the literature review and expert consultations described above, a DSI-P interview was developed to tap the KEs/Cs and parallel as closely as possible the DSI-D interview. While focus groups with adolescents were proposed for item development work, they were not held given the continuing difficulty in reaching parents of adolescents for permission to approach their adolescent. Our continued discussions with directors and staff of participating treatment programs revealed that large percentages of youth consented themselves to treatment with little if any involvement by their parent(s)/legal guardian(s). Programs informed us that it is usual for them to not have contact with parents of youth in their program particularly those youth who are juvenile justice involved. Consequently, additional item-level developmental work was undertaken by Dr. Meyers beginning in October, 2010 upon her hire so as to have questions that would be ready for cognitive testing. Dr. Meyers, author of the CASI, is skilled in instrument development and was principal in finalizing the DSI-P for testing. For example, the overlap of the TSR-A service items with the DSI-P draft questions proved to be too great to justify the further development of two separate measures. Thus, the DSI-P was edited to include the necessary serviced items to minimize redundancy, maximize efficiency, and better streamline the interview itself. During the process of further item development work, five of the ten KEs contained components for which adolescents would have little or no information with two of these KEs having a majority of components for which they would have limited knowledge (see Table 6 below). Consequently, questions to tap these components were not developed for the DSI-P. Expert panel members concurred with this approach.

Table 6: Components within Key Element Not Asked of Adolescents
KE1: Assessment
Does the program have criteria to determine treatment eligibility and level of care?
KE3: Family Involvement in Treatment
Does the program involve family members of adolescent substance abusers in programming or planning (e.g., through Board of Director Involvement, Family Advisory Panel, Consumer Satisfaction Surveys)?
KE6: Staff Qualifications and Training
Do all clinical staff have training in adolescent or developmental psychology? Do all clinical supervisors possess at least a master's degree? Does your program provide direct service staff with ongoing supervision, feedback and evaluation regarding their clinical skills? Does the program provide ongoing in-service training, and reimbursement or paid leave for direct service staff and supervisors to obtain training?
KE7: Cultural and Gender Competence
Does the program provide diversity and cultural competence training to their staff?
KE9: Program Evaluation
Does the program have a comprehensive electronic medical record? Does the program analyze its internal program performance data (e.g., time in treatment, type of discharge, and during treatment substance use) to measure the effectiveness of its treatment services? Does the program collect and analyze its own data related to client post-discharge outcomes for internal or external reports? Has the program had others independently conduct formal treatment effectiveness or outcomes evaluations? Has the program used program performance or outcomes data to improve treatment delivery?

Recruitment and Cognitive Testing of the DSI-P: Given the nature of parental uninvolvement in their child's substance abuse treatment, we were able to contact only 8 parents despite numerous and varied attempts. We experienced delays at the first two sites that agreed to let us recruit parents and adolescents, as we had not foreseen that parents were largely unavailable during the intake process, nor did they typically attend the programs on a regular basis. We worked around this issue by asking for and receiving permission from the TRI and Philadelphia Health Department IRBs to verbally consent parents over the telephone. While this gave us much needed flexibility to recruit parents for their own and/or their adolescent's participation, we continued to have difficulty in reaching parents via mailings and telephone calls. We attempted to contact parents at multiple times of the day, even making phone calls during evening hours (as late as 10:00 pm) and on weekends. Despite leaving messages with other people who answered the phone number, on voicemails, and on multiple lines (cell phone, home phone, and "other" phone), and despite mailing out follow-up letters asking for the parent to contact us, making contact remained difficult. As we continue this research under new funding, we have requested (and have been granted) a waiver of consent for parents who are not involved

in their child's treatment - as minors can consent to treatment in PA without parental consent, and under federal and state law they can also consent to medical research. (See NOTE* below.)

In total, we were able to consent eight parents for the Parent Needs Interview and all eight also allowed us to approach their child. Two adolescents were not approached as we were told they were not in treatment long enough (>30 days) to participate, one adolescent agreed to participate but was never available to meet with us (always too "busy" at the moment), and one was unable to be scheduled until after the grant was closed (but was consented and interviewed under a new grant). The remaining four adolescents consented to and participated in individual DSI-P cognitive testing interviews

These early interviews revealed (and subsequent interviews under a different funding source confirmed) two areas where youth had difficulty understanding the concepts behind the items: developmentally appropriate programming and cultural sensitivity. We searched additional literature in these areas and revised the questions in these areas. While improved, additional work on these areas is indicated.

*NOTE: To address this significant barrier in an extension of this project under a new funding source which we were competitive for due to the extensive work completed under CURE dollars, we requested a **waiver of consent for parents who are not involved in their child's treatment under: 1) Drug and Alcohol Abuse Control Act, 71 P.S. § 1690.112** which states that a minor who "suffers from the use of a controlled or harmful substance" can consent to medical care and counseling related to the diagnosis or treatment of a substance abuse problem. The consent of the minor's parents or legal guardians is not necessary to authorize medical care or counseling related to such diagnosis or treatment; **and 2) 45 C.F.R. §§ 46.402, 46.404, 46.405, 46.406, and 46.408** a minor (defined under federal regulation as "persons who have not attained the legal age for consent to treatment or procedures involved in the research, under the applicable law of the jurisdiction in which the research will be conducted) must have parental permission in order to participate in medical research but if a minor is able to consent to medical, dental and health services under state law, the minor is also able to consent to take part in medical research. Since minors can consent to treatment in PA without parental consent, under federal and state law they can also consent to medical research. Although there is no lower age limit for providing consent to treatment under Pennsylvania law, we ask for this waiver for any youth **14 years of age or older** (high school age) whose parents: 1) do not accompany the youth to the treatment intake appointment; and 2) who do not participate in any way in the youth's treatment early on as reported by the treatment program (e.g., does not return phone calls, does not call and ask for youth progress, etc). While there are no legal statutes that require informing the parent of their child's participation in treatment or research [see Drug and Alcohol Abuse Control Act, 71 P.S. § 1690.112 62 and 42 U.S.C.A. § 290dd-2; 42 C.F.R. §§ 2.3, 2.12, 2.13, 2.14(b) which state that a physician, organization, or agency operating a substance abuse program which provides counseling to a minor may, but is not obligated to inform the parents or legal guardian of the minor as to the substance abuse treatment given or needed and if the program is federally assisted, the program may only disclose such information to the minor's parent or guardian with the minor-patient's prior written consent], we will request permission from the youth to inform the parent of his/her participation in the study. It should also be mentioned that this is a study that does not involve greater than minimal risk [45 C.F.R. § 46.405. Minimal risk means that the

probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests. 45 C.F.R. § 46.102(i)]. The waiver was recently approved.

Parent Informational Interview

Parents of adolescent alcohol and other drug users are one of the major anticipated users of the web-based Consumer Guide, so it is essential that we hear directly from them about what is important to them as it relates to treatment. To this end, eight parents were interviewed using a 15-item interview that contained primarily open-ended questions. 87% of the parent participants were female, 71% African-American, and 13% of Hispanic Origin. Half of the parent participants (50%) were born in the 1970s with 87% at least high school educated. As illustrated by quantitative data summarized below in Table 7, parent needs and opinions supported a number of the Key Elements. For instance, parents would find information about a program’s success rates important in deciding to select a program. The program’s availability of such data is subsumed under Key Element 9, Program Evaluation.

<p align="center">Table 7: Summary of Qualitative Data (n=8) vis-à-vis Parent Needs For and From Treatment As It Relates to the Key Elements</p>			
Information Useful for Decision-Making	Knowledge That Would Be Useful	Aspects of Treatment that are Most Important	Type and Frequency of Communication Desired From Program
Success Rates supports KE 9	Learning to Communicate with Their Child supports KE 3	Engagement Approaches supports KE 5	Weekly Urine Results and Progress Reports supports KE 3
Length of Stay Program Information	Symptoms of Use supports KE 3	Caring Staff supports KE 6	Weekly Attendance Information supports KE 3
		Assistance with Education supports KE 2	Monthly Recommendations re: What Parents Can Do to Help Their Child supports KE 3
		Linkages with Positive Free Time Activities supports KE 2	
		Aftercare Supports KE 8	

Stage 3: Development and Testing of a new measure of Services Provided

As stated earlier, the overlap of the planned TSR-A service items with the DSI-P draft questions proved to be too great to justify the further development of two separate measures. Thus, the DSI-P was edited to include TSR-A items to minimize redundancy, maximize efficiency, and better streamline the interview itself.

Related Presentations:

Cacciola, JS, Meyers K (November 2010). *Early work on Developing a Consumer Guide to Adolescent Substance Abuse Treatment*. Presentation to the Scientific Advisory Panel for the NIDA Parents' Translational Research Center, Philadelphia, PA.

Meyers, K, Cacciola, JS, Arria, A., & Bates, S. (December, 2010). *Developing a Consumer Guide to Adolescent Substance Abuse Treatment: Where We Are, Where We Are Going*. Paper presented at the annual meeting of the Joint Meeting on Adolescent Treatment Effectiveness, Baltimore, MD.

Summary

To summarize, we now have the following as a result of work completed under this grant:

1. An updated listing of *Key Elements and Components of Adolescent Substance Abuse Treatment* that has been vetted with national adolescent substance abuse treatment experts;
2. A revised DSI-D with preliminary evidence of reliability for use in a NIDA-funded project;
3. A DSI-P whose questions in eight of the ten Key Elements areas are understood by youth, and upon revision and additional cognitive testing, will be used in a NIDA-funded project;
4. A compilation of substance-abuse treatment programs in the greater Philadelphia region that includes a variety of program-level information (e.g., type of patients served, daily census, level of care);
5. A coding strategy that will more precisely measure Components beyond the original Drug Strategies presence/absence coding system;
6. A newly developed methodology (including the instruments and coding schema mentioned above) that when tested in the NIDA-funded project, will result in:
 - A *preliminary indication* of the patient and program-level relationships between evidence-based principles (EBPs) and practices and during-treatment performance;
 - Comparative data on the availability of these EBPs within community treatment programs that will be available to parents as they make the critical decision about where to get care for their substance abusing adolescent;

- A web-based Consumer Guide which will describe and summarize these EBPs;
- A comparative evaluation protocol and dissemination plan for a *Consumer Guide* protocol suitable for use in other cities and counties.

18. Extent of Clinical Activities Initiated and Completed. Items 18(A) and 18(B) should be completed for all research projects. If the project was restricted to secondary analysis of clinical data or data analysis of clinical research, then responses to 18(A) and 18(B) should be “No.”

18(A) Did you initiate a study that involved the testing of treatment, prevention or diagnostic procedures on human subjects?

Yes
 No

18(B) Did you complete a study that involved the testing of treatment, prevention or diagnostic procedures on human subjects?

Yes
 No

If “Yes” to either 18(A) or 18(B), items 18(C) – (F) must also be completed. (Do NOT complete 18(C-F) if 18(A) and 18(B) are both “No.”)

18(C) How many hospital and health care professionals were involved in the research project?

_____ Number of hospital and health care professionals involved in the research project

18(D) How many subjects were included in the study compared to targeted goals?

___ Number of subjects originally targeted to be included in the study
 ___ Number of subjects enrolled in the study

18(E) How many subjects were enrolled in the study by gender, ethnicity and race?

Gender:
 Males
 Females
 Unknown

Ethnicity:
 Latinos or Hispanics
 Not Latinos or Hispanics
 Unknown

Race:

- American Indian or Alaska Native
 Asian
 Blacks or African American
 Native Hawaiian or Other Pacific Islander
 White
 Other, specify: _____
 Unknown

18(F) Where was the research study conducted? (List the county where the research study was conducted. If the treatment, prevention and diagnostic tests were offered in more than one county, list all of the counties where the research study was conducted.)

19. Human Embryonic Stem Cell Research. Item 19(A) should be completed for all research projects. If the research project involved human embryonic stem cells, items 19(B) and 19(C) must also be completed.

19(A) Did this project involve, in any capacity, human embryonic stem cells?

- Yes
 No

19(B) Were these stem cell lines NIH-approved lines that were derived outside of Pennsylvania?

- Yes
 No

19(C) Please describe how this project involved human embryonic stem cells:

20. Articles Submitted to Peer-Reviewed Publications.

20(A) Identify all publications that resulted from the research performed during the funding period and that have been submitted to peer-reviewed publications. Do not list journal abstracts or presentations at professional meetings; abstract and meeting presentations should be listed at the end of item 17. **Include only those publications that acknowledge the Pennsylvania Department of Health as a funding source** (as required in the grant agreement). List the title of the journal article, the authors, the name of the peer-reviewed publication, the month and year when it was submitted, and the status of publication (submitted for publication, accepted for publication or published.). Submit an electronic copy of each publication, listed in the table, in a PDF version 5.0.5 format, 1,200 dpi. Filenames for each publication should include the number of the research project, the last name of the PI, the number of the publication and an abbreviated research project title. For example, if you submit two publications for PI Smith for the “Cognition and MRI in Older Adults” research project (Project 1), and two publications for PI Zhang for the “Lung Cancer” research project (Project 3), the filenames should be:

- Project 1 – Smith – Publication 1 – Cognition and MRI
- Project 1 – Smith – Publication 2 – Cognition and MRI
- Project 3 – Zhang – Publication 1 – Lung Cancer
- Project 3 – Zhang – Publication 2 – Lung Cancer

If the publication is not available electronically, provide 5 paper copies of the publication.

Note: The grant agreement requires that recipients acknowledge the Pennsylvania Department of Health funding in all publications. Please ensure that all publications listed acknowledge the Department of Health funding. If a publication does not acknowledge the funding from the Commonwealth, do not list the publication.

Title of Journal Article:	Authors:	Name of Peer-reviewed Publication:	Month and Year Submitted:	Publication Status (check appropriate box below):
None				<input type="checkbox"/> Submitted <input type="checkbox"/> Accepted <input type="checkbox"/> Published

20(B) Based on this project, are you planning to submit articles to peer-reviewed publications in the future?

Yes X No _____

If yes, please describe your plans:

At the completion of the NIDA grant that will extend this work, we will publish the results about whether evidence-based practices are linked to program level and/or client level performance.

21. Changes in Outcome, Impact and Effectiveness Attributable to the Research Project.

Describe the outcome, impact, and effectiveness of the research project by summarizing its impact on the incidence of disease, death from disease, stage of disease at time of diagnosis, or other relevant measures of outcome, impact or effectiveness of the research project. If there were no changes, insert “None”; do not use “Not applicable.” Responses must be single-spaced below, and no smaller than 12-point type. DO NOT DELETE THESE INSTRUCTIONS. There is no limit to the length of your response.

None.

22. Major Discoveries, New Drugs, and New Approaches for Prevention Diagnosis and Treatment.

Describe major discoveries, new drugs, and new approaches for prevention, diagnosis and treatment that are attributable to the completed research project. If there were no major discoveries, drugs or approaches, insert “None”; do not use “Not applicable.”

Responses must be single-spaced below, and no smaller than 12-point type. DO NOT DELETE THESE INSTRUCTIONS. There is no limit to the length of your response.

None.

23. Inventions, Patents and Commercial Development Opportunities.

23(A) Were any inventions, which may be patentable or otherwise protectable under Title 35 of the United States Code, conceived or first actually reduced to practice in the performance of work under this health research grant? Yes _____ No X

If “Yes” to 23(A), complete items a – g below for each invention. (Do NOT complete items a - g if 23(A) is “No.”)

- a. Title of Invention:
- b. Name of Inventor(s):
- c. Technical Description of Invention (describe nature, purpose, operation and physical, chemical, biological or electrical characteristics of the invention):
- d. Was a patent filed for the invention conceived or first actually reduced to practice in the performance of work under this health research grant?
Yes _____ No _____

If yes, indicate date patent was filed:

- e. Was a patent issued for the invention conceived or first actually reduced to practice in the performance of work under this health research grant?
Yes _____ No _____
If yes, indicate number of patent, title and date issued:
Patent number:
Title of patent:
Date issued:

- f. Were any licenses granted for the patent obtained as a result of work performed under this health research grant? Yes _____ No _____

If yes, how many licenses were granted? _____

- g. Were any commercial development activities taken to develop the invention into a commercial product or service for manufacture or sale? Yes _____ No _____

If yes, describe the commercial development activities:

23(B) Based on the results of this project, are you planning to file for any licenses or patents, or undertake any commercial development opportunities in the future?

Yes _____ No X _____

If yes, please describe your plans:

24. Key Investigator Qualifications. Briefly describe the education, research interests and experience and professional commitments of the Principal Investigator and all other key investigators. In place of narrative you may insert the NIH biosketch form here; however, please limit each biosketch to 1-2 pages

BIOGRAPHICAL SKETCH

Provide the following information for the key personnel and other significant contributors in the order listed on Form Page 2.

Follow this format for each person. **DO NOT EXCEED FOUR PAGES.**

NAME John Cacciola, Ph.D.	POSITION TITLE Senior Scientist
eRA COMMONS USER NAME JCACCIOLA	

EDUCATION/TRAINING (*Begin with baccalaureate or other initial professional education, such as nursing, and include postdoctoral training.*)

INSTITUTION AND LOCATION	DEGREE (if applicable)	YEAR(s)	FIELD OF STUDY
Vassar College, Poughkeepsie, NY	A.B.	1974	Psychology
Temple University, Philadelphia, PA	M.A.	1983	Psychology
Temple University, Philadelphia, PA	Ph.D.	1989	Psychology

A. Positions and Honors

- 1978-80 Research Associate, Addiction Prevention and Treatment Foundation, New Haven, CT
- 1981-86 Research Specialist, Department of Psychiatry, Philadelphia VA Medical Center, Philadelphia, PA
- 1982-86 Project Coordinator, Department of Psychology, University of Pennsylvania, Philadelphia, PA
- 1986-87 Intern in Psychology, Department of Psychiatry, Thomas Jefferson University, Philadelphia, PA
- 1990- Asst. Director, Division of Assessment and Treatment, PENN/VA Center for Studies of Addiction
- 1990-92 Investigator, MacArthur Foundation DSM-IV Data Reanalysis Project
- 1991-94 Advisor to DSM-IV Substance Use Disorders Work Group
- 1994- Senior Scientist, Treatment Research Institute, Philadelphia, PA
- 1995- Senior Scientist/Scientific Director, DeltaMetrics, Philadelphia, PA
- 1995-03 Research Psychologist, Department of Psychiatry, Philadelphia VA Medical Center
- Faculty Appointments:
- 1987-89 Instructor, Department of Psychiatry, University of Pennsylvania School of Medicine
- 1989-95 Research Assistant Professor of Psychology in Psychiatry, University of Pennsylvania School of Medicine
- 2000- Associate Professor of Psychology in Psychiatry, University of Pennsylvania School of Medicine

Licensed Psychologist, Pennsylvania - Certificate # PS-005109-L (inactive)

B. Selected peer-reviewed publications (out of 91 peer-reviewed publications)

1. Cacciola, J.S., Alterman, A.I., Rutherford, M.J., McKay, J., & Mulvaney, F.D. (2001). The relationship of psychiatric comorbidity to treatment outcomes in methadone maintained patients. *Drug and Alcohol Dependence*, 61, 271-280.

2. Alterman, A.I., Bovasso, G.B., Cacciola J.S., & McDermott, P.A. (2001). A comparison of the predictive validity of four sets of baseline ASI summary indices. *Psychology of Addictive Behaviors*, 15, 159-162.
3. Alterman, A.I., Cacciola, J.S., Mulvaney, F.D., Rutherford, M.J., & Langenbucher, J. (2002). Alcohol dependence and abuse in three groups at varying familial alcoholism risk. *Journal of Consulting & Clinical Psychology*, 70(2), 336-343.
4. French, M.T., McCollister, K.E., Cacciola, J., Durell, J., Stephens, R.L. (2002). Benefit-cost analysis of addiction treatment in Arkansas: specialty and standard residential programs for pregnant and parenting women. *Substance Abuse*, 23(1), 31-51.
5. McLellan A.T., McKay J.R., Forman R., Cacciola J., & Kemp J. (2005). Reconsidering the evaluation of addiction treatment: From retrospective follow-up to concurrent recovery monitoring. *Addiction*, 100(4), 447-458.
6. Rikoon, S.H., Cacciola, J.S., Carise, D., Alterman, A.I., McLellan, A.T. (2006) Predicting DSM-IV Dependence Diagnoses from ASI Composite Scores. *Journal of Substance Abuse Treatment*, 31, 17-24.
7. Alterman, A.I. Cacciola, J.S., Habing, B., Lynch, K.G. (2007). Addiction Severity Index recent and lifetime summary indexes based on nonparametric item response theory methods. *Psychological Assessment*, 19, 119-132.
8. Cacciola, J.S., Alterman, I., McLellan, A. T., Lin, Yi-Ting., Lynch, K. G. (2007). Initial evidence for the reliability and validity of a "Lite" version of the Addiction Severity Index. *Drug and Alcohol Dependence*, 87, 297-302.
9. Eyrich-Garg, K.M.; Cacciola, J.S.; Carise, D.; McLellan, A.T.; Lynch, K.G. (2008) Individual characteristics of the literally homeless, marginally housed, and impoverished in a US substance abuse treatment-seeking sample. *Social Psychiatry and Psychiatric Epidemiology*, 43(10), 831-842.
10. Cacciola, J.S., Alterman, I., Lynch, K. G., Martin, J.M., Beauchamp, M.L., McLellan, A.T. (2008). Reliability and validity studies of the revised Treatment Services Review (TSR-6). *Drug and Alcohol Dependence*, 92, 37-47.
11. Cacciola, J.S.; Camilleri, A.C.; Carise, D., McKay, J.R.; Wilson, C., Schwarzlose, J.T., McLellan, A.T.; Rikoon, S.H. (2008). Extending residential care through telephone counseling: Initial results from the Betty Ford center focused continuing care protocol. *Addictive Behaviors*, 33(9), 1208-1216.
12. Cacciola, J.S., Pecoraro, A., Alterman, A.I. (2008). Development of ASI psychiatric severity cut-off Scores to identify co-occurring psychiatric disorders. *International Journal of Mental Health and Addiction*, 6, 77-92.
13. Cacciola, J.S.; Dugosh, K.L.; Camilleri, A.C. (2009) Treatment history: Relationship to treatment outcomes. *Substance Use & Misuse*, 44(3), 305-321.
14. Alterman, A.I.; Cacciola, J. S.; Ivey, M.A.; Lynch, K.G.; Habing, B. (2009) Reliability and validity of the alcohol short index of problems and a newly constructed drug short index of problems. *Journal of Studies on Alcohol and Drugs*, 70(2), 304-307.
15. Cacciola, J.S., Koppenhaver, J.M., Alterman, A.I., McKay, J.R. (2009) Posttraumatic stress disorder and other psychopathology in substance abusing patients. *Drug and Alcohol Dependence*, 101(1-2), 27-33.

NAME Meyers, Kathleen	POSITION TITLE Senior Research Scientist		
eRA COMMONS USER NAME (credential, e.g., agency login)			
EDUCATION/TRAINING <i>(Begin with baccalaureate or other initial professional education, such as nursing, and include postdoctoral training.)</i>			
INSTITUTION AND LOCATION	DEGREE <i>(if applicable)</i>	YEAR(s)	FIELD OF STUDY
Rutgers University, New Brunswick, NJ	BA	1980	Psychology
Hahnemann University, Philadelphia, PA	MS	1983	Evaluation and Applied Research
Temple University, Philadelphia, PA	PhD	1999	Educational Psychology

A. Positions and Honors

Primary Author of the Comprehensive Adolescent Severity Inventory (CASI)

Employment in Past 20 Years

1987-92 Assistant Director of Research, Carrier Foundation, Belle Mead, NJ
1995-99 Senior Scientist, Treatment Research Institute, Univ. of Pennsylvania, Phila. PA
1997-2006 Research Psychologist/Director of Clinical Assessment Services, Systems Measures, Inc., Schwenksville, PA 19473
1992-2005 Adjunct Assistant Professor of Psychology in Psychiatry, Center for Studies of Addiction, Dept. of Psychiatry, School of Medicine, Univ. of Pennsylvania, Phila. PA
2002-04 Associate Professor, Dept. of Psychiatry, UMDNJ, New Brunswick, NJ/Camden, NJ
2004-08 V.P. of Research, Philadelphia Safe and Sound, Phila. PA
2008-2010 Director, Research and Evaluation, Greater Philadelphia Urban Affairs Coalition, Phila. PA
2010- Senior Research Scientist, Treatment Research Institute, Phila, PA

Consultant

1999-2003 Community Assessment Centers, OJJDP, Washington, DC
1999-2002 Development of Standardized Model of Assessment for Substance-Involved Adolescents, State of Florida, Miami, FL
2000-05 Adolescent Drug Courts, Mercer and Camden Counties, NJ
2001-2006 Juvenile Assessment Center & Juvenile Diversion Program, Miami-Dade Cty, FL
2001 Development of a Residentially-based Comprehensive Assessment Program, British Columbia, Canada
2001-07 Development of Standardized Model of Care for Substance-Involved Adolescents, State of Nebraska, Lincoln, NE
2002-03 Development of Standardized Model of Assessment for Substance-Involved Adolescents, State of Tennessee, Nashville, TN
2003 Development of Standardized Model of Assessment for Substance-Involved Adolescents, State of Oklahoma, Oklahoma City, OK
2004-07 Development of Standardized Model of Assessment for Substance-Involved Adolescents, State of Louisiana, Baton Rouge, LA
2009 Scientific Advisory Panel, Adolescent Consumer Guide, Phila, PA

B. Selected Peer-Reviewed Publications (Selected from 62 peer reviewed publications)

1. Meyers, K., Metzger, DS, Navaline, H., Woody, GE & McLellan, AT. (1994) HIV vaccine trials: Will IDUs enroll? Am J Public Health, 84, 761-766.
2. Davis, RD, Metzger, DS, Meyers, K, McLellan, A, Mulvaney, F, Navaline, HA, & Woody, GE. (1995). Long-term changes in psychological symptomatology as a function of HIV serostatus among male IDUs, AIDS, 9, 73-79.
3. Meyers, K, Metzger, DS, McLellan, AT, Navaline, H, Sheon, AR & Woody, GE. (1995). Are preventive HIV vaccine efficacy trials possible with female IDUs? J Acquired Immune Deficiency Syndromes and Human Retrovirology, 10, 577-585.
4. Fureman, MA, Meyers, K, McLellan, AT, Metzger, D & Woody, GE. (1997). Evaluation of a video-supplement to informed consent: Injection drug users and preventive HIV vaccine efficacy trials. AIDS Education and Prevention, 9, 330-341.
5. Meyers, K, Hagan, TA, Zanis, D, Webb, A, Frantz, J., Rutherford, M, Ring-Kurtz, S, & McLellan, AT. (1999). Critical issues in adolescent assessment: Assessing the treatment needs of adolescent substance abusers. Drug and Alcohol Dependence, 55, 235-246.
6. Meyers, K., Webb, A., Frantz, J.A., & Randall, M. (2003). What does it take to retain substance-abusing adolescents in research protocols? Delineation of effort required, strategies undertaken, and baseline and outcome differences by retention difficulty. Drug and Alcohol Dependence, 69, 73-85.
7. Meyers K. & McLellan A.T. (2005). The American Treatment System for Adolescent Substance Abuse: Formidable Challenges, Fundamental Revisions and Mechanisms for Improvements. In M.E.P. Seligman and D. Evans (Editors) *Treating and Preventing Adolescent Mental Health Disorders: What We Know and What We Don't Know*. Oxford University Press. New York.
8. Dembo, R., Walters, W. & Meyers, K. (2005). A practice/research collaborative: An innovative approach to identifying and responding to psychosocial functioning problems and recidivism risk among juvenile arrestees. Journal of Offender Rehabilitation, 41 39-66.
9. Meyers, K, Hagan T.A., McDermott, P., Webb, A., Randall, M., Frantz, J. (2006). Factor structure of the Comprehensive Adolescent Severity Inventory (CASI). American Journal of Drug and Alcohol Abuse; 32 (3), 287-310.
10. Meyers, K., McDermott, P., Webb, A. Hagan T.A. (2006) Mapping the clinical complexities of adolescents with substance use disorders: A typological study. Journal of Child and Adolescent Substance Abuse; 16, 5-24.
11. Dembo, R., Wareham, J., Poythress, N., Meyers, K., Cook, B., Schmeidler, J. (2007). Continuities in problem behavior in high-risk youth. Journal of Child and Adolescent Substance Abuse, 16, 91-118.
12. Dembo, R., Wareham, J., Poythress, N., Meyers, K., Cook, B., Schmeidler, J. (2008). Psychosocial functioning problems over time among high risk youth: A latent class transition analysis. Crime and Delinquency, 54, 664-670.