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Retention and Ongoing Participation in Residential Substance Abuse Treatment: Perspectives from Adolescents, Parents and Staff on the Treatment Process

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Abstract

Many adolescents entering substance abuse treatment do not stay for the full course of prescribed treatment. There have been few explorations into what facilitates the ongoing participation of adolescents while in treatment. This paper describes adolescent, parent, and treatment staff perceptions of the barriers and facilitators to retention and participation. Interviews were conducted with 87 adolescents, parents, and staff from three residential substance abuse treatment agencies in two states. Data were coded thematically and organized into themes by respondent type. Respondents reported barriers related to treatment population, program design, and communication and relationships, and reported facilitators related only to communication and relationships. Staff reported far more barriers than facilitators in comparison to either adolescents or parents. Findings suggest that parents and staff underestimate their contributions to the treatment process and practitioners might benefit from rethinking how to communicate the value of these stakeholders.

Introduction

Substantial negative outcomes are associated with untreated or undertreated substance abuse among adolescents, including lower educational and occupational attainment, violence and gang involvement, reduced satisfaction with one's relationships and life, and premature death.^{1–3} Completing treatment is the strongest predictor of continued sobriety and positive health outcomes,⁴ so it is important that youth participate in and finish substance abuse treatment services. Despite evidence that adolescent substance abuse can be treated successfully,^{5–8} premature dropout (around 50%) and a lack of sustained participation in drug treatment remain major challenges in drug treatment among adolescents.^{9–12} Furthermore, the variables that contribute to the retention and active participation of youth

in substance abuse treatment are not well understood, and little research has looked at consumer perspectives that may inform understanding of these issues or the specific programmatic elements of treatment that may mediate these indicators.^{13,14} This manuscript explores the barriers and facilitators to retention and participation in substance abuse treatment as articulated by adolescents, their parents, and treatment agency staff. The inclusion of perspectives from multiple parties is rare in the existing literature and may help to identify how the experience of substance abuse treatment can be improved for adolescents, as well as their parents.

It is important to clarify definitions of terms that commonly are used interchangeably in substance abuse treatment literature: treatment attendance, treatment engagement, treatment retention, and treatment participation. *Attendance* is defined as being physically present in residential treatment (i.e., not leaving against medical advice) or in outpatient treatment sessions (i. e., continuing to show up for scheduled appointments). The term *engagement* has been used in multiple ways; it can refer to an initial connection to services (e.g., following through on a referral, completing an intake, and beginning treatment) and can also refer to an ongoing connection to treatment over time.^{15,16} Engagement has also been used synonymously with attendance.^{14,17} The distinction between initial and ongoing engagement is valuable because strategies to improve initial versus ongoing engagement may be different¹⁷ and because research has identified barriers and facilitators to initiating treatment that are distinct from remaining in treatment over time.¹⁸

This paper also distinguishes between retention and participation as two related but unique concepts. *Retention*—the completion of a full course of prescribed treatment¹⁵—is important because research has demonstrated that completing treatment is predictive of abstaining from substance use in the future.^{4,19} Meanwhile, *participation*, defined as the active taking part and emotional involvement in substance abuse treatment activities,²⁰ is key because it may produce even better outcomes than merely showing up to treatment and because there may be individual-, familial-, and environmental-level factors that influence participation.^{21,22} Research on adolescent depression, for example, has demonstrated that teens are more likely to participate in treatment when they feel normal, autonomous, and connected.²³ This manuscript focuses on retention and participation.

A growing body of literature addresses the specific barriers and facilitators to retaining adolescents in substance abuse treatment. Barriers to retention have been attributed to: (1) the treatment population, (2) specific programmatic elements, and (3) communication and relationship factors. In reference to the treatment population, studies provide mixed evidence about the influence of patient demographic characteristics on retention; some studies suggest dropping out of mental health services, and substance abuse treatment is greater among youth from lower-income, minority, and single-parent families,^{16,24,25} while other research has found no difference in drug treatment participation along the lines of race, parent age, family income, or structure.⁹ There is also evidence that population traits other than demographic variables influence retention; Battjes and colleagues²⁶ found that adolescents who reported emotional problems and peer deviance exited substance abuse treatment earlier than other adolescents. Programmatic barriers include practical obstacles such as transportation,²⁵ as well as specific treatment components such as the perceived relevance of the program and the availability of qualified staff.^{14,25–27} Communication and relationship barriers are related primarily to clients' perceptions of their counselors; clients who feel that their counselors are less committed and less understanding are significantly more likely to drop out of treatment.²⁸

Facilitators to retention can also be identified in specific programmatic elements, communication, and relationship factors. In terms of programming, research on the

adolescent community reinforcement approach has identified components, including pro-social recreation planning, as significantly related to treatment retention.^{13,21,29} In addition, characteristics of the treatment agency itself, such as the size of the agency, ancillary services provided (such as family therapy or mental health treatment), and accreditation status, can also be associated with retention in treatment.^{30–32} Communication and relationship factors such as therapeutic involvement, measured by engagement, counselor rapport, and working alliance, have been identified as a key predictor of treatment retention.³³ This has been reconfirmed by studies demonstrating that therapeutic relationships and attendance have a reciprocal relationship¹⁴ and that interpersonal connectedness is a predictor of treatment participation.²⁵ In addition, family involvement has been shown to increase engagement and treatment completion.^{15,25}

The present study examines barriers and facilitators to retention and participation during the treatment process as articulated by adolescents, their parents, and agency staff. While literature has identified some mechanisms that increase adolescent retention and participation in substance abuse treatment, there remains little understanding of how they operate or why they are important. This paper contributes to understanding such mechanisms by focusing on consumer perspectives of barriers and facilitators experienced during the treatment process, including those related to population characteristics, program design, and communication and relationships. The attention to during-treatment barriers and facilitators and the comparison of perspectives from three groups is intended to give providers a better sense of their clients' experiences and to underscore the particular value of involved parents and staff. Given the acknowledged risks associated with untreated and undertreated substance abuse, identifying what prevents or sustains adolescent participation in substance abuse treatment after their initial engagement and entry is imperative to providing clinicians with a more detailed roadmap of what a successful substance abuse treatment program looks like.

Methods

Semi-structured, in-depth interviews were conducted with adolescents, parents, and staff at three substance abuse treatment agencies in two states. Two of these agencies were publicly funded; the third was funded both publicly and privately. Semi-structured interviews allowed researchers to probe multiple categories related to finishing treatment while enabling participants to present opinions in their own words. This paper is part of a larger study on stakeholder perspectives of adolescent residential treatment.^{34,35}

Participants

Adolescents, their parents, and staff were invited to participate in a 90-min semi-structured interview. Twenty-eight adolescents aged 15–21 years old (mean = 17.1, standard deviation [sd] = 1.48) were interviewed, most of whom were male (86%) and Caucasian (75%; 21% African American, 11% also identified as Hispanic). All adolescents were enrolled in residential substance abuse treatment programs with agency-stated length of treatment ranging from 3 to 15 months. At the time of the interviews, adolescents had been at these residential treatment agencies for between 3 weeks and 16 months, with an average time in treatment of 6.8 months (data missing from $n=1$ adolescents). However, it should be noted that exactly half of the adolescents interviewed ($n=14$; 50%) reported having been admitted to residential treatment at least once in the past, and 23 of the adolescents (82%) indicated that they had been to outpatient treatment prior to their current residential treatment.

Also, 30 of the same adolescents' parents (77% female; 80% Caucasian) were interviewed and 29 agency staff (66% female, 76% Caucasian). In some cases two parents of an adolescent were interviewed together, thus resulting in 26 interviews among 30 parents. In

coding interviews with two parents present, each parent's statements were counted separately when they were unique (i.e., if two parents of an adolescent said the same thing, it was counted only once); this step was taken in order to weight family experiences equally regardless of whether one or two parents were present. Staff were included if they spent a substantial amount of time with youth, resulting in interviews with direct-care and counseling staff such as counselors and social workers ($n=17$), clinical and agency directors ($n=7$), and other ancillary staff (e.g., two nurses, one administrator, one chef, one intake coordinator; the chef worked directly with youth as part of a work program).

Interviews and analysis

Trained researchers and research assistants conducted individual interviews in person at the treatment facilities for all youth and staff and for most parents; some parents were interviewed over the phone. For this paper on barriers and facilitators during treatment, adolescent interviewees were asked "Does anything ever keep you from continuing treatment or from participating in it?" and parents were asked "Does anything ever keep your child from continuing treatment or from participating in it?" Staff were asked similar questions about their perspectives of barriers and facilitators for adolescents.

Interviews were tape-recorded and transcribed verbatim. Research staff analyzed interviews using the Atlas.ti 5.2 software, which aids in coding, organizing, and retrieving qualitative data.³⁶ Four coders coded the interviews, seeking consensus to ensure consistent and reliable data. The reliability was calculated across analysts for codes on barriers and facilitators to treatment by calculating the proportion of primary coder hits compared to independently confirmed occurrence of accurately coded text; our primary coder was correct for 90% of these occurrences. After coding was completed, all coded material related to adolescent, parent, and staff answers to questions about barriers and facilitators to treatment were reviewed. Interpretations were refined through an iterative process in which data were organized into broad categories and then modified categories as analysis continued. It became evident during the sorting of data into categories that some categories related specifically to barriers and facilitators to entering treatment, while other categories related to barriers and facilitators to retention and participation in treatment (addressed in this paper). From all data on barriers and facilitators to retention and participation in treatment, themes were grouped logically into four major areas: (1) population barriers, (2) program design barriers, (3) communication and relationship barriers, and (4) communication and relationship facilitators. There is also a fifth category of "other" responses. Once the data were grouped categorically, Fisher's exact tests were conducted to determine if there were any significant differences between responses given by adolescents, their parents, and agency staff on each item.

Results

Adolescents, parents, and staff reported far more barriers during treatment ($n=103$) than they did facilitators ($n=65$). Adolescents reported an average of 1.56 barriers and 1.36 facilitators, parents reported an average of 0.70 barriers and 0.47 facilitators, and staff reported an average of 1.3 barriers and 0.43 facilitators. While each group identified more barriers than facilitators, they did so in different ratios; the barrier to facilitator ratio was 1.13 for adolescents, 1.49 for parents, and 3.02 for staff. Staff were, thus far, more likely to identify barriers than facilitators in relation to either adolescents or their parents, who identified barriers and facilitators in relatively equal terms. See Table 1 for a summary of barriers and facilitators.

Adolescents, parents, and staff identified barriers to treatment that stemmed from perceptions about the population involved in treatment. Adolescents more frequently

reported frustration with the agencies' patient populations ($n=5$; 18%), where residents have very different addictions (e.g., alcohol, heroin) and varied reasons for being at the agency (e.g., sent by their parents, mandated by a judge) than did parents or staff ($p=0.02$). Adolescents ($n=4$; 14.29%) were also more likely than parents or staff ($p=0.01$) to mention that their past experiences (i.e., traumatic experiences or memories of life prior to residential treatment) made it difficult for them to adjust to the new environment and engage in treatment. For example, one youth noted "you have all the stuff that went on in your life that you're still worried about here." Staff ($n=6$; 21%) cited language and cultural barriers presented by their clients most often, a factor that neither adolescents nor their parents considered problematic ($p<0.01$). Interestingly, parents articulated only three barriers due to the population at all; one guardian (3%) cited family problems and two (7%) cited the fact that their children kept running away from the agency.

In addition to barriers presented by the population characteristics, all three groups identified certain program design barriers that they believed hindered the treatment process. Adolescents cited program rules ($n=7$; 25%) as the most common barrier, and they did so significantly more often than did parents or staff ($p=0.045$). Adolescents articulated frustration with trying to follow stringent rules (e.g., "you stress out so much on trying to follow the rules that you don't really work on your treatment.") and "get[ting] in trouble for not doing anything." Adolescents also noted staffing problems such as lack of time for counseling or multiple staffing changes due to hiring and firing counselors ($n=5$; 18%). In the words of one youth, "my shrink doesn't do much for me... I don't talk to her for more than 10 minutes." Meanwhile, a different youth spoke about the impact of staffing changes: "It was kind of stressful. I'd get close to them [a counselor] for a bit, then they'd leave." Staff ($n=5$; 17%) also acknowledged staffing problems, particularly related to not having adequate coverage, but these issues were never mentioned by parents ($p=0.02$). Parents ($n=3$; 10%) and staff ($n=8$; 26%) cited transportation difficulties as the primary programmatic barrier hindering parental involvement in treatment. However, the fact that staff cited transportation barriers for parents in far higher numbers than parents themselves may indicate that staff overestimate the extent to which parent involvement is due to difficulties in getting to the program; there were significant differences in responses among adolescents, parents, and staff for transportation ($p<0.01$).

In terms of communication and relationship barriers to the treatment process, results seemed to align with the particular group's place in the agency. Adolescents cited negative relationships with staff ($n=5$; 18%) most frequently and significantly more often than parents and staff ($p<0.01$). One adolescent reported feeling that staff "don't really know what kids are going through," while another adolescent was more cynical: "I feel like they're all here to get their paycheck," he said. "They just don't go the extra mile." Meanwhile, parents were most likely to note the lack of communication from the agency ($n=5$; 17%). Staff reported only seven total barriers in this category, with a maximum of two responses in each category. The categories that received two responses each were lack of communication with parents and lack of parental involvement. Parents and staff thus perceive the other group as being chiefly responsible for causing barriers in communication and engagement.

Despite the barriers that were cited by adolescents, their parents, and staff, each group also cited facilitators to the treatment process, all of which were related to communication and relationships. Adolescents and parents cited positive adolescent/staff relationships ($n=16$; 57% and $n=4$; 13% for adolescents and parents, respectively) and strong communication with staff ($n=9$; 32% and $n=7$; 23% respectively) significantly more often than staff ($p<0.01$ for each). Adolescents described staff as being "understanding of where [they] come from," and "good at calming me down," and they also spoke about the ease with which they could "talk about anything" or "speak my mind." Adolescents also spoke of parent involvement as

a facilitator for participation in treatment ($n=9$; 32%). This was echoed by staff ($n=11$; 38%), who noted the positive influence of parent involvement more frequently than other responses, but not by parents ($p=0.00$).

Discussion

These results are consistent with the existing literature on barriers and facilitators to retention and participation in adolescent substance abuse treatment. Viewed across groups, the most commonly cited barriers to treatment—transportation, staffing changes and shortages, and program rules—speak to the programmatic barriers cited in the literature such as practical obstacles to participation, including being able to travel to the treatment center easily, and perceived program relevance (i.e., reports from adolescents demonstrate that they perceive the rules at the treatment center as arbitrary and overly stringent). The most commonly cited facilitators to treatment—positive relations between adolescents and staff, parent involvement, and strong communication with staff—likewise underscore the idea that therapeutic relationships and family involvement are integral to successful completion of substance abuse treatment for adolescents. While adolescents, parents, and staff clearly see more barriers to their continued participation in the treatment process, it is encouraging that they also acknowledge facilitators that have been cited consistently in the literature. That there was more agreement within and across groups regarding facilitators to treatment (i.e., all facilitators mentioned fell within the category of communication and relationships) suggests that building communication and relationship skills may be a particularly promising approach to improving treatment retention and participation. The agreement of participants on these facilitators suggests addressing them is likely to improve treatment for a large proportion of clients.

The data presented in this study also point to some interesting reflections on how different parties involved in substance abuse treatment perceive facilitators during the treatment process. Perhaps most importantly, it is notable that adolescents cited almost as many facilitators as barriers, and that such high percentages endorsed the existence of positive relationships with staff, as well as strong communication with staff and high involvement from their parents. These responses suggest that adolescents see staff and their parents as crucial actors in their treatment and credit them for their continued participation in the program.

Responses from adolescents about facilitators during treatment are particularly interesting because parents and staff were unlikely to see themselves as important to this process. While adolescents and staff noted the importance of parent involvement, parents themselves did not credit their own involvement as a facilitator. Given that family-based treatment is the most thoroughly studied treatment modality for adolescent substance abuse and that studies consistently demonstrate the critical importance of parent involvement for treatment engagement, retention, and outcomes,¹⁵ it is essential for parents to understand how central they are to their adolescent's recovery. Treatment agencies may need to adjust the ways they communicate the significance of such involvement so that parents feel like valued members of the treatment team.

Similar steps may need to be taken to communicate the importance of staff in the treatment process. Although both adolescents and parents credited strong communication with staff as facilitating treatment, this was not mentioned by any staff. In combination with data showing that staff cited many more barriers than facilitators and almost never considered themselves as facilitators to adolescent participation in treatment, it is worth looking more closely at how staff conceive of their role in facilitating substance abuse treatment. This may

be particularly important in light of the prevalence of staff “burnout” among substance abuse treatment workers.^{37–39}

The conclusions drawn from this study are limited in several ways. First, while a small sample is appropriate for a qualitative study with lengthy interviews like this one, further qualitative and quantitative research is needed with larger samples in order to generalize findings. Second, the adolescents interviewed in this study were currently in treatment; adolescents who had dropped out of treatment prematurely were not interviewed, but adolescents that may have dropped out of treatment at some point after the interview were not ruled out. Future studies should elicit the perspectives of adolescents who leave treatment in order to understand the full range of barriers and facilitators experienced once adolescents enter substance abuse treatment. Finally, this study consisted of a sample of adolescents who were in residential treatment specifically, who may be different from adolescents involved in other service venues. Additional comparative research on adolescents in other substance abuse treatment venues (e.g., outpatient), adolescents who have already dropped out of treatment, and longitudinal studies of adolescents in residential treatment may further illuminate the nature of barriers and facilitators within and across individuals over time and setting.

Implications for Behavioral Health

This study provides additional evidence of the barriers and facilitators that adolescents, their parents, and agency staff experience as they participate in substance abuse treatment. The findings of this study demonstrate that each of these groups has unique perspectives on how treatment retention and participation are affected by the treatment population, program design, and relational issues. The challenge for providers is to find effective ways to address existing barriers to retention and participation while capitalizing on the strengths that parents and staff bring to the treatment process. This may be particularly important in the case of staff; if staff underestimate their own influence and believe there are more barriers to treatment than facilitators, they are likely to perceive limited options in treating adolescents. In turn, staff may come to rely more often on crisis management interventions instead of employing strategic and evidence-based treatment practices. Both of these trends may then translate to higher levels of staff burnout. Substance abuse treatment agency leaders may want to obtain perspectives from their agency's clients regarding barriers to participation in treatment and consider how staff attitudes and perspectives may facilitate or hinder treatment participation.

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Table 1
Barriers and facilitators to retention and participation during adolescent substance abuse treatment

	Adolescents (N=28)		Parents (N=30)		Staff (N=29)		Total (N=87)	
	N	%	N	%	N	%	N	%
Population barriers								
Mixed population *	5	18	0	0	2	7	7	8
Language/cultural barriers **	0	0	0	0	6	21	6	7
Past experiences *	4	14	0	0	0	0	4	5
Family problems	1	4	1	3	1	3	3	3
Runaways	1	4	2	7	0	0	3	3
Alternative to jail	3	11	0	0	1	3	4	5
Program design barriers								
Transportation **	0	0	3	10	8	28	11	13
Location	0	0	2	7	1	3	3	3
Rules *	7	25	2	7	1	3	10	11
Fairness	4	14	1	3	1	3	6	7
Staffing changes/shortages *	5	18	0	0	5	17	10	11
Transitions	0	0	0	0	3	10	3	3
Length of program	2	7	1	3	3	10	6	7
Communication and relationship barriers								
Negative adolescent/staff relationships *	5	18	0	0	1	3	6	7
Exclusion from treatment planning	3	11	2	7	0	0	5	6
Lack of communication with parents	1	4	5	17	2	7	8	9
Lack of parent involvement	0	0	0	0	2	7	2	2
Misinformed about length	1	4	1	3	1	3	3	3
Lack of trust	1	4	1	3	1	3	3	3
Total barriers	43	42	21	20	39	38	103	100
Communication and relationship facilitators								
Positive adolescent/staff relationships **	16	57	4	13	2	7	22	25
Strong communication with staff **	9	32	7	23	0	0	16	18

	Adolescents (N=28)		Parents (N=30)		Staff (N=29)		Total (N=87)	
	N	%	N	%	N	%	N	%
Strong parent/child communication *	4	14	1	3	0	0	5	6
Parent involvement **	9	32	0	0	11	38	20	23
Parent solidarity	0	0	2	7	0	0	2	2
Total facilitators	38	58	14	22	13	20	65	100
Other								
External motivators	1	4	1	3	0	0	2	2
No barriers	0	0	3	10	0	0	3	3
Total other	1	20	4	80	0	0	5	100
Total	82	47	39	23	52	30	173	100

* $p < 0.05$;

** $p < 0.01$