ADOLESCENT DRUG TREATMENT & DRUG COURT META-ANALYSIS

CODING MANUAL

Last Updated August 20, 2015

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#### Coding Manual for Updates to:

Tanner-Smith, E. E., Wilson, S. W., & Lipsey, M. W. (2013). The comparative effectiveness of outpatient treatment for adolescent substance abuse: A meta-analysis. *Journal of Substance Abuse Treatment*. doi: 10.1016/j.jsat.2012.05.006

Mitchell, O., Wilson, D. B., Eggers, A., & MacKenzie, D. L. (2012). Drug courts’ effects on criminal offending for juveniles and adults. *Campbell Systematic Reviews, 4.*

# ELIGIBILITY CRITERIA

## Drug Treatment Studies

Intervention

1. There must be some form of intervention or treatment present that addresses substance use. The intervention can be targeted at a specific type of substance use, multiple substances, or substance use in general. The substances at issue include alcohol, illicit drugs, or misused prescription or over-the-counter drugs. Relevant treatments may be provided in any format (e.g., group, individual, family, multi-family group), may involve pharmacological treatments, and may use either particular manualized interventions, less well defined treatments or approaches, or combinations of any of these. The following specific considerations also apply:
   1. The intervention must explicitly have as its aim the reduction, treatment, remediation or elimination of substance use and be essentially the same for all of the subjects in the treatment group (i.e., there may be variation across individuals in what they receive but distinctly different treatments should not be applied to different subsamples that are aggregated into a single study sample).
   2. Interventions aimed solely at reducing/treating/remediating tobacco and/or caffeine use are not eligible. However, an intervention will still be eligible if attention to these co-occurs with a focus on a relevant substance.
   3. Early intervention/prevention programs for individuals who are “at risk” for substance use disorder (e.g., exhibiting non-clinical levels of use) are not eligible.
   4. Interventions directed only at collateral persons or caregivers, or systems interventions that would not generally be recognized as client-oriented substance use treatment, are not eligible.
   5. Pre-clinical interventions (e.g., screening or brief interventions aimed solely at getting people into treatment) and which do not themselves involve treatment are not eligible.
   6. Supply-side interventions designed to reduce substance use through reductions in availability of illicit substances are not eligible.

Participants

1. The study sample\* on which the intervention outcomes are measured should consist of adolescents, defined as persons between the ages of 12 and 18 inclusive (a range selected to be consistent with the DHHS definition of youth). Study samples including individuals above or below this range are eligible if 68% or more of the subjects fall within the range and none are older than 20 years of age.
2. The study sample\* must include only individuals who are current or recent substance abusersor have indications of other problems associated with substance use (this includes subjects in both the treatment and control groups). To be eligible, the sample must meet at least one of the three following criteria:

* The treatment(s) is presumed to target, or only be appropriate for, person with substance use disorders or substance related problems (e.g., court-mandated treatment, methadone out-patient treatment, long-term residential treatment).
* The individuals in the study sample meet DSM criteria for a substance use disorder.
* The individuals in the study sample have characteristics that imply DSM criteria for a substance use disorder, or the sample selection is based on criteria that imply DSM substance use disorder criteria have been met (e.g., “experiencing alcohol/drug problems,” “severe involvement with drug use”, “previous treatment experience”).

**NOTE**: “Study sample” refers to the sample of respondents that we identify as having eligible outcome and effect size information, not necessarily the entire study an author refers to in a report. For instance, a report may provide breakout information on adolescents and adults within a data collection, and we may identify the adolescent subsample as our study of interest. Or, a report may provide breakout information on adolescent substance users and a non-clinical community sample within a data collection and we may identify the abusing subsample as our study of interest.

Research Design

1. Treatment groups and control groups (if used) must each contain at least 10 individuals at the time of assignment to study conditions.
2. The study must use an experimental or controlled quasi-experimental design that compares subject groups receiving one or more identifiable treatments with either a control/placebo condition, a different treatment approach.

To be eligible as an experimental/quasi-experimental design, a study must meet at least one of the following criteria:

1. Subjects were randomly assigned to treatment and comparison conditions or assigned by a procedure plausibly equivalent to randomization.
2. Quasi-experiments for which the subjects in the treatment and control conditions (if used) are generally similar with regard to their demographic characteristics and can be compared for initial equivalence on pretest data for prior substance use, risk for subsequent use, or some analogous measure.
3. Studies will qualify as quasi-experiments if the treatment and control groups are matched on some or all of these variables as part of the study design **if** the matching variables include at least one variable representing prior substance use, risk for use, etc. as above. Note that if the groups are matched at the individual level (subject by subject), it is not necessary that the pretest data comparing the groups be reported so long as there is no indication that the matching failed to produce near equivalence between the groups on the prior substance use/risk variable. If the groups are matched groupwise (selection of a group that has similar mean values), however, then such information must be reported as for the case described below. Designs that use statistical controls for pretest substance use (e.g., analysis of covariance) will be taken as equivalent to individual level matching.
4. If the study design does not involve individual level matching, or a prior substance use/risk variable was not used in the matching, it will be eligible only if the study report provides pretest data that allows the equivalence of the groups to be compared quantitatively on at least one substance use/risk measure. The pretest must occur prior to the receipt of treatment services.
5. A nonrandomized study is not an eligible quasi-experiment under this category if one or more of the comparison groups is comprised of subjects who self-selected into the group(s) under circumstances in which they were aware of the options, e.g., subjects volunteered for a particular treatment from among a set of choices or control groups were assembled from subjects offered or selected to receive treatment but who then declined or from subjects who dropped out of treatment before completion.

Outcome Measures

1. The study must report at least one substance use outcome variable describing the subject sample(s) at or after the conclusion of treatment. This may be self- or other-report, direct observation, clinical tests such as urinalysis, blood chemistry, etc. or any other measure with at least face validity for measuring substance use. Substance use diagnoses (e.g., from a clinical interview or DSM criteria) are considered eligible substance use outcomes for our purposes.

Eligible substance use measures are those that describe actual use, for example, frequency of use, level of use, use/no use, time since last use, etc. Measures indexing substance use related problems (e.g., scores on RAPI, AIC) drug-related criminal activity (e.g., DUI, selling drugs), drug knowledge, behavioral intentions, etc. would not by themselves qualify a study as eligible.

1. It is not required that the study report provide sufficient statistical information for computing an effect size.

Publication Date, Type, and Source

1. The research must have been published during or after 1980. However, studies are not eligible if they are published during or after 1980 but the research or data collection occurred in or before 1975.
2. Studies must have been conducted in the United States or Canada. Studies can be reported in any language.

There are no restrictions on the type or form of publication; any relevant article, chapter, technical report, conference paper, etc. is eligible as long as it meets the other eligibility criteria.

## Drug Court Studies

Intervention

1. There must be some form of a juvenile drug court program, or an analogous specialized juvenile court that involves the following features: specialized court for handling drug-involved cases that are processed in a non-adversarial manner, refer youth to appropriate treatment programs, and have a judge who actively monitors progress. Note that any program that self-identifies as a juvenile drug court is eligible for inclusion; although some programs may not self-identify as juvenile drug courts but may be eligible if they meet the criteria noted above.
2. 1

Participants

1. The study sample\* on which the intervention outcomes are measured should consist of juveniles, defined as persons age 18 or under.

Research Design

1. The population of evaluations eligible for this review was experimental and quasi-experimental evaluations of drug courts that utilized a comparison group that was treated in a traditional fashion by the court system (e.g., probation with or without referral to treatment)

To be eligible as an experimental/quasi-experimental design, a study must meet at least one of the following criteria:

1. Subjects were randomly assigned to treatment and comparison conditions or assigned by a procedure plausibly equivalent to randomization.
2. Quasi-experiments for which the subjects in the treatment and control conditions (if used) are generally similar with regard to their demographic characteristics and can be compared for initial equivalence on pretest data for prior substance use, risk for subsequent use, or some analogous measure.
3. Studies will qualify as quasi-experiments if the treatment and control groups are matched on some or all of these variables as part of the study design **if** the matching variables include at least one variable representing prior substance use, risk for use, etc. as above. Note that if the groups are matched at the individual level (subject by subject), it is not necessary that the pretest data comparing the groups be reported so long as there is no indication that the matching failed to produce near equivalence between the groups on the prior substance use/risk variable. If the groups are matched groupwise (selection of a group that has similar mean values), however, then such information must be reported as for the case described below. Designs that use statistical controls for pretest substance use (e.g., analysis of covariance) will be taken as equivalent to individual level matching.

Outcome Measures

1. The study reported a measure of criminal behavior, such as arrest or conviction for some measurement period following the start of the program (the measure may have been based on official records or self-report and may have been reported on a dichotomous or continuous scale) **or** the study reports at least one substance use outcome variable describing the subject sample(s) at or after the conclusion of treatment. This may be self- or other-report, direct observation, clinical tests such as urinalysis, blood chemistry, etc. or any other measure with at least face validity for measuring substance use. Substance use diagnoses (e.g., from a clinical interview or DSM criteria) are considered eligible substance use outcomes for our purposes.

Eligible substance use measures are those that describe actual use, for example, frequency of use, level of use, use/no use, time since last use, etc. Measures indexing substance use related problems (e.g., scores on RAPI, AIC), drug knowledge, behavioral intentions, etc. would not by themselves qualify a study as eligible.

Effect Size Data

1. It is not required that the study report provide sufficient statistical information for computing an effect size.

Publication Date, Type, and Source

1. The research must have been published during or after 1989. However, studies are not eligible if they are published during or after 1989 but the research or data collection occurred in or before 1984. This date was chosen given that the first U.S. drug courts appeared in 1989.
2. Studies must have been conducted in the United States or Canada. Studies can be reported in any language.

There are no restrictions on the type or form of publication; any relevant article, chapter, technical report, conference paper, etc. is eligible as long as it meets the other eligibility criteria.

# FULL-TEXT CODING

## Study Level

Study Identifiers

The unit coded here consists of a study, i.e., one research investigation of a defined subject sample or set of subsamples compared to each other, and the treatments, measures, and statistical analyses applied to them. Sometimes there are several different reports (e.g., journal articles) about a single study. In such cases, the coding should be done from the full set of relevant reports, using whichever report is best for each item to be coded; BE SURE YOU HAVE THE FULL SET OF RELEVANT REPORTS BEFORE BEGINNING TO CODE. Sometimes a single report describes more than one study, e.g., one journal article could describe a series of similar studies done at different sites. In these cases, each study should be coded separately as if each had been described in a separate report.

Each study has its own study identification number (StudyID, e.g., 619). Each report also has an identification number (ReportID, e.g., 619.01). The ReportID has two parts; the part before the decimal is the StudyID, and the part after the decimal is used to distinguish the reports within a study. When coding, use the studyID (e.g., 619) to refer to the study as a whole, and use the appropriate reportID (e.g., 619.01) when referring to an individual report.

While reading reports for coding, be alert to any references to other early intervention studies that may be appropriate to include in this meta-analysis. If you find appropriate-looking references that are not currently entered into the Bibliography, the references may need to be entered by hand and retrieved in full-text format.

**[studyid]**

Study identification number

**[coder]**

Coder's initials

**[sh6][country]**

Country in which the study was conducted

1. USA
2. Canada

***Group Identification and Selection***

At this stage, you will need to identify the groups in the study for which effect size statistics can be computed. Note that for any group comparison coding, the two groups involved must be from the same experiment or quasi-experiment; that is, they must have been involved in the same randomization, matching, etc. from the same design. If two or more experiments or quasi-experiments are presented in the same report, each must be handled separately.

If there are only two qualifying groups in the study (e.g., one treatment group and one control group or two treatment groups) then they are the only two groups that will be compared in the group comparison coding. If there is more than one qualifying treatment group and only one control/comparison group, each treatment group will be coded in comparison to that control/comparison group and to each other treatment group.

If there is more than one qualifying treatment group and more than one control/comparison group, each treatment group will be coded in comparison to one selected “best” control/comparison group and to each other treatment group. The “best” control/comparison is selected from the rank order listing below (best listed first):

(a) “no treatment” control (control gets no treatment, left alone)

(b) “treatment as usual” control (controls get “usual” handling instead of special treatment, but the usual handling does not involve treatment, e.g., juveniles in a residential facility who receive all the usual services of the facility except for drug treatment)

(c) placebo control (controls get some attention or sham treatment).

List below all treatment and comparison groups in the study, regardless of whether you plan to code any other information for that group.

**[sh8a-d]**

**[txa-d]** Write in Name

Treatment 1-4 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Groups

**[sh10a-d]**

**[cta-d]** Write in Name

Comparison 1-4 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Groups

**[sh9]**

[txtot]

Total number of all treatment groups (whether eligible/ineligible for coding)

**[sh11]**

[cttot]

Total number of all comparison groups (whether eligible/ineligible for coding)

***Study Design***

**[sh27]**

**[design]**

Method of assignment to groups. This item focuses on the initial method of assignment to groups regardless of subsequent degradations due to attrition, refusal, etc. prior to treatment onset. These latter situations are coded elsewhere.

Random or near-random:

1. randomly assignment at the individual level. Individual participants are randomly assigned to conditions. In some cases random assignment may be done after individuals have been matched or blocked.
2. random assignment by group; that is, intact groups such as classrooms are assigned (this will be rare)
3. regression discontinuity design: quantitative cutting point defines groups on some continuum (this will be rare)
4. quasi-randomized procedure presumed to produce comparable groups. This applies to groups which have individuals assigned by some naturally occurring process that is apparently random, e.g. alternation, date of birth, medical record number. The key here is that the procedure used to select groups is not strictly random, but the method of allocation should not create nonequivalence between groups.

Non-random, but matched or statistically controlled:

Note: Matching refers to the process by which individuals are selected for conditions (e.g., treatment and comparison) in a manner that ensures that the individuals in one group are matched on certain relevant characteristics in the other group. Comparing the characteristics of the groups AFTER they have been assigned to experimental conditions does NOT constitute matching.

1. Matched individually, through sampling, on one or more baseline measures of substance use, substance use risk factors, demographic characteristics, offending behavior, or other measures.
2. Statistical controls used to equate individuals on one or more baseline measures of substance use, substance use risk factors, demographic characteristics, offending behavior, or other measures (e.g., through regression control, ANCOVA, analysis of covariance, propensity score methods).
3. Matched at a larger group level; that is, intact groups were matched on their means for some set of characteristics; e.g., the mean ages of the groups are similar, but each subject in one group has not been individually matched to a subject in the other group on age.

**[matchedvarlist]**

Please list all of the variables used in the matching and/or statistical controls.

## Treatment and Comparison Groups

Create one record in this database for each of the treatment and/or comparison groups you selected earlier for coding. For example, studies with a single treatment group and a single comparison group will have two records in this section of the database.

##### *Group Identification and General Nature of Treatment*

**[groupid]**

**[groupid]**

Number each group consecutively within a study, starting with 1.

**[g1]**

[tvc]

Select the type of group you are coding.

1. Treatment group
2. Control/comparison group

**[g2]**

[type]

What type of services does this group receive?

1. Focal/primary treatment program. There may be several focal programs in a study, as when two different types of treatments are compared, both of which are expected to be effective.
2. Focal/primary drug court program. There may be several focal drug courts in a study.
3. Alternate program or treatment. This is a group that receives a program or treatment, but is used as a reference for comparison with the treatment of focal interest or is expected to be less effective than the focal treatment(s).
4. Placebo. This group gets a placebo, which is something which appears to the subject to be a treatment, but is not expected by the researchers to work.
5. No treatment, Assessment only. This is a group that receives no treatment and gets only assessments.
6. Historical controls
7. Eligible but not referred to treatment/drug court
8. Treatment as usual (e.g., probation)
9. ~~Alternative treatment (DON’T USE THIS)~~
10. Other

**[g8]**

[name]

Program name. Write in the program or treatment label for this group (e.g., Cognitive Behavioral Therapy, Motivational Interviewing). For drug court studies, list the name/jurisdiction of the drug court here.

**[g9]**

[descrip]

Program description. Write in a brief description of the treatment this group receives. If the program for this group includes different treatment segments (e.g., inpatient, outpatient, and group therapy), summarize each of the segments here. Make sure you include ALL treatment elements in your description. As much as possible, quote or give a close paraphrase of the relevant descriptive text in the study report; include page numbers to the report when appropriate. It is acceptable to copy and paste directly from the article as long as you include the information in quotations and provide a page number for the quotation.

##### *Participant Characteristics*

**[g35]**

[permale]

Enter the percent of males in this group. Use -9 for cannot tell.

**[gx]**

[perwhite]

Enter the percent of White participants in this group. Use -9 for cannot tell.

**[gx]**

[pernonwhite]

Enter the percent of Non-White participants in this group. Use -9 for cannot tell.

**[gx]**

[perblack]

Enter the percent of Black participants in this group. Use -9 for cannot tell.

**[gx]**

[perhisp]

Enter the percent of Hispanic participants in this group. Use -9 for cannot tell.

**[g43]**

[age]

Enter the average age of the sample using number of years. Use -9 for cannot tell.

**[g88]**

[delq]

Delinquency level of sample. Enter the highest level of prior delinquency involvement for the sample. Note that this items explicitly refers to prior delinquent behavior prior to the current intervention or treatment program.

1. nondelinquents, normal (no evidence of LE or JJ contact or illegal behavior; no identified symptoms or risk factors; regular kids)
2. nondelinquents, symptomatic (no evidence of LE or JJ contact or illegal behavior, but risk factors such as poverty, family problems, school behavior problems, Glueck scale scores, teacher referrals, etc.)
3. predelinquents, minor police contact (no formal probation or court contact or minor self-reported delinquency minor drug infractions, traffic and status offenses, counseled and released, etc. )
4. delinquents (formal probation and/or court adjudication but noncustodial or significant self-reported delinquency, e.g., burglary, property crimes, auto theft; any juvenile who went to court
5. institutionalized, non JJ setting (e.g., mental health in-patient; not just detained pending hearing)
6. institutionalized, JJ setting (e.g., in group home, camp, reform/training school, etc. under court order)

These first six constitute our risk scale; the remaining items are for mixed groups in which no single "type" predominates.

1. mixed, mostly low end of range (nondelinquent & predelinquent)
2. mixed, mostly moderate to high end of range (predelinquent & delinquent/sometimes institutionalized) [Note: This is appropriate if there are offenses for all of the kids.]
3. mixed, full range (nondelinquent through delinquent/institutionalized)

-9. Cannot tell

**[g71]**

[comorbid]

Comorbidity in any subjects. Comorbidity refers to other mental health/psychiatric issues the subjects may have, such as depression, conduct disorder, ADHD, or anxiety. It does not refer to other substance use problems, or family histories of problems.

1. Yes, comorbidity identified as an explicit clinical (i.e., diagnosed) problem
2. No, comorbidity is explicitly not present in the sample

-9. Cannot tell / not mentioned

**[-]**

[comorbid\_tx]

Treatment of comorbidity. Do the services provided to the adolescent address any comorbidities or co-occurring problems?

1. Yes, the treatment description explicitly states that comorbidities are addressed
2. Maybe; implied by description of services received

3 No, or not mentioned

-8 N/A: no tx rec’d

***Baseline Substance Use Severity***

The next section refers to the level of substance use severity in the specified subject sample. Alcohol severity refers to consumption of any alcoholic product (e.g., beer, wine, hard liquor). Marijuana severity refers to consumption of any cannabis product (e.g., marijuana, hashish). Mixed substance use refers to any combination of alcohol, marijuana, tobacco, or other unspecified mix of substances. Hard substance use refers to any single or combination of substances other than alcohol, marijuana, or tobacco (e.g., cocaine, inhalants, hallucinogens, amphetamines).

**[g101d]**

[alcsev\_des]

Provide a page number and brief description of the baseline alcohol severity of the sample.

**[g102d]**

[mjsev\_des]

Provide a page number and brief description of the baseline marijuana severity of the sample.

**[g103d]**

[mxsev\_des]

Provide a page number and brief description of the baseline mixed substance use severity of the sample.

**[g104d]**

[hdsev\_des]

Provide a page number and brief description of the baseline hard substance use severity of the sample.

**[g32]**

[monitored]

Monitoring of treatment implementation. Was the implementation of the program monitored by the author/researcher or program personnel to assess whether it was delivered as intended?

1. Yes, but no indication of feedback to treatment providers. Do not infer that monitoring happened. Select “yes” ONLY if the report specifically indicates that implementation was monitored.

2. Yes, with indication that treatment providers received feedback. Do not infer that monitoring happened. Select “yes” ONLY if the report specifically indicates that implementation was monitored.

0. No indication that service delivery was monitored.

-8. N/A: no tx rec’d

**[g26]**

[impprob]

Implementation quality. Based on evidence or author acknowledgment, was there any uncontrolled variation or degradation in implementation or delivery of treatment, e.g., high dropouts, erratic attendance, low treatment compliance, treatment not delivered as intended, wide differences between settings or providers, etc. Note that this question has to do with variation in treatment delivery, not research contact. That is, there is no “dropout” if all juveniles complete treatment, even if some fail to complete the outcome measures.

1. Yes

2. Possible

3. No, apparently implemented as intended

-8. N/A: no tx rec’d

### *Treatment Modality – Drug Treatment Studies Only*

Service Coding Codes:

1 – Focal

2 – Minor or secondary treatment element

3 – Tx element but cannot tell how much or how many subjects

**[prog---]**

[loc]

Level of care

1. Inpatient
2. Outpatient
3. Outpatient continuing care {continuing care delivered in an *outpatient* setting, regardless of the setting of the primary treatment}
4. Residential treatment

Focal treatment elements are those that are the primary or majority type of treatment received by subjects. Minor or secondary treatment elements are those that are clearly not focal treatment elements for the entire sample, or were a focal treatment element for only a portion of the group. The final category should be used sparingly, and only when the focal and secondary treatment elements are unclear.

If possible and/or reasonable, make sure you code at least one focal treatment element for each group, and try to code ONLY one focal treatment element for each group. In some instances it will not be possible to code only one focal treatment element (e.g., CBT/MET). However, in many other instances, there will be only one focal element. For instance, if a treatment program includes two components that are cognitive/behavioral therapy, and one component that is contingency management/behavioral therapy, you would code the focal treatment element as “Cognitive/behavioral therapy” since it comprises 2/3 of the treatment received. You would “Behavioral management/contingency management” as a secondary treatment element.

When coding the focal/secondary elements of treatment types, do not code the same element as both focal and secondary within a group. For instance, if group members received cognitive restructuring as a focal element, and a subsample of the group also received cognitive rehearsal therapy, you would only code “Cognitive/behavioral therapy” as the focal treatment (i.e., NOT a secondary treatment element). The only exception to this is for Multi-service package programs: for these groups you will code the focal treatment elements as “Multi-service package” and the individual components included within the program as secondary treatment elements.

###### Generic Treatment type [see Group Appendix for descriptions]

**[prog---]**

[txtype1-10]

1. Behavioral/contingency management
2. Cognitive/behavioral therapy (CBT)
3. Family therapy
4. Generic counseling
5. Motivational enhancement/Motivational interviewing (MET/MI)
6. MET + CBT
7. Psycho-educational (PET)

Note: Only use this if the treatment group you are coding does not fall within any of the other specific treatment elements.

1. Skills training (generic skills, not including relapse prevention, social/interpersonal, or anger management, which would all be coded elsewhere).
2. Psycho-pharmacology treatment/ psychiatric treatment services

Note: If an article states that subjects received psychiatric services, but does not specify whether it was pharmacological tx or counseling, code here as a ‘3’ (tx element but cannot tell how much) unless there are contextual clues that indicate the psychiatrist only provided counseling services

1. Multi-service package

Note: Only code treatments as multi-service packages if they are part of a treatment program that routinely provides numerous treatment elements and has no face validity as a different specific type of treatment. For instance, many residential treatment programs include individual counseling, group counseling, case management, cognitive behavioral therapy, and behavioral management. In this case you would code the focal treatment element under “Multi-service packages” and code the remaining treatment elements as secondary.

**[g90]**

[manual]

Did this group receive a manualized treatment?

1. Yes. Do not infer that the treatment was manualized. Select “yes” ONLY if the report specifically indicates that the treatment was manualized.
2. No, but some indication of a written curriculum/script/protocol that is not called a treatment manual.
3. No indication of a treatment manual /script/protocol.

**[---]**

[brand\_des]

List the name and acronym for the name brand treatment(s) that was provided

NOTE: The authors must specifically refer to the named treatment (e.g., "adolescents received Brief Strategic Family Therapy") to be eligible for this code. It is not sufficient for the authors to merely state commonly used therapy components from a branded treatment to be coded here — that will be captured in the generic program codes.

Common name brand treatments include:

ACC — Assertive Continuing Care

ACRA — Adolescent Community Reinforcement Approach

APT — Adolescent Portable Therapy

CHS — Chestnut Health Systems Treatment Manual

DYC — Dynamic Youth Community, Inc.

EBFT—Ecologically-Based Family Therapy

EMPACT — Suicide Prevention Center Teen Substance Abuse Treatment Program

FFT — Functional Family Therapy

FSN — Family Support Network

IFCBT—Integrated Family and Cognitive Behavioral Therapy

LC — La Cañada: Adolescent Substance Abuse Step-Down Treatment Model

MDFT — Multidimensional Family Therapy

MET/CBT-5 — Motivational Enhancement Therapy/Cognitive Behavioral Therapy - 5 sessions

MET/CBT-7 — MET/CBT5 +2 family sessions

MET/CBT-12 — MET/CBT5 + 7 more CBT sessions

MMTC — Mountain Manor Treatment Center

MST — Multisystemic Therapy

PACM — Phoenix Academy Clinical Manual

PBFT — Purdue Brief Family Therapy

SC/7C — Seven Challenges

SS—Seeking Safety

TRTM — Thunder Road Treatment Manual

**[g80]**

[format]

Check all of the formats used in the treatment sessions (Note: The primary emphasis of this question is on who was typically present with the juvenile during treatment).

[g80anew] \_\_ Juvenile alone (self-administered treatment, e.g., bibliotherapy)

[g80bnew] \_\_ Juvenile and provider(s), one on one (e.g., individual counseling)

[g80cnew] \_\_ Juvenile group and provider(s)

[g80dnew] \_\_ Juvenile with family/parents and provider(s)

[g80enew] \_\_ Cannot tell

[g80gnew] \_\_ N/A: No tx rec’d

[g80fnew] \_\_ Other:

**[g3]**

[familv]

Presence/absence of family involvement in treatment components

* 1. Family present for most sessions
  2. Family absent for most sessions
  3. Family present sometimes

-9. Cannot tell

-8. N/A: No tx rec’d

**[g87]**

[mandated]

Client participation voluntary or mandatory

1 Voluntary; no overt or implied coercion

2 Voluntary but client may have been pressured or in coercive situation (e.g., volunteer when alternative is going to court)

3 Mandatory; required by controlling agency (e.g., court ordered, part of terms of probation, required program in custodial institution)

4 Mixed client participation

-8 N/A: No tx rec’d

**[g20]**

**[txdays]**

Duration of treatment in DAYS. Approximate (or exact) number of days for the period over which the adolescents received treatment, from first treatment event to last excluding follow-ups designated as such. Multiply weeks by 7; multiply months by 30.4; multiply years times 365; round to a whole number. Code -9 if cannot tell. Code -8 if n/a because group received no tx. Estimate for this item if necessary and if you can come up with a reasonable order of magnitude number (e.g., take the midpoint of a range if it is all that’s provided).

**[g22]**

[numsessions]

Approximate (or exact) frequency of contact between adolescent and provider or treatment activity. This refers only to the element of treatment that is different from what the control group receives or would have received had a control group been formed in treatment circumstances.

1 continuous (e.g., milieu therapy, residential substance use program)

2 daily contact (not 24 hours of contact per day but some treatment during each day, perhaps excluding weekends)

3 3-4 times a week

4 1-2 times a week

5 less than weekly

6 one day only (brief interventions)

-9 cannot tell

-8 N/A: no tx rec’d

**[g24]**

[hrsperwk]

Approximate (or exact) mean hours actual contact time between adolescent and provider or treatment activity per week if reported or calculable. Round to one decimal place. Code -8 for institutional, residential, or around the clock program; code -9 if not available. Assume that each counseling session is probably an hour long unless otherwise specified.

**[-]**

[devapp]

Is there explicit mention that the treatment program uses developmentally appropriate treatment approaches for youth in different developmental stages?

1. Not explicitly mentioned in description (no relevant information on this issue)
2. Explicitly mentioned in description of program

### *Drug Court Characteristics – Drug Court Studies Only*

**[--]**

**[dcyear]**

Year first opened (i.e., first client admitted) \_\_\_\_\_\_\_\_\_\_\_

**[--]**

**[dcviol]**

Does this drug court exclude violent offenders?

1. No
2. Yes

-9 Cannot tell

**[--]**

**[dcphases]**

Number of drug court phases.

0 court doesn’t use phases

-9 Cannot tell

**[--]**

**[dcuas]**

Number of drug tests per week in phase 1.

-9 Cannot tell

**[--]**

**[dchrngs]**

Number of status hearings per month in phase 1.

-9 Cannot tell

**[--]**

**[dcexit]**

What happens to charges/sentence upon graduation?

1. Dismissed/expunged
2. Reduced
3. Discretionary (i.e., judge decides on case-by-case basis)

-9 Cannot tell

**[--]**

**[dcnumprov]**

Number of treatment providers

1. Multiple providers
2. Single treatment provider

-9 Cannot tell

[**-]**

**[dcprocess]**

Method of case processing

1. Pre-adjudication-plea
2. Post-adjudication-plea
3. Uses both pre- and post-plea case processing

-9 Cannot tell

[**--]**

**[dcil]**

Length of primary intervention in months (weeks/4.3)

[**--]**

**[dcful]**

Length of aftercare or follow-up program in months (weeks/4.3).

**[--]**

**[dcebt]**

Does the drug court refer youth to a name brand treatment program?

1. No
2. Yes – all youth referred to name brand program
3. Yes – some youth referred to name brand program

-9 Cannot tell

[**--]**

**[dcpriors]**

Average number of prior offenses (any type) \_\_\_\_\_\_\_

[**--]**

**[dcdgpriors]**

Average number of prior drug-related offenses \_\_\_\_\_\_\_

**[--]**

**[dcelig]**

Were drug offenses (not just drug use) an eligibility criterion for participation in the drug court?

1. No
2. Yes

-9 Cannot tell

**[--]**

**[dcstaff]**

Is there explicit mention of a drug court clerk coordinator and/or case manager, or any other dedicated drug court staff besides the judge, attorney, or prosecutor?

1. Not mentioned in description (no relevant information on this issue)
2. Explicitly mentioned in description of program
3. Implied by description of program
4. Description implies or states that this strategy/practice is not used

**[--]**

**[dcrefloc]**

What levels of care (e.g., inpatient, outpatient, extended aftercare) of treatment programs were youth participants referred to?

1. One level of care (i.e., everyone was referred to the same level)
2. Multiple levels of care

-9 Cannot tell

**[--]**

**[dcrefmod]**

What modality (e.g., family therapy, cognitive behavioral therapy, group counseling) of treatment programs were youth participants referred to?

1. One modality
2. Multiple modalities

-9 Cannot tell

**[--]**

**[dcconting]**

Are participants given a written document the explains the behavioral contingencies of the program, that is, sanctions for program failures and rewards for program successes?

1. No
2. Yes

-9 Cannot tell

**[--]**

**[dcriskassess]**

Is there explicit mention of the use of a risk assessment tool (e.g., LSI-R).

1. Not mentioned in description (no relevant information on this issue)
2. Explicitly mentioned in description of program
3. Implied by description of program
4. Description implies or states that this strategy/practice is not used

**[--]**

**[dcdedicated]**

What is the structure of the drug court within the larger court context?

1. Dedicated drug court
2. Drug court embedded in a juvenile/family court

-9 Cannot tell

[**--]**

**[dccapacity1]**

Average number of juvenile drug court participants per year \_\_\_\_\_\_\_

[**--]**

**[dccapacity2]**

Number of juvenile drug court participants in most recent year available \_\_\_\_\_\_\_

**The 16 Drug Court Strategies**

Indicate whether the description of the program makes mention of using the each of the strategies and practices listed below.

[**--]**

**[dcs1]**

**Collaborative planning** (Engage all stakeholders in creating an interdisciplinary, coordinated, and systemic approach to working with youth and their families.)

1. Not mentioned in description (no relevant information on this issue)
2. Explicitly mentioned in description of program
3. Implied by description of program
4. Description implies or states that this strategy/practice is not used

[**--]**

**[dcs2]**

**Teamwork (**Develop and maintain an interdisciplinary, non-adversarial work team.)

1. Not mentioned in description (no relevant information on this issue)
2. Explicitly mentioned in description of program
3. Implied by description of program
4. Description implies or states that this strategy/practice is not used

[**--]**

**[dcs3]**

**Clearly Defined Target Population and Eligibility Criteria (**Define a target population and

eligibility criteria that are aligned with the program’s goals and objectives.)

1. Not mentioned in description (no relevant information on this issue)
2. Explicitly mentioned in description of program
3. Implied by description of program
4. Description implies or states that this strategy/practice is not used

[**--]**

**[dcs4]**

**Judicial Involvement and Supervision (**Schedule frequent judicial reviews and adaption of this schedule as needed.)

1. Not mentioned in description (no relevant information on this issue)
2. Explicitly mentioned in description of program
3. Implied by description of program
4. Description implies or states that this strategy/practice is not used

[**--]**

**[dcs5]**

**Community Partnerships (**Build partnerships with community organizations to expand the range of opportunities available to youth and their families.)

1. Not mentioned in description (no relevant information on this issue)
2. Explicitly mentioned in description of program
3. Implied by description of program
4. Description implies or states that this strategy/practice is not used

[**--]**

**[dcs6]**

**Comprehensive Treatment Planning (**Tailor interventions to the complex and varied needs of youth and their families.)

1. Not mentioned in description (no relevant information on this issue)
2. Explicitly mentioned in description of program
3. Implied by description of program
4. Description implies or states that this strategy/practice is not used

[**--]**

**[dcs7]**

**Developmentally Appropriate Services** (Tailor treatment to the developmental needs of adolescents.)

1. Not mentioned in description (no relevant information on this issue)
2. Explicitly mentioned in description of program
3. Implied by description of program
4. Description implies or states that this strategy/practice is not used

[**--]**

**[dcs8]**

**Gender-Appropriate Services** (Design treatment to address the unique needs of each gender.)

1. Not mentioned in description (no relevant information on this issue)
2. Explicitly mentioned in description of program
3. Implied by description of program
4. Description implies or states that this strategy/practice is not used

[**--]**

**[dcs9]**

**Cultural Competence** (Create policies and procedures that are responsive to cultural differences and rain personnel to be culturally competent.)

1. Not mentioned in description (no relevant information on this issue)
2. Explicitly mentioned in description of program
3. Implied by description of program
4. Description implies or states that this strategy/practice is not used

[**--]**

**[dcs10]**

**Focus on Strengths (**Maintain a focus on the strengths of youth and their families during program planning and in every interaction between the court and those it serves.)

1. Not mentioned in description (no relevant information on this issue)
2. Explicitly mentioned in description of program
3. Implied by description of program
4. Description implies or states that this strategy/practice is not used

[**--]**

**[dcs11]**

**Family Engagement (**Recognize and engage the family as a valued partner in all components of the program.)

1. Not mentioned in description (no relevant information on this issue)
2. Explicitly mentioned in description of program
3. Implied by description of program
4. Description implies or states that this strategy/practice is not used

[**--]**

**[dcs12]**

**Educational Linkages (**Coordinate with the school system to ensure that each participant enrolls in and attends an educational program that is appropriate to his or her needs.)

1. Not mentioned in description (no relevant information on this issue)
2. Explicitly mentioned in description of program
3. Implied by description of program
4. Description implies or states that this strategy/practice is not used

[**--]**

**[dcs13]**

**Drug Testing (**Design drug testing to be frequent, random, and observed. Document testing policies and procedures in writing.)

1. Not mentioned in description (no relevant information on this issue)
2. Explicitly mentioned in description of program
3. Implied by description of program
4. Description implies or states that this strategy/practice is not used

[**--]**

**[dcs14]**

[**--]**

**[dcs15]**

**Goal-Oriented Incentives and Sanctions (**Respond to compliance and noncompliance with

incentives and sanctions that are designed to reinforce or modify the behavior of youth and their families.)

1. Not mentioned in description (no relevant information on this issue)
2. Explicitly mentioned in description of program
3. Implied by description of program
4. Description implies or states that this strategy/practice is not used

[**--]**

**[dcs16]**

**Confidentiality** (Establish a confidentiality policy and procedures that guard the privacy of the

youth while allowing the drug court team to access key information)

1. Not mentioned in description (no relevant information on this issue)
2. Explicitly mentioned in description of program
3. Implied by description of program
4. Description implies or states that this strategy/practice is not used

## Outcomes

**Step 1. Study and DV Identification**

Create one record for each dependent variable that you will be coding. If the study measures alcohol use and delinquency, you will have two dependent variable records. This is different from the number of times a dependent variable is measured in a study. For example, if the study measures amphetamine use before and after treatment, you will have only one record here – for the amphetamine use measure.

**[varno]**

[varid]

Variable number. This number is an identification number for the dependent variable you are coding. Each dependent variable is numbered consecutively, within the study you are coding so that each has a unique VarNo for that study. If there is only one dependent measure for this study, you will create only one record in this worksheet, and the variable number will be 1. If there are three dependent measures, they will be numbered 1, 2, and 3.

**[dvdes]**

Write in a brief description of the dependent measure you are coding. This should include the authors’ label for this variable (e.g., alcohol related problems, average number of re-arrests), the instrument (e.g., Rutgers Alcohol Problem Index), the direction of scoring (e.g., lower scores are better), and information about what is being measured (e.g., problems associated with drinking, etc.). Quote or closely paraphrase the description that is provided in the original report.

**[dv1]**

[dvmacro]

Construct Group

1. Substance Use/Abuse
2. Criminal Recidivism
3. Other Characteristics Used for Group Equivalence Effect Sizes

**[dv2]**

[dvmicro]

Specific Construct. Following is a list of specific constructs for each construct group.

**01 Substance Use/Abuse**

86 Alcohol: Any measure of alcohol use or alcohol related problems

87 Marijuana: Any measure of marijuana use or marijuana related problems

88 Mixed Substance Use: Any substance use that includes alcohol or marijuana mixed with another substance

89 Other Specific Substance: Use of drugs other than alcohol or marijuana; can be use of one drug or use of a combination of drugs that does not include alcohol or marijuana

**02 Criminal Recidivism**

24 General recidivism: Arrest, conviction, re-incarceration, revocation, technical supervision violation, or other criminal involvement recidivism measure.

1. Drug recidivism: Drug arrest, conviction, re-incarceration, revocation, technical supervision violation, or other criminal involvement recidivism measure R: number of arrests.

**03 Other Characteristics Used for Group Equivalence Effect Sizes**

65 Gender:

66 Race/Ethnicity:

67 Age:

72 Other Measure of Comorbidity, Risk, Substance Use:

**[dv5]**

**[dvrecid]**

Type of recidivism outcome.

1 Arrest

2 Conviction

3 Incarceration

4 Revocation

5 Technical supervision violation

1. Other

-8 Not applicable (not a recidivism outcome)

-9 Cannot tell

**[dv5]**

**[dvsource]**

Source of information. Who provided the original information for this dependent variable?

1 Self-report (including subject filling out survey)

2 Other report

6 Official records (e.g., court, school)

7 Physiological (e.g., urine testing)

8 Multiple sources, cannot tell which is dominant

-9 Cannot tell

**[dv31]**

[dvtype]

Type or format of instrument.

1 Standardized measure

2 Unstandardized questionnaire or survey (ad hoc measure)

3 Therapist/doctor diagnosis

4 Official records (court or school)

5 Direct observation (including physical tests)

-8 Not applicable

-9 Cannot tell

**[dv18]**

[dvsucat]

Substance use measurement.

1 Yes/no use

2 Yes/no heavy use

3 Frequency of use

4 Frequency of heavy use

5 Quantity of use

6 Quantity of heavy use

7 Multi-item scale

9 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

-8 Not applicable (i.e., non-substance related outcome)

**[dvsucat\_other]**

If other, please specify

**[dv30]**

**[dvdays]**

Number of Days: Enter the number of days over which outcome was counted. Enter -8 if N/A mainly for the multidimensional measures that don’t have specific time frames.

Note that the time frame refers to the number of days over which drug use was counted. Thus, a question that asks subjects how many joints they smoked per week since getting out of treatment 6 months prior would have a time frame of 182.4 days (not 7 days).

**[dv18]**

[dvoverlap]

Does the outcome measurement period overlap with adolescents’ participation in the treatment or drug court program?

1. Completely
2. Partially
3. No overlap

-9 Cannot tell

[--]

[dvdelcat] Elements reported in this delinquency measure irrespective of type incident and reporting source (check best one):

1. global dichotomy or polychotomy (e. g., offended or recidivated, yes/no)
2. summed dichotomous (e.g., sum of yes/no on list of specific offenses)
3. frequency or rate, (count of incident; incidents per 1000 persons)
4. severity (seriousness rating or index)
5. event timing (e.g., days without recidivism; time to first offense)
6. proportion or amount of time in custody, under supervision, etc.
7. rating of amount of delinquency, severity, change, etc. (e.g., therapist rating of extent delinquent behavior improved)
8. more than one of above elements combined in composite measure
9. other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

-9 cannot tell

**[dvdelcat \_other]**

If other, please specify.

## Effect Sizes

Although this is the final section of coding, it is a good idea to identify at least one codable effect size before you start coding a study, because studies that appear eligible frequently end up presenting data that cannot be coded into an effect size.

This portion of coding requires familiarity with some basic statistics, including means, standard deviations, proportions, t-tests, chi-squares, ANOVA (or F-tests), and the like.

**[reportID]**

[reportid]

Report ID for this effect size. Indicate the report number (e.g., 2098.01) for the report in which you found the information for this effect size. This is important so that we can find the source information for the effect sizes later on, if necessary, and is especially important for studies with multiple reports.

**[pagenum]**

[page]

Page number for this effect size. Indicate the page number of the report identified above on which you found the effect size data. If you used data from two different pages, you can type in both, but use a comma or dash between the page numbers.

**[--]**

[estype]

Type of effect size you are coding.

1. Pretest
2. Group equivalence
3. Posttest

There are 3 types of effect sizes that can be coded: pretest, posttest, and group equivalence (or baseline similarity) effect sizes. They are defined as follows:

* **Pretest effect size**. This effect size measures the difference between a treatment and comparison group (control or another treatment) before treatment (or at the beginning of treatment) on the samevariable used as an outcome measure, e.g., substance use measured before the treatment begins is used as a pretest for substance use measured the same way after the treatment ends.
* **Group equivalence effect size**. Group equivalence effect sizes are used to code the equivalence of two groups prior to treatment delivery on variables that might be related to outcome.

The only eligible variables for group equivalence effect sizes are: (a) gender, (b) age, (c) race/ethnicity, (d) psychiatric comorbidity and variables relating to (e) risk of substance use/delinquency or (f) prior substance use/delinquency.

A pretest that is used later in the study as a posttest would not be coded here – you would code it as a pretest effect size. If the study reports group equivalence outcome data for multiple psychiatric comorbidity, risk factor, and/or prior use/delinquency variables, group equivalences effect size information should be coded for up to four variables in these categories. Thus 7 is the maximum number of group equivalence effect sizes that should be coded (1 for gender, 1 for age, 1 for race/ethnicity, up to 4 for psychiatric comorbidity/risk factors/prior substance use/delinquency). If more than four variables are available, code the four most relevant ones. When deciding which are most relevant, use the following criteria:

1. First preference should be given to behavioral measures (e.g., prior substance use, reported delinquent behavior, association with delinquent peers).

2. Second preference should be given to measures of psychological conditions, predispositions, or attitudes (e.g., depression, conduct disorder, impulsivity, sensation seeking, deviant attitudes).

3. Lowest preference should be given to broad measures of social disadvantage or family history (e.g., socioeconomic status of parents, residence in inner-city, family substance use disorder).

• **Posttest effect size.** This effect size measures the difference between two groups after treatment intake on some outcome variable. Thus, a posttest can occur during treatment (after intake), right after treatment ends, or anytime after treatment ends.

***Group Selection***

**[es40]**

[esgroup1]

Group 1

If you are coding a treatment-control effect size, select the appropriate treatment group here. If you are coding a treatment-treatment effect size, select the focal treatment group here or, in neither is focal, select one here and the other as Group 2 below.

[**es41]**

[esgroup2]

Group 2

If you are coding a treatment-control effect size, select the appropriate control group here. If you are coding a treatment-treatment effect size, select the second of the two treatment groups here.

***Dependent Variable Selection***

**[varno]**

[varid]

Select the dependent variable for this effect size.

**[esx]**

[estiming]

Timing of measurement. Approximate (or exact) number of weeks after intake when measurement occurred. Divide days by 7; multiply months by 4.3. Enter -9 if cannot tell, but try to make an estimate if possible. ***[es47\_ck]***

***Effect Size Calculation and Data Entry***

It is now time to identify the data you will use to calculate the effect size and to calculate the effect size yourself if necessary (see below). Effect sizes can be calculated ONLY from data based on the number of subjects, e.g., mean number of drinks per subject (and the corresponding standard deviation) or proportion of subjects who drank during a given time period. Effect sizes can NOT be calculated from data based solely on the incidence of events, e.g., total number of drinks per group. THIS IS VERY IMPORTANT—BE SURE YOU KNOW WHICH KIND OF DATA YOU HAVE.

You need to determine what effect size format you will use for each effect size calculation. There are two general formats you can use, each with its own section in Filemaker:

1. Compute ES from means, sds, variances, test statistics, etc.

2. Compute ES from frequencies, proportions, contingency tables, odds, odds ratios, etc.

Also note that within each of the above effect size formats, effect sizes can be calculated from a variety of statistical estimates; to determine which data you should use for effect size calculation, please refer to the following guidelines in order of preference:

1. Compute ES from descriptive statistics if possible (means, sds, frequencies, proportions).

2. If adequate descriptive statistics are unavailable, compute ES from significant test statistics if possible (values of t, F, Chi square, etc.).

3. If significance tests statistics are unavailable or unusable but p value and degrees of freedom (df) are available, determine the corresponding value of the test statistic (e.g., t, chi-square) and compute ES as if that value had been reported.

Note that if the authors present both covariate adjusted and unadjusted means, you should use the covariate adjusted ones. If adjusted standard deviations are presented, however, they should not be used.

**[es17]**

[esfavor]

Which group is favored?

For treatment-control comparisons, the treatment group is favored when it does “better” than the control group. The control group is favored when it does “better” than the treatment group.

For treatment-treatment comparisons, the treatment 1 group is favored when it does “better” than the treatment 2 group (i.e., the comparison group). The treatment 2 group is favored when it does “better” than the treatment 1 group.

For group equivalence comparisons, the treatment group is favored when it is at lower risk of substance use than the control group (i.e., when respondents are female, younger in age, White (for drug court studies), have lower psychiatric comorbidity, are less at risk, and have lower prior substance use, or lower prior delinquency). In the case of treatment-treatment group equivalence comparisons, the treatment 1 group is favored when it is at lower risk of substance use than the treatment 2 group (i.e., the comparison group).

Remember that you cannot rely on simple numerical values to determine which group is better off. For example, a researcher might assess the amount of substance use, and report this substance use in terms of the number of drinks per subject per day. Less substance use/delinquency is better than more, so in this case a lower number, rather than a higher one, indicates a more favorable outcome.

Sometimes it may be difficult to tell which group is better off because a study uses multi-item measures in which it is unclear whether a high score or a low score is more favorable. In these situations, a thorough reading of the text from the results and discussions sections usually can bring to light the direction of effect – e.g., the authors will often state verbally which group did better on the measure you are coding, even when it is not clear in the data table.

Note that if you cannot determine which group has done better, you will not be able to calculate a numeric effect size. (You will still be able to create an effect size record—just not a numeric effect size.)

Select the group that has done “better”:

1 Treatment (or Treatment 1 for Tx-Tx comparisons)

2 Control (or Treatment 2 for Tx-Tx comparisons)

3 Neither, Exactly Equal

-9 Cannot tell

**[es23]**

[esdata]

Effect size derived from what type of statistics?

1 N successful/unsuccessful (frequencies)

2 Proportion successful/unsuccessful (percentage successful or not)

3 Means and SDs; means and variances; means and standard errors

4 Independent t-test

5 Chi-square statistic (1 degree of freedom)

6 Effect sizes as reported directly in the study

7 Other statistical approximation

**[es50]**

[esadj]

For this effect size, did you use adjusted data (e.g., covariate adjusted means) or unadjusted data? If both unadjusted and adjusted data are presented, you should use the adjusted data for the group means or mean difference, but use unadjusted standard deviations or variances. Adjusted data are most frequently presented as part of an analysis of covariance (ANCOVA). The covariate is often either the pretest or some personal characteristic such as socioeconomic status. If you encounter data that is adjusted using something other than a covariate, please see Emily.

1 Unadjusted data

2 Pretest adjusted data (or other baseline measure of an outcome variable construct)

3 Data adjusted on some variable other than the pretest (e.g., socioeconomic status)

4 Data adjusted on pretest plus some other variables

**Assigned and Observed N**

Assigned N, Observed N. These fields refer to the number of subjects who were originally assigned to the group(s) involved in this effect size (Assigned N) and to the number of subjects who were actually “observed” or “measured” (Observed N). If you cannot tell how many subjects were originally assigned to a group, look at the number of subjects (Observed N) at pretest; you can frequently use pretest sample sizes for assigned N. However, in cases where the authors have removed the subjects who do not have both pretest and posttest measures (such that the pretest N and the posttest N are the same), do not assume that the number of subjects at pretest is the correct number for Assigned N and, instead, leave this field blank. In cases where there is no attrition, the Assigned N is the same as the Observed N. Only use the same numbers for Assigned N and Observed N when you are SURE that there is no attrition.

**[es36]**

**[estxasn]**

Assigned N for the treatment group

**[es37]**

[esctasn]

Assigned N for the comparison group

**[es1]**

[estxobn]

Observed N for the treatment group

**[es2]**

[exctobn]

Observed N for the comparison group

**[es9]**

[estxmean]

Mean for treatment group

**[es10]**

**[esctmean]**

Mean for comparison group

**[es13]**

**[estxsd]**

Standard deviation for treatment group

**[es25]**

[esctsd]

Standard deviation for comparison group

**[es31**]

[escella]

N successful for treatment group

**[es32]**

[escellc]

N successful for comparison group

**[es86]**

[escellb]

N failed for treatment group

**[es87]**

[escelld]

N failed for comparison group

**[es33]**

[esindt]

Independent t-value

**[es35]**

[eschisq]

χ2 (df=1)

**[es74]**

[esauth]

Effect size reported by authors

**[es60]**

[esor]

Odds ratio reported by authors

***Final Effect Size Determination***

**[es21]**

[es\_fmsmd]

Effect size value- standardized mean difference

**[es81]**

[es\_fmor]

Effect size value- odds ratio

Remember that you cannot rely on simple numerical values to determine which group has done better. For treatment-control comparisons, a positive effect size should indicate that the treatment group did “better” on the outcome measure than the comparison group, while a negative effect size indicates that the comparison group did “better” than the treatment group, and a zero effect size means that the two groups are exactly equal on the measure.

You must make sure that the sign of the effect size matches the way we think about direction, such that the effect size is positive when the treatment group (or posttest) is better and negative when the comparison group (or pretest) is better.

Effect sizes can range anywhere from around –3 to +3. However, you will most commonly see effect sizes in the –1 to +1 range.

Note: If the authors report an effect size, include that in your coding and use it for the final effect size value if no other information is reported. However, if the authors also include enough information to calculate the effect size, always calculate your own and report it in addition to that reported in the study.

**[es39]**

[esprob]

Any problems coding this effect size?

# APPENDICES

## Appendix A: DSM Criteria for SUDs

**DSM-V Criteria for Substance Use Disorder:**

1. Taking the substance in larger amounts or for longer than the you meant to
2. Wanting to cut down or stop using the substance but not managing to
3. Spending a lot of time getting, using, or recovering from use of the substance
4. Cravings and urges to use the substance
5. Not managing to do what you should at work, home or school, because of substance use
6. Continuing to use, even when it causes problems in relationships
7. Giving up important social, occupational or recreational activities because of substance use
8. Using substances again and again, even when it puts the you in danger
9. Continuing to use, even when the you know you have a physical or psychological problem that could have been caused or made worse by the substance
10. Needing more of the substance to get the effect you want (tolerance)
11. Development of withdrawal symptoms, which can be relieved by taking more of the substance

**DSM-IV Criteria for Substance Abuse:**

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more of the following, occurring within a 12-month period:

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household).
2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use).
3. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct).
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).

**DSM-IV Criteria for Substance Dependence:**

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

1. Tolerance, as defined by either of the following:
   1. A need for markedly increased amounts of the substance to achieve intoxication or desired effect
   2. Markedly diminished effect with continued use of the same amount of the substance
2. Withdrawal, as manifested by either of the following:
   1. The characteristic withdrawal syndrome for the substance
   2. The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
3. The substance is often taken in larger amounts or over a longer period than was intended
4. There is a persistent desire or unsuccessful efforts to cut down or control substance use
5. A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain smoking), or recover from its effects
6. Important social, occupational, or recreational activities are given up or reduced because of substance use
7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption) .

## Appendix B: Substance Use Severity Classification

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Average Scale Scores** | | |
| **Scale Name** | **Low** | **Medium** | **High** |
| SPI- Substance Problem Index (GAIN) | 0 | 1-9 | 10-16 |
| SFI- Substance Frequency Index (GAIN) | 0 | .01-.13 | .14-1 |
| CWI – Current Withdrawal Index (GAIN) | 0 | 1-11 | 12-22 |
| ASI – Addiction Severity Index | 0-.33 | .34-.66 | .67-1 |
| PEI – Personal Experience Inventory | 0-33 | 34-66 | 67-100 |
| DUF – Drug Use Frequency from PEI | 1-2.33 | 2.34-4.66 | 4.67-7 |
| DAST – Drug Abuse Screening Test | 0-5 | 6-10 | 11-20 |
| TASI – Teen Addiction Severity Index | 1-1.66 | 1.67-3.33 | 3.34-5 |
| SUDI – Substance Use Density Index (GAIN) | 0 | 1-9 | 10-16 |
| SAI – Substance Abuse Issues (GAIN) | 0-.33 | .34-.66 | .67-1 |
| SDS – Substance Dependence Scale (GAIN) | 0-2 | 3-5 | 6-7 |
| SUDS – Substance Use Disorder Scale (GAIN) | 0-2 | 3-5 | 6-7 |
| AAIS – Adolescent Alcohol Involvement Scale (276.01) |  |  | 42-72 |
| SADD- Short Alcohol Dependence Data (2606.01) | 1-9 | 10-19 | 20+ |
| AUDIT – Alcohol Use Disorders Identification Test (297.01) | 8-15 | 16-19 | 20+ |

## Appendix C: Treatment Modality Descriptions

Behavior al Therapy/Contingency Management: Behavioral interventions with adolescents are most often presented as a form of contingency management. Contingency management is based on the behavioral principle that behavior which is reinforced or rewarded is more likely to occur in the future. Contingency management may take the form of monetary vouchers which are used to reward desired behaviors, such as negative drug screens. Other examples of behavior management include behavioral contracts and the use of a token economy.

Cognitive Behavioral Therapy (CBT)

CBT is defined as an intervention that helps the client recognize the situations in which they are most likely to use, avoid those situations when appropriate and cope with a range of problems and behaviors associated with substance abuse. CBT activities may include cognitive restructuring, functional analysis, skills training such as coping mechanisms and self management techniques, fostering the recognition of automatic thoughts, cognitive rehearsal, behavioral homework, systematic desensitization, relaxation techniques, and/or validity testing.

Family Therapy: Family therapy involves more than one member of a family in the same session. It generally addresses family relationships and processes and seeks to understand the individual within the context of the family. The person abusing drugs is seen as a subsystem within the family. Family therapy is sometimes called ‘systems therapy’. Family therapy includes Multidimensional Family Therapy (MDFT), Multisystemic Therapy (MST), Functional Family Therapy (FFT), Brief Strategic Family Therapy (BFST) & Ecological Family Therapy.

Generic Counseling: The term ‘counseling’ is occasionally used as being synonymous with ‘talk therapy’ or therapy in general. It is not psychotherapy. Instead, counseling focuses on day to day life issues that are less severe than those addressed in psychotherapy and is often provided by a Masters level clinician.

Motivation Enhancement/Motivation Interviewing (MI): The five strategies of MI include: expressing empathy through listening and accurate reflection, assisting the client in recognizing the discrepancy between the consequences of drug use and how they would like to their life to be, avoiding argumentation in order to reduce resistance, rolling with resistance by reflecting the clients ambivalence towards change, and supporting the clients belief that they can change by building on previous successes. Brief motivational interventions often include comparison of client drug or alcohol use to state or national norms. Reflective listening and the use of open ended questions are also standard.

Psycho-education Training (PET): Psycho-education is an instructional intervention that teaches the client (either individual or family) about substance abuse. Activities may include presentations by the group leader or therapist, topic focused discussion, assisting clients in identifying and naming symptoms and homework that reinforces the practice of new skills. Psycho-education requires less personal ‘work’ on the part of the client than do other interventions.

Skills Training: Skills training interventions are instructional interventions that teach the client specific, new skills and are sometimes called behavioral social skills training. Activities may include interpersonal skills building, behavioral-social skills building, assertiveness training, exercises in learning ‘how to say no’, anger management techniques and relapse prevention skills.

Psychopharmacology: The use of a psychoactive drug to affect thinking, feeling or behaviors. Examples of such drugs include: Methadone, Disulfiram, Fluoxetine (Prozac), Lithium and Naltrexone.