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The Seven Challenges® Comprehensive Counseling Program: Effectiveness for Adults with Substance Use Problems

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Abstract

This study examined the acceptability and effectiveness of The Seven Challenges®, a comprehensive substance use counseling program focused on decision making, compared with commonly provided, or "standard," cognitive-behavioral substance use treatment implemented with a focus on abstinence. Results, based on data from 71 adult drug court clients, indicated higher acceptability of The Seven Challenges than standard cognitive-behavioral treatment as reflected in treatment satisfaction, honesty, and disclosure, as well as perceived impact of treatment. Results also showed that The Seven Challenges was as effective as standard cognitive-behavioral treatment at improving vocational engagement and was more effective at reducing substance use, related problems, and internal mental distress. The Seven Challenges was also effective at reducing criminal activity, whereas clients of the standard cognitive-behavioral treatment appeared to increase criminal activity. These findings strengthen the existing evidence base of The Seven Challenges as a comprehensive counseling program addressing substance use, mental health problems, and criminality.

Keywords

The Seven Challenges, mental health, treatment, adult, substance abuse

The need for effective, evidence-based substance use treatment programs that take a comprehensive approach to addressing substance use and co-occurring problems is a national concern. Based on 2015 National Survey of Drug Use and Health (NSDUH) data, an estimated 15.5% of U.S. young adults aged 18 to 25 years and 7.2% of adults aged 26 years or older meet the definition of substance use disorder (SUD) and were in need of substance use treatment (Lipari, Park-Lee, & Van Horn, 2016). In addition to this need is the need for treatment of co-occurring problems as 39.1% of adults with a past-year SUD had a co-occurring mental illness (Center for Behavioral Health Statistics and Quality [CBHSQ], 2015). The cost of SUD is great as it is often associated with chronic health conditions (Clarke & Currie, 2009), poorer health outcomes (McCusker et al., 2007), crime (Bouchery, Harwood, Sacks, Simon, & Brewer, 2011), and involvement in the justice system (Glasheen, Hedden, Kroutil, Pemberton, & Goldstrom, 2012).

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Examining the effectiveness of substance use treatment programs that take a comprehensive approach, simultaneously addressing substance use–related problems as well as co-occurring problems, will help to build the pool of evidence-based programs to better serve adults in need of substance use treatment services.

The Seven Challenges® Program (http://www.sevenchallenges.com/; Schwebel, 2010, 2015, 2017) is a comprehensive counseling program that addresses substance use issues and co-occurring psychological and situational problems, such as internal mental distress, unstable housing, and unemployment. It teaches and motivates individuals to cope with co-occurring problems in positive ways without drugs. When The Seven Challenges was created in 1991, it was innovative in its approach to address the co-occurring nature of drug and other problems and provide integrated mental health and SUD counseling, giving equal weight to each.

The Seven Challenges uses a nonjudgmental approach that encourages self-evaluation and focuses on the decision-making process rather than insisting upon a particular behavior such as abstinence. Careful attention is paid to meeting clients at their own starting point and providing interventions that help them self-identify their own concerns and issues to make thoughtful decisions, including about criminal behavior, substance use, and other health-related behavior. In a field that has been dominated by an ideology calling for "abstinence-based" drug treatment, The Seven Challenges has allowed clients to make their own choices about drugs and has trained counselors in the importance of delivering the message, "You don't have to quit. It's not my job to tell you what to do. You make your own decisions" (Schwebel, 2010, 2015, 2017). The Seven Challenges' counselors emphasize the collaborative nature of the counseling process. To support this effort, counselors are reminded of the importance of explaining confidentiality (and its limits) to their clients, thus maximizing the possibility that their clients will explore whatever options they want to consider.

The Seven Challenges uses a motivational and behavior change model designed to account for the individuals' stage of change and the developmental challenges associated with the age of the individuals—whether they are adolescents or adults—with three core components. These include Mastery Counseling to support clients in solving their situational and psychological issues of greatest concern, The Seven Challenges decision-making process to help clients make fully informed decisions about their drug use and other behaviors, and Individualized Support to guide clients to success in their decisions to change their drug use. The theoretical underpinnings for the program synthesize the client-centered therapy of Carl Rogers (1951) with the practical problem-solving approach of transactional analysis (Berne, 1961) in which clients set their own therapeutic goals. The program also incorporates a Piagetian approach to understanding how people change their views of reality (Inhelder & Piaget, 1958), with more recent studies about the stages of behavioral change (Prochaska, DiClemente, Velicer, & Rossi, 1993).

The Seven Challenges decision-making process incorporates the cognitive/emotional public health model of decision making (Janis & Mann, 1977), encouraging individuals to weigh the benefits of particular behaviors against the associated costs. It also incorporates cognitive-behavioral and other strategies for behavior change. With regard to drugs, clients in counseling use seven distinct challenges related to self-appraisal, the process of informed decision making, and working toward enacting decisions. The Seven Challenges Program and these challenges are discussed in detail in the program manuals (Schwebel, 2010, 2015, 2017).

In the program, counseling is conducted in a client-centered manner. Face-to-face sessions are supplemented with Supportive Journaling in which clients and counselors interact in written communication. In addition, clients receive a book of basic readings. Because The Seven Challenges is client-focused, it is designed to be individualized and, therefore, quite flexible and adaptable to individuals in different stages of life. As such, the adolescent and adult versions of the program are the same in basics, yet different in strategies used to attract and engage clients. Developmentally, adolescents are working to establish their own independent identities; to

master formal logical thinking; and to prepare for adult roles. Thus, the program is presented to adolescents with a strong emphasis on self-determination, reassuring clients that adult counselors do not want to control them, and that they will have an opportunity to think through their drug use and their lives for themselves, determine where they stand in relationship to drugs, and make their own informed decisions. Efforts are made to avoid adolescent/adult power struggles.

The strategies used to attract and engage adult clients are different. Research shows that adults with SUD are disinclined to seek treatment (Ali, Teich, & Mutter, 2015), but for different reasons than for adolescents. NSDUH data indicate that 42% of adults in need of treatment do not go for it because they are "not ready to stop using alcohol or drugs" (Ali et al., 2015). In addition, a review of data from the National Epidemiologic Survey on Alcohol and Related Conditions (Schuler, Puttaiah, Mojtabai, & Crum, 2015) found that the most frequently endorsed barrier to seeking alcohol treatment was the attitude that they should be "strong enough" to handle it on their own. This review also cites other attitudinal factors that make treatment unappealing such as fear of stigma. Furthermore, almost half of adults in treatment went into treatment at least in part because of "legal coercion" (Hser, Maglione, Polinsky, & Anglin, 1998). For these and other reasons, The Seven Challenges' written material, program introduction, and engagement efforts for adults emphasize that clients will not be labeled or judged, will have an opportunity to be in charge of their own lives and make their own decisions (with the support of a counselor), and that there are various pathways to success, not limited by a requirement of immediate abstinence. Written materials for this population are presented in a respectful adult-to-adult voice, using the second person singular, "you," as the pronoun.

All provider agencies authorized by The Seven Challenges, LLC to provide The Seven Challenges Program are required to follow a standardized process to ensure program fidelity. Implementation begins with a 3-day Initial Training at the provider agency. Clinical supervisors attend an additional 3-day Leader Training where they learn advanced program skills and how to monitor for program fidelity. They are also taught and qualified to deliver the Initial Training to new hires. A trainer from The Seven Challenges, LLC facilitates quarterly support calls and an annual Support/Fidelity Visit. In addition, representatives from The Seven Challenges, LLC are available to lend clinical and implementation support as needed.

Research has shown that The Seven Challenges Program is effective at addressing substance use, related problems, and co-occurring problems with adolescents. Data have indicated that it is effective at reducing substance use and related problems (Korchmaros, in press; Korchmaros & Stevens, 2013; Stevens, Ruiz, & Schwebel, 2007), increasing treatment motivation (Stevens et al., 2007), decreasing mental health–related problems (Korchmaros, in press; Korchmaros & Stevens, 2013; Stevens et al., 2007), decreasing criminality (Korchmaros, in press), and increasing involvement in self-help activities (Korchmaros, in press) with adolescents. Furthermore, data indicated that The Seven Challenges Program was as effective as Strengths Oriented Family Therapy at reducing substance use and related problems in adolescents (Smith, Hall, Williams, An, & Gotman, 2006).

These findings have established an initial evidence base for The Seven Challenges Program, showing that it has been effective in addressing substance use and related co-occurring problems in adolescents. Studies are needed to build the evidence base of the effectiveness of The Seven Challenges Program with adults.

Purpose of Study

The present quasi-experimental, longitudinal study examined the acceptability and effectiveness of The Seven Challenges Program in general and in comparison with commonly used cognitive-behavioral substance use treatment. The acceptability and effectiveness of The Seven Challenges Program is examined in comparison with a cognitive-behavioral substance use treatment program

because cognitive-behavioral therapy (CBT) is currently a dominant therapeutic paradigm (Epp & Dobson, 2010) and The Seven Challenges Program incorporates components of CBT as part of its overall approach. Thus, this comparison examines the differential effectiveness of The Seven Challenges Program with programs of a similar theoretical basis for understanding and changing behavior. The present study examined program acceptability and effectiveness at 3 months post-program intake to assess immediate response to and impact of the programs after the most intensive treatment phase.

Critical to meeting the need for effective treatment that addresses substance use and co-occurring problems and disorders is identifying programs that are acceptable to clients because program participants are less likely to complete treatment and, thus, experience its full effectiveness if they do not find it acceptable. Because The Seven Challenges Program is individualized and meets clients where they "are at" in terms of developmental stage and stage of change and because of the combination of its nonjudgmental approach, its emphasis on confidentiality, and its empowerment of clients to make their own decisions, it is expected that acceptability—as reflected in treatment satisfaction, honesty and disclosure during treatment, and perceived impact of treatment—will be high and higher than that of commonly used cognitive-behavioral substance use treatment that does not take this same approach.

This study also examines the effectiveness of The Seven Challenges across multiple outcomes, including substance use, mental health, criminality, housing, and vocational engagement. The Seven Challenges Program and commonly used cognitive-behavioral substance use treatment are expected to achieve positive outcomes across these multiple areas because cognitive-behavioral approaches to substance use treatment are aimed at effecting the thought and decision-making processes underlying control of and choices related to external behaviors, with a particular focus on substance use and related issues. In addition, cognitive-behavioral approaches have generally been effective (Drummond et al., 2005; Epp & Dobson, 2010; Magill & Ray, 2009; Windsor, Jemal, & Alessi, 2015). However, it is also expected that The Seven Challenges Program will achieve better outcomes than the commonly used cognitive-behavioral treatment because of its client-centered, nonjudgmental approach; its emphasis on confidentiality; its empowerment of clients to make their own decisions; session-to-session support in maintaining behavioral change; and its equal emphasis on co-occurring situational and psychological problems through the use of the Mastery Counseling component.

Method

Participants

The initial sample included 91 participants in a drug-treatment court program. Seventy-one of these participants (78%) provided data at program intake and at 3 months post-intake and, thus, were included in the analytic sample. The participants who provided data only at program intake were excluded from the analytic sample. The analytic sample and the excluded participants were compared to determine the extent to which the analytic sample was representative of the excluded participants in terms of demographic characteristics, including gender identity, ethnicity, racial minority status, and age, and in terms of participant characteristics and behaviors assessed at program intake that are related to the outcome variables of interest, such as substance use and mental health. The specific characteristics and behaviors are listed in Table 3. The analytic sample and the excluded participants appear to be similar; they did not differ on any of the examined characteristics or behaviors (ps = .071 to .829). Additional statistics from the tests comparing the analytic sample and excluded participants are available upon request.

Of the analytic sample (N = 71), 35% were female identified, 14% identified as Hispanic, and 16% were of racial minority status. Their ages ranged from 18 to 58 years (M = 32.9).

Table 1. Treatment Satisfaction.

The counselors . . .	The Seven Challenges group (n = 33) M	Standard CBT group (n = 38) M	$t(df)$	p	d
Did a good job	100%	95%	1.33(67)	.094	0.32
Were fair with clients	97%	92%	0.88(69)	.191	0.21
Explained the rules of the program	97%	97%	−0.10(69)	.461	0.02
Had the time to see me	97%	100%	−1.08(67)	.143	0.26
Respected clients	100%	95%	1.35(68)	.090	0.33
Explained what my treatment was supposed to accomplish	94%	95%	−0.15(67)	.442	0.04
Asked for my opinions about my problems and how to solve them	100%	89%	1.94(69)	.028	0.47
Helped me do something about my alcohol and other drug use	100%	94%	1.35(66)	.091	0.33
Helped me do something about my other problems	100%	91%	1.73(66)	.044	0.43
Were sensitive to my cultural background	100%	94%	1.33(65)	.094	0.33
Gave me enough help for now	100%	95%	1.34(69)	.093	0.32

Note. CBT = cognitive behavioral therapy.

Measures

Participant characteristics and behaviors were measured based on self-report interviews using the standardized, reliable, and validated Global Appraisal of Individual Needs (GAIN; Dennis, Titus, White, Unsicker, & Hodgkins, 2003) supplemented with measures created specifically for the present study. Demographic characteristics of gender, ethnicity, race, and age were assessed with single GAIN items. Responses to the item querying race were recoded to reflect racial minority status, coded as 1 (vs. 0).

Fidelity to The Seven Challenges was assessed in two ways. The developer of The Seven Challenges conducted a site visit 3 months after the start of the study to assess treatment fidelity by observing treatment sessions and reviewing the client/counselor interaction in the written journals. Treatment fidelity was also assessed at 3 months post-intake with a 12-item scale. These items were designed to assess the extent to which counselors acted in alignement with key components of The Seven Challenges. For all items, participants reported the extent to which their counselor acted in alignment with components of The Seven Challenges on a scale ranging from 0 (*not at all*) to 4 (*a great extent*). Items queried, for example, the extent to which the counselor gave participants a chance to discuss the issues that were most important to them during their sessions. Responses to all items were averaged to create a composite score reflecting treatment fidelity, with larger values reflecting greater fidelity. Internal consistency was high, Cronbach's $\alpha = .92$.

Treatment satisfaction was assessed at 3 months post-intake with 11 items from the GAIN treatment satisfaction scale (Table 1). Responses were coded to reflect participants' perceptions of their counselor's performance and treatment of them (1 vs. 0).

Honesty during treatment was assessed at 3 months post-intake with one item that queried the extent to which participants had been *not honest at all* (0%) to *completely honest* (100%). Disclosure during treatment was assessed at 3 months post-intake (a) with one item that queried

Table 2. Perceived Impact of Treatment.

	The Seven Challenges group (n = 33) M	Standard CBT group (n = 38) M	$t(df)$	p	d
Extent have more control over life since getting treatment	3.27	2.55	3.14(69)	.001	0.76
Extent other people have less control over life since getting treatment	2.76	1.82	3.47(69)	<.001	0.84
Extent have improved problem-solving skills since getting treatment	3.24	2.68	3.16(69)	.001	0.76
Extent reached goals since getting treatment	3.21	2.76	2.02(69)	.024	0.49
Extent gain control over drug use since getting treatment	3.81	2.87	4.83(68)	<.001	1.17
Extent able to reduce the harm from drug use since getting treatment	3.50	2.86	2.40(67)	.010	0.59
Extent changed to safer ways of using drugs since getting treatment	2.40	1.17	2.84(64)	.003	0.71
Extent there are unfair and oppressive conditions in your life	1.79	2.70	−3.13(68)	.002	0.76
Extent conditions of life (other than with the court) improved since getting treatment	3.18	2.66	2.13(69)	.018	0.51
Extent family life improved since getting treatment	3.12	2.95	0.63(69)	.266	0.15
Extent employment situation improved since getting treatment	3.35	1.97	4.19(67)	<.001	1.02
Extent situation with the court improved since getting treatment	3.38	2.66	2.49(68)	.008	0.60
Extent relationships with friends improved since getting treatment	2.73	2.00	2.06(69)	.022	0.50
Extent relationships with family improved since getting treatment	3.30	2.89	1.45(69)	.076	0.35
Extent treatment really helped you with your drug use	3.50	2.76	2.85(68)	.003	0.69
Extent treatment really helped you with the rest of your life	3.27	2.49	3.03(68)	.002	0.73

Note. CBT = cognitive behavioral therapy.

the extent to which participants had revealed personal issues from *did not disclose at all* (0%) to *self-disclosed very much* (100%) and (b) using the self-disclosure index (Miller, Berg, & Archer, 1983) somewhat modified. Instead of querying disclosure related to "things they wouldn't do in public," "their deepest feelings," and "their worst fears," participants were queried about "things they could get in trouble for," "their deep feelings," and "their fears." Newly created items queried things they "have done that embarrass them," "have hidden from other counselors," and "have hidden from their family." For all items, participants reported extent of disclosure ranging from *did not discuss it at all* (0) to *discussed it fully and completely* (4). Responses to all items were averaged to create a composite score with larger values reflecting greater disclosure. Internal consistency was high, Cronbach's $\alpha = .90$.

Table 3. Change Over Time From Intake to 3 Months Post-intake by Treatment Group.

	The Seven Challenges group (n = 33)		Standard CBT group (n = 38)		Main effect of time			Time by type of treatment interaction effect		
	Intake %/M	3 months post-intake %/M	Intake %/M	3 months post-intake %/M	$F(df)$	p	Partial η^2	$F(df)$	p	Partial η^2
Housing and vocational engagement										
Homeless in past 90 days	15.2%	12.1%	5.3%	5.3%	0.16 (1, 69)	.690	.002	0.16 (1, 69)	.690	.002
Currently employed or in school	60.6%	93.9%	55.3%	81.6%	20.95 (1, 69)	<.001	.233	0.29 (1, 69)	.592	.004
Substance use and related problems										
Substance use in past 90 days	60.6%	18.2%	52.6%	36.8%	17.87 (1, 69)	<.001	.206	3.74 (1, 69)	.057	.051
Days drunk or high most of the day in past 90 days	12.55	0.30	8.34	7.55	9.11 (1, 69)	.004	.117	7.04 (1, 69)	.010	.093
Any use of alcohol in past 90 days	54.5%	9.1%	18.4%	10.5%	16.56 (1, 69)	<.001	.194	8.21 (1, 69)	.006	.106
Any use of THC in past 90 days	27.3%	0.0%	15.8%	7.9%	11.33 (1, 69)	.001	.141	3.44 (1, 69)	.068	.047
Any use of methamphetamine in past 90 days	36.4%	6.1%	28.9%	18.4%	12.28 (1, 69)	.001	.151	2.88 (1, 69)	.094	.040
Days of abstinence from using substances in past 90 days	74.79	86.52	79.11	80.87	6.92 (1, 69)	.010	.091	3.78 (1, 69)	.056	.052
Substance Frequency Scale	0.91	0.18	0.68	0.50	20.15 (1, 69)	<.001	.226	7.15 (1, 69)	.009	.094
Substance Problem Scale	0.24	0.00	0.21	0.29	1.73 (1, 69)	.193	.024	6.69 (1, 69)	.012	.088
Mental health										
Emotional Problem Scale	1.03	0.82	1.18	1.18	1.64 (1, 69)	.205	.023	1.64 (1, 69)	.205	.023
Internal Mental Distress Scale	0.97	0.39	0.61	0.50	20.45 (1, 69)	<.001	.229	9.76 (1, 69)	.003	.124
Behavior Complexity Scale	0.55	0.39	0.45	0.45	0.93 (1, 69)	.340	.013	0.93 (1, 69)	.340	.013
Criminal activity										
Engaged in activities that could get you in trouble in past 90 days	45.5%	27.3%	50.0%	68.4%	0.00 (1, 69)	.987	<.001	6.63 (1, 69)	.012	.088
Amount of crimes committed in the past 90 days	0.55	0.24	0.68	1.05	0.08 (1, 69)	.776	.001	8.61 (1, 69)	.005	.111

Note. CBT = Cognitive behavioral therapy; THC = tetrahydrocannabinol.

Perceived impact of treatment was assessed at 3 months post-intake with items that assessed the extent to which treatment affected participants' lives on a scale from 0 (*not at all*) to 4 (*to a great extent*). The items queried, for example, the extent participants felt that they have more control over their lives since getting treatment (Table 2).

In response to GAIN items, participants reported at intake and 3 months post-intake whether they were homeless in the past 90 days and whether they were currently employed and/or in school. Responses were coded to reflect homelessness (1 vs. 0) and current vocational engagement (1 vs. 0).

Multiple GAIN variables that represent substance use and related problems were utilized at intake and 3 months post-intake. Substance use in the past 90 days was coded based on responses to multiple items that queried use of different types of drugs in the past 90 days. Recent days of relatively severe alcohol and other drug (AOD) use was based on one item that asked how many of the past 90 days participants were drunk or high for most of the day. Separate single GAIN items were used to assess use of any alcohol, use of tetrahydrocannabinol (THC), and use of methamphetamine during the past 90 days. Days of abstinence in the past 90 days is based on one item that asked on how many of the past 90 days participants went without using any alcohol, marijuana, pills, or other drugs. The multiple-item Substance Frequency Scale reflects reported frequency of substance use, staying high most of the day, and substance use causing problems during the past 90 days ranging from 0 (*no use*) to 2 (*high severity use*). The multiple-item Substance Problem Scale reflects the amount of substance problems clients have experienced during the past 30 days coded for severity of the problems where 0 = *no substance problems*, 1 = *substance abuse*, and 2 = *substance dependence*.

Multiple GAIN variables that represent mental health problems were utilized at intake and 3 months post-intake. These items were modified from the original GAIN items so that they reflect problems experienced in the past 90 days. The multiple-item Emotional Problem Scale reflects severity of emotional problems during the past 90 days ranging from 0 (*no problems*) to 2 (*high severity problems*). The multiple-item Internal Mental Distress Scale reflects amount of internal mental distress symptoms experienced during the past 90 days from *no symptoms* (0) to *high severity symptomatology* (2). The multiple-item Behavior Complexity Scale reflects the amount of problems controlling external behavior experienced during the past 90 days from *no symptoms* (0) to *high severity symptomatology* (2).

Two GAIN variables were utilized to assess criminal activity at intake and 3 months post-intake. Engagement in activities that could get participants in trouble in the past 90 days was based on one item. Amount of crimes reflects the total number of property, drug, and violent/interpersonal crimes committed during the past 90 days recoded to range from 0 (*no crimes committed*) to 2 (*more than 10 crimes committed*) to address the skewed distribution.

Procedure

Participants were recruited from an outpatient substance use treatment agency that had three sites serving mainly clients of drug courts. All adult substance use treatment clients at any of three agency sites who were mandated to treatment as a condition of drug court were invited to participate in the study. Of the 95 clients invited, 91 (95.8%) consented to participate. Participants were assigned to treatment based on the particular agency site at which they received treatment, which was determined by proximity to where the participant lived. Participants who were clients of this agency receiving treatment from Site A received The Seven Challenges—the The Seven Challenges group. Participants who were clients of this agency who received treatment from the other two sites received commonly used cognitive-behavioral substance use treatment—the Standard CBT group. Study participants were recruited on an ongoing basis over the course of 18 months as they entered treatment.

The commonly used cognitive-behavioral substance use treatment provided to the Standard CBT group consisted of Dialectical Behavior Therapy (DBT; Dimeff & Linehan, 2001) and Moral Reconation Therapy® (MRT; Ferguson & Wormith, 2013). DBT is a cognitive-behavioral psychotherapy initially developed to treat borderline personality disorder. Since its development, it has been used to treat people suffering from mood disorders as well as people who need to change unhealthy or risky patterns of behaviors such as substance use. MRT, developed for a prison-based therapeutic community, is a cognitive-behavioral program for substance use treatment that focuses on enhancing moral reasoning, better decision making, and more appropriate behavior.

Amount of treatment sessions and time involved in treatment for all participants were dictated by the drug court as a condition of their mandated treatment. Thus, amount of sessions and amount of time with counselors did not vary by type of treatment—The Seven Challenges or Standard CBT. All study participants were mandated to a yearlong step-down program with four distinct 3-month-long phases. These phases were the same for all participants in terms of intensity of treatment as well as extent of drug court supervision regardless of whether they received The Seven Challenges or the Standard CBT. The court personnel monitoring clients' behavior were not aware of client participation in the study or of clients' assignment to treatment group. During the present study, clients received Phase 1 of this four-phase program. Phase 1, the most intensive treatment phase, occurs during the first 3 months of treatment post-intake and consists of two 2-hr group therapy sessions a week and one 1-hr individual session a week.

As is standard practice in drug courts generally, the standard practice within this provider agency for its drug court clients was for counselors to report any rules broken, including substance use to the drug court team. As part of using The Seven Challenges Program, the provider agency was urged to renegotiate with the court for more limited disclosures, including about drug use. Agency staff were trained in how to broach the topic. As a result of negotiations between agency staff and the court, the drug court teams of clients receiving The Seven Challenges agreed that counselors could limit their disclosure of rules broken, including about drug use, to a greater extent than they had in the past. In contrast, the Standard CBT clients operated under standard practice where all rules broken would be reported to their drug court teams. Thus, the cognitive-behavioral substance use treatment provided to the Standard CBT group was implemented with a focus on abstinence, which is a common occurrence given that there are 3,057 drug courts in the United States (Marlowe, Hardin, & Fox, 2016) and that almost half of adults in treatment went into treatment at least in part because of "legal coercion" (Hser et al., 1998).

Agency staff acted as research assistants (RAs). They recruited and collected data from study participants at program intake (pretreatment) and 3 months post-intake (immediately post-Phase 1 treatment, henceforth referred to as post-treatment). These RAs were not involved in providing substance use treatment to the study participants they recruited and from whom they collected data. The RAs met individually and privately with study participants for data collection sessions lasting about 60 min during which they read the survey questions aloud and recorded responses to decrease challenges related to literacy. At the start of each session, the RAs informed participants of their rights as participants and that their participation and responses would be confidential and not affect the services they receive from the treatment agency nor their court status. All RAs were trained in ethical conduct of human subjects research and the study was approved by the University of Arizona Institutional Review Board.

Analysis

Two-tailed independent-samples *t* tests were used to examine differences between the analytic sample and excluded participants. With the analytic sample, one-tailed independent-samples *t* tests were used to test the hypotheses of the present study related to differences between The

Seven Challenges and Standard CBT groups in dependent variables assessed only at 3 months post-intake. To examine treatment outcomes, with the analytic sample, mixed-model analyses of variance were used to examine differences between The Seven Challenges and Standard CBT groups in change over time from program intake to 3 months post-intake. The main effect of time examines change over time from program intake to 3 months post-intake on average for all participants regardless of type of treatment and, thus, assesses the impact of treatment on outcomes. The Time × Type of treatment interaction effect examines the difference between The Seven Challenges and Standard CBT groups in change over time in the outcomes from program intake to 3 months post-intake. Thus, this interaction effect assesses whether The Seven Challenges had a differential impact on outcomes compared with the Standard CBT.

For analyses testing hypotheses, results include both statistical significance and effect size. The reported effect sizes are partial eta squared (partial η^2) and Cohen's d (Cohen, 1988). Partial η^2 indicates the proportion of the variance in the outcome (e.g., days of abstinence) that is accounted for by the independent variable. Cohen's d indicates the standardized difference between two groups (e.g., average self-disclosure of participants in The Seven Challenges group vs. average self-disclosure of participants in the Standard CBT group). By Cohen's (1988) standards, a partial η^2s of .01 reflects a small-sized effect, .06 reflects a moderately sized effect, and .14 reflects a large-sized effect; a Cohen's d of 0.20 reflects a small-sized effect, 0.50 reflects a moderately sized effect, and 0.80 reflects a large-sized effect.

Results

Fidelity to The Seven Challenges

Based on in person observations of treatment sessions, the developer of The Seven Challenges determined that counselors were implementing The Seven Challenges with high quality and good fidelity. The only criticisms were that The Seven Challenges written materials were not used enough as intended and clients were not spending adequate time journaling. The Seven Challenges counselors addressed these issues and, consequently, improved program fidelity even further within 4 months of the first study participants being recruited.

Participants in both treatment groups reported that counselors acted according to the queried components of The Seven Challenges on average at more than "a moderate amount" ($M_{The\ Seven\ Challenges}$ = 3.71; $M_{Standard\ CBT}$ = 3.21). However, as one would expect, The Seven Challenges group reported greater fidelity to the components of The Seven Challenges than the Standard CBT group, $t(69) = 4.11$, $p < .001$, $d = 0.99$, a large-sized effect.

Treatment Satisfaction

The majority of participants in both treatment groups were satisfied with their treatment (Table 1). However, participants in The Seven Challenges group were more satisfied with their treatment than the Standard CBT group in terms of the counselors helping them to do something about their other problems (100% of The Seven Challenges group vs. 89% of the Standard CBT group) and the counselors asking for their opinions about their problems and how to solve them (100% of The Seven Challenges group vs. 91% of the Standard CBT group). These are both moderately sized effects (d = 0.47 and 0.43, respectively).

Honesty and Disclosure During Treatment

Participants in both treatment groups reported being honest and self-disclosing during treatment. However, The Seven Challenges group reported greater honesty, M = 94.39 versus. M = 84.27,

$t(68) = 3.07$, $p = .002$, a large effect: $d = .074$, and self disclosure about personal issues, $M = 90.85$ versus $M = 79.82$, $t(69) = 2.67$, $p = .005$, a moderate effect: $d = 0.64$, during counseling than the Standard CBT group. They also reported more self-disclosure across numerous relevant topics, $M = 3.20$ versus $M = 2.54$, $t(69) = 3.88$, $p < .001$, a large effect: $d = 0.93$.

Perceived Impact of Treatment

Participants in both treatment groups perceived a positive impact of treatment (Table 2). However, The Seven Challenges group reported greater positive impact across 14 of the 16 types of positive impact queried than the Standard CBT group. Participants in The Seven Challenges group reported greater control over their lives and drug use; greater improvements in problem-solving skills, employment situation, court situation, and relationships with friends; greater goal accomplishment; greater reduction in harm from drug use; greater change to safer ways of using drugs; and greater help with drug use and the rest of their lives because of treatment than the Standard CBT group (moderate to large effects: ds = 0.49 – 1.17). In addition, participants in The Seven Challenges group reported less unfair and oppressive conditions in their lives because of treatment than the Standard CBT group (a large effect: $d = 0.76$). Participants' perceptions of improvement in family life and in relationships with family because of treatment did not vary by treatment group.

Participant Outcomes: Effects of Treatment and Type of Treatment

Statistics for the main effect of time and the Time × Treatment interaction effect are listed in Table 3. These tests test the hypotheses regarding the overall effectiveness of The Seven Challenges and its effectiveness compared with that of Standard CBT. For brevity, statistics for the main effect of treatment, which do not test the hypotheses, are available upon request.

Housing and vocational engagement. Participants did not experience a change over time in homelessness. Participants overall, regardless of type of treatment, experienced an improvement in vocational engagment with 57.9% engaged at program intake (pretreatment) and 87.8% engaged at 3 months post-intake (post-treatment). This improvement, which was a large-sized effect (partial η^2 of .23), did not vary by type of treatment.

Substance use and related problems. Participants showed reductions in substance use and related problems from intake to 3 months post-intake across numerous related outcome measures. For two of these outcomes, participants overall experienced a reduction in substance use, which did not vary by type of treatment. The percent of participants who used marijuana, hashish, blunts, or THC in the past 90 days decreased from 21.5% at intake to 3.9% at 3 months post-intake, a large-sized effect (partial η^2 of .14). The percent of participants who used methamphetamine in the past 90 days decreased from 32.7% at intake to 12.2% at 3 months post-intake, a large-sized effect (partial η^2 of .15).

For two of the substance use and related problems outcomes, participants overall experienced a reduction in substance use, with a suggestion that the reduction varied by type of treatment. The percent of participants who used substances in the past 90 days decreased from 56.6% at intake to 27.5% at 3 months post-intake, a large-sized effect (partial η^2 of .21). However, although not statistically significant ($p = .057$), the moderate effect size (partial η^2 of .05) suggests a reduction of 42.4% for The Seven Challenges group compared with a reduction of 15.8% for the Standard CBT group. Relatedly, the mean number of the past 90 days participants abstained from using any drugs increased from 76.95 at intake to 83.69 at 3 months post-intake, a moderate- to large-sized effect (partial η^2 of .09). However, although not statistically significant ($p = .056$), the

moderate effect size (partial η^2 of .05) suggests that The Seven Challenges group experienced an increase of 11.73 days on average compared with an increase of 1.76 days on average for the Standard CBT group.

For three of the substance use and related problems outcomes, participants experienced an improvement in substance use that varied by type of treatment. The Seven Challenges group and the Standard CBT group experienced reductions in number of the past 90 days that they were drunk or high most of the day, on average, from 10.44 days at intake to 3.93 days at 3 months post-intake, a moderate- to large-sized effect (partial η^2 of .12). However, The Seven Challenges group experienced a greater reduction over time of 12.25 days compared with 0.79 days on average for the Standard CBT group, a moderate- to large-sized effect (partial η^2 of .09). This pattern was similar for use of any alcohol in the past 90 days. Overall, fewer participants used any alcohol at program intake (36.5%) compared with at 3 months post-intake (9.8%), a large-sized effect (partial η^2 of .19). However, The Seven Challenges group experienced a greater reduction in percentage of participants using alcohol over time of 45.4% compared with a reduction of 7.9% for the Standard CBT group, a moderate- to large-sized effect (partial η^2 of .11). Furthermore, participants overall experienced a decrease in severity of substance frequency, on average, from 0.78 at intake to 0.34 at 3 months post-intake, a large-sized effect (partial η^2 of .23). However, The Seven Challenges group experienced a greater decrease over time of 0.73 compared with a decrease of 0.18 on average for the Standard CBT group, a moderate- to large-sized effect (partial η^2 of .09).

For substance problems, The Seven Challenges group experienced a reduction over time from 0.24 at intake to 0.00 at 3 months post-intake. The Standard CBT group did not experience a change over time ($M_{\backslash}$ = 0.21 vs. 0.29): a moderate- to large-sized effect (partial η^2 of .09).

Mental health. Participants, regardless of type of treatment, showed improvement in internal mental distress from intake (M = 0.79) to 3 months post-intake (M = 0.45), a large-sized effect (partial η^2 of .23). However, The Seven Challenges group experienced a greater reduction over time of 0.58 compared with a reduction of 0.11 for the Standard CBT group, a moderate- to large-sized effect (partial η^2 of .12). Emotional problems and behavior complexity did not change over time for either treatment group.

Criminal activity. The Seven Challenges group experienced a reduction over time from 45.5% of participants engaging in activities that could get them into trouble in the past 90 days at intake to 27.3% of these participants doing so at 3 months post-intake. In contrast, a larger percentage of participants in the Standard CBT group engaged in activities that could get them into trouble in the past 90 days at 3 months post-intake (68.4%) compared with at intake (50.0%). This interaction effect was of moderate to large size (partial η^2 of .09). Similarly, The Seven Challenges group committed fewer crimes in the past 90 days at 3 months post-intake (M = 0.24) than at intake (M = 0.55). In contrast, the Standard CBT group committed more crimes in the past 90 days at 3 months post-intake (M = 1.05) than at intake (M = 0.68). This interaction effect was of moderate to large size (partial η^2 of .11).

Discussion

Summary of Findings

This article adds to a growing body of literature demonstrating the effectiveness of The Seven Challenges as a comprehensive counseling program for individuals with AOD problems. Moreover, it is the first to examine and demonstrate its effectiveness with adults. Findings showed reductions in substance use and related problems over time from pre- to post-treatment

for The Seven Challenges Program clients as well as greater reductions over time for them compared with reductions experienced by clients of the standard cognitive-behavioral substance use treatment. Notably, adult clients of The Seven Challenges showed clinically meaningful reductions in recency and frequency of substance use and high-risk substance use, whereas clients of the standard cognitive-behavioral treatment experienced lesser changes over time in these outcomes. Furthermore, the findings suggest that clients of The Seven Challenges achieved greater increases in abstinence over time compared with clients of the standard CBT.

Findings of the present study also showed effectiveness in addressing co-occurring mental health problems, criminal behavior, and vocational engagement. Adults who received The Seven Challenges showed greater clinically meaningful reductions in internal mental distress and criminal activity from pre- to post-treatment than experienced by adults who received the standard CBT. In fact, the findings indicate that clients of the standard CBT actually engaged in more criminal activity from pre- to post-treatment, which is an undesirable outcome particularly for participants in the present study who were clients of drug court. In addition, participants who received The Seven Challenges experienced an improvement in vocational engagement equal to that experienced by participants who received the standard CBT.

These findings are consistent with findings of past research that examined the effectiveness of The Seven Challenges with adolescents (Korchmaros, in press; Korchmaros & Stevens, 2013; Smith et al., 2006; Stevens et al., 2007). They strengthen the existing evidence base of The Seven Challenges by replicating past findings, by showing the positive impact of The Seven Challenges across multiple types of health-related outcomes, and by showing the positive impact of The Seven Challenges on adults. These findings indicate the effectiveness of The Seven Challenges as a comprehensive counseling program addressing the thought processes, motivations, decision-making processes, and behaviors that underlie and influence substance use as well as other types of health-related outcomes and behaviors.

Findings also add to the existing body of evidence of the effectiveness of CBT. There is consistent evidence that CBT is effective at reducing substance use (e.g., Drummond et al., 2005; Epp & Dobson, 2010; Magill & Ray, 2009; Windsor et al., 2015) and mental health issues (e.g., Beltman, Voshaar, & Speckens, 2010; Bomyea & Lang, 2012; Epp & Dobson, 2010). Similarly, findings from the present study suggest reduced substance use and mental health problems as a result of CBT.

Strengthening the evidence base of a comprehensive counseling program such as The Seven Challenges and of CBT that seem to affect substance use as well as co-occurring and correlated problems is critical to addressing the public health concern of adult substance use. Individual providers and local agencies need to know about the evidence base of treatment approaches that they might want to implement in their communities. A large portion of adults with SUD have co-occurring mental health disorders (CBHSQ, 2015) and are more likely to experience chronic health conditions (Clarke & Currie, 2009), poorer health outcomes (McCusker et al., 2007), crime (Bouchery et al., 2011), involvement in the justice system (Glasheen et al., 2012), and lost productivity (Bouchery et al., 2011). Comprehensive counseling programs or integrated systems of care are needed to improve access to a coordinated comprehensive set of services and supports that correspond with the complex needs of the adults and effectively address the co-occurring and correlated problems that individuals are experiencing (Robert Wood Johnson Foundation Commission to Build a Healthier America, 2009; Substance Abuse and Mental Health Services Administration, 2009) and, ultimately, reduce costs to the individual and community. Programs such as The Seven Challenges that address substance use problems as well as co-occurring and correlated problems do not require cross-agency collaborations and, thus, reduce the impact that siloed systems have on adults attempting to access services. Such comprehensive programs also simplify coordination of services and matching individuals to services.

To address the public health concern of adult substance use and co-occurring problems, it is, however, not sufficient to have practices and programs that are evidence-based. Practices and programs cannot be effective if potential clients do not enroll or engage in them. Potential clients, even those who are mandated to treatment, who find the practices or programs to be acceptable, are more likely to enroll and then engage in the practices and programs than potential clients who do not find them acceptable. A meta-analytic review of treatment dropout (Fernandez, Salem, Swift, & Ramatahal, 2015) found an average pretreatment dropout rate of 14.5% and a during treatment dropout rate of 36.4% for studies examining the effect of CBT on substance abuse and other addictions. So, about one in seven clients do not receive and, therefore, do not experience any impact of treatment. Furthermore, about one in three clients do not receive a full dose of the treatment and, therefore, do not experience the full potential impact of treatment. Implementing programs that clients find acceptable is one way to elicit improved enrollment and engagement in evidence-based treatment and to increase the likelihood that individuals with substance use and co-occurring problems receive effective treatment.

Findings of the present study indicate that adults found The Seven Challenges Program to be more acceptable than standard CBT. Of particular note is that adults who received The Seven Challenges perceived a greater positive impact of treatment than adults who received standard CBT. This perception could reflect an actual difference in impact of the treatments, indicating that The Seven Challenges had a greater noticeable positive impact than standard CBT. Furthermore, this perception could result in an even greater impact of The Seven Challenges over time. People who perceive a positive impact of treatment are more likely, than those who don't, to stay in treatment and to participate more fully in treatment and, consequently, to experience an even greater impact.

The greater positive impact of The Seven Challenges compared with standard CBT, both perceived and realized as indicated in the outcomes, might be because the nonjudgmental and decision-making approach of The Seven Challenges allowed clients to feel safe and be more honest and willing to self-disclose to their counselors than clients who received standard CBT. Greater honest disclosure facilitates the therapeutic process, allowing for more productive treatment. This increased honest disclosure in and of itself might have led these adults to feel a positive impact of The Seven Challenges. In addition, the increased honest disclosure might have led to counseling sessions more focused on the issues of most importance for the adults and issues underlying these adults' struggles with substance use and co-occurring problems, resulting in more effective treatment.

The Seven Challenges Program is unique among substance use treatment. Its client-centered approach focused on decision making allows clients to work on the issues that matter most to them and to make their own choices, including about drugs. In this way, it encourages clients to make decisions for themselves that they might, as a result, be more committed to, compared with decisions perceived to be imposed upon them or made under pressure from external forces. Furthermore, in this way, The Seven Challenges counselors show respect for their clients and support them in a collaborative manner rather than prescribe behaviors that they, or the court or broader society, think the clients should engage in. A substantial proportion of people who receive substance use services do so within the context of abstinence-based treatment in which there is pressure for abstinence and abstinence is expected or required, and may even be imposed. Many adults receive substance use treatment as a condition for participation in drug court. These drug courts are common and becoming more common. At the end of 2014, there were 3,057 drug courts in the United States, a 24% increase in the previous 5 years (Marlowe et al., 2016). Furthermore, almost half of adults in treatment went into treatment at least in part because of "legal coercion" (Hser et al., 1998). People who receive treatment because of their participation in drug court, or because they are otherwise mandated to treatment, typically face significant negative ramifications if they engage in any illegal behavior including illicit drug use and

sometimes even if they engage in AOD use at all. The Seven Challenges counselors create a safe, effective, collaborative therapeutic environment, regardless of whether the clients are justice-involved or not. Within this environment, people who are not yet committed to abstinence can be honest and get help that can result in eventual abstinence or reduced substance use problems and correlated improvements such as reduction in criminal activity. Also within this environment, people who might already be inclined to abstinence are encouraged to think more deeply about their decision and, therefore, might be better prepared to succeed.

Although the results of the present study do not indicate the process by which The Seven Challenges leads to positive outcomes and more positive outcomes than standard CBT, they clearly indicate the effectiveness of The Seven Challenges Program. This program, designed to engage, increase honesty, give an empowerment message, and promote clients in thoughtful decision making, was more effective in reducing substance use and co-occurring and correlated problems than standard CBT. Further research could provide insight into how The Seven Challenges Program achieves its effectiveness.

Strengths and Limitations

The strengths of the present study include utilization of longitudinal outcome data, a comparison group, and standardized intake and follow-up measures. Having results based on longitudinal and comparison data is a strength in that it allows for the examination of the acceptability and effectiveness of The Seven Challenges Program in general to be interpreted based on the measures and scales utilized (e.g., days of abstinence in the past 90 days) and change over time. Moreover, it allows for interpretation of outcomes based on differential change over time experienced by the two treatment groups.

Another strength of the present study is that fidelity to The Seven Challenges Program was assessed. The fact that fidelity was found to be high supports the conclusion that the positive outcomes experienced by The Seven Challenges group were due to having received The Seven Challenges.

The present study, however, also has a few limitations. First, it is quasi-experimental. Although a comparison treatment group was utilized, participants were not randomly assigned to treatment group; they were assigned to group depending on at which agency site they received treatment. Thus, differences between The Seven Challenges group and the Standard CBT group could be the result of underlying differences in the participants in these groups. However, having longitudinal data allowing for analyses that considered pretreatment outcome-related characteristics and behavior (e.g., substance use) and focused on differential change over time eliminates differences in pretreatment outcome-related characteristics and behavior as an explanation for difference in the treatment groups on post-treatment outcome-related characteristics and behavior. These findings support the conclusion that the detected differences between the treatment groups in their effectiveness were due to type of treatment and not to preexisting differences in the treatment groups. The evidence-base of The Seven Challenges Program would, however, be further strengthened by similar findings from experimental research using random assignment into experimental group and a control group.

Other limitations are that the findings are based on a subset of adults who were enrolled in the study and reflect outcomes only at 3 months post-program intake. Although 96% of those invited to participate in the study enrolled in it, 3-month post-intake data were available for only 78% of participants. It is possible that the results reflect what is true for this subset of adults as opposed to what is true for all adults who received treatment from the provider agency. The fact that analysis of existing program intake data did not detect statistically significant differences between the analytic sample and the excluded participants on key characteristics and behaviors suggests that the analytic sample was similar to the excluded participants and supports the conclusion that the

results of the present study are likely reflective of all of the adults who received treatment from the provider agency. However, it is possible that the analytic sample differed from the excluded participants in a way that affected response to treatment that was not captured in the present study. It is also possible that the impact of The Seven Challenges Program, as well as the Standard CBT, are short-lived and lessen over time as the program decreases in intensity but the risk of recidivism remains high. Further research, particularly research examining other factors that might affect response to treatment that were not measured in the present study, such as motivation to reduce substance use, might inform these issues.

Other limitations related to the generalizability of the findings include the relatively small size of the analytic sample and the fact that participants were enrolled in drug court and received treatment from counselors at one treatment agency. It is also possible that the study findings reflect what is true for adults in substance use treatment programs as a condition of their participation in drug court as opposed to what is true for all adults because those adults might be prompted to change their behavior because of court-imposed negative consequences for continuing to use substances. However, although avoidance of these negative consequences might help to explain the reduction in substance use and criminality over time, it does not explain the improvement in mental health. Even so, caution should be taken when considering the generalizability of these findings to substance abuse treatment populations not involved in drug court. In addition, caution should be taken when considering the generalizability of these findings to other treatment agencies and counselors. When implementing The Seven Challenges, as when implementing any treatment program, program fidelity is key to achieving the greatest potential program impact.

Conclusion

The findings of the present study add to the current literature. They strengthen the existing evidence base regarding the effectiveness of The Seven Challenges Program as a comprehensive substance use counseling program focused on decision making, and demonstrate effectiveness with an adult population. The Seven Challenges Program effectively reduced substance use and related problems, mental health problems, and criminal behavior among adults. Furthermore, it increased their vocational engagement. These findings indicate the effectiveness of The Seven Challenges across multiple types of health-related outcomes, decreasing unhealthy behaviors and experiences, suggesting the strength of a decision-making model that allows client self-determination of behavior.

Author's Note

The views expressed here are the author's and do not necessarily represent the views of D7 Treatment. Although D7 Treatment had input into the design of the study and its staff played a role in the collection of the data, it did not have any input or play any role in the data analysis, interpretation of the data, the writing of the article, and the submittal of this article for publication. These were solely the efforts and decisions of the author.

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References

Ali, M. M., Teich, J. L., & Mutter, R. (2015). The role of perceived need and health insurance in substance use treatment: Implications for the affordable care act. *Journal of Substance Abuse Treatment*, *54*, 14-20.

Beltman, M. W., Voshaar, R. C. O., & Speckens, A. E. (2010). Cognitive-behavioural therapy for depression in people with a somatic disease: Meta-analysis of randomised controlled trials. *British Journal of Psychiatry*, *197*, 11-19.

Berne, E. (1961). *Transactional analysis in psychotherapy: A systematic individual and social psychiatry*. New York, NY: Grove Press.

Bomyea, J., & Lang, A. J. (2012). Emerging interventions for PTSD: Future directions for clinical care and research. *Neuropharmacology*, *62*, 607-616.

Bouchery, E. E., Harwood, H. J., Sacks, J. J., Simon, C. J., & Brewer, R. D. (2011). Economic costs of excessive alcohol consumption in the U.S., 2006. *American Journal of Preventive Medicine*, *41*, 516-524.

Center for Behavioral Health Statistics and Quality. (2015). *Behavioral health trends in the United States: Results from the 2014 national survey on drug use and health* (HHS Publication No. SMA 15-4927, NSDUH Series H-50). Retrieved from http://www.samhsa.gov/data/

Clarke, D. M., & Currie, K. C. (2009). Depression, anxiety and their relationship with chronic diseases: A review of the epidemiology, risk and treatment evidence. *The Medical Journal of Australia*, *190*(7 Suppl), S54-S60.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum.

Dennis, M. L., Titus, J. C., White, M. K., Unsicker, J. I., & Hodgkins, D. (2003). *Global appraisal of individual needs: Administration guide for the GAIN and related measures* (Version 5.0). Bloomington, IL: Chestnut Health Systems. Retrieved from http://www.gaincc.org/gaini

Dimeff, L., & Linehan, M. M. (2001). Dialectical behavior therapy in a nutshell. *The California Psychologist*, *34*, 10-13.

Drummond, C., Kouimtsidis, C., Reynolds, M., Russell, I., Godfrey, C., McCusker, M., . . . Porter, S. (2005). The effectiveness and cost effectiveness of cognitive behaviour therapy for opiate misusers in methadone maintenance treatment: A multicentre, randomised, controlled trial. *Drugs: Education, Prevention and Policy*, *12*, 69-76.

Epp, A. M., & Dobson, K. S. (2010). *The evidence base for cognitive-behavioral therapy*. New York, NY: Guilford Press.

Ferguson, L. M., & Wormith, J. S. (2013). A meta-analysis of moral reconation therapy. *International Journal of Offender Therapy and Comparative Criminology*, *57*, 1076-1106.

Fernandez, E., Salem, D., Swift, J. K., & Ramatahal, N. (2015). Meta-analysis of dropout from cognitive behavioral therapy: Magnitude, timing, and moderators. *Journal of Consulting and Clinical Psychology*, *83*, 1108-1122.

Glasheen, C., Hedden, S. L., Kroutil, L. A., Pemberton, M. R., & Goldstrom, I. (2012). *CBHSQ data review: Past year arrest among adults in the United States: Characteristics of and association with mental illness and substance use*. Retrieved from http://samhsa.gov/data/

Hser, Y. I., Maglione, M., Polinsky, M. I., & Anglin, M. D. (1998). Predicting drug treatment entry among treatment-seeking individuals. *Journal of Substance Abuse Treatment*, *15*, 213-220.

Inhelder, B., & Piaget, J. (1958). *The growth of logical thinking from childhood to adolescence: An essay on the construction of formal operational structures*. London, England: Routledge.

Janis, I. J., & Mann, L. (1977). *Decision making: A psychological analysis of conflict, choice, and commitment*. New York, NY: Free Press.

Korchmaros, J. D. (in press). Examining the effectiveness of The Seven Challenges® comprehensive counseling program with adolescents. *Journal of Social Work Practice in the Addictions*.

Korchmaros, J. D., & Stevens,S. J. (2013). Examination of the Role of Therapeutic Alliance, Treatment Dose, and Treatment Completion in the Effectiveness of The Seven Challenges. *Child and Adolescent Social Work Journal*, *31*, 1-24.

Lipari, R. N., Park-Lee, E., & Van Horn, S. (2016). *America's need for and receipt of substance use treatment in 2015* (The CBHSQ report). Rockville, MD: CBHSQ, Substance Abuse and Mental Health Services Administration.

Magill, M., & Ray, L. A. (2009). Cognitive-behavioral treatment with adult alcohol and illicit drug users: A meta-analysis of randomized controlled trials. *Journal of Studies on Alcohol and Drugs*, *70*, 516-527.

Marlowe, D. B., Hardin, C. D., & Fox, C. L. (2016). *Painting the current picture: A national report on drug courts and other problem-solving courts in the United States*. National Drug Court Institute. Retrieved from https://www.ndci.org/wp-content/uploads/2016/05/Painting-the-Current-Picture-2016.pdf

McCusker, J., Cole, M., Ciampi, A., Latimer, E., Windholz, S., & Belzile, E. (2007). Major depression in older medical inpatients predicts poor physical and mental health status over 12 months. *General Hospital Psychiatry*, *29*, 340-348.

Miller, L. C., Berg, J. H., & Archer, R. L. (1983). Openers: Individuals who elicit intimate self-disclosure. *Journal of Personality and Social Psychology*, *44*, 1234-1244.

Prochaska, J. O., DiClemente, C. C., Velicer, W. F., & Rossi, J. S. (1993). Standardized, individualized, interactive, and personalized self-help programs for smoking cessation. *Health Psychology*, *12*, 399-405.

Robert Wood Johnson Foundation Commission to Build a Healthier America. (2009). *Beyond health care: New directions to a healthier America: Recommendations from the Robert Wood Johnson foundation commission to build a healthier America: Executive summary* [Internet]. Princeton, NJ. Retrieved from http://www.rwjf.org/content/dam/farm/reports/reports/2009/rwjf40483/subassets/rwjf40483_1

Rogers, C. (1951). *Client-centered therapy*. Cambridge, MA: The Riverside Press.

Schuler, M. S., Puttaiah, S., Mojtabai, R., & Crum, R. M. (2015). Perceived barriers to treatment for alcohol problems: A latent class analysis. *Psychiatric Services*, *66*, 1221-1228.

Schwebel, R. (2010). *The seven challenges-brief program*. Tucson, AZ: Viva Press.

Schwebel, R. (2015). *The seven challenges manual* (2nd ed.). Tucson, AZ: Viva Press.

Schwebel, R. (2017). *The seven challenges manual for adult program*. Tucson, AZ: Viva Press.

Smith, D. C., Hall, J. A., Williams, J. K., An, H., & Gotman, N. (2006). Comparative efficacy of family and group treatment for adolescent substance abuse. *The American Journal on Addictions*, *15*(Suppl. 1), 131-136.

Stevens, S., Ruiz, B., & Schwebel, R. (2007). The seven challenges: An effective treatment for adolescents with co-occurring substance abuse and mental health problems. *Journal of Social Work Practices in the Addictions*, *7*, 29-49.

Substance Abuse and Mental Health Services Administration. (2009). *Integrated treatment for co-occurring disorders: The evidence* (DHHS Pub. No. SMA-08-4366). Rockville, MD: Center for Mental Health Services, SAMHSA, U.S. Department of Health and Human Services.

Windsor, L. C., Jemal, A., & Alessi, E. J. (2015). Cognitive behavioral therapy: A meta-analysis of race and substance use outcomes. *Cultural Diversity and Ethnic Minority Psychology*, *21*, 300-313.

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