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A GUIDE TO DEVELOPING SUBSTANCE ABUSE TREATMENT PROGRAMS FOR ADJUDICATED JUVENILES

by

THE AMERICAN CORRECTIONAL ASSOCIATION
4321 Hartwick Road
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NOVEMBER 1988

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THE 12 STEPS OF ALCOHOLICS ANONYMOUS

1. I admit I am powerless over alcohol - that my life has become unmanageable.

2. I have come to believe that a Power greater than myself can restore me to sanity.

3. I have decided to turn my will and my life over to the care of God as I understand Him.

4. I make a searching and fearless moral inventory of myself.

5. I have admitted to God, to myself, and to another human being the exact nature of my wrongs.

6. I am entirely ready to have God remove all these defects of character.

7. I humbly ask God to remove my shortcomings.

8. I have made a list of all persons I have harmed, and become willing to make amends them all.

9. I have made direct amends to such people wherever possible, except when to do so would injure them or others.

10. I have continued to take personal inventory and when I am wrong, promptly admitted it.

11. I have sought through prayer and meditation to improve my conscious contact with God as I understand Him, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, I have tried to carry this message to alcoholics, and to practice these principles in all our affairs.

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FOREWARD

In July, 1987 the American Correctional Association (ACA) was awarded a grant from the U.S. Department of Justice's Office of Juvenile Justice and Delinquency Prevention (OJJDP). One of the objectives of this grant award was the development of a resource guide that would describe substance abuse treatment of adjudicated juveniles.

Overview

The guide we have produced includes the following:

- An overview of the link between substance abuse and delinquency with an in-depth examination of substance abuse trends amongst incaracerated youth.
- The results of a needs assessment and a survey conducted in preparation for the guide.
- Profiles of five substance abuse treatment programs.
- Practical tips on how to develop a treatment program.
- Research that establishes the need for aftercare as part of a continuum of treatment; a model post-treatment program is then proposed.
- Recommended guidelines for evaluating services offered by substance abuse treatment programs.
- Current models of substance abuse treatment and their relative effectiveness.

- o Future developments in the field of substance abuse treatment are contemplated.
- o A list of pertinent national resources.
- o An extensive search of the literature in annotated form.

DEVELOPMENT OF A NEEDS ASSESSMENT

The project staff of ACA developed a needs assessment survey to determine 1) how agencies had responded to the problem of substance abuse among adjudicated juveniles and 2) what kinds of information would be most useful to juvenile corrections administrators and their staffs. In October of 1987 a copy of a substance abuse needs assessment (see Appendix D) was sent to correctional administrators in each of the 50 states. Below are listed the results of this assessment that we think could be potentially useful to the field.

DEVELOPMENT OF A SUBSTANCE ABUSE RESOURCE GUIDE
NEEDS ASSESSMENT SURVEY RESULTS
JULY 1, 1988

Please indicate how your agency has responded to juvenile substance abuse.

Number of Programs	% of Programs Using Listed Items	Item
53	84	Staff training
47	75	Education/prevention programming
45	71	Treatment programming
43	68	Contracting with private
37	59	Using assessment instruments
31	49	Gathering of statistics
27	43	Establishing a referral network of providers
4	6	In-house treatment provided by clinical staff
2	3	Coordation/cooperation with state substance abuse agencies
2	3	Youth supporting youth groups
2	3	Provide community outreach/training
1	2	Drug screening
1	2	AA/NA

Do you have any type of cooperative agreement(s) with any state agency or other resource(s) to provide substance abuse education and/or treatment for juveniles?

Response	Number of Programs	% of Programs Using Listed Items
Yes	48	76
No	13	21
Being developed	02	03

Check the items which describe the type of assistance you would find useful. Information concerning:

Number of Programs	% of Programs Using Listed Items	Item
47	75	Information on funding sources
46	73	Model treatment programs
45	71	Post-treatment care/ reintegration
40	63	How to evaluate a treatment program
39	62	Treatment methods
45	71	Staff training
35	56	Sample assessment instruments
33	52	How to develop a treatment program
32	51	Available resources
28	44	Intra/interagency service collaboration
		Other:
1	2	Employee Assistance Programs
1	2	Programs for Hispanics
1	2	Specialized staff in substance abuse treatment
1	2	Consultant services
1	2	Physically secure treatment settings
1	2	Girls' programs

To clarify areas not covered in our needs assessment, we developed a substance abuse treatment survey and sent it to state administrators (see Appendix F).

SURVEY OF SUBSTANCE ABUSE TREATMENT PROGRAMS FOR ADJUDICATED YOUTH BY STATE NOVEMBER 1988

	Question	Inpatient Treatment	Outpatient Treatment
1.	Total # of substance abuse programs surveyed	128	209
	Contracted/private	74%	66%
	State run	25%	34%
2.	Usual length of treatment	1-3 months	1-15 months
3/4.	Ratio of females to males treated statewide	12:71	4:7
5.	Who does the state treat?		
	a) Ages	8-21	8-21
	b) Types of offenses	all	all
	c) Personality types	all	all
	d) IQ	all	all
6.	Who does the state not treat?	Less than 5% did not treat:	
	a) Offenses	arson, murder or rape	
	b) Behavioral risks	assault\escape	
	c) IQ	60 or below	
	d) Personality types	-	
	e) Other	active psychotics	

	Question	Inpatient Treatment	Outpatient Treatment
7.	How many programs assess clients':		
	a) Drug use/dependency	97%	96%
	b) Psychological makeup	82%	69%
	c) Educational needs	96%	58%
	d) Medical problems & needs	97%	67%
8.	How many of your programs provide:		
	a) 12-steps programs	66%	49%
	b) Education curriculum	91%	16%
	c) Journal writing	47%	30%
	d) Drug education	100%	93%
	e) Vocational training	31%	15%
	f) Social skills training (i.e., indep. living skills, social problem solving, self-esteem enhancement & life skills)	94%	31%
	g) Recreation/exercise programs	91%	19%
	h) Wilderness/ropes courses	27%	10%
	i) Medical services	79%	45%
	j) Drug testing	46%	64%
	If so, how often?	Random or for cause varied weekly to monthly	
	k) Strip searches	31%	0

	Question	Inpatient Treatment	Outpatient Treatment
8.	How many of your programs provide:		
	l) Community outreach	31%	58%
	m) Family outreach	64%	92%
	n) Mental health services	67%	44%
	o) Family counseling	53%	80%
	p) Group/peer counseling	67%	75%
	q) Individual counseling	80%	99%
	r) Drug crisis counseling	56%	62%
	s) AIDS education	6%	0%
	Specialized programs	4%	0%
9.	Therapeutic models and approaches used:		
	a) Disease concept	56%	80%
	b) Family disease concept	62%	64%
	c) Therapeutic community	42%	3%
	d) Symptoms of youth's criminality	7%	.05%

Question			Inpatient Treatment	Outpatient Treatment
10.	Methods of behavioral control			
	a)	Staff run	96%	86%
	b)	Peer run	8%	4%
	c)	Other	N/A	23%
	d)	Types of consequences:		
		Prolonged Incarceration	17%	N/A
		Violation of Parole	N/A	10%
		Loss of privileges	55%	23%
		Expulsion	N/A	23%
		Work assignments, restraints or isolation	5%	N/A
11.	How many provide aftercare?			
	a)	Administered by the treatment program	42%	90%
	b)	Administered by another agency	35%	32%
	c)	Overseen by sponsors	7%	11%
	d)	Overseen by probation	37%	37%

Questions		Inpatient Treatment	Outpatient Treatment
12.	Research		
a)	How many have conducted self evaluations?	58%	55%
b)	How many have conducted independent evaluations	32%	4%
c)	# to have conducted other types of research	9%	5%

Twenty of the fifty states reponded to our inventory of treatment programs. According to our findings most state correctional systems use contractual and privately run substance abuse treatment programs. A few offer substance abuse counseling in their institutions in lieu of treatment. Of note, we discovered that length of treatment for both inpatient and outpatient programs is much more varied than expected, ranging from 28 days to one and a half years. Most treatment programs treat all types of offenders, behavioral risks and IQ ranges. The few who are refused for treatment have committed arson, murder, rape or serious assault; have very low IQs; or are actively psychotic.

The number of females treated is quite low compared to males treated in inpatient programs. The ratio is 12:71. In outpatient programs the ratio is 4:7.

Most programs comprehensively assess their clients. Inpatient treatment usually includes an educational curriculum, drug education, social skills training and recreation/exercise. Only 66% of the inpatient programs reported using a 12-steps program. Outpatient treatment programs predominantly teach social skills and drug education. Again, only about half offer 12-steps programs.

Very few programs use drug testing. Those that do, test for cause and at random.

Outpatient treatment programs seem to focus heavily on family outreach, family counseling and individual counseling, where inpatient treatment programs tend to offer a more diverse array of services. Those services which are most emphasized include mental health services, group/peer, drug crisis and family counseling. Only 31% focus on community outreach.

In- and outpatient programs seem to combine the disease model of addiction together with the family disease concept. Less than half of the inpatient programs reported using therapeutic community models of treatment.

In both treatment types, staff members tend to manage behavioral control. Very few use peer control. Consequences for undesirable behavior typically include: prolonged incarceration or violation of parole, loss of privileges, work assignments, restrictions, isolation and expulsion.

A surprising number of programs offer aftercare; however this is an area where development is still needed by in-patient treatment programs.

Last, over half of both treatment types reported they had performed self-evaluations.

SELECTION OF CONSULTANTS

ACA chose consultants who had extensive backgrounds in substance abuse among adjudicated juveniles. Each consultant was subcontracted to write a portion of the Resource Guide within their area of expertise. The following consultants were used:

Mr. David Brenna, M.A., Program Administrator, Division of Juvenile Rehabilitation, State of Washington, Department of Social and Health Services, Olympia, Washington;

Richard Catalano, Ph.D, Research Assistant Professor, Center for Social Welfare Research, School of Social Work, University of Washington, Seattle, Washington;

Richard Dembo, Department of Criminology, University of South Florida, Tampa, Florida;

Dr. Jeffrey Fagan, Ph.D, Associate Director, Criminal Justice Center, John Jay College of Criminal Justice, New York, New York;

Patrick Henry, Ph.D, Department of Sociology, Eckerd College, P.O. Box 12560, St. Petersburg, Florida;

Dr. Richard Kimball, Private Consultant for Adolescent Experiential Programs, Santa Fe, New Mexico;

Jim Oleson, Coordinator, Extended Care Services, PARC Place, Phoenix Adolescent Recovery Center, Phoenix, Arizona; and

Betsy Wells, Ph.D, Research Assistant Professor, Center for Social Welfare Research, School of Social Welfare Research, School of Social Work, University of Washington, Seattle, Washington.

DEVELOPMENT OF AN ALCOHOL/DRUG TREATMENT PROGRAM INTERVIEW INSTRUMENT

In conjunction with Dr. Jeffrey Fagan, ACA project staff developed a seven page interview instrument to assist administrators and practitioners to determine the quality of drug and alcohol treatment program's prior to referring clients for treatment. The questionnaire is offered as a guide and is in no way considered a final product. While visiting the programs profiled in this document, we used this instrument as a guide. Problems we found within it were repetition of questions, and some questions were inapplicable. However, the categories targeted were well covered. A future project could productively use this as a basis to fully developing an assessment instrument.

SITE VISITS

Based on the list of especially "effective" treatment programs suggested by juvenile justice administrators and professionals, five programs were chosen to be profiled. It was anticipated that these programs would serve as "model" programs. However, the term "model" is not easily defined, nor is it universally applicable. This term was finally ruled out and replaced by "program profile," a generic term that is value free. We present these programs as samples of innovative approaches to treatment.

ACA staff/consultants began by agreeing on categories of treatment programs to be examined. It was decided that the following categories should be represented:

Outpatient, public (West Virginia),

Inpatient, private (Pennsylvania), and

Inpatient, public (Washington, Wisconsin and Ohio).

Letters requesting visits were sent to the directors of five chosen programs, after which visitation dates were scheduled. Each site visit lasted approximately 1 to 1 1/2 days and included a thorough review of the agency's features, interviews with key staff members and clients, and a tour of the facility.

CONCLUSION

We hope you will find the Resource Guide practical and useful. We recommend that you develop continuum of care approaches when you can afford the expense, and encourage you to develop innovative approaches to substance abuse treatment in your state. Finally, we would be pleased if you would contact any of the consultants of this project or the treatment programs profiled herein, if you should desire further information or advise.

OVERVIEW OF DRUG USE AND DELINQUENCY AMONG YOUTH

by

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INTRODUCTION

Alcohol and other drug use by America's young people is a serious concern to our society. Although there are indications that the use of some substances, particularly marijuana, has declined in recent years, the prevalence of the use of drugs by young people remains high. There is particular concern regarding the use of drugs by high risk youth (these are young people who come to the attention of public service agencies for behavior problems in the community who are likely to move into delinquent lifestyles).

The purpose of this overview is to address the issue of drug use among youth, with particular reference to drug usage and its relationship to delinquency among youngsters who enter the juvenile justice system. We will first review existing survey data on youths in the general population. Through this review we will obtain a national picture of the use of various drugs, with their demographic and socio-cultural correlates. Second, we will review major theories of alcohol and other drug use among youths.

This review completed, we will direct our attention to youths who come to the attention of the juvenile justice system. We will first discuss methods of identifying drug use among high risk youths and then we will provide an analysis of the strengths and limitations of those methods. Next, drawing upon data from a variety of studies, we will

discuss the prevalence, patterns and correlates of alcohol and other drug use among high risk youths. Following this review, we will examine what we know about the relationships between alcohol and other drug use and other delinquent behaviors. Finally, consideration is given to various intervention strategies that can assist drug involved youths who are entering the juvenile justice system to lead more salutary lives.

PREVALENCE, PATTERNS AND CORRELATES OF ALCOHOL AND OTHER DRUG USE AMONG YOUTHS IN THE GENERAL POPULATION

Two national surveys that were funded by the National Institute on Drug Abuse have provided valuable information about the use of alcohol and other drugs by youths in the U.S. The purpose of these assessments was to study prevalence and trends for the use of a wide range of licit and illicit drugs.

The first of these data sets are results from the national household survey on drug abuse. The data were derived from a study of a population age 12 and over. Selected respondents were personally interviewed in their homes. The results from these periodic surveys have been published for three distinct age groups: 1) youth (age 12-17), 2) young adults (age 18-25), and 3) older adults (age

26+). These surveys were completed in 1972, 1974, 1976, 1979, 1982 and 1985.[1]

The second source of information on youth drug use was an annual survey of a representative sample of U.S. high school seniors. Initiated in 1975, these surveys were designed to: 1) study high school seniors' drug use behaviors, or their attitudes toward drug use and the perceived availability of drugs; 2) obtain data on the prevalence and trends in the use of various substances; and 3) gain a better understanding of the lifestyles and values associated with various patterns of drug use as well as to learn how these value orientations shift over time.[2]

DRUG USE AMONG YOUTHS IN THE NATIONAL HOUSEHOLD SURVEY

According to the national household survey, alcohol, cigarettes and marijuana/hashish were the most popular substances used by 12 to 17 year olds. In terms of lifetime prevalence of their use, 56% of the youths who were sampled claimed to have used alcohol, 45% to have smoked cigarettes and 24% to have smoked marijuana/hashish one or more times in their lives; and 52%, 26% and 20% claimed to have used alcohol, smoked cigarettes and used marijuana/hashish, respectively, in the past year.[3] Further analysis of the 1972-82 household survey data indicated that the prevalence

of, and past months' use of each of these drugs increased by adolescent age level with 16-17 year olds having the highest use rates, and youths 12-13 the lowest.[4] Interestingly, 60% of the youths who claimed to have used alcohol in the 30 days preceding their interviews indicated they had used marijuana, and 22% claimed to have used cocaine, at least once in their lives. In addition, the lifetime and annual prevalence rates for the use of marijuana/hashish dropped from 31% in 1979 to 24% in 1985.

Detailed analyses of the demographic characteristics besides age relating to youths' use of marijuana/hashish for the 1982 national household survey indicated that males (28%) had slightly higher lifetime use rates than females (25%), and white youths (27%) had somewhat higher use rates than those from other races (23%). In addition, lifetime prevalence of use rates were higher for young people living in large metropolitan areas (32%) compared to youngsters residing in small metropolitan or nonmetropolitan locations (25% and 24%, respectively).[5]

DRUG USE AMONG HIGH SCHOOL SENIORS

The comprehensive data on the prevalence of drug use provided by the study of high school students, conducted from 1975 to 1986, also highlighted that alcohol, cigarettes and marijuana/hashish were the most popular drugs among high

school seniors. Ninety-one percent of the seniors claimed to have used alcohol at least once in their lives, 68% indicated they had ever used cigarettes and 51% indicated they had ever used marijuana\hashish. Considerable proportions of the seniors surveyed claimed they had used stimulants nonmedically (23%), inhalants (20%) and cocaine (17%) one or more times in their lives. Correspondingly, 84% of the seniors claimed they had used alcohol, 39% reported to have used marijuana\hashish, and 13% indicated they had used cocaine during the past year.

Much has been said in the media about the decline in illicit drug use among America's young people. These reports have usually derived their information from the annual high school senior survey. It is important to note that this downward trend was most evidenced in seniors' use of cannabinoids. Lifetime and annual prevalence rates for the use of marijuana and hashish peaked in 1979 (60% and 51%, respectively) and declined to 51% and 39%, respectively, in 1986. More disturbing, however, is the fact that cocaine use showed little decline since the 1975 survey. In 1986, 17% of the seniors surveyed claimed they had used cocaine at least once in their lives, and 13% reported they had used the drug in the past year. Another troubling aspect of the cocaine story relates to the increased use of crack, an inexpensive purified, smokable form of cocaine. The percent of seniors

who claimed to have smoked cocaine more than doubled between 1983 (2.5%) and 1986 (6.0%).[6]

The decline in the reported use of marijuana\hashish appears to be stable. Further analyses of the annual survey data suggests that this reduction in use has been related to increasing levels of disapproval associated with regular marijuana use in recent years, that has been coupled with a rise in the perceived risks associated with the use of the drug.[7]

A number of demographic characteristics were consistently found to differentiate the rates of use of the various drugs surveyed by the high school senior study. Males reported higher rates of illicit drug use than females. Seniors who planned to complete four years of college reported higher illicit drug use than students with no plans for college or who planned to complete less than four years of additional schooling. Additionally, seniors living in nonmetropolitan areas reported lower rates of illicit drug use than their counterparts residing in urban areas.[8]

It is important that the use of alcohol and other drugs be seen from a developmental perspective.[9] The use of legal drugs tends to precede the use of illegal ones (regardless of the age at which initiation of illegal drug use occurs), and marijuana usually serves as a "gateway" drug to the taking of

the other illegal substances. Different processes and factors are involved at each stage of illicit drug use. For example, peer influence is much more important in marijuana use, than other illicit drug use. Such factors as depression, lack of closeness to parents and expressed lower levels of psychological functioning are important in understanding the use of illicit drugs besides marijuana.

While the national household survey and high school senior survey data have been useful in their depiction of drug use among youths in the general population, each has limited value when applied to youths whose behaviors have brought them to the attention of official agencies. For example, the national household survey excluded institutionalized youths, and the high school senior survey did not include dropouts (estimated to account for 15% of each class cohort) and both of these groups are over represented among adolescents in the juvenile justice system. Research has shown that school dropouts have higher rates of illicit drug use than students who attend school regularly.[10] Further, although there is evidence that the prevalence of drug use has declined among young people in general, there is no indication that this has occurred among youths who come to the attention of juvenile courts; further, these young people generally have a multiplicity of problems.[11]

THEORIES OF ALCOHOL AND OTHER DRUG USE AMONG YOUTHS

Kandel (1980) distinguishes between four major theoretical frameworks that have been developed to account for involvement of youths in drug use: (1) propensity towards problem behavior,[12] (2) social learning theory,[13] (3) self-derogation theory (based on the self-esteem motive),[14] and (4) socialization theory.[15] According to Jessor and Jessor (1977), problem behaviors, such as marijuana use and alcohol abuse, are those which deviate from societal norms. They also tend to be graded according to age. As Kandel notes (1980), "behavior is problematic that occurs at an inappropriate time in the life cycle," usually at an earlier age than is culturally sanctioned.

The social learning perspective is based on the theory of differential association[16] and the psychological theories of operant conditioning[17] and imitation.[18] The social learning perspective assumes that social behavior is learned through operant conditioning and imitation, together with the mechanisms of reinforcement and punishment.

Kaplan's self-derogation theory (1980) asserts that individuals come to engage in deviant activities in an effort to regain a sense of self-esteem which was damaged by their self-devaluing experiences in important membership groups, such as friends, family and school. By identifying with a

deviant subculture, and participating in deviant activities, the young person generates respect and approval from his delinquent peers.

Kandel's socialization theory[19] focuses on the influences of parents and peers in the life of the developing adolescent. Drug use by adolescents is seen to result from the interaction between the individual's characteristics and competing influences of the multiple groups with which the young person affiliates. The theory incorporates concepts and processes derived from several theories, particularly social control[20] and social learning.[21]

Recent work[22] indicates that none of these theories is sufficient to provide a comprehensive understanding of adolescent drug use. Rather, integrated theories which contain concepts from several theoretical frameworks provide more insight into the reasons why individuals adhere to conventional norms and behaviors; and they illuminate better the processes by which disaffiliation from conventional social activities is initiated, reinforced and maintained.[23]

METHODS OF IDENTIFYING DRUG USE AMONG YOUTHS IN THE JUVENILE JUSTICE SYSTEM

Figure 1, taken from a recent paper by Wish (1986) and summarized by the National Institute of Justice (NIJ) (1987), indicates four major techniques have been used to identify drug use among those who come into contact with the justice

system: (1) self-reports, (2) official records, (3) urine tests and (4) hair analyses. Of the four techniques, urine tests and hair analyses provide the most valid indications of drug taking.

In surveys of drug use in the general population, where confidentiality is maintained and the interviews are conducted in private settings, response validity tends to be high.[24] However, there is evidence that youths heavily involved in delinquency tend to under report their law violating behaviors.[25]

Response bias is a serious concern in research studies. Wish and his associates consistently have found that adult arrestees under report recent drug usage.[26] Evidence is being accumulated that shows a similar pattern applies to youths entering the juvenile justice system,[27] particularly in their reportage of cocaine use. Hence, self-reports of drug use are likely to provide a poor indication of drug involvement on the part of high risk youths; however, those who admit to drug use should be further evaluated.

Official juvenile justice system records have limitations as sources of information about drug use. Research work in Tampa consistently has found high rates of drug use by juvenile detainees, especially marijuana\hashish and, secondarily, cocaine.[28] However, relatively few of these detainees have ever been arrested on drug charges, nor

have they had referral histories that indicated a history of such offenses. Well established and maintained official records can provide valuable information, however these records are often incomplete.

Urine testing, particulary the EMIT R (enzyme multiplied immunoassay technique) procedure, has proven to be valuable for identifying recent drug use by youths as they are entering the juvenile justice system. The threshold for a drug positive is usually set quite high to reduce the rate of false positives (i.e., test identification of recent drug use where no use has occurred); and initial positives are often confirmed by another, more sensitive test (such as gas chromatography\mass spectrometry). Urine testing of juvenile arrestees is currently being completed as part of the National Institute of Justice's (NIJ's) Drug Use Forecasting Program,[29] which is in place in a number of U.S. cities. The procedure has also been a valuable tool in our research and service activities in the Hillsborough Regional Juvenile Detention Center in Tampa.[30]

Radio immunoassay of hair promises to become a widely used procedure. It determines recent use as well as the patterns of drug use over a span of time which can be determined by taking several samples of hair. Indications are that the procedure is more sensitive than urinalysis. However, hair analysis is currently much more costly,

reducing its usefulness for mass screening. As it takes a longer period of time for the biological traces of a drug to reach hair tissue than urine, the procedure has a longer turn around time. Clinical studies are now in process to improve the diagnostic usefulness of this procedure.

Sufficient evidence has been accumulated to confirm that biological analyses provide the most valid data about recent drug use. Other sources of information on drug use, such as self-reports and official records, are, for the reasons pointed out above, of lesser value in correctional settings.

THE PREVALENCE AND CORRELATES OF ALCOHOL AND OTHER DRUG USE AMONG YOUTHS IN THE JUVENILE JUSTICE SYSTEM

As noted earlier, youths whose behaviors in the community bring them into contact with the legal system are often experiencing multiple problems. Accordingly, their rates of substance use are likely to be higher than their same aged counterparts in the general population; and their usage of drugs is often related to a number of psychosocial difficulties.[31]

Self-report studies of drug use among youths in the juvenile justice system[32] have found considerably higher use rates than those reported by the 12 to 17 year old youths interviewed in the national household survey. In addition,

many of these youths have been found to be multiple drug users.

The recent application of urine testing to juveniles involved in the legal system has produced some striking findings. We began voluntary urine testing of adolescents entering a Tampa-based juvenile detention center in November 1985.[33] In 1987, the juvenile courts of Memphis and Shelby Counties, in cooperation with the Shelby County Health Department, collected and analyzed urine specimens from 456 participating youths, aged 14 to 17, who had been admitted to their detention centers. Also, in 1986, the Pretrial Services Agency in Washington, D.C., in collaboration with Toborg Associates, began routine urine testing of juveniles who were in detention or under pretrial supervision. Further, as noted earlier, in 1987, urine testing of juveniles entering the justice system was incorporated into the NIJ Drug Use Forecasting Program.

All these efforts revealed high rates of drug use among the youths who were tested, with drug types varying regionally. For example, in Tampa, we consistently found high rates of drug positives for cannabinoids, and low rates for cocaine.[34] Among youths tested in Washington, D.C., PCP was frequently identified in urine specimens, with marijuana and cocaine use being reported less often.[35]

In both Tampa and Washington, there were disturbing indications that the rate of cocaine use was increasing among high risk youths.[36] This trend paralleled that found among adult arrestees in Manhattan, New York City.[37]

Recently, attention has focused on the relationship between child maltreatment and delinquent behavior.[38] These studies, which are primarily descriptive in nature, support the conclusion that children's physical and sexual abuse experiences are associated with their use of illicit drugs. Our own research, involving a systematically selected cohort of 145 male and female detainees, housed at the Tampa detention center during the summer of 1984, found statistically significant relationships between their physical abuse and sexual victimization experiences and use of illicit drugs.[39] These findings were replicated in a subsequent study of a new cohort of youths entering the detention center in late 1986 and early 1987.[40]

These studies suggest that physical and sexual maltreatment of children causes deep psychological and physical pain which can lead to a number of adverse developmental outcomes. A number of additional studies we have completed provides support for this view.[41]

In a further study of the data collected in our 1984 study of juvenile detainees, it was found that both males and females were experiencing difficulties in a number of areas

in their emotional and psychological functioning.[42] The data was examined to determine if specific behavioral problems were associated with a young person's psychological orientation towards a deviant lifestyle. The results indicated significant, positive associations existed between a youth's "antisocial" value\behavior orientation and the number of times he\she had been placed in secure detention, his\her alcohol and illicit drug use, his\her history of physical abuse and his\her self-derogation (or low self-esteem). These relationships held when demographic characteristics were controlled.

The findings of our research, and that of others, make it clear that the many troubled youths entering the juvenile justice system are more appropriately viewed holistically. Service programs which focus on only one problem will neglect the multiple difficulties that these adolescents are often experiencing. Thus. the attempts these programs' make to change their clients' psychological orientation to deviant lifestyles are likely to fail.

RELATIONSHIPS BETWEEN ALCOHOL AND OTHER DRUG USE AND DELINQUENCY\CRIME AMONG YOUTHS IN JUVENILE JUSTICE SYSTEM

Urine testing conducted in a number of cities[43] has revealed that the majority of all adult arrestees have positive urine results for drugs. Arrestees with two or more

drugs identified in their urines have been found to have higher mean arrest rates at each age level, compared to drug negative arrestees. Similar findings are emerging from a growing number of studies involving juvenile arrestees.

Analysis of the urine specimens of youths entering the Tampa detention center in November 1985 found cannabinoids appeared in 34 of the 66 persons tested. A further study of the data was performed to determine the relationship of the youths' demographic characteristics, juvenile court referral history, physical abuse and sexual victimization experiences, and lifetime frequency of use of marijuana\hashish to the results of the EMIT R tests for the presence of cannabinoids. The results indicated that youths whose urines were found to be drug positive for cannabinoids had over two times as many nondrug felony referrals to juvenile court as youths with negative urine results. Burglary, auto theft and grand theft accounted for most of the nondrug felony referrals.

These findings strikingly documented a linkage between heavy use of marijuana and involvement in delinquent behavior. Similar findings have been found in our expanded replication of the November 1985 analyses.[44]

A subsequent study of juvenile detainees in Tampa enabled us to extend the scope of our coverage of drug use to include the use of cocaine.[45] Our analyses of marijuana/ hashish and cocaine use was based on results from the EMIT R

test and self-reported use data. Results consistently indicated that recent users of these substances had higher property, drug delinquency and status offense referral rates than nonusers.

An important research topic remains which concerns the interrelationship between youths' drug use and other delinquent behaviors over time. The findings of the research we are currently pursuing in Florida, and the work of others, should enable us to gain a better understanding of a number of important developmental issues, as well as permit us to identify characteristics or experiences that increase the likelihood for crime and drug use among young people.

STRATEGIES FOR INTERVENTION WITH YOUTHS IN THE JUVENILE JUSTICE SYSTEM

Drawing upon our understanding, youths involved in the juvenile justice system are often experiencing multiple difficulties in the areas of drug use, psychosocial functioning and delinquent behavior. We need to engage such persons and their families in effective intervention services at first contact with the human service or legal systems. Quality services are needed to serve dependency/neglect cases and delinquent youths; and service providers need to view troubled young people from a broader biopsychosocial perspective.

In regard to youths who are dependent and experiencing neglect/abuse, our research has indicated that these referrals to the social service system or juvenile court usually occur at an early age and often precede the initiation of delinquent behavior. This experience supports our view that there is a need for early, long-term, continuous, and intensive intervention efforts for children and families where physical and sexual abuse occurs at home, or for families that neglect their children or behave in ways known to be related to the abuse of children.[46] These efforts should seek to reduce the multiple problems often experienced by these parents, and provide deep reaching mental health services to children growing up in these settings. Where indicated, early separation of children from their families should be achieved, and the children raised in more wholesome environments. These issues point to increasingly important areas for policy review and change.

For youths who are involved with the juvenile justice system, a number of intervention efforts are indicated. For many youths, their entry into a secure detention center represents their first prolonged contact with the justice system. Detention represents an important juncture at which youths who are high risks for future drug use and delinquent

activities can be identified. This also creates the opportunity for constructive interventions to be made in their lives.

The relationships we have consistently found between physical abuse, sexual victimization and illicit drug use, as well as between drug use and delinquent behavior, among the adolescents who enter the detention center in Tampa, points to the need for appropriate screening of detained young people. Incorporating screening into the intake process will help to identify mental health or substance abuse problems the young person may be experiencing.

Based, in part, on the findings reported in our first article on this topic,[47] we have been engaged in a screening-triage project at the detention center since the fall of 1985.[48] Staff includes two full-time mental health counselors and a half-time counselor who provide mental health services. Our screening-triage project attempts to link youths needing assistance for mental health or substance abuse problems to community-based programs. Staff use criteria developed in collaboration with mental health and substance abuse service providers, when determining which youths to refer for further evaluation or assistance.

In addition to their routine screening-triage activities, project staff help train detention center personnel to identify detained juveniles who are probably

experiencing mental health difficulties, and particularly, who are at risk for suicide. Center staff are also instructed in interaction techniques that will reduce the chances of tense encounters with youths culminating in violent outcomes. Staff training in this area, as well as project services provided to detainees, has also been helpful in reducing staff stress.[49]

Research has repeatedly found that criminal behavior increases following addiction; and that arrests for drug offenses and property offenses decline with decreasing frequencies of drug use.[50] These results stress the need for treatment to reduce crime among drug dependent persons.

Contrary to public misconceptions, there is evidence that treatment for drug dependence can be effective. Programs that are based on social learning theories are particularly effective for drug users who are involved in the justice system, particularly for those whose drug use lifestyles have slowly developed over a period of years.[51]

In the treatment process, it is important to appreciate that altering drug dependence is often a prolonged process, involving periodic relapses. However, repeated interventions over a protracted period, which are reinforced by improvements in social, vocational and educational skill levels, are most likely to be successful.

A serious commitment to help the many troubled youths who enter the juvenile justice system is both humane and to the long-term benefit of society. If not helped, many of these youths will become more involved in substance use and pursue adult criminal careers.

Many of the young people we have studied have been "failed" youths. They were born into austere life circumstances, often raised by families who have neglected or abused them, or in other ways have failed to provide for their nurturance and wholesome development. At an early age, they have come to the attention of an over burdened and under resourced public service system, which was unable to provide them or their families with quality, deep reaching services for protracted periods. It is not surprising that these youths have experienced difficulties in directing their lives in more salutary directions, or that they have become involved in delinquent activities. They represent a challenge to our society, as a sizeable proportion of these young people will become members of the adult criminal justice system. Had society provided effective early intervention services for these youths and their families much human potential could have been saved and the personal and social costs of their delinquent/criminal behaviors would have been reduced substantially. It is hoped that the painful lessons we have learned, and are currently experiencing,

will lead to the development of more enlightened social policies.

FIGURE 1

COMPARISON OF FOUR TECHNIQUES FOR IDENTIFYING DRUG USING OFFENDERS

CHARACTERISTICS	SELF REPORTS	OFFICIAL CJS RECORDS	URINE TESTS	RADIOIMMUNOASSAY OF HAIR (RIAH)
TYPES OF DRUGS DETECTED:	All drugs.	Limited to drugs causing attention by bizarre behavior/sale/ treatment.	All commonly abused drugs.	All commonly abused drugs.
ACCURACY/VALIDITY:	Poor in criminal justice settings; good, in neutral settings or if person wants to talk.	Poor; often missing from records and consists of anecdotes.	Depends on test; EMIT better than TLC.	Too soon to tell; early reports suggest it is more sensitive than urinalysis.
COST:	Depends on whether new staff are needed to to conduct interviews.	Low, if maintained by existing staff in available data systems.	EMIT: $1-$5/drug TLC: $2 for a multidrug screen.	At least $30 for each drug.
PERIOD OF USE DETECTED:	Current and lifetime.	Depending on record detail, could include recent and lifetime.	Varies by drug; Heroin/cocaine last 24-72 hrs. PCP, marijuana, up to 1 month.	Months.

FIGURE 1 (CONTINUED)
COMPARISON OF FOUR TECHNIQUES FOR IDENTIFYING DRUG USING OFFENDERS

CHARACTERISTICS	SELF REPORTS	OFFICIAL CJS RECORDS	URINE TESTS	RADIOIMMUNO-ASSAY OF HAIR (RIAH)
DIFFERENTIATE USER FROM ABUSER?	Yes.	Yes, if details have been recorded.	Only by repeated testings.	Can provide record of chronic use over time.
COMMENTS:	Poor technique for mass screening for drug use. Is best method for diagnosing abuse, once use is known.	Records on drug involvement are too incomplete to be useful. Large potential value exists if recording is improved.	Best technique for mass screening. Can only indicate one-time use. Confirmation by retest or other data sources is needed to verify abuse.	Experimental techniques; turn around time of 24 hrs lessens feasibility for pre-trial use when results are needed quickly. May prove to be an excellent means to confirm other indicators of drug use and to track individual patterns.

NOTE: Figure taken from Wish (1986)

FOOTNOTES

1. Miller, Cisin, Gardner-Keaton, Harrell, Wirtz, Abelson, & Fishburne, 1983; National Institute on Drug Abuse, 1986.

2. Johnston, O'Malley, & Bachman, 1987.

3. National Institute on Drug Abuse, 1986.

4. Miller et al., 1983.

5. Miller et al., 1983.

6. Johnston et al., 1987.

7. Bachman, Johnston, & O'Malley, 1988.

8. Johnston, et al., 1987.

9. Kandel, 1975a, 1980.

10. Kandel, 1975b.

11. Elliott & Huizinga, 1984; Dembo, LaVoie, Schmeidler, & Washburn, 1987; Dembo, Dertke, Borders, Washburn, & Schmeidler, 1988.

12. Jessor & Jessor, 1977.

13. Akers, 1985.

14. Kaplan, 1980.

15. Kandel, 1973, 1974, 1975a; Kandel, Kessler & Margulies, 1978; Kandel & Adler, 1982.

16. Sutherland & Cressey, 1978.

17. Skinner, 1959.

18. Bandura, 1977.

19. Kandel 1973, 1974; Kandel & Adler, 1982; Kandel, Kessler, & Margulies, 1978.

20. Hirschi, 1969.

21. Akers, 1985.

22. Kaplan, Martin, & Robbins, 1984; Elliott, Huizinga, & Ageton, 1985.

23. See Johnson, 1979.

24. Miller et al., 1983.

25. Hindelang, Hirschi, & Weis, 1981; Elliott, Ageton, Huizinga, Knowles, & Carter, 1983.

26. Wish, Johnson, Chedekel, & Lipton, 1983; Wish, Anderson, Miller, & Johnson, 1984.

27. Boyer & McCauley, 1988; Dembo, Williams, Berry, Getreu, Washburn, Wish, & Schmeidler, in press.

28. Dembo, Washburn, Wish, Schmeidler, Getreu, Berry, Williams, & Blount, 1987a; Dembo, Washburn, Wish, Yeung, Getreu, Berry, & Blount, 1987b; Dembo et al., in press.

29. National Institute of Justice, 1988.

30. Dembo et al., 1987a, 1987b; Dembo et al., in press.

31. Blindman, Hutchings, & Perrotto, 1976; Dembo, LaVoie, Schmeidler, & Washburn, 1987; Dembo, Dertke, LaVoie, Borders, Washburn, & Schmeidler, 1987; Dembo, Dertke, Borders, Washburn, & Schmeidler, 1988.

32. Dembo, Tjaden, Dertke, Garrett, & Wanberg, in press; Dembo, Dertke, Schmeidler, & Washburn, 1986-87.

33. Dembo et al., 1987a, 1987b.

34. Dembo et al., 1987a, 1987b.

35. Boyer & McCauley, 1988.

36. Dembo, Williams, Berry, Getreu, Kern, Genung, Wish, Schmeidler, & LaVoie, 1988; Boyer & McCauley, 1988.

37. Wish, 1987.

38. Hunner & Walker, 1981; Alfaro, 1981; Paperny & Deischer, 1983.

39. Dembo, et al., 1988.

40. Dembo, Williams, Berry, Getreu, Washburn, Wish, Schmeidler, & Dertke, in press.

41. Dembo, Dertke, LaVoie, Borders, Washburn, & Schmeidler, 1987; Dembo, Williams, LaVoie, Berry, Getreu, Wish, Schmeidler, & Washburn, under review.

42. Dembo, LaVoie, Schmeidler, & Washburn, 1987.

43. Toborg, 1984; Wish et al., 1984; Wish, Brady, & Cuadrado, 1985; Wish et al., 1987; National Institute of Justice, 1988.

44. Dembo et al., 1987b.

45. Dembo, et al., in press.

46. See Garbarino & Gilliam, 1980.

47. Dembo et al., 1988.

48. Dembo, Washburn, Broskowski, Getreu, & Berry, 1986; also see Dembo et al., 1987a.

49. Dembo, Williams, & Stafford, 1986-87.

50. McGlothlin, Anglin, & Wilson, 1978; Ball, Rosen, Flueck, & Nurco, 1981; Ball, Shaffer, & Nurco, 1983; Anglin & Speckart, 1988.

51. Wexler, Lipton, & Foster, 1985; Wexler & Williams, 1986; DeLeon, 1986.

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SUBSTANCE ABUSE PROGRAM

PROFILES

ABRAXAS FOUNDATION
ABRAXAS I
MARIENVILLE, PA

PROGRAM PROFILE

The Abraxas Foundation operates treatment programs for juvenile offenders in several facilities located in five communities. It offers programs of private in- and outpatient therapeutic treatment to male and female clients who have histories of drug and alcohol abuse, suicide attempts, and crimes against property and people. Most clients are ordered to Abraxas Foundation's programs by the court as an alternative to incarceration. The treatment program has three phases. Phase I involves intensive residential treatment for 6 to 9 months. Phase II, or re-entry, takes 3 to 6 months. Clients live in houses with 25 to 30 other residents while they attempt to make the transition back into the community. During the final sequence, clients live with their families, or they set up households for themselves, while maintaining contact with staff and attending counseling sessions. This phase lasts one to 3 months. For some residential graduates, Abraxas has developed SIL (Supervised Independent Living) where they can reside while concentrating on attaining education and employment.

Abraxas I, which is located in Marienville, is the Abraxas Foundation program we will focus upon in this

profile. This inpatient treatment facility opened its doors in 1973 to provide the first phase in the Foundation's three phase intensive process. All their clients are male offenders, between the ages of 15 and 18. Two-thirds are between 16 and 17 years old. The majority are from broken homes. Seventy-four percent of those referred to the program reside in either Pittsburgh or Philadelphia. Thirty-five percent are minorities. Although a large percentage of their clients are involved in polydrug use, the program has recently been receiving an increased number of rural referrals in which alcohol is the drug of preference.

Abraxas I has a 138-bed facility which is generally filled to capacity. The program is situated on 100 acres in Allegheny National Forest, to which access is gained by a 6 mile dirt road. The program's remote location generally discourages clients from attempting to leave without consent. Recently several buildings have been added which include a 28-bed duplex dormitory and a school building, both of which are accessible to the disabled.

PROGRAM PHILOSOPHY

Abraxas Foundation programs treat substance abuse as a family disease. Their treatment programs place emphasis on trust and integrity, positive peer pressure, self-discipline, and self discovery. A modified Therapeutic Community Model

is used which emphasizes "family ethics." This approach involves shared problem solving, development of positive peer relations, and clarification of positive values through personal responsibility and concern for others. All their individual, group, and family services attempt to integrate the therapeutic community model with learning program approaches (such as the "Keys to Excellence" program, a video series designed to heighten self-esteem, build leadership, and so forth), current psychodynamic concepts (i.e., value clarification and ego growth), and the approaches used by other treatment programs.

Those who complete the program appear to fair much better than those who drop out or who are discharged. Program staff feel they are most successful with those clients whose primary diagnosis is drug or alcohol dependency, rather than mental/ emotional diagnoses where substance abuse is a secondary problem.

PROGRAM STRUCTURE

The Abraxas program primarily uses group dynamics and peer support recovery methods which are outlined in Alcoholic Anonymous' 12-steps. Individual sessions are scheduled weekly for the identification and review of treatment objectives. The types of assessment and treatment services provided include:

1. psychosocial evaluation, personality testing, drug use assessment; and behavioral and family assessment;
2. group and individual therapy;
3. family and multi-family therapy;
4. self-help groups for clients and their families;
5. treatment services for special populations that require unique approaches, for instance, teenage parents and the learning disabled;
6. psychodrama, peer counseling and legal services;
7. comprehensive treatment planning and monthly updates of goals and objectives;
8. job assignments;
9. an educational program that offers English, social studies, science, math, crafts, theatre/drama, art and physical education;
10. regular seminars on drug and alcohol abuse and other topical issues;
11. therapeutic recreation which includes swimming, fishing, hiking, racquetball, intramurals, cross-country skiing, ice skating, skiing, snow shoeing and yearly five-day wilderness trips;
12. vocational education, i.e., wood working and welding.
13. classes in health and nutrition; and

14. regularly scheduled progress reports to referring agencies.

Abraxas I runs a small, private high school which has been licensed since 1974. The program teaches each client at his/her functioning grade level. Small classes, individual study projects, and certified instructors make the school more inviting to most of the program's clients. Abraxas I has been successful at helping many learning disabled students to significantly increase their achievement scores. The progress of each client is measured by general education pre- and post-tests.

Students attend school Monday through Friday, year round. Credits may transfer but no formal relationship has been established between Abraxas and local school systems.

Clients are generally referred by the juvenile justice system. Acceptance into the program is based on: 1) attitude and motivation towards treatment, 2) an evaluation of background information which includes the offense record, 3) the determination of appropriateness for residential treatment, 4) a demonstration of ability to conceptualize, 5) the appropriation of sufficient funding for their treatment, and 6) the arrangement of necessary legal matters. The program will not treat those who:

1. clearly are resistant to residential treatment;

2. have histories of uncontrolled dangerous behavior towards themselves and/or others (to include sexual offenses and arson);
3. have medical or psychological problems beyond the program's scope; or
4. have an IQ less than 78 or have severe physical handicaps that would require medical attention beyond the program's capability.

The intake process includes an interview with the client to determine their motivation towards treatment; discern problem areas; explain the philosophy, policies and treatments of the program; and answer any questions the prospective client may have. Information regarding the program's structure, philosophy and regulations is provided to anyone interested. Clients are placed on a waiting list after they are accepted and they fill places as they open. This maintains an even population flow.

During the initial 30-day diagnostic period, staff and client agree to a preliminary treatment contract. Each client can expect to work with the same counselor throughout their stay in the program. One of the major tasks of the staff is to help each client maintain a commitment to treatment.

When a serious infraction is committed, a series of interventions are available. The staff first talks the

matter over with the client and, if required, facilitates confrontation by other clients, teachers, or counselors. Next is a stage called "learning experience/loss of privilege," which may involve writing an essay or reading an assignment. This is followed by intervention by significant others and/or a referral source, where family members and/or a probation officer may be involved. The final step is to discharge the client.

Seventy percent of Abraxas I's participants have progressed through all four phases of their inpatient treatment. Most of those who have been expelled have been dismissed for mental health or medical reasons.

A participant may complete the Abraxas program in six to nine months. However, participants may be held back to ensure successful program completion. A ceremony is held bi-annually in honor of graduates, to which residents, staff, family, judges, probation officers, friends and other supporters are invited.

The treatment plan, which is developed during the diagnostic period includes provisions for aftercare. By a client's third month in the program, discharge plans are developed. Seventy-five to eighty percent of Abraxas I's clients are placed in an Abraxas Foundation reentry program. Wherever a client is placed, aftercare typically lasts 90 to 180 days.

Significant others who wish to be involved are recognized and treated as family members. A person might qualify as a "family" member who is a neighbor, friend, boy/girlfriend, and so forth.

Family counseling sessions are conducted as early as family members are able to meet. Sessions are conducted before and after visits at the family's home, and at the facility. Special effort is made to involve private family therapists.

Abraxas I also provides peer group support to family members involved in their treatment, education, and prevention programs. These are offered through a statewide network of concerned families. Additionally, Abraxas I often transports families to Marienville for their visits with clients. The program also holds family picnics and generally encourages relationships with significant others.

Volunteers from the Abraxas therapeutic community, which include counselors, social workers, Foundation executives, program graduates, residents, and members of the Abraxas Family Association, speak to interested groups about drug and alcohol abuse, related social and behavioral problems, and Abraxas Foundations' rehabilitation programs. Residents and staff have also appeared on TV, and participated in radio talk shows.

Abraxas I will refer clients to local resources when needed. Referrals may be made to a local rape crisis center, medical health care programs and a psychiatrist.

In an effort to increase the visibility of the program, elicit support from the community at large, and generate referrals, Abraxas has created an Information and Court Services Department (ICSD) to oversee and coordinate outreach efforts. The ICSD:

1. initiates speaking engagements with criminal justice system representatives, referral agencies and community groups;
2. coordinates tours and on-site visits from schools, criminal justice representatives, referral and other agencies, community groups, and private individuals;
3. provides programmatic information to parents, community groups, referral agencies, and criminal justice representatives;
4. assists in the presentation and development of workshops and seminars offered at community meetings, conferences and at Abraxas I; and
5. maintains professional liaison with the criminal justice system and the community.

To ensure continuity of care, staff members regularly have contact with all referral sources. Progress reports are

provided at 30 days, 3 months, 6 months and 9 months of treatment, and include a discharge summary at the end of treatment. Progress reports are presented at court hearings by an agency liaison.

Treatment success is measured with follow-ups after a client leaves the program. Clients are tracked up to 5 years after graduation.

STAFF

Abraxas I employs 110 staff members. Of these, 22 have college degrees and seventeen are recovering substance abusers. Teachers have a minimum of a Bachelor's degree in Education and are certified in their specialty areas. Requirements for a Treatment Supervisor are a Bachelor's degree plus 3 years experience, or a high school diploma and 5 years experience with youth and drug/alcohol abuse. A Counselor II must have a Bachelor's plus 1 year experience, or a high school diploma plus 3 years experience. All of Abraxas' clinical staff work toward certification as alcohol and drug counselors by the Pennsylvania Drug and Alcohol Commission while they work in the program.

Forty hours of training is required of the entire staff by the Department of Public Welfare; sixty hours is required of certified addiction counselors. Continuous in-service training is provided to staff members. Topics covered

include pharmacology, CPR, first aid, case management, suicide, and self-esteem. Abraxas will also pay for 3 college credits per semester.

The program's staff/client ratio is 6:19. Staffing patterns vary to maintain continuous coverage. Some employees work four-day weeks and others work five. Clinical staff are scheduled between 7 a.m. and 11 p.m., and two house parents are on duty on each unit from 9:30 p.m. til 7 a.m. Staff are aided by volunteers, who include librarians, a local pastor, and AA/NA members.

ADMINISTRATIVE ISSUES

In case of medical or other emergencies, the nearest hospital is 30 miles away and the nearest fire department is 20 minutes away. Medical staff employed includes 1 LPN, 1 RN, and 3 EMTs, in addition to having a doctor on-call at all times.

Abraxas will perform urinalyses on clients and employees, for cause. They can potentially offer employees treatment.

Abraxas' drug and alcohol treatment facilities are licensed by the Pennsylvania Department of Health's Office of Drug and Alcohol Programs, the Department of Public Welfare and the Department of Education. They are also certified by

the Pennsylvania Department of Labor and Industry and are approved by local health departments.

Granting agencies which support Abraxas include the Office of Drug and Alcohol Programs, the Department of Education, and the Department of Public Welfare. Many fund-raising activities provide Abraxas with additional income. Most of their costs are derived from a per diem rate which is invoiced monthly to referring county agencies. County courts and Pennsylvania's Department of Public Welfare reimburse 75 percent of their referrals' placements. Though Abraxas is not qualified to receive third-party insurance payments, the program provides a sliding scale for private paying clients.

EVALUATION

Internal evaluation has been conducted since 1973, when the program began. Demographic, social, psychological and educational variables are measured before and after treatment. Clients are followed for up to five years after discharge. Because Abraxas emphasizes quality control, it has a research department which devotes itself to internal evaluation and research.

Data on clients is maintained with the aid of a computerized client information system. Client progress is tracked through all facilities and programs. In this way,

changes in the character of the general population that is served by Abraxas are continually monitored. Abraxas also conducts and publishes research that is of general interest to those in the field. Abraxas itself has never been evaluated by a third party; however the program has cooperated with research projects that have been sponsored by outside agencies.

ABRAXAS I CLINICAL/EDUCATIONAL SCHEDULE

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
Wake Up 10:00 AM	Wake Up 7:00 AM	Same as Monday 7:00 AM- 7:00 PM	Same as Monday 7:00 AM-7:00 PM	Same as Monday 7:00 AM-7:00 PM	Same as Monday 7:00 AM-4:00 PM	Wake Up 8:00 AM
Brunch 11:00 AM-1:00 PM	Breakfast 7:00 - 8:00 AM					Breakfast 8:00-9:00 AM
House Mtg. 1:30-2:00 PM	Dorm Assign. 8:00-8:30 AM					Morning Mtg. 9:00-9:30 AM
Free Time 2:00-4:00 PM	AM Homeroom 8:30-9:10 AM					G.I. 9:30-12:00
NA Mtg. 4:00-5:00 PM	School 9:10-11:30AM					Intramural 12:00-4:00 PM
Dinner 5:30-6:00 PM	Lunch 11:30-12:00					Seminar 4:00-5:00 PM
Phone Calls 6:00 7:30 PM	School 12:00-2:30PM					Free Time 5:00-5:30 PM
Com AA Mtg. 7:30-9:00 PM	PM Homeroom 2:30-3:10 PM					Dinner 5:30-6:00 PM
Relate Time 9:00-10:00 PM	Study Time 3:10-4:00 PM					House Mtg. 6:00-6:30 PM
Closure 10:00-10:30 PM	NA/AA Step 4:00-5:00 PM				Issue Group 4:00-5:30 PM	Clinical Movie 6:30-9:00 PM
Bed	Free Time 5:00-5:30 PM					Free Time 9:00-10:00 PM
	Dinner 5:30-6:00PM				Dinner 5:30-6:00PM	Closure 10:00-10:30 PM
	Seminar 6:00-7:00PM				Seminar 6:00-7:00 PM	Bed
	Clean Up 7:00-7:30 PM				NA/AA 7:00-8:30PM	
	NA/AA Step 7:30-9:30 PM	Family Night. 7:30-10:00 PM	NA Mtg. 7:30-9:30 PM	On-going group 7:30-9:30 PM	Letter Writing 8:30-9:00 PM	
	Letter Writing 9:30-10:00 PM		Letter Writing 9:30-10:00 PM	Phone Calls 9:30-10:00 PM	Free Time 9:00-10:00 PM	
	Closure 10:00-10:30 PM	Closure 10:00-10:30 PM	Closure 10:00-10:30 PM	Closure 10:00-10:00 PM	Closure 10:00-10:30PM	
	Bed	Bed	Bed	Bed	Bed	

PROGRAM PROFILE
OF
THE STATE OF WASHINGTON
DEPARTMENT OF HEALTH SERVICES
THE EXODUS PROGRAM

PROGRAM PROFILE

Exodus is a co-educational, eight-week, inpatient treatment program which is located in a secure setting, surrounded by natural boundaries. Since it began on April 1, 1985, 75% of its clients have been adjudicated males. Twenty-five percent have been between the ages 17 and 19, and 25% have been between 15 and 16 years old. Reflective of Washington state's population, 70% of those treated have been Caucasian. Most clients have been from the Seattle area. All have been polydrug users in the late stages of addiction, and have been incarcerated for six months or more prior to entering the treatment program. The offenses which they have been committed have been varied. Participants' drugs of choice are usually cocaine, alcohol, LSD and marijuana.

The program's facility is located in a rural setting on the premises of Echo Glen Children's Center (EGCC) in Snoqualmie, Washington. Clients reside in one of EGCC's 13 cottages; however, Exodus' programming is entirely separate, and the program's participants have very little contact the EGCC facility.

The cottage houses 16 beds. Its building is accessible to the physically disabled. It is located on one level and has no steps. Exodus receives four new clients every two weeks and treats an average daily client load of 15.

PROGRAM PHILOSOPHY

Exodus treats chemical dependency as a disease that affects the quality of the individual's life. Ninety-five percent of Exodus' clients are the children of drug-using parents. Pressure from peers also is an important contributing force to drug use among this client population.

Those who succeed in Exodus' treatment program are usually older (17 to 18), mature for their age, and seeking emancipation. They generally have been incarcerated for 2 to 3 years, have seen enough damage to their lives by drugs prior to placement, and are motivated towards healthier lifestyles. Those 15 years old and younger have a more difficult time accepting that they have used enough and that their lives are troubled enough to require change on their part.

PROGRAM STRUCTURE

Exodus' sole focus is on chemical dependency. It is Exodus' goal to help young people free themselves from the bondage of their disease by committing themselves to total

abstinence and by seeking support from other recovering alcoholics and addicts. The program offers an eight-week inpatient co-ed program for adolescents which includes drug and alcohol education, and group/individual counseling that is closely connected, when possible, to aftercare services.

Exodus' program is drug-free (including caffeine, sugar and nicotine) with the exception of prescriptions from a psychiatrist or medical doctor.

Program activities include community AA/NA meetings, drug/alcohol education and urinalysis, Exodus' program provides small and large group sessions, family workshops, journal writing, NA\AA step-work, and aftercare coordination. Exodus' client population has been institutionalized for some time before admission to the program, so detoxification is not provided.

Therapy is provided to all clients. It includes individual, group, and family counseling, psychodrama, and art therapy. Medical, dietary, psychological and psychiatric consultations are also available.

A primary component is the 12-steps of AA and NA. These are taught in a series of lectures, daily study, and step meetings.

Group therapy is a way of life in the program. Youngsters are involved in two to three groups each day, over

and above the 12-step and AA meetings they attend. In these groups, they share their personal stories, process in the program, give and receive support, encouragement and confrontation. Special groups are held which focus on particular topics, such as growing up as children of alcoholics, self-esteem, how to handle stress and methods of relaxation, and the process of undoing the hurt of sexual and physical abuse. Sexual abuse is an issue that has affected most of Exodus' clients. Additionally, 85% of the female participants have had histories of prostitution.

Psychological reports and diagnostic tests are completed prior to admission. Additional assessment information includes family history, criminal behavior, social skills, educational achievement and other pertinent factors which is reviewed by the counselor and from which an initial treatment plan is developed.

Exodus carefully integrates education, employment and recreational components into the program. Three high school credits are earned by each participant. GED testing also is offered. Classes, which typically serve six to eight students, intensively study the problems of drug and alcohol abuse. Two classes a day are provided at the Echo Glen school: One is in physical education, and the other may include the topics of sex or drug/alcohol education. Journal writing is also required of everyone.

Exodus has an extensive recreational program. Activities are designed to promote teamwork and enhance self-esteem. Each participant is challenged to surpass his/her own expectations. Activities include volleyball, jogging, exercises, aerobics, river rafting, rock climbing and rope courses.

Nutrition is also taught with the purpose of making all students aware of the effects of addictive dietary substances, (i.e., caffeine, sugar, and chocolate) and the presence of addictive substances in medication.

Exodus provides treatment to voluntary clients who, prior to admission, must demonstrate motivation for treatment and willingness to address chemical dependency issues. Applicants are to complete several pre-admission exercises which entail attending Alcoholics Anonymous meetings, being given urinalyses tests every two weeks, and learning about the consequences of addictive behavior. Writing a 34 page self-assessment is used as an optional assignment in cases where denial is strong.

Eligibility criteria includes: 1) an admitted history of substance abuse and being motivated to change; 2) taking a diagnostic test which measures drug use and dependency (the Client Substance Index, an instrument developed to measure drug/alcohol use and dependency); 3) being assessed to be at

the later stages of addiction; 4) not having committed any acts of violence towards others in the past 2-3 months; 5) ability to read at least the fifth grade level or be willing to accept peer/volunteer help in reading; and 6) have at least four months of their sentence remaining after completing the program. Those who will not be admitted to Exodus' program include unmotivated addicts, untreated sex offenders (as the program treats a co-ed population), or high suicide, assault or escape risks.

Referrals may be made by a social worker or by the institution in which applicants are involved. The final admissions decision is made by the Program Manager, who attempts to choose a client population that is reflective of the State's incarcerated population.

The program has four phases. Focus is on increased responsibilities, privileges and therapeutic intensity. The AA/12-step process is a continuing activity throughout. Primary emphasis is on the assumption of responsibility and a commitment to and belief in the AA philosophy.

All participants reach Phase 2, and 10 out of 16 finish this phase. Two out of 16 make it to the highest level, Phase 4. This is a particularly difficult phase to complete, as cigarette smoking is prohibited and many participants are

smokers. Graduation is commemorated with a "Coining Ceremony," where the AA coin is given to each graduate.

Residents in the advanced phases attend weekly self-help (AA/NA) group meetings off-campus. Everyone attends weekly on-campus meetings. A client must reach Phase 2 before being allowed to leave the EGCC grounds. Those attending off-campus meetings choose a same sex sponsor before entering Phase 3. The sponsor will make on-ground visits and keep in frequent contact with the client by phone. During Phase 4 client and sponsor may leave the grounds together for a specified period of time. All sponsors are carefully screened prior to working with a client.

Each participant is assessed daily for addictive behaviors. Low scores can result in removal from group activities (for up to 5 hours), being returned to a previous phase with ensuing loss of privileges, written assignments or expulsion. The program has a central isolation area which may be used if a client acts out dangerously. A client may be removed from the program for assault, escape, attempting suicide, or involvement in a co-ed violation.

If there is damage to property, the client can make financial restitution by working on campus. If a resident has a positive urine test, they are returned to Phase 1 for five or more days. One to 24 hours of isolation may also be given, and/or written assignments are additional options.

Daily schedules: See attachment.

Individually, clients are assessed daily on the basis of behavioral goals they set for themselves. These goals are shared during an informal group. Formal assessment is performed on a weekly basis by the counselor and client, and obstacles to progress are examined. Assessment of progress is measured against the goals of each phase of the program.

Eight weeks is the maximum length that a client can stay at Exodus. Everyone graduates, regardless of the level to which they attain. It is hoped that each client will leave the program with skills to deal with their chemical dependency.

The referring institution is responsible for implementation of aftercare services. A steady focus is maintained on aftercare at Exodus. Two staff members facilitate aftercare for EGGC residents after graduation. Recovery is only begun during the client's brief stay at Exodus. Adolescents who complete intensive treatment programs have a relapse rate of about 80%. Reasons for this high rate of relapse are: the pressure to use drugs and alcohol from society at large and from their peers; physical and psychological needs; and the absence of any community based support, such as schools and family. Exodus views relapse as a chance to learn from mistakes and a time to impress upon the adolescent that drug use causes them pain.

Exodus assists its graduates in locating support groups and sponsors, as well as identifying community programs that will support them in their recovery. To facilitate this process, a computerized list of community resources is currently being compiled.

Aftercare can take place in an institution, in a group home or in the community. Washington State has designed several group home placements which specifically treat clients who are in recovery. Six out of 10 Exodus graduates are placed in these group homes. One or two clients are sent to long-term treatment facilities. The rest either return to their home institutions or are released to the community. Probation and parole provide referrals in the community.

The strongest support system for recovery from addiction and improvement of a client's lifestyle is a variety of 12-step groups offered by AA and NA. In the beginning of recovery, it is recommended that these groups be used daily, or at least three to four times a week. Joining a support group is required for 12-16 weeks for 1 hour per week. The support group can provide the young person with:

a. Encouragement to continue in their decision to remain drug free;

b. Clarification of issues not understood well enough while they were in Exodus;

c. Continuation of unfinished work begun in the intensive program; and

d. Direction for handling ongoing problems such as peer pressure, relapse, family and transition.

Except for sexual abuse, other problems are not treated while the client is in the program. Drug dependence and sexual abuse both involve feelings of powerlessness and are treated simultaneously. Generally, no referral for other treatment is made during the client's stay, so that the program's sole focus can be on chemical dependency. Problems not treated in the program, are addressed during aftercare.

Exodus is making a serious effort to involve members of their clients' families. All members of the family are impacted by the disease of addiction. Family involvement may include one or both parents, brothers/sisters, and grandparents. Families are offered a series of educational lectures and movies each Sunday, which cover enabling, detachment, chemical dependency as a family disease, and an introduction to the 12-steps of AA/NA. Family events are scheduled to help all to understand the disease of addiction and how to deal more effectively with their experience of living with someone who is chemically dependent.

Only those parents who attend the workshops are allowed to bring money, gifts, food, clothing, or send presents to

their children. It is felt that to do otherwise would encourage gifts that would not be supportive of recovery. Those families who do attend family workshops and whose sons/daughters achieve the program's highest phase, will be allowed some off-campus time together.

Toward the end of treatment, participants and staff make presentations to schools and other audiences. Staff also provide training to professionals and parents at various community locations.

To ensure continuity of care, constant communication goes on between the referring institution and Exodus, before and during treatment. Exodus trains staff at referring institutions to make referrals, conduct interventions, and oversee the pre-admission contract. Clients are to call their referring counselors within the first two weeks of entering the program to report about their progress. Exodus counselors will share all progress and treatment information with referral sources on an as needed basis.

STAFF

There are eight staff members: six males and two females. The ratio of staff to clients is one to five. The minimum requirement for a staff member is a Bachelor's degree and two years experience with youth. They also must qualify

for the State's Alcohol and Drug Counselor's Certification within two years of being hired. Two staff members are currently certified Alcohol and Drug Counselors by the Joint Commission on Accreditation of Hospitals, and the other six are working towards certification.

Because of certification requirements, 100 hours of continuing education must be obtained every two years by each staff member. As part of orientation, each staff member must attend a ten-day training given by the State, some of which addresses drug and alcohol issues. In-service training is offered on an ongoing basis, and attendance at workshops is encouraged. Nonetheless, it is preferred that employees have prior knowledge and experience in the areas of alcohol and drug issues, sexual abuse, and wilderness activities.

All of the program's staff has been employed between one and three years. The staff works 3 shifts: 7 a.m. - 3 p.m., 3 p.m. - 11 p.m., 11 p.m. - 7 a.m. Staff are asked to come in early, so shifts overlap and parting and arriving staff can meet. There is evening programming which includes groups, recreation, AA meetings and Friday video shows.

Volunteers may become AA/NA sponsors and facilitate on-grounds AA/NA meetings, co-facilitate orientation groups, and help clients with their step-work. To insure quality, there is a State policy which requires that a background check be

conducted on all volunteers. Volunteers are trained by Exodus in confidentiality, volunteerism, correction's philosophy in general, and Exodus' philosophy, in particular.

ADMINISTRATIVE ISSUES

An oversight committee plays an important role in the Exodus program. It has private and public sector representatives who designed the program, and currently deal with ongoing issues, troubleshoot, and facilitate resolution of inter- and intra-agency conflicts.

The medical facility is accredited by the Joint Commission for the Accreditation of Hospitals. A nurse is on duty 24 hours a day, and a doctor is always on call.

Exodus has adopted the practice of urine testing as one of the ways to control and confirm drug use. Drug screens are conducted when participants enter and leave the program, for cause and at random. The program's drug and alcohol use policy states that excessive drug/alcohol use by an employee <u>can</u> lead to dismissal, and if the use of illicit drug is involved, the person <u>will be</u> dismissed.

The educational program at Exodus is accredited by Issoquah School District. Its treatment program is accredited by Washington State's Bureau of Alcohol and Substance Abuse (BASA).

EVALUATION

Self-evaluation is required by Echo Glen and BASA. Evaluation of Exodus is done internally on an annual basis. The evaluation relies heavily on staff interviews. Additionally, one external evaluation has been conducted by BASA.

The State of Washington has its own research unit. Currently a factor analysis of the Client Substance Index is being conducted. The Personal Experience Inventory is being validated, and a clinical rating tool is being developed.

THE EXODUS PROGRAM

DAILY SCHEDULE

MONDAY

8:00	Rise/grooming
8:30	Breakfast
9:00	Clean-up
9:15	Meditation
9:45	Step group/Core talk
10:45	Core talk/Orientation/Group
11:30	Lunch
12:45	Study time/First group to school
1:30	Second group to school/Counseling time
2:25	Exchange classes
3:15	Whole group back from school
3:45	Cottage recreation
4:45	Community AA meeting
5:00	Supper
6:00	Study time
6:30	Journal sharing/Orientation
7:30	Campus NA meeting
9:15	Snack/Quick cottage clean-up
9:30	Bedtime/Counseling
10:00	Doors locked
10:30	Lights out

TUESDAY

7:15	Jogging time (voluntary)
8:00	Rise/Grooming/Breakfast/Details
9:15	Meditation
9:45	Step group/Core talks
10:15	Community AA meeting
10:45	Group/Core talks
11:30	Lunch
12:45	First group to school/Rest of group in study time
1:00	Staff meeting
1:30	Second group to school
3:15	Whole group back from school
5:00	Supper
6:00	Study time/Counseling time
7:00	Journal sharing/Orientation
7:15	Community AA meeting
8:00	Core talks
9:15	Snack/Quick cottage clean-up
10:00	Doors locked
10:30	Lights out

WEDNESDAY

8:00	Rise/Breakfast/Grooming/Chores
9:15	Meditation
9:45	Step group/Core talk
10:45	Core talk/Group
11:15	Community meeting
11:30	Lunch/Chores
12:45	First group to school/Rest in study period
1:30	Second group to school/Counseling
2:20	Exchange classes
3:15	Whole group back from school
3:45	Girls' and boys' survivors group
5:00	Supper
6:00	Study time/Counseling
7:00	Journal sharing/Orientation
7:15	Community meeting
8:00	Core talk/Group
9:15	Snack/Quick cottage clean-up
9:30	Bedtime/Counseling
10:00	Doors locked
10:30	Lights out

THURSDAY

7:15	Jogging (voluntary)
8:00	Rise/Breakfast/Grooming/Chores
9:15	Meditation
9:45	Core talk/Group/Orientation
10:45	Core talk/group
11:30	Lunch
12:35	First group to school
1:30	Second group to school
2:20	Exchange classes
3:15	Whole group back to cottage
3:45	Cottage recreation/aerobics
5:00	Supper
6:00	Study time/Counseling
7:00	Journal sharing/Orientation/Transition
8:00	Core talk/Group
9:15	Snacks
9:30	Bedtime/Counseling
10:00	Docks locked
10:30	Lights out

FRIDAY

8:00	Rise/Breakfast/Grooming/Chores
9:15	Meditation/Women only AA group
9:45	Step group/Core talk
10:45	Core talk/Group
11:30	Lunch
12:45	First group to school
1:30	Second group to school/Counseling
2:20	Exchange classes
3:15	Whole group back to cottage
3:45	Cottage recreation/Trampoline
5:00	Supper
6:30	Journal sharing
7:00	Movie/Discussion
9:00	Quick cottage clean-up/Snacks
9:30	Recreational movie (select group)/Bedtime
10:30	Lights out

SATURDAY

9:00	Rise/Grooming
9:30	Breakfast
10:00	Meditation
10:30	Cottage/Room clean-up
12:15	Lunch
1:00	Visiting
2:00	Family workshop
2:45	Shift change
3:00	Family workshop
3:15	Free time
5:00	Supper
5:45	Study time/Counseling
6:30	Journal sharing
7:00	Prepare for home AA meeting
7:30	Exodus AA meeting
9:30	Clean-up
10:00	Bedtime
10:30	Lights out

SUNDAY

8:15	Jogging (voluntary)
9:00	Rise/Grooming/Breakfast/Chores
9:30	Leave for AA meeting
10:00	Meditation
10:30	Free time
12:15	Lunch/Clean-up
1:00	Visiting/Family workshop/Voluntary gym
2:30	Snack
2:45	Shift change
3:00	Family workshop
3:15	Free time
5:00	Supper
6:00	Study time/Counseling
7:00	Journal sharing
7:45	Core talk
8:30	Cottage gym
9:30	Snack/Quick cottage clean-up
9:45	Bedtime/Counseling
10:15	Doors locked
10:30	Lights out

LINCOLN HILLS' SCHOOL ANTI-DRUG PROGRAM
IRMA, WISCONSIN

PROGRAM PROFILE

Lincoln Hills' School Anti-Drug Program (LHSADP) is situated on the grounds of Lincoln Hills' School (LHS), a closed juvenile co-educational correctional facility, located in North Central Wisconsin. LHS provides institutional programming for an average daily population of 170 male and 35 female juveniles, between the ages of 12 and 19. All have been adjudicated by the juvenile courts throughout the state for being a danger to the public and in need of restrictive custodial care. Commitments are renewable by the original court of jurisdiction on an annual basis, either for continued dangerousness or for continued treatment.

Clients who are treated by LHSADP are selected at the time of an initial assessment that is conducted by the institution. At the end of a thirty day evaluation period, a Juvenile Offender Review Board (JORB), a representative from the county of commitment, and a representative from LHS meet tc determine: the suitability of the youth's placement to a closed correctional facility (JORB has releasing authority), whether or not the youth has exhausted community resources, a review date, a tentative release plan, and treatment goals. Goals may include the need for inpatient alcohol/substance abuse treatment prior to their release from the institution.

The typical person to be assigned to LHSADP is a multi-adjudicated felonious offender, sixteen and a half years of age, who has failed one or more inpatient alcohol or drug abuse program. He/she has exhausted all community resources and is almost always a polydrug abuser. Additionally, he/she is of average intelligence, at least three years behind in school, and almost totally void of positive community support. His/her family unit is generally dysfunctional and the youth has strained its members to their limits.

LHSADP is based upon three premises. First, because of their backgrounds, the degree of psychosocial damage they have experienced, and the high potential for future antisocial behavior, LHSADP's clients have lost the option to determine if they will participate in inpatient substance abuse treatment. Second, continued participation and program completion are decisions the youths may not make. They are encouraged to express their opinions about their participation but they may not decide not to complete the program. Third, all participants who might reasonably be placed in community inpatient treatment programs will be referred elsewhere.

PROGRAM PHILOSOPHY

LHSADP believes that the chemically dependent adolescent has developed a pathological relationship with a mind/mood

altering experience. He/she has formed a bond with an object or event. The program's staff believes that bonding can not only be arrested, the pathological relationship can be replaced with positive growth inducing interpersonal relationships. Although the choice to change rests within the person, LHSADP believes that the choice to change in a positive and socially acceptable direction can be affected from an external source. This is achieved by bombarding the young delinquent addict with comprehensive and flexible treatment approaches and techniques. Such methods can be employed through a humane, yet ever challenging process which not only offers the person constructive behavioral alternatives, it urges him/her to go beyond. This is achieved by placing him/her in a therapeutic bind, where s/he must substitute positive behaviors for negative behaviors. Of necessity, positive behavior is positively reinforced while, at the same time, natural and logical consequences are provided for unacceptable behaviors.

Ultimately, the program's clients must and do assume personal responsibility for their treatment by taking personal initiative for the positive change process. It is LHSADP's belief that abstinence is a prerequisite to this change process and that a positive peer culture enhances their treatment process. Finally, and most important, an

effective transition into an appropriate supportive community environment, is of paramount importance for long-term treatment success.

PROGRAM STRUCTURE

All male juveniles, when they enter LHSADP, are assigned to a separate twenty-five bed living unit within the institutional compound. The females, on the other hand, when assigned to the program, continue to reside in the compound. All youths residing in the male unit are required to participate in two of three programs: the eighteen bed LHSADP, the Pre-AODA (Alcohol and Other Drug Abuse) Program, or the Re-entry AODA Program. The actual number of participants in the later two programs varies and its size depends on programmatic needs. The usual capacity is ten persons.

Pre-AODA Program - Clients are placed on a, first come first serve, waiting list for entry in LHSADP after they have been assessed to need inpatient substance abuse treatment. They continue to live in the institution and to participate in a school program. All may enter the institution's programs, which include the Indian Tribes of Wisconsin Program (ITW) and the Jesus Discovery Group.

Each Pre-AODA program youth is also assigned to a primary counselor attached to their living unit and is

required to successfully complete the following before their entering LHSADP:

1. An initial diagnostic assessment. Instruments used include the Adolescent Alcohol Involvement Scale, the Youth Diagnostic Screening Device, the MacAndrews Scale of the Minnesota Multiphasic Personality Inventory, and the Assessment of the Problem Drinker.
2. Identify unwanted and negative complications resulting from their alcohol and drug use in each of the following areas: family, friendships, school, finances, legal and intrapersonal. Each of these areas also contains nine to nineteen subparts.
3. Complete a family goal task list. This is used to begin the process of targeting major family issues to be addressed as part of the primary treatment program.
4. Provide operational definitions of twelve major life areas (school/job, ability to have fun, family relationships, values, guilt, self-concept, feelings, defense system, circle of friends, spirituality, physical health and mental health) and, in writing, explain how chemical use has affected each of these areas of their lives.

5. With their primary counselor, each youth is required to complete a personal assessment in which they are to identify, outline and define their individual strengths and weaknesses.

6. Finally, attend a weekly pre-LHSADP group meeting that is designed to prepare them for the intensity of primary treatment.

The Recycle Group - From time to time it becomes necessary to physically remove clients from the LHSADP program for unacceptable behavior. These youths are placed in one of two security-control programs operated by the institution. One provides medium security to the passive/resistive person and the other provides a maximum security program for the more aggressive individual who is in danger of harming persons and/or property. When either placement is made for more than 3 days, the youth must forfeit his/her place in LHSADP. They are once again returned to the program's waiting list. While in the control program, they complete specific requirements determined necessary by that program and perform AODA programming assignments they will be released back to their institutional living units. Activities are tailored to each youth and may include written assignments relating to the reason for their security placement; a redrafting of their LHSADP goals with plans for how they will more appropriately address these

areas in the future; and specific reading assignments. After successfully completing the security program, the young person is returned to his institutional living unit and there completes a modified version of the Pre-AODA program.

The core of the LHSADP program is "edutherapy," where every therapeutic intervention is viewed as a learning experience and every learning experience is viewed as a therapeutic intervention. The program can be divided into five components: 12-steps, individual and group counseling, educational programming and aftercare. Although these five areas are defined separately here, operationally they are interrelated so as to defy separation.

A. Participation in the 12-step program of Alcoholics Anonymous is required of each client. Although some modification is allowed, such as Narcotics Anonymous, the AA model has been mandated. It is more universally available in the community, especially in the rural areas of the state. Each youth must obtain a community sponsor prior to program completion and release from the institution. To assess their progress in the AA program, each person must complete the fifth step of admitting their wrongs to themselves, to God and to another human being. To assist in this process, both of the institution's chaplains make themselves

available. For those who are from a Native American culture, the director of the institution's ITW program makes himself available for this assignment.

B. Individual therapeutic counseling is provided at a minimum of one hour per week per youth by one of four social workers. This counseling relationship follows a specific developmental process modeled after cognitive-behavioral therapy. It begins by establishing a supportive relationship where the person is provided the message that he/she is valued as a human being and has the capacity to grow. Second, the client and worker engage in a process of clarifying communication, misconceptions and irrational beliefs. Third, the person describes his/her world of reality to gain greater understanding of him/herself and to differentiate their needs from their desires. Finally, termination is carefully structured to help the young client to make a positive transition to a home community. To facilitate this step and to aid the client to appropriately identify issues of concern, a series of tools and techniques are selected. They include timelines, feeling journals, family histories, worksheets, autobiographies and imagery.

C. Each client participates in forty-two hours of group work per week. Adjustments are made to the size and length of the groups to accommodate individual progress through the program and to meet programmatic needs.

Group therapy is divided according to stage, type, method and content. This division facilitates communication between staff members who work different shifts and different days of the week.

1. Group Stages: Staff members follow the group stages of exploration, internal conflict, conflict resolution, optimum productivity, and termination. By following these stages of the group process, staff members are able to fill in for each other and continue on in an uninterrupted fashion with method and content.

2. Group Types: The types of groups that are operated by the LHSADP consist of confrontation, recreation, task, support and therapy. Confrontation groups are directed and controlled by staff. These sessions are considered essential when addressing behavioral problems. The confrontive process directly attacks the client's defense system.

The second type of group is recreational. Recreational activities are staff-directed and are considered an integral part of the treatment process. After an activity, all participants process how each person participated. If a person's participation was lacking, they are required to identify how they might improve.

Task groups are used primarily to introduce and process new material so it becomes part of each member's inner resources. An example might be to view a video on alcohol and its effects on the family, being followed by a group discussion on the role of the enabler in the family unit. Support groups are based on the principle of guided group interaction. They are usually held on a weekly basis. Participants are selected by staff based on their progress in the program. The staff act primarily as facilitators and the clients assume a major portion of the groups' process and direction.

Therapeutic groups are conducted with specifically selected clients who have shown progress in the program and have demonstrated

some internalization of the program's lessons. These groups are conducted by at least two social workers and have a high degree of supervision and consultation.

3. Group Methods: Since adolescents are easily bored, group methods vary from group to group and are manipulated to maintain a challenging and stimulating program. An important method used is role playing, where members of the group are selected to act out a scene, such as a court appearance, a review before JORB and a demonstration of the client's assertiveness. Modeling is used to demonstrate how to use "I" statements and to practice saying "No" when confronted by peers to use drugs. Observational methods of learning are employed along with high interest videos, a plethora of written materials, lectures, art forms, and experiential educational experiences. Some of the experiential learning tools that have been developed by LHSADP include a ropes course modeled after Outward Bound, and a game developed by the staff called Blind Soccer, where only a blindfolded participant is allowed to kick the ball.

4. Content: The content of the material covered in therapeutic groups and educational programs has been developed by LHSADP staff over the past seven years. Among its repertoire are two exceptional full length feature films and specific materials developed by the program's staff that each person is required to assimilate before completing the program. These materials target the areas of anger management, stress reduction, peer pressure, assertiveness, sexuality, decision-making, family roles, values, depression, suicide, defense mechanisms, interpersonal communications, self-esteem, spirituality, and needs versus wants.

Each youth who participates in the above activities is evaluated on a daily basis as to the appropriateness and effectiveness of their participation. A point system has been devised to rate their interactions. Where possible, post-tests are used to determine if clients have, at a minimum, "learned" the materials that have been presented.

D. A full-time teacher has been assigned to LHSADP who provides thirty hours a week of educational

programming. Each youth participates in pre- and post-testing, for which he/she will receive a one-half high school credit in Basic Drug Education-Health Education.

Educational programming is divided into three main parts: health and wellness, drug knowledge, and decision-making. The health and wellness program includes information on alcohol's trip through the body and covers its effects on bodily parts and on the emotions. The connection of drug use to suicide, accidents, homicide, chronic brain syndromes, disorders on the central nervous system, etc. is studied.

To better understand the differentiation between the educational and group therapy portions of the program, the issue of sex versus sexuality might be used as an illustration. In the educational program, the physiology of sex is covered and in the group therapy, sexuality is discovered.

E. Lincoln Hills' School, at the time of the youth's initial assessment, formulates a tentative aftercare plan. This is subject to continuous updating throughout the client's stay at LHSADP.

At a minimum, aftercare is followed by institutional staff and the youth's assigned parole officer.

Recently, in response to a legislative mandate, the Office of Alcohol and Other Drug Abuse designated the nine largest counties of Wisconsin to receive special funds for the operation of transitional aftercare programming. This will provide an opportunity for LHSADP to assist the majority of its clients to reintegrate in their home communities.

Those youth who do not qualify for the transitional aftercare program will be required to participate in the Transition Group. This group will begin the formalization of release plans upon the client's entrance into LHSADP. It will be designed to afford clients progressively increasing responsibility and freedom through the use of transitional furloughs. Participants will be required to contact those with whom they will live upon release. If at all possible, prior to eligibility for transitional furloughs, family members or voluntary agency staff will be asked to come to the institution to become part of the youth's treatment experience. Additionally,

clients will be required to maintain close ties with their aftercare workers, and will be required to develop approved work and/or school plans to be implemented upon release. Finally, they will be required to obtain an AA sponsor, who will help facilitate their return to the home community. This aftercare transition group will use the methods as are employed in the core of LHSADP. For example, participants may role play re-entry into the home community, including re-entry into school, or perform mock employment interviews. Finally, they will be required to do such things as role play problematic situations and demonstrate an ability to handle stress and conflict, especially in the area of peer or family pressure to return to drug use.

Once a youth has entered LHSADP it will take a minimum of twelve to sixteen weeks to successfully complete the program. On the other end of the continuum, to date, is a young man who struggled in the program for five and a half months before being deemed successful. On a daily basis, clients are constructively engaged in activities from 8 a.m. to 8 p.m. All participants are provided reading and writing assignments and if a youth's work is complete, they are able to enjoy their free day off, Sunday.

Successful completion of the program has been very carefully defined. There are two categories of completion: success and failure. When JORB, the staff of LHSADP and the county of commitment literally give up on a youth, they are defined as failures. If the youth is not considered an imminent danger to the public and not in need of restrictive custodial care, he/she is moved on to some other more appropriate programming when discharged from the institution.

Successful completion of the program can be positive or negative. Positive success means the youth has completed all required materials and, in the judgment of the staff, has integrated those materials and made identifiable personal changes. Such a person is ideally suited for an aftercare facility or program and is rather easily transitioned into a community resource. A negative success is an individual who has demonstrated cognitive knowledge of the material but has not demonstrated any internalization of it. The program is designed to require that this internalization take place.

ADMINISTRATIVE ISSUES

Should an emergency occur, medical staff at the correctional facility will administer aid. If a client were to need hospitalization, a locked ward is available in one of several nearby hospitals.

LHS has the capacity to perform random urinalysis on its residents. No testing is performed on staff members. Drug screens are conducted primarily for the control of contraband in the institution and is not used as a treatment tool.

EVALUATION

Although LHSADP, to date, has not performed any evaluative research, in time the program hopes to be able to provide follow-up statistics and measure its long-term treatment success.

OHIO DEPARTMENT OF YOUTH SERVICES
SUBSTANCE ABUSE SERVICES
SCIOTO VILLAGE RESIDENTIAL TREATMENT UNIT
AND
BUCKEYE YOUTH CENTER RESIDENTIAL TREATMENT UNIT

PROGRAM PROFILE

The Ohio Department of Youth Services (ODYS) has instituted a comprehensive program for the treatment of adolescent substance abusers. All ODYS' clients are court mandated felony offenders between the ages of 12 and 21. All have been adjudicated and committed by one of Ohio State's 88 county juvenile courts. Most clients who participate in the inpatient treatment programs offered at Buckeye and Scioto Village are involuntarily admitted, and the beds at both facilities are reserved exclusively for ODYS clients.

The average length of treatment for females is 4.2 months and for males it is twenty-eight days. Scioto Village's treatment is longer. It is ODYS' only female treatment facility in the state.

Buckeye Youth Center Residential Treatment Unit

Buckeye Youth Center, which opened in December of 1987, as a male residential facility, has 28 substance abuse treatment beds within a medium security ODYS juvenile corrections facility. During the program's brief history, it has predominantly served young men between the ages of 15 and

18. Seventy-seven percent of its clients are Caucasian. Most have been from urban areas (73%), and 65% are receiving treatment for abuse of drugs other than alcohol.

Scioto Village Residential Treatment Unit.

This female residential treatment program is located on the edge of the Scioto River. It is a secure facility, surrounded by natural boundaries. The facility is housed in a separate cottage within a juvenile correction facility. Scioto Village serves predominantly urban girls whose average age is 16.7. 76% of the clients have been Caucasian and 24% Black. Ninety-five percent of its treatment population is involved in polydrug use. The program has a bed capacity of 24, and its average daily population is 23 to 24.

PROGRAM PHILOSOPHY

Chemical dependency is viewed by ODYS as a treatable disease. The primary factors that lead young people to use chemicals are dysfunctional and substance abusing families. It is felt that effective treatment must consider how gender, race, culture, family dynamics, and ethnicity will affect an adolescent's recovery process.

ODYS' most successful clients are usually somewhat older and more mature. They also tend to have more functional and

supportive families. The least successful clients, in addition to being younger and less mature, have not fully realized the consequences of their drug use.

PROGRAM STRUCTURE

All of ODYS' residential facilities have the following five major components:

1. Holistic assessment of each youth who enters the system.
2. Forty hours of substance abuse education and early intervention for all ODYS residents.
3. Intensive counseling for adolescents who have or whose family members have a substance abuse problem.
4. Residential treatment of males and females who require structured chemical dependency treatment.
5. Substance abuse aftercare which is provided to anyone who has completed a residential program, or who is referred by a regional youth counselor or institutional social worker.

Both Buckeye and Scioto Village are drug-free and provide: meditation, community meetings, individual and group therapy, education, AA/NA step-work, recreation, alternatives to drug use, level systems, weekly team

meetings, family counseling, weekly visits by family members, crisis intervention, medical and dental services, and psychiatric/psychological services. Treatment at either facility addresses chemical usage/ dependency, social behavior, criminal behavior patterns, family problems, physical/sexual/emotional abuse and/or neglect, mental health (i.e. stability, reality orientation, modes of thinking, etc.), victim stance thinking, denial and relapse prevention.

Before treatment begins, each client is assessed for substance abuse, criminal activities, and attitudes towards their chemical problem by a drug and alcohol assessment specialist. A family, social, educational, cultural, medical, abuse and/or neglect history is compiled, and an emotional assessment is also performed.

As all ODYS' clients have been incarcerated for a length of time before receiving drug/alcohol treatment, none of their residential units are medically staffed to handle detoxification. However, if a client were to need detoxification, he/she would be referred to their institution's medical services department.

Both programs have educational programs in which health and nutrition are incorporated, and each has a medical department that provides counseling to individuals on a consultant basis. Buckeye and Scioto Village also have

extensive recreational programs which include off-grounds skating parties and fishing trips to State parks. Both programs believe that young persons need to learn how to have fun sober, alone or while interacting with peers.

Academically, the programs are quite different. Scioto Village has a fully accredited high school. School is considered to be part of their treatment program. A school teacher is part of the treatment team, and behavior in school is considered when a female petitions for a "level" move.

Females attend three classes: math, history and English. Special education classes and business office education classes are provided to those who are eligible. Credit earned is transferred to the client's community school. The GED cannot be taken while the resident is in the treatment program; however, a female can receive guidance counseling in preparation for the exam.

In contrast, clients at Buckeye are taken out of school for the twenty-eight days of their treatment. They may be given the GED exam by qualified education personnel if they have a written "authorization letter" from the Ohio Department of Education. To date, a total of three males have been given the GED exam while at the Buckeye.

Admission criteria includes:

1. chemical use is a significant part of the client's lifestyle;

2. the youth has not undergone drug treatment at ODYS within the last 2 years;

3. in the last 3 months of incarceration for a female; and the last 28 days in a ODYS institution for a male.

The final decision for admission of males is made by the Assistant Administrator of the assessment program and by the Program Coordinator for females.

After a two day assessment, in which the initiate is assigned a "buddy" to orient him in the program, Buckeye's structure has three levels. Thirty points must be earned to move from Level 1 to Level 2, and 46 points, to then reach Level 3. A maximum of 60 points can be earned during a week. Privileges, such as bedtime hour, off-grounds time, number of phone calls allowed, length of visitations and amount of weekly allowance, improve as the client climbs from level to level. An estimated 70% of the program's participants move from phase to phase each week.

At Scioto Village, the level system begins with orientation, which is two weeks long. This is followed by placement in Level 1, which reflects the female participant's compliance with institutional rules and schedules. In two weeks the girl will be eligible for Level 2, where she must show interest and responsibility towards herself, peers,

staff and the program. Within three weeks of entering Level 2, she will be eligible for Level 3. To be placed at this level, she must demonstrate willingness to be a positive role model for her peers, helpfulness towards others, and self-motivation in her treatment. In three weeks she will be eligible for the next level. At Level 4 the participant will, in addition to all the above, be working through issues/problems and demonstrating continued effort in the program. Typical program structures/daily schedules for both programs are outlined in Attachments A and B.

Negative behavior is managed by an established structure. Staff first counsels the resident and then files an incident report which will contain statements from staff, witnesses (if possible), and the youth. When a participant does not follow the treatment program, he/she may be restricted from group activities, be given special programming until compliance is met, be isolated from the group or, be dismissed from the program.

Progress in treatment is measured through weekly evaluations (completed by an assigned social worker or youth leader), weekly team meetings, staff consultations, social work progress notes, progress in the level system, staff observations and evaluations, and social work discharge

summaries. Female clients are reviewed every two weeks (and more frequently during emergency situations). Treatment plans are written at intake, within 45 days and upon program completion. For males, reviews are weekly or as required, and treatment plans are updated on an as needed basis. Females must serve ninety days and complete a twelve-week lecture series and twelve-week step series. Basically, any male will finish who stays for the designated time, if he is not removed from the program for disciplinary reasons.

When a young person is selected to be placed on the male residential treatment unit, the regional substance abuse specialist and the regional youth counselor are informed of his discharge date. They can then begin to develop an aftercare plan. Typically this plan is formulated three weeks before the client enters his unit, and up-dated or revised four weeks before he is released from the institution. For a female at Scioto Village, the regional substance abuse specialist and her regional youth counselor are notified at least ninety days before she is released from incarceration.

Aftercare will address problems that cannot be adequately focused upon during treatment. The length of his/her substance abuse aftercare will vary. In the seven regions, contracts and agreements with other facilities and

community agencies are frequently used in the provision of services. Most clients are referred to community agencies, but when such services are not available, an ODYS drug and alcohol specialist will provide the needed services. If the individual is referred to a community agency, the type and length of aftercare is determined by that agency.

In both residential programs, treatment and aftercare portions are separate. A drug and alcohol specialist, at each facility, oversees aftercare services. Regional youth counselors (or parole officers) share responsibility for monitoring aftercare progress with the regional substance abuse specialist. They verify that the youth is attending aftercare meetings and that he/she is staying sober. Youth counselors also meet with clients and their families to monitor overall aftercare progress.

During or following aftercare, females are generally referred to outpatient treatment (21%), group homes (21%), to their own homes (49%) and to foster homes (22%). All males are referred to outpatient treatment, of which some are also referred to group homes (6%) and to their own homes (94%).

ODYS strongly believes that upon discharge, the client will need a supportive family system which is conducive to recovery. It is also believed that recovering alcoholics have the unique experiences and skills to provide this

environment. A regional pilot program provides licensed foster families education on the disease of chemical dependency and supports their parenting experiences with family therapy. ODYS monitors the progress of foster families, and provides additional support at times of crises.

Referral sources are used in the course of treatment when needed or requested. Both programs will direct clients to medical, psychiatric, psychological, and religious community resources. For females, specialists from community programs, such as Planned Parenthood, and legal representation, may also be consulted.

Outside referrals are formally evaluated by Buckeye's administrative structure to insure proper coordination with ODYS' services. At Scioto Village, all staff are responsible for the verification of credentials, monitoring and reporting of what they know about outside services to the Deputy Superintendent.

In general, all ODYS staff strongly encourage family members to become involved in self-help groups and in their child's treatment process. They attempt to talk with family and encourage visitations. Each adolescent served by a residential treatment program is assigned a social worker. The social worker generally attempts to work with family members. At times, the unit manager will work with the

family, and during visits the youth leader III may interact with family members. During aftercare, families are the focus of the regional youth counselor's and regional substance abuse specialist's attention.

For continuity of care, social workers and the youth counselors maintain ongoing communication with juvenile court officials until a resident is discharged from ODYS. Information shared includes the youth's progress in the institution and in treatment, aftercare plans and a final progress report.

STAFF

All staff at both facilities are required to have at least 32 hours of continuing education in the field of substance abuse each year. This training is given through in-services, conferences and other workshops and is paid for by the Central Office unit of Substance Abuse Services. Staff are trained in counseling and group facilitation, pharmacology, the disease concept, and other issues relevant to progress in treatment and relapse prevention.

Staff/client ratio in the female program is 1 unit manager, 1 social worker, 7 youth leader IIIs, 2 youth leader IIs and 1 secretary to serve 24 girls. For males, 1 unit manager, 1 youth leader supervisor, 4 social workers, 7 youth leader IIIs, 2 youth leader IIs and 1 secretary serve 28

boys. The difference between staffing patterns is due to treatment length. The male program being shorter, uses staff time more intensely.

Each client has the same primary counselor throughout treatment, and a different counselor throughout the aftercare program.

Both unit managers have masters degrees and all social workers have at least a bachelors degree. Both unit managers and all social workers are either certified by the Ohio Chemical Dependency Counselor's Credentialing Board or are in the process of receiving certification.

Youth leaders are highly experienced in the field of criminal justice. All have received extensive training in the field of substance abuse. Although not required, 66% of the staff on the female unit, and 26% on the male staff, are involved in recovery programs themselves.

Volunteers play an important role in both residential treatment programs. They act as chairpersons at AA/NA/Alateen house meetings, family planning counselors and as Big Brothers and Big Sisters. Volunteers are not required to receive formal unit/institutional training, but all must understand chemical dependency and the disease concept; know unit procedures/rules and institutional policies; have sincere, honest, realistic ideals regarding their roles as

volunteers; know they are not permanent staff members; tell staff any pertinent information that could affect a youth's treatment and/or behavior; have been sober at least one year; not be on parole or probation at the time; and be over 18 years of age. All are extensively interviewed by the Unit Manager to evaluate their potential, background, sincerity and ability to cooperate with a unit's staff.

ADMINISTRATIVE ISSUES

If a medical emergency should arise, staff at either program would provide immediate emergency first aid. The institution's clinic or the duty office would then be contacted. In the case of a serious emergency, a medical squad would be called, and the person would be transported to a local hospital.

Drug screens are not used in pre-treatment or during treatment. In some cases testing may be used during aftercare, but this is not an "across the board" policy.

Drug tests are not performed on ODYS' staff members. If a staff member were found to be working under the influence of drugs and/or alcohol, union laws are in effect which would require strict enforcement of policies and procedures regarding this matter.

At this time, ODYS' programs are not accredited. It is ODYS' intention to have their programs become accredited.

The accrediting bodies they intend to apply to are the Ohio Department of Health and Mental Health's Bureau of Alcohol Abuse and Alcoholism Recovery, and the Bureau of Drug Abuse.

The continuum of ODYS' substance abuse programs is funded by three sources: State of Ohio General Revenue Funds, Ohio Governor's Office of Criminal Justice Services and Governor's 30% Discretionary Funds. As all participants of residential treatment programs have been committed to ODYS, the program does not qualify to receive insurance payments and there is no charge to clients or their families.

EVALUATION

The Central Office administering Substance Abuse Services has been evaluating ODYS' program since its inception in December of 1987. The first phase of evaluation will be completed by July 1, 1988. Each residential treatment unit is visited at least twice per month by the Assistant Administrator of Substance Abuse Services who oversees the residential treatment programs. Treatment recipients are also given questionnaires to complete when they leave treatment to evaluate the program's content and its staff. Each unit conducts weekly team meetings, at which time staff will monitor and evaluate their effectiveness with the youth they serve. Also, the Evaluation Subcommittee of

the Community Advisory Committee for Substance Abuse Programs will evaluate residential treatment units internally. All of these pieces of evaluation are pulled together and compared to give an overall picture of the program.

Neither of the treatment programs has been evaluated by a third party, nor has any ODYS institution been involved in any substance abuse related research to this point.

Attachment A

SCIOTO VILLAGE RTU DAILY SCHEDULE

The 24 youth are divided into two groups (A and B), and they remain in their assigned groups for the duration of their stay in the program. Monday through Friday the youth participate in a highly structured program from 6:00 a.m. to 9:30 p.m. The schedule is as follows:

6:00 - 7:00 a.m.	Wash and dress
7:00 - 7:30 a.m.	Breakfast
7:30 - 8:05 a.m.	Clean rooms
8:05 - 11:00 a.m.	Group A in school; Group B in d/a program and peer group treatment
11:00 - 11:30 a.m.	Meditation group
11:30 - 12:00 p.m.	Lunch
12:00 - 12:20 p.m.	Free time
12:20 - 3:15 p.m.	Group B in school; Group A in d/a program and peer group treatment
3:15 - 4:30 p.m.	Showers, recreation, free time
4:30 - 5:00 p.m.	Dinner
5:00 - 6:00 p.m.	Step study
6:00 - 7:30 p.m.	Step education group, values clarification group, A.A. meetings
7:30 - 8:30 p.m.	Recreation
8:30 - 9:30 p.m.	Social/free time

Weekends are structured as follows:

7:30 - 8:45 a.m.	Wash and dress
9:00 - 9:30 a.m.	Breakfast
9:30 - 11:30 a.m.	Cottage chores
11:30 - 12:30 p.m.	Free time
12:30 - 1:00 p.m.	Lunch
1:00 - 4:00 p.m.*	Structured recreation "Alternatives to Using"
4:00 - 4:30 p.m.	Free time
4:30 - 5:00 p.m.	Dinner
5:00 - 6:00 p.m.	Free time
6:00 - 7:30 p.m.	Big peer group
7:30 - 10:00 p.m.	Structured group activity, free time, recreation

*On Sundays, those youth who have visitors, meet from 1:00 to 4:30 p.m.

Attachment B

BUCKEYE YOUTH CENTER RTU DAILY SCHEDULE

5:30 - 6:15 A.M.	WAKE UP	WAKE UP	WAKE UP	WAKE UP	WAKE UP	WAKE UP	WAKE UP
6:15 - 7:00	BREAKFAST CLEAN-UP	BREAKFAST CLEAN-UP	BREAKFAST CLEAN-UP	BREAKFAST CLEAN-UP	BREAKFAST CLEAN-UP	BREAKFAST CLEAN-UP	BREAKFAST CLEAN-UP
7:00 - 7:30	MEDITATION	MEDITATION	MEDITATION	MEDITATION	MEDITATION	MEDITATION	MEDITATION
7:30 - 8:30	COMM. MTG.	COMM. MTG.	COMM. MTG.	COMM. MTG.	COMM.MTG.	COMM.MTG.	FREE TIME
8:30 - 9:00	INDV.COUNS. QUIET TIME	INDV.COUNS. QUIET TIME	INDV.COUNS. QUIET TIME	INDV.COUNS. QUIET TIME	INDV.COUNS. QUIET TIME	INDV. COUNS. QUIET TIME	FREE TIME
9:00 - 10:15	LECTURE GROUP 1&2	ED.LECT. II ICT I	LECTURE GROUP 1&2	ED.LECT.II ICT I	LECTURE GROUP 1&2	ED.LECT.II GROUP II	FREE TIME CHURCH
10:15 - 10:45	ICT*/DETAILS	ICT/DETAILS	ICT/DETAILS	ICT/DETAILS	ICT/DETAILS	ICT/DETAILS	FREE TIME CHURCH
10:45 - 11:30	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH
11:30 - 12:00 P.M	PHT**/ICT DETAILS	PHT/ICT DETAILS	PHT/ICT DETAILS	PHT/ICT DETAILS	PHT/ICT DETAILS	PHT/ICT DETAILS	DETAILS
12:00 - 1:15	RECREATION	RECREATION	RECREATION	RECREATION	RECREATION	RECREATION	VISITATION (12:30 P.M.)
1:30 - 2:45	I GROUP II STEP W.	I GROUP GROUP II-ICT	I GROUP II STEP W.	I GROUP II-ICT	I GROUP II STEPWORK	I GROUP II-ICT	VISITATION FREE TIME
2:45 - 3:15	ICT- SHIFT CHNG.	ICT- SHIFT CHNG.	ICT- SHIFT CHNG.	ICT- SHIFT CHNG.	ICT- SHIFT CHNG.	ICT- SHIFT CHNG.	VISITATION FREE TIME
3:15 - 4:30	I STEP W. II GROUP	ED. LECT - I II GROUP	I STEP W. II GROUP	ED. LECT - I II GROUP	I STEP W. II GROUP	ED. LECT I II GROUP	VISITATION FREE TIME
4:45 - 5:30	DINNER/PHT	DINNER/PHT	DINNER/PHT	DINNER/PHT	DINNER/PHT	DINNER/PHT	DINNER/PHT
5:30 - 6:00 6:00 - 7:15	ALTERN	GP.II SHOWERS GP.I ALTERN	ALTERNATIVE	GP.I SHOWERS GP.II ALTERN.	ALTERNATIVE	ALTERNATIVE	ICT FREE TIME SHOWERS
7:15 - 8:30	NA/AA	GP.I SHOWERS GP.II AA	COA DETAILS	GP.II SHOWERS GP.I AA	AA	ICT	
8:30 - 10:00	SHOWERS DETAILS	ICT DETAILS	SHOWERS DETAILS	ICT DETAILS	SHOWERS DETAILS	SHOWERS FREE TIME	
10:00 P.M.	BEDTIME LIGHTS OUT	BEDTIME LIGHTS OUT	BEDTIME LIGHTS OUT	BEDTIME LIGHTS OUT	BEDTIME LIGHTS OUT	BEDTIME LIGHTS OUT	BEDTIME LIGHTS OUT

SHAWNEE HILLS COMMUNITY MENTAL HEALTH/MENTAL RETARDATION CENTER
YOUTH AND ADOLESCENT SERVICES
CHARLESTON, WEST VIRGINIA

PROGRAM PROFILE

Shawnee Hills Community Mental Health provides outpatient substance abuse treatment to adults and adolescents. Clients are in the early to moderate stages of addiction, or are recovering from substance abuse. Shawnee Hills Youth and Adolescent Services (YAS), which began their treatment program in June of 1987, treats adolescents.

Shawnee Hills YAS outpatient program treats clients between the ages of 11 and 18 in a conveniently located office building in Charleston. Their average participant is between the ages of 13 and 16. The vast majority are white (93%) males (82%) who are being treated for polydrug usage. Slightly more than half are from West Virginia's rural regions.

Shawnee Hills' adolescent participants are encouraged to build relationships with non-abusing adolescents and recovering peers, and are asked to find alternatives to drug-oriented social activities. This part of the program is call social detoxification. Social detoxification, education and psychotherapy are the primary methods Shawnee Hills uses

with adolescents who are in the mild stages of substance abuse. Those who are in the moderate to severe stages are referred for more restrictive, inpatient care.

PROGRAM PHILOSOPHY

Shawnee Hills views chemical dependency as a primary disease. While some individuals can occasionally use chemicals and not become addicted, others may be genetically predisposed towards dependence. Individuals who show a greater capacity for alcohol and drugs, may be more likely to abuse drugs. Chemical dependency is a problem which may trigger a multitude of psychological problems (depression, anxiety, grandiosity, antisocial behavior, etc.). Also a person who "self medicates" a mental health problem may end up with a dual diagnosis (where a psychological and medical problem are both considered primary.)

Shawnee Hill's staff have found that the ease of acquiring chemicals and the level of peer pressure both contribute to drug and alcohol usage. Chemicals are often introduced by family members or by friends. Initial experimentation may advance to more regular use if the adolescent believes drugs to be more life enhancing or destructive.

The professionals at Shawnee Hills feel they are most successful with the adolescent who is in the early

experimentation stages of use and abuse. This client is often less interested in social image and more capable of developing self control.

Others who also do well are participants in the YAS aftercare program. These adolescents have more serious histories of abuse and dependency and have invested a good deal of time and energy in making changes in their lives. YAS' aftercare program provides them with much needed support.

PROGRAM STRUCTURE

Shawnee Hills' treatment of adolescents is primarily focused on developing life and social skills. YAS program's emphasis is educational. It is felt that their young clients need to be taught life skills, such as non-chemical coping, relaxation techniques, problem solving, and maintenance of personal health and fitness.

Listed below are the major components of their program:

1. An Adolescent Substance Abuse Program (ASAP), which meets twice weekly for 10-12 weeks. The group is based on educational and psychotherapeutic peer counseling. Weekly topics are introduced ranging from chemical abuse/dependency symptoms, stages, and recovery, to life and social skills (i.e., decision making, problem solving, interpersonal

relationships, self-esteem, anger control, etc.). Group discussion is encouraged in all sessions, and personal issues are welcomed for group consideration.

2. An aftercare group for those who have completed inpatient treatment and an adolescent substance abuse group, whose members are maintaining sobriety. These groups meet once a week, for up to 3 months, according to individual needs. The groups focus on carrying and implementing contracts, building drug-free relationships, learning to have fun again, and personal issues.

3. A Serious and Tough Offenders Program (STOP), which is a highly structured and intensive 8-week probation group that meets for one hour per session. It is designed for persons, 13-18, who have committed serious offenses or who have not been able to comply with normal/standard probation requirements. The therapist works closely with the probation officer to determine if continued therapy or possible inpatient/residential treatment may be needed. Probation officers may bring their clients to these groups. Life and social skills are taught; impulse control, decision making and

problem solving skills are emphasized. Individual and family therapy are available on request.

4. Two Adolescent Adjustment Groups (AAGs) are available for emotionally disturbed adolescents. Through psychotherapy and peer counseling, members deal with emotional, family, and school problems and how these problems relate to substance abuse. Each group meets once a week for one hour. Individual or family therapy is also available as needed.
5. Individual and/or family therapy may be offered to the young person when their substance abuse is not appropriately treated with group sessions.
6. Peer groups in high schools meet through a Student Assistance Program (SAP). The therapists visit the schools once a week to facilitate volunteer groups composed of members who have substance abuse and emotional problems.
7. Family therapy is offered through the program's family education component.
8. An intensive home-based program for juveniles who are seriously emotionally disturbed. The therapist makes home visits to meet with the client and his/her family. Sessions may last 2 to 12 hours,

and may be provided up to 6 weeks. Ten percent of seriously emotionally disturbed youngsters have substance abuse related problems. As these young people are generally in danger of being placed outside of their homes, the program focuses on improving their home environments.

The entire YAS program at Shawnee Hills is oriented towards crisis intervention. It provides a range of services from emergency assessments for schools, court, hospitals, and referring individuals, to short-term crisis therapy interventions conducted through group, individual, and/or family sessions.

Treatment for voluntary and involuntary clients is essentially the same. Denial is dealt with, as it is often still present in the voluntary client. Involuntary clients are often sent by their probation officers, or have other forms of leverage involved in their getting treatment. This assures their attendance, and thus insures their exposure to educational materials and group discussions.

Assessment is the initial phase for all who enter the YAS program. Because of the wide range of programs and referrals provided, this part of the process is mandatory. Assessment is not only provided for every person upon entering the program, but for courts, Department of Health

(DOH) services, and schools when an emergency arises. An assessment includes the collection of: a medical, behavioral, social, recreational, substance abuse, psychiatric and educational/vocational history; in addition to a legal, biographical and family history. Support systems and role performance are also assessed.

While adolescent treatment at Shawnee Hills is tailored to the individual, emphasis is on small group therapy, which at times incorporates audiovisuals, role playing and family sculpturing techniques. All clients are encouraged to participate in AA/NA and to secure sponsors. These responsibilities are given to clients to help them work through denial and to actively promote recovery. Emphasis is on new ways to use leisure time and the development of relationships.

The foci of adolescent substance abuse groups are on: alcohol/drug education; etiology of use/abuse; communication, problem solving and decision making skills; life skills training; stress management techniques; improving self-concept; signs and symptoms of relapse; and relapse prevention. A typical group session begins with each member summarizing his/her work over the week. Personal issues related to remaining sober are then raised. Following this, a topic for the session is introduced, and group discussion will follow.

Shawnee Hills' treatment program provides outpatient care only and therefore, does not offer educational services. The program, however, frequently makes referrals to the Board of Education to help youths to reenter school. Clients are also referred for GED preparation and vocational rehabilitation.

Involuntary clients are accepted into Shawnee Hills by a Mental Hygiene Commissioner. Individuals may be referred by Juvenile Probation, in which case they will face penalties if they do not comply with the program's requirements. Final admission is decided upon by the therapist at intake, who will then direct the client to a particular program.

To be eligible for admission the individual must be between 11 and 18 years old and have a primary diagnosis of substance abuse. Adolescents who have a history of experimentation but have identifiable adjustment disorders or other primary diagnoses will be placed in an adjustment group. Those who have a primary diagnosis of psychosis, mental retardation or organic brain syndrome will be referred elsewhere for treatment.

For those adolescent clients who continue to abuse substances, inpatient or residential treatment is usually advised. It is pointed out at evaluation that if the client does not maintain abstinence, attend meetings regularly,

attend school or job training, then he/she will be recommended for residential treatment. Program participants are told that YAS has the option to do drug screens at any time. Additionally, probation officers may request random urinalyses.

A disruptive group member will be asked to leave a group and be required to make up the missed session. If the group member happens to be on probation, the probation officer is contacted and further action may be taken. Since completing sessions is required as part of probation, failure to complete a session carries with it the possibility of incarceration.

Shawnee Hills uses a substance abuse pre/post-test to measure overall progress. Unfortunately, many clients do not complete the program. Many members drop out, and often their families do not encourage them to stay. Members who are on probation frequently are reincarcerated by the court.

Treatment plans are individualized so that completion of group sessions, maintaining sobriety, and being able to verbalize the basic premises of the program's educational components might then be followed by individual and/or family therapy. In general, to complete the program the client is only required to complete eight group sessions.

Aftercare may be given in the form of group, individual and/or family sessions. The duration of outpatient aftercare

treatment is normally three months, though this may vary. YAS is an active participant in the coordination of community programs and uses all available services as potential referrals for its clients. The DOH is Shawnee Hills' primary referral source. If an applicant appears appropriate for inpatient treatment, YAS contacts a representative at DOH to seek funding approval. Two DOH beds are located at the Adolescent Care Unit in Charleston, West Virginia and eight are located at the Olympia Center in Kingwood, West Virginia. If DOH beds are available in either of these facilities and funding has been approved, YAS will assist the client's family in admitting their child for treatment.

In cases of sexual abuse, YAS will refer clients to the Sexual Assault Center at Family Services, Inc. In some instances YAS will work with the court and DOH on behalf of those who need out-of-home placements.

In the case of a medical detoxification, YAS will refer the individual to a local emergency room, the Shawnee Hills CARES (Chemical Abuse Reduced through Education and Services) program or to the Adolescent Care Unit. The referral choice is based on the adolescent's needs and his/her financial status. In cases where 5-day detoxification is appropriate, referrals are made to nearby state hospitals and inpatient programs.

Shawnee Hills views alcoholism/drug addiction as a family disease. Therefore, educational programs, counseling and self-help groups are routinely recommended to their clients' family members. At the present time, plans are in place to provide a family education group to parents of participants at Shawnee Hills. The program will consist of a 10-week module of 90 minute weekly meetings which will use videos, lectures and group discussions on aspects of chemical abuse/dependency.

Shawnee Hills offers a substance abuse prevention program to schools, churches, community organizations, and law enforcement groups. The program focuses on the disease model of alcoholism, the symptomatology of addiction and where to find help. A variety of educational programs are also offered to professionals who work with adolescents. They range from ways of determining if a substance abuse problem exists, to training magistrates, probation officers, and law enforcement officers how to deal with inebriated persons.

Shawnee Hills provides for continuity of care to its clients. The program works closely with Juvenile Probation, DOH, Family Services, several local agencies and school systems. It is an active participant on the Interdisciplinary Planning and Placement Committee Board of

DOH which coordinates all residential placements. It is also actively involved in FACT, an agency that coordinates community resources; and the Keep a Child in School Program, which coordinates services for school children in danger of dropping out or being expelled. Probation officers are informed of attendance on a weekly basis. The therapists, who work closely with inpatient counselors to develop aftercare plans, also assume case management responsibilities when the client leaves an inpatient facility.

STAFF

YAS' personnel maintain an approximate client caseload of between 15 and 35 in the Shawnee Hill outpatient program. One of these staff persons is the regional youth specialist who acts as a catalyst in the community; identifying needs and resources, and providing aftercare linkages. S t a f f maintains an 8 a.m. to 4 p.m. daytime schedule, offering evening appointments one to two days per week.

The minimum qualifications that Shawnee Hills requires of its substance abuse staff is a master's degree in a human services field from an accredited college or university. Staff are also expected to pursue internal and external postgraduate development training. Attendance is typically required for job advancement. Topics of in-house training

include substance abuse/dependence, other relevant clinical topics, and guidelines regarding confidentiality which are specific to the program.

All staff at Shawnee Hills have been employed at the program for at least a year. Although staff members remain flexible and often assume additional job duties, rotation of jobs is not allowed. Clients can expect to complete their treatment and aftercare program with the same therapist.

ADMINISTRATIVE ISSUES

The program maintains an excellent manual standardized record keeping system. For instance, it is required that all charts be returned in a day's time. When a file is taken out, its whereabouts is noted and the counselor checking it out is held responsible for its care. Corrections to charts must be made within 30 days.

Shawnee Hill's program is accredited by the Joint Commission on Accreditation of Hospitals and by the West Virginia Department of Behavioral Health Services. If a medical emergency should arise, YAS' medical staff is backed up by an emergency room, which is adjacent to Shawnee Hills' facility.

Breathalyzers, urinalysis drug screens and blood tests are administered to program participants. Tests may be given when deemed appropriate or when requested.

Drug testing is not routinely performed on staff. Employees who experience substance abuse problems are referred for services through YAS' Employee Assistance Program.

Shawnee Hills receives reimbursement from a variety of third party sources. Fees for outpatient treatment are determined by a sliding fee scale which is based on the client's family income and size. The program is also funded through a number of state and federal sources. These funds are administered both through West Virginia's Department of Human Services and West Virginia's Department of Behavioral Health Services.

EVALUATION

Internal mechanisms for evaluation are conducted through a Quality Assurance Committee (QAC). This committee coordinates standards for the provision of services with provider staff panels, and oversees the extensive activities of a Monitoring and Evaluation Committee. For each client, QAC conducts an admission review, a clinical case review, and a discharge review. QAC holds each therapist responsible for 90% of the requirements for each of these reviews.

External evaluation of YAS is conducted by the Joint Commission and by the West Virginia Department of Behavioral Health Services on an ongoing basis. Participation in research has been done in an informal fashion at Shawnee Hills. Interest in more formalized research endeavors is currently being voiced within the program.

DEVELOPING SUBSTANCE ABUSE TREATMENT IN A JUVENILE JUSTICE SETTING

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DEVELOPING SUBSTANCE ABUSE TREATMENT IN A JUVENILE JUSTICE SETTING

Many studies have established the link between substance abuse and delinquency.[1] Consequently, substance abuse problems are prevalent in the client population of juvenile justice settings. Training schools, detention facilities and community treatment programs must respond to these problems with careful and deliberate planning if they are to provide effective treatment.

Development of an effective treatment program is only one aspect of a comprehensive approach. Program administration, policy and goals should also be considered when addressing this issue. Comprehensive strategies take time, however, and even well planned program development will initially be weak in some areas and strong in others. To effectively plan programming for substance abusing juvenile offenders, the existing system must be carefully reviewed. Problem identification and a needs assessment is an essential first step for developing recommendations for improvement.

Administrative support is imperative. Substance abuse treatment in juvenile justice settings comes under attack as being too liberal ("the kids need to take responsibility for their actions") or too conservative ("what's the big deal over getting high?"). Without clear administrative support,

program staff will view changes with suspicion or indifference. To assure implementation, an administration needs to: 1) establish an overall philosophy for why substance abuse treatment programming is being developed; 2) sell the concept effectively; and 3) give the issue a high priority.

This approach is necessary for any initiative; however, it is particularly important with substance abuse programming in a justice system setting. Considerations of the unique nature of substance abuse treatment, the demands that treatment places on staff, and the fact that clients also are criminally involved present administrators with particular challenges. Specifically, treatment staff will be asked to deliver or participate in a treatment modality that uses unfamiliar concepts, such as "spirituality" and "disease." Staff will be expected to administer urinalysis and confront users about their results. Finally, staff will need to be aware that most of their attempts to impact delinquency, without complimentary substance abuse interventions, are likely to be ineffective if the client is an abuser.[2] This is a difficult proposition for staff who have been schooled in practical traditional juvenile justice service delivery.

To facilitate a clear understanding of substance abuse which will enable the juvenile justice administrator to

develop program initiatives, this paper will address key issues in program development on a broad perspective, avoiding specific recommendations to accommodate the variance in juvenile systems.

POLICY PLANNING

Problem identification and needs assessment provide an excellent basis for examining possible change in policy. A drug use study of the population is a first step in identifying the extent of the problem. The problem identification process should include questioning staff to identify programming needs in assessment education, treatment and aftercare. What may be missed in this initial analysis is the extent of the role of drugs in the daily life of juveniles. Typically, 70% or more of juvenile offenders have serious drug/alcohol problems.[3] Juvenile substance use is attributed as a major factor in rehabilitation effectiveness, group control and staff security.[4] Even in secure settings, juvenile offenders have a surprising level of access to illicit substances. In open settings, the level of involvement among residents or parolees can virtually overwhelm staff. This should be the only treatment goal for adjudicated juveniles.

The first obstacle to establishing an effective policy is theoretical: the debate between abstinence and moderation of

use. While abstinence may be unrealistic and rarely attainable as a treatment goal, it makes complete sense as a policy. Significant changes will occur in programming only when an agency adopts a strong stance on use of substances by clients and staff. There must be a constant reminder that juveniles are still children, still developing physically, emotionally and socially, and they need to refrain completely from the ingestion of substances. This fact, alone, drives a policy which demands drug-free attitudes and programs.

Several additional approaches will encourage a sound policy. An open debate at the administrative level, which is then encouraged throughout the system, will begin to clarify a "non-enabling" perspective for the agency. Decisions about each program component will recall the debate and necessitate further clarification. At this stage, a technical consultant can play a critical role. The formation of a program's "philosophy" should include discussion about the medical model, the religious overtones of the AA's approach, and accountability for clients' behavior versus their "loss of control." Policy can help clarify that chemical dependency, even if it is a disease, requires that the "patient" be responsible for maintaining his/her health i.e., by remaining abstinent.

A second major obstacle to effective policy establishment is program ownership. In most states there are state or

county agencies responsible for providing substance abuse services. Interagency agreements are necessary to clarify each agency's responsibilities. Juvenile justice agencies need to closely evaluate the pros and cons for contracting services through substance abuse agencies, or for developing their own internal capacity for substance abuse programming. It is true that the greater the involvement of all agency staff, the greater the success of substance abuse interventions. Substance abuse problems ultimately affect all agency operations.

If services are contracted, great care must be used in developing policies that assure staff support, both during and after those services are offered by the contractor. Most typically, administration will find a mix of internal services and contracted services will provide the most comprehensive approach.

A final noteworthy obstacle is the consideration of the unforseen, indirect costs of developing a substance abuse treatment program. Even when resources are readily available, substance abuse services and their supporting programs require significant staff time, training time, and administrative attention. These costs are very real, if not immediately noticed. Substance abuse treatment must still be offered in the context of delivering traditional juvenile

justice services, and requires a substantial investment by the agency if it is to be effective. A plausible rationale for this considerable investment is to place these programming efforts in the contextual framework of juvenile justice goals already established by the agency, e.g., the reduction of criminal behavior. This is analogous to "re-tooling" in private industry; the product remains the same while the methods change.

ESTABLISHMENT OF POLICY AND PROCEDURES

Policy for substance abuse programming must state, in clear terms, strong attitudes about drug and alcohol use. Focus should be on the health hazards that substance use presents to adolescents as they are still developing.

Policy should take into account the statistically validated correlation between drug/alconol use and criminal behavior.[5] It should clarify agency expectations for both punishment and treatment. Policy should place the issue of the provision of treatment in a juvenile justice framework and relate it to recidivism. Last, policy should be based on the concept of a comprehensive continuum that addresses levels of intervention appropriate to the needs of individual clients, that is supportive of other agency operations.

Procedures need to be developed with caution. One outcome of developing substance abuse programs is a rapidly

changing environment, both for clients and staff. Unexpected and seemingly unrelated issues emerge as these programs are implemented, e.g., disciplinary actions needed in response to positive urinalysis results. Procedures should remain true to the organization's philosophy as it is outlined in policy, and respond to legal confidentiality. Some components of programming may require more detailed development of procedures (i.e., the use of substance abuse assessment instruments and urinalysis testing). Also, existing components of the system, such as parole, may require alteration to accommodate drug/alcohol treatment case planning.

STAFF DEVELOPMENT AND TRAINING

Substance abuse training for staff can make or break program initiatives. As discussed earlier, some difficult issues for staff arise when substance abuse treatment is imposed on traditional correctional services. These issues underlie philosophical differences in our society. It is estimated that one out of every three American families is effected in some way by alcoholism. Society's attitudes towards substances are, in large part, fairly confused. The helping professions, juvenile justice included, typically report significant numbers of staff with family histories of

alcoholism. Staff, in many cases, can deny, even enable the client's substance use.

The first approach to staff development is an awareness campaign. This can be in the form of training. It should provide direct information and assistance to employees who are most likely to be adversely affected by changes in policy and service delivery. Employee assistance programs are an invaluable ally in this process. Training should directly and unabashedly address staff enabling and resistance issues.

Training curricula should include basic awareness of chemical dependency, information about treatment approaches, and methods for improving case management methods. Training should also encompass policy direction and expectations from management. Advanced training should be targeted for staff who are expected to deliver services and to coordinate activities. Training is best delivered by professionals with experience in both juvenile corrections and substance abuse treatment; some suspicion exists towards individuals solely with substance abuse treatment backgrounds. As more detailed training is identified, experts from the substance abuse field can be use more frequently.

It is also important that adolescent specific substance abuse treatment be addressed in training. Most treatment methods for adolescents originally emerged from what was

known about the adult alcoholic. As professionals increasingly encountered adolescents in treatment, new approaches were established that responded to the specific experience and needs of that population. Children do not react the same to substance use as adults. Potential damage, particularly on social and emotional development, is more severe. The long-term impact on their physiology is yet to be fully understood. In addition, the involvement of the family in treatment and recovery of the adolescent client is essential. A number of innovations in adolescent-specific approaches have occurred in recent years and it is essential that new programs continue to examine ideas for developing treatment more specifically directed at the adolescent client.[6]

CASE MANAGEMENT

The successful development of a substance abuse treatment programs requires an examination of organizational issues and, ultimately, the case management system. Staff with specific expertise need to be identified to play key roles in case management. Their responsibilities can be relatively straight forward: assessment of substance abuse problems, documentation of treatment progress, recommendations for treatment follow-up, and monitoring of program activities.

A high level of client involvement is required of the staff delivering substance abuse treatment. The degree of

expertise required of staff depends both on the role they play in the treatment, and the nature of their regular duties. For a probation/parole officer, a service "broker" role may only require monitoring treatment progress from a distance, with little expectation for them to identify goals and progress.

The case management of the substance abusing client requires that the line staff in residential programs be highly trained and skillful. The case plan must contain conditions for treatment, a system to monitor use of substances, and expectations for accountability. Staff are also responsible for security to assure the safe operation of the living unit.

ASSESSMENT

An assessment of the client's level of chemical dependency is critical to effective substance abuse treatment in juvenile justice programs. Assessment provides not only information specific to the individual client, but also baseline data on the nature and extent of the drug/alcohol problem in the client population. Assessment data can support the need for resources, help emphasize the severity of the substance abuse issues to treatment staff, and act as ongoing "training" by constantly reviewing substance abuse issues in treatment planning.

The majority of the validated instruments available have been developed for adults. Some instruments have been developed for a youthful audience (i.e., the Adolescent Alcohol Involvement Screen and the Client Substance Index), but they are based on an adult theoretical model. The only instrument constructed for an adolescent client population, and validated against a chronic delinquent population, appears to be the Personal Experience Inventory (PEI). The PEI was developed in Minnesota by a private consortium of treatment professionals, researchers and test developers. It is computer administered and interpreted and provides a comprehensive assessment. It has a validated scale of defensiveness and measures behavioral, emotional/social and psychiatric dysfunction. It will be available for general distribution in September of 1988.

The State of Washington, in concert with the test developers, validated the PEI with a chronic delinquent population.[7]

EDUCATION

All clients should receive basic information and skills on drugs and alcohol as the first level of substance abuse intervention. The initial attempts to use existing curricula in juvenile justice settings were problematic; students with

significant substance abuse problems did not respond effectively to education developed for "normal" audiences.

The "Here's Looking at You, Two" curriculum, as developed by Roberts, Fitzmahen, and Associates, is a consistent teaching tool for all its school operations. The curricula is a nationally accepted teaching package which addresses drug/alcohol information, awareness and skills development.

The State of Washington, Division of Juvenile Rehabilitation revised the "Here's Looking at You, Two" curriculum for a juvenile justice population. Field work with the teaching package demonstrated a need for more sophisticated material to present to juvenile offender clientele. The original curriculum was specifically designed as a prevention/information tool. With the assistance of Roberts, Fitzmahen, and Associates, a committee of Division staff and educators selected material within the package and added learning activities that would enhance the curriculum's impact on a young offender audience. The result was the "Innervisions" curriculum, piloted in Division programs during the 1985-86 school year. This instructional package proved to be a more viable design, with greater emphasis on information needed by adolescents who have serious drug problems.

Following its pilot, the Innervisions curriculum underwent yet another revision. During the 1987-88 school

year, the curricula was widely used throughout Washington's juvenile justice programs, including alternative education programs for nonoffenders and detention facilities for short-term detainees.

The Innervisions' curriculum is copyrighted material, but it is available from the State of Washington. Arrangements can be made, through the State, to obtain the information and permission to use it.

SETTING THE STAGE FOR TREATMENT: ATTITUDES, VALUES AND CONSEQUENCES

A key element of a successful drug/alcohol program is the imposition of values and expectations on all clientele. Staff members in authority, acting as adult role models, need to express attitudes consistent with the overall agency philosophy. Continuum of care is directly facilitated by intervention methods that are applied evenly throughout the system. These include:

1. Policy which clarifies the agency's attitudes about drugs.
2. Procedures which are congruent with established attitudes.
3. Natural and logical consequences for client misbehavior.
4. Providing a drug-free environment for youth.

The approaches for this intervention model are so significant that each of the above statements requires further discussion and action.

Staff and societal attitudes greatly impact adolescent attitudes and values toward drug/alcohol consumption, and policy must clarify the agency's position. Substance consumption is a choice which must be made with a full understanding of the consequences of that choice. A client should not be protected from these consequences. Staff meeting time is necessary to clarify staff values and to develop a consistent approach to the messages staff give to residents about drug and alcohol consumption.

Written procedures assist in delineating guidelines for staff response to drug/alcohol subculture issues. Staff must be able to impose sanctions on clients, thus challenging their attitudes and values and making continued drug/alcohol subculture identification more difficult. Furthermore, written guidelines insure that sanctions are evenly applied so that usage and drug/ alcohol values are addressed with action. Consequences for use of substances are natural and logical and based on the person's behavior. A firm, measured and predictable response to substance use or expression of drug/alcohol attitudes can force denial issues to surface and will prepare clients for treatment.

A Reality Therapy approach assists in addressing the problems of denial. Drug and alcohol use medicates the user from painful realities in their life. As abuse becomes dependency, the user loses control and his/her denial system protects him/her from these realities. Counseling staff act as reminders of what is real in the abuser's life.

Finally, all programs within the agency must offer to all its clients a drug-free environment. This point cannot be over stated and will be an extremely difficult implementation issue.

Attitudes and values in programs must exemplify high expectations and support for youth abstaining from drug/alcohol usage. One of the most difficult experiences for the chemically dependent adolescent is resisting peer pressure to return to reuse. Staff must provide role models and interventions which support client efforts towards abstinence. This should include a ban on all posters, periodicals, clothing, jewelry and music with substance use messages.

TREATMENT

Small group treatment should be provided to young persons who are assessed as abusing substances. Group work can be facilitated by counseling staff who have been trained in

substance abuse treatment issues and small group therapy approaches. Community programs can contract this service with certified agencies or professionals.

Clients should be monitored by case managers or parole officers who coordinate treatment with other interventions. Peer oriented treatment groups present an effective and efficient method of breaking through client denial and beginning the recovery process.

Treatment issues need to include value clarification, refusal skills, decision-making, understanding the progression of the disease of chemical dependency, social contracting, grief work and family issues.

The treatment effort in both individual and group counseling is based on the theoretical foundation of the medical model of substance abuse and dependency. Chemical dependency is seen as a progressive disease with poor prognosis for recovery without treatment. The disease concept provokes concern and confusion with professionals reliant on a system of personal accountability. The disease model, however, does not eliminate the responsibility of the client or shield the client from consequences.

The significance of the disease concept lies with its impact on clients in denial. Understood as a disease, substance dependency becomes a problem which demands help and

cannot be controlled by choice. Clients with this basic understanding avail themselves to treatment more readily. Additionally, when treatment professionals cease treating substance abuse as a symptom and address it directly, treatment outcomes tend to improve.

Treatment groups are most effective if kept small (7-10), have strict group rules regarding participation and are supported by intervention systems and aftercare groups. Intervention provides incentive for participation in treatment, while aftercare supports and nurtures that participation. Treatment staff should be skilled in group therapy and understand the three levels of denial (basic, minimizing, and rationalization), as well as the progression of chemical dependency. Groups should be provided regularly, at least once daily. Treatment contracts will need to be formed with group members to address their length of attendance, compliance to group rules and abstinence. The group process may vary widely, but the primary focus should be client recognition of substance problems and consequences, acknowledgment of treatment goals, recognition of dependency issues, and a commitment and plan for maintaining abstinence.

INPATIENT TREATMENT

The chemically dependent client in juvenile corrections presents a difficult treatment challenge. Studies indicate

two in five juvenile justice clients are severely dependent on chemicals, requiring detoxification and intensive inpatient treatment. However, there is little consensus on what constitutes state-of-the-art treatment.[8] Research suggests that inpatient, multi-modal treatments on a short-term basis with aftercare treatment and self-help support groups, present the best chance for altering substance consumption behavior.[9]

Residential treatment of the adolescent substance abuser is a relatively new service. Establishing inpatient treatment within closed, secure residential programs is an administrative challenge. However, it may quickly become a centerpiece program, drawing significant public and professional attention.

There are still questions about how long treatment should occur, and what components are necessary. A steering committee consisting of outside professionals working in concert with program administration can identify issues and barriers and chart an implementation course. To assure program viability, evaluation and pre- and post-testing procedures should be developed as an initial step.

Program policy should be developed by an oversight committee, composed of state and private agency experts in the field of drug/alcohol treatment. This committee can

develop admission criteria. Ideally new residents may enter the program every two weeks and replace one or two graduates. This maintains a core group of positive residents committed to abstinence; a necessary component of a therapeutic milieu. Referrals should be accepted from throughout a system and an effort can be made to balance the treatment population with clients from different settings.

The educational component of an inpatient program requires special attention. A regular educational curriculum is unnecessary and is a time consuming component in a program which requires intense treatment. However, education administrators may not view the education component so lightly! Compromise should focus on providing educational assignments specific to the treatment experience. A streamline course load with credit provided for health and exercise classes, reading (treatment materials) and speech (group lectures on assigned treatment topics) should balance the educational needs of clients with the demands of the treatment regime. A school teacher or tutor should be directly assigned to the unit.

There are many transition issues for graduates of the inpatient program as they return to residential programs to complete their sentences. These are critical to continued treatment and maintenance of therapy gains. The graduate of

any short-term, intensive inpatient program for chemical dependency often demonstrates a fervent attitude and behavior toward his/her new found lifestyle. Chemical freedom must be supported with in place aftercare systems and an understanding, nurturant staff. Attendance in AA/NA groups is mandatory for residents in remission to keep the energy of strong commitment.

In Washington State, an increasing number of local detention facilities are developing short-term intensive treatment within their facilities. Segregated living quarters and high staff-client ratios are required to create what is essentially an inpatient center. Although outcome studies have not yet identified the value of such programming, antidotal information suggests that a high impact treatment experience for detention clients can be successful in providing very workable skills to the client who is ready to be released to the community.

Another interesting approach to providing inpatient residential treatment is the alteration of existing group home programs into intensive substance abuse treatment centers. Washington's juvenile justice system has transformed five programs into residential treatment programs which specialize in substance abuse. Each program was designed differently. Some used existing resources.

Others developed programs in collaboration with local substance abuse treatment agencies. Each program developed specific treatment measures similar in nature to the classic "inpatient" approach: treatment groups; lectures; education; health and nutrition; and a strong AA component.

DETECTION

Urinalysis, or drug testing, is an area of major interest, and unfortunately, is sometimes viewed as a solution. Urinalysis cannot be relied on to assess client dysfunction, and will not completely deter client use. Nevertheless, drug detection plays a vital role in juvenile justice programs. It is used to monitor client use, and supports interventions towards a drug-free environment. It is best to establish clear philosophical and policy guidelines around its use before proceeding. If urinalysis is used only in conjunction with a punitive response in an environment which is not drug-free, it will drive drug activities further underground, and establish an ongoing battle between residents and staff. Youths involved in drug testing programs without supportive treatment or intervention models in place become quite sophisticated in their ability to "beat" testing methods. Additionally, they learn to experiment with a wider range of drugs in an effort to avoid being detected.

Good equipment is essential. There are a number of portable and easy to operate detection machines on the market, all claiming a share of the corrections' dollar. The first step is to identify a testing location and provide existing medical staff with some technical training. It is then necessary to develop detailed procedures for: 1) identifying clients for testing; 2) collecting samples; 3) chains of evidence; 4) reporting; and 5) disciplinary responses.

Drug canines are another area of interest to juvenile justice agencies. The use of drug dogs and appropriate warnings to visitors in institutional settings establishes a clear message: substance abuse is not tolerated.

Community alternative placements provide less restrictive options to institutional placement, however they are more vulnerable to resident drug use. Such programs can conduct regular urinalysis drug screening as a mandatory requirement for placement. Substance abuse treatment, aftercare, and education also support a chemically-free environment in these community programs. A detection procedure assures compliance to expectations while youth reintegrate into open society. Testing can be used to augment and reinforce overall treatment.

Clear consequences, including options for treatment, must exist in response to positive test results. Testing might

otherwise be reduced to a game of increasing levels of unenforceable consequences. Adolescents can learn to rely on testing as a support for refusing drugs offered to them by peers.

AFTERCARE

Aftercare, or follow-up support services, are an essential element to a continuum of care approach to drug/alcohol treatment. Peer pressure and societal norms quickly erode a commitment to a chemically-free lifestyle. The progression to addiction can be rapid when the chemically dependent individual relapses.

Alcoholics Anonymous (AA) is the most famous and successful aftercare/self-help group. Juvenile justice agencies should rely on the AA network for ongoing services for a number of reasons:

1. AA and Narcotics Anonymous (NA) develop and use state-of-the-art treatment components.
2. AA/NA groups are available in virtually every community, making post-placement planning possible for all clients.
3. The success rate for AA/NA members is higher than any other modality. It is the single most effective approach for the chemically dependent person.

4. Participation in AA/NA is free for clients and is available for the duration of their recovery.

The support received in self-help groups balances the peer pressure to consume. They provide an assurance for continued abstinence. Aftercare begins as soon as a client honestly enters the treatment process. The goal is to provide groups at every facility within the system.

ACCREDITATION

Most states have an agency responsible for policy and programming in the substance abuse field. These agencies are also charged with the responsibility of determining requirements for treatment programs and treatment professional qualifications. Requirements are strict and include adherence to federally mandated rules of confidentiality.

The state agency responsible for certification should be involved in the ongoing development of all substance abuse programs. Special exception to policy is often required to certify staff and programs. It is relatively simple to maintain the program certification once it has been granted and to hire only qualified staff in the future.

It is recommended that working agreements be established with the responsible substance abuse agency for technical

assistance and support as a first implementation step. The exercise will also assist in recruitment of new staff. It is difficult to find personnel who are experienced in child care, corrections, and substance abuse treatment. Finally, the cost of programming can be deferred if certification is achieved through third party billing, when client families have insurance.

FUNDING

In public agencies, funding is dependent on the support of elected officials, and therefore, public support is important. In the face of tight revenues and competition for dollars within the traditional service structure, there are some approaches that may be valuable.

Initial program funding can be developed through grant application. There are numerous opportunities through federal agency grants to develop a program with research and demonstration monies. Private foundations are also interested in this area, as are professional associations.

Program development can begin with existing revenues. Alteration of existing programs is costly, but less costly than building new components. Staff interest is often high for new initiatives, and expanded career opportunities is a worthwhile benefit. Agencies should, however, plan to build budgets in advance of any serious undertaking.

PUBLIC SUPPORT

The confusion and skepticism surrounding treatment approaches, and the public's denial of the existence of the problem, make public support a difficult proposition. While national attention has been focused on the issue, legislation designed to address the problem has concentrated largely on the supply side with law enforcement solutions. Demand side policies continue to fail passage, or are under funded. Adolescent specific policy legislation has received minimal attention.

The political reasons for this lack of support are easy to recognize upon closer inspection. The public responds well to issues which hit close to home. Everyone is against drug abuse, thus making the issue politically attractive. The problem becomes one of solutions. The issue of substance abuse is under studied; even neglected.[10] The field itself is divided about what works in treatment.

In recent years, the public has asked for stricter sentences, not better treatment. Politicians are reluctant to champion an issue that has little appeal. What is needed is a focus which accomplishes two goals: 1) a revival of hopes for a "cure" to youth crime; and 2) a preventive emphasis. Substance abuse treatment in juvenile corrections presents both possibilities.

It is incumbent on the substance abuse program in the juvenile justice agency to disseminate information on the extent of the problem and the solutions that are being developed. It is clear from initial work that substance abuse treatment with youthful offenders does offer hope for rehabilitation. The correlation between delinquency and drugs/alcohol, although quite well established, remains as new information to the public. While, research in the field is limited, local universities can assist in a collaborative approach to bring light to the issue. Additionally, juvenile justice agencies can often take the lead in developing treatment approaches needed for a wider, nonoffender population. The lessons to be learned are likely to be universally valuable.

The preventative angle is often overlooked as a selling point to the development of these programs. Young offenders become adult offenders, and perhaps even more significantly, they become parents. The intergenerational nature of substance abuse is well established. There is a desperate need for social service agencies to help troubled adolescents to become effective parents. Substance abuse treatment is essential to this goal.

A final problem remains in relation to nonelected public officials. Educational and preventive policies still draw

the most attention and support. This tends to mirror the fact that school systems are responding more effectively than public agencies that are responsible for adolescent care, particularly agencies responsible for runaway or "street kid" populations. As leadership of these agencies place greater emphasis on the issue, and mount campaigns for the support of program development, public support should follow. It would be advised to present treatment programming as a part of a prevention strategy: treat today's troubled youth before they become engulfed in a way of life that is very resistant to treatment or punishment; before they have children of their own who will become tomorrow's high risk youth.

FOOTNOTES

1. Clayton, 1981; Elliot & Ageton, 1976; Jessor, 1976; Leukefeld & Clayton, 1979; Simonds & Kashani, 1979.

2. Elliot & Ageton, 1976.

3. Inciardi, 1981; Santo et al., 1980.

4. Fagan & Hartstone, 1984.

5. Beachy, Petersen & Pearson, 1979; Hartstone & Hansen, 1984; U.S. Department of Justice, 1983.

6. Smith, Levy & Striar, 1979.

7. Guthmann & Brenna, 1988.

8. Braukmann, et al., no date.

9. Fagan & Hartstone, 1984.

10. Braukmann, et al., no date.

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TRANSITION AND AFTERCARE SERVICES FOR ADJUDICATED YOUTH

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TRANSITION AND AFTERCARE SERVICES FOR ADJUDICATED YOUTH SERVICES

Transition and aftercare services for delinquent adolescents who are involved with drugs are lacking, both in quantity and quality. Rates of criminal recidivism among adjudicated delinquents are high. Estimates derived from research literature indicate that 15% to 77% of incarcerated juveniles repeat criminal offenses.[1] Rates of relapse to alcohol or other drug use following treatment are also high. Approximately two-thirds of adults who complete treatment for alcohol or drug dependence have a relapse within 90 days of discharge from treatment.[2] Research also appears to show that juveniles have high rates of post-treatment relapse.[3]

A MODEL FOR DESIGNING AFTERCARE INTERVENTION

Theoretical Approach

Despite gains made during treatment, many children return to lives of drug abuse and crime. Several areas of the treatment and post-treatment environment are implicated in their return to problem behavior - factors in the family, and school, and factors related to peers, the individual and

the community. Since these children had multiple problems in more than one area of their lives before they became adjudicated, we can expect that many of these problems will still exist in their post-treatment environments. In response, what is needed is a comprehensive approach to rehabilitation that addresses the multiple factors that will affect a youth during and after treatment.

Faced with this task, how does one go about designing interventions to reduce risk of relapse and recidivism?

The Social Development Model of Rehabilitation (SDMR)[4] is designed to provide a strategy that one can use to reduce the factors associated with a return to drug abuse and crime. The model synthesizes control theory[5] and social learning theory.[6] SDMR is unique in that it explicitly includes intervention points. The model, presented in Figure 1, hypothesizes that a strong bond of attachment to conventional others, commitment to conventional lines of action, and beliefs in conventional moral order will inhibit frequent drug use and delinquency.[7] Strong bonds will inhibit a return to delinquency and drug abuse because antisocial behavior will threaten relationships to conventional others, threaten investments in conventional lines of action, and contradict beliefs in the moral order. In addition, strong

bonds to conventional others will decrease the likelihood of association with delinquent and drug using peers which, in turn, will reduce delinquent and drug using behaviors.[8]

The conditions for the development of this bond are specified by SDMR. It is hypothesized that the bond is produced from social processes in the family, school, peer group, and the community. These entail: 1) opportunities for involvement and interaction in conventional activities with conventional people; and 2) skills to successfully participate in these involvements and interactions and 3) rewards forthcoming from performance in conventional activities and interactions. If these conditions are present, a child is likely to perceive that his/her environment provides a chance for him/her to be conventionally successful and reinforces such actions. In the absence of such bonds and interactions, frequent drug use and crime may become preferable alternatives.[9]

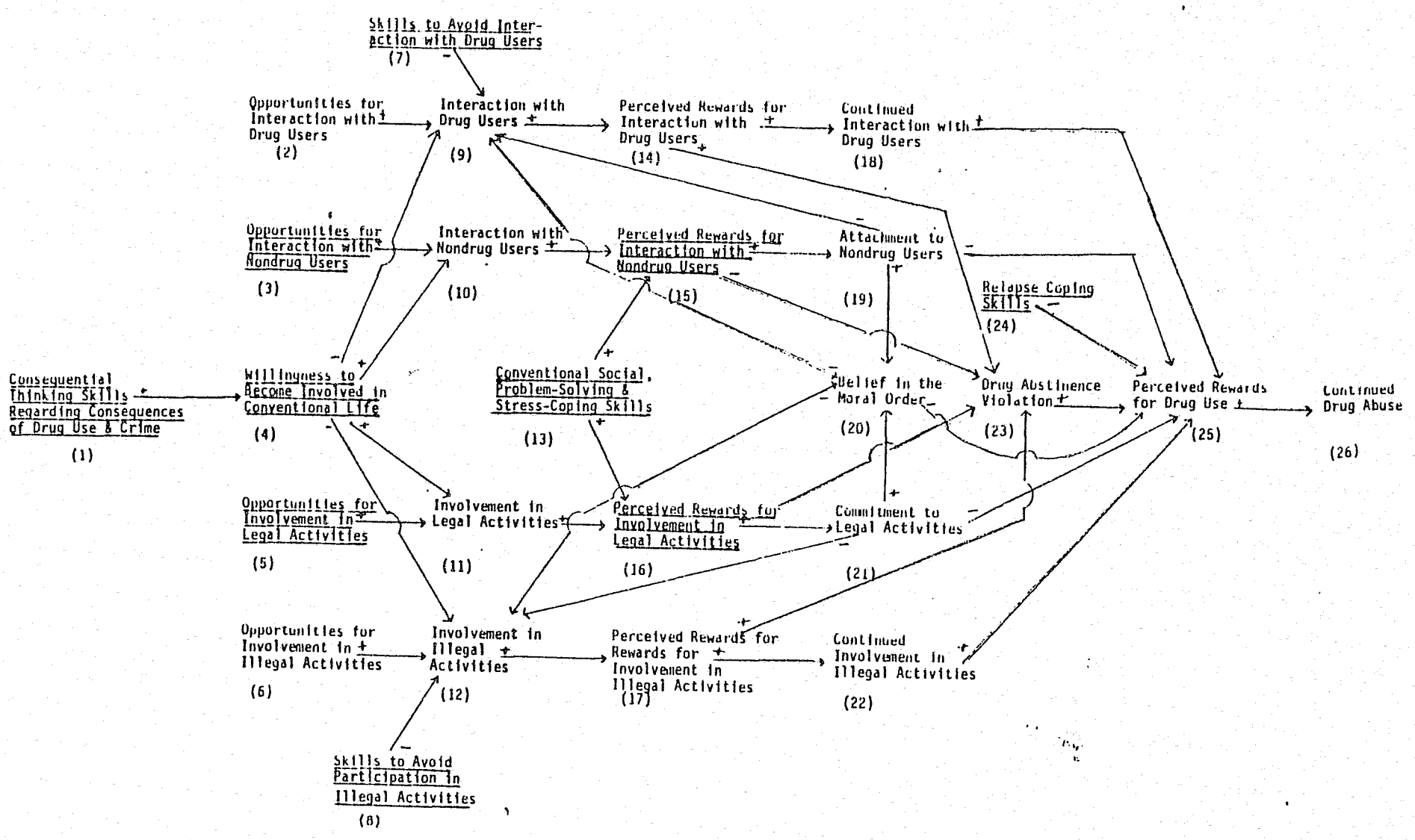
The SDMR approach suggests that each factor related to relapse or recidivism must be addressed in ways that increase bonding through provision of increased opportunities, involvement, skills and rewards for prosocial involvement.

Aftercare Intervention

The fundamental goal of aftercare in delinquency and adolescent drug abuse treatment is to maintain treatment

FIGURE 1

THEORETICAL MODEL OF REHABILITATION



Underlined concepts are proposed intervention points.

gains and prevent young offenders from returning to their former antisocial, disruptive, or illegal patterns of behavior. As an intervention, aftercare is based on the assumption that continued assistance following treatment can strengthen factors associated with a adolescent's successful community adaptation.[10] In recognition of these factors, aftercare interventions generally seek to strengthen supports in a reentering youth's family, peer network, school, and place of employment, and they strive to teach the young person appropriate social and behavioral skills.

Despite a recognition of the importance of post-treatment support, few adolescent treatment facilities have adequate resources to prepare their residents for community reentry.[11] If lasting behavioral change is desired transition and aftercare services must provide the adjudicated delinquent with new opportunities to become involved in a conventional lifestyle. Many youths return to environments whose economic conditions or lack of social order offer few conventional activities or interactions.

Young offenders often need to acquire new skills for interacting with conventional others and becoming involved in healthy activities. These young people need to develop skills for refusing involvement in antisocial activities. The presence of deviant peers and social pressure to become

involved in antisocial activities are potent predictors of relapse and recidivism.

The young person's environment must provide positive recognition and support to the changes he/she makes. Often changes that are significant for the child are not of sufficient magnitude for others to recognize.

Interventions must also deal directly and quickly with drug use relapse in a way that discourages its continuance and supports a return to abstinence. Given the high rates of relapse after treatment, the role of substance use in delinquent behavior, and the fact that a single lapse need not necessarily lead to a full blown relapse,[12] it is important to train adolescents to deal with the a relapse in a way that reduces the likelihood that they will return to frequent drug use.

In preventing a return to drug use and delinquent behavior following treatment, interventions need to address the multiple factors contributing to, and maintaining, these problems. Since these factors vary for each person, adequate assessment is necessary to identify which areas of risk should be focused upon. Once a client's primary problems have been identified, individualized treatment is the best approach.

Existing services often fall short of these requirements. In many cases, no aftercare services are

provided. Behavior changes made in the institution are not supported in the community. When transition services do exist, they frequently are unidimensional in focus.[13] In our attempts to link adolescents to community services, we found that community agencies often only met one of the clients' many service needs. Other agencies excluded delinquent adolescents, because they were too "high risk" or difficult to manage.

Model Transition/Aftercare Program

We have designed and are testing a transition/aftercare program called Project ADAPT which is based on the hypotheses of the Social Development Model and on what is known about the factors related to relapse. Project ADAPT is a three--and-one-half year field experiment which works with institutionalized delinquents. The goals of this project are: 1) to reduce the likelihood of association with drug using peers in the community following release; 2) to reduce drug dependent or addictive behavior patterns; 3) to reduce criminal activities; and 4) to prevent later need for drug treatment and correctional services.

The purpose of Project ADAPT is to create conditions for bonding once incarcerated youth return to the community by enhancing the delinquent's opportunities, skills, and rewards for conventional social involvement. The

project aims to increase the participant's skills for involvement in prosocial activities through systematic training in social networking, impulse control, drug refusal, consequential thinking, relapse coping, and problem solving skills. The program uses a case management system to help participants to: 1) generalize and maintain skills across life situations; 2) increase opportunities for involvement in prosocial activities and relationships; 3) provide coordinated post-treatment rewards for conventional social involvements, and negative consequences for antisocial involvements.

Program Phases

Project ADAPT's intervention combines behavioral skill training, supportive network development and involvement in prosocial activities. Intervention is conducted in two phases - reentry preparation and aftercare. During the reentry preparation phase the client participates in a ten-week goal setting and skill training group, and works with an ADAPT case manager while the client is still in the institution. In preparation for the reentry phase, group members are introduced to the program's two goals: staying out of trouble and having fun. Case managers review the program's goals and take clients for visits to schools, to activities they are interested in exploring, and to their

parents' home or expected residential placement where the client will live after he/she leaves the institution.

During the aftercare phase, case managers continue contact with their clients for six months after they are released. The case manager works to reintegrate the client into the family or alternative placement; provides skill practice and reinforcement; helps the client enroll in school, find a job, obtain needed services; assists the client to seek out prosocial activities and develop a supportive social network; and reinforces the client's development of supportive activities and contacts.

Skill Training

The skill training component of Project ADAPT addresses seven areas in response to factors that are related to relapse and recidivism.

1. Consequential Thinking:

This section focuses on the antecedents and consequences of delinquent behavior and drug use. Clients learn that they are responsible for their behavior and its consequences. They are taught to identify the thoughts, behaviors, and situational antecedent signals of getting into trouble, and are taught to use self-talk to anticipate the consequences of their behavior.

2. Self-Control:

The ability to resist initial impulses and peer pressure toward substance use are postulated prerequisites to the prevention of reoffending. Skills taught in this area are "Anger Control" and "Turning Down a Drug Offer."

3. Avoiding Trouble:

Clients are taught to recognize and avoid specific people, places and situations associated with antisocial behavior or substance use. The skill taught is entitled "Avoiding Trouble with Others."

4. Social Networking:

When clients have learned to avoid trouble they need to find and engage with socially acceptable people, places and activities. Skills covered in this segment are "Identifying Prosocial Activities and Organizations," and "Meeting New People."

5. Coping with Authority:

Successful reintegration into the community is often dependent on the young person's ability to get along with authority figures. Two skills are taught and practiced in this segment, "Negotiation" and "Compliance."

6. Problem Solving:

To be successful in coping with the problems that are a part of their lives, it is hypothesized that clients must be able to generate solutions to new and complex problems. This portion of the curriculum teaches "Brainstorming Options," "Problem Solving" and "Asking for Help."

7. Relapse Coping:

Clients are taught strategies for coping with relapse so that such an event does not lead to a full blown relapse. This portion of the curriculum teaches self-talk, which has been shown to counter the negative self statements that often follow relapse, and to develop a plan for coping with a relapse when in the client is in the community.

The skill training curriculum uses a method identified as "guided participant modeling" by Rosenthal and Bandura (1978). Skills, which are modeled by trainers and other students, are then discussed by participants.[14] After skill steps are reviewed, participants practice the steps with each other by role playing.[15] They receive feedback on their performance from trainers and group members. Videotape is frequently used in modeling or during practice. Group members also receive homework assignments and are encouraged to practice skills outside of group. To maximize effectiveness,

the training focuses on cognitive as well as behavioral aspects of performance.[16]

Case Management System

ADAPT's intervention addresses several important aspects of a participant's post-treatment environment. The role of the case manager is fivefold: 1) to provide a continuous supportive relationship with the client; 2) to assess the client's post-treatment environment and develop a reentry plan that will reduce drug use and delinquent behavior; 3) to provide prosocial opportunities for the client; 4) to practice and reinforce skills so they are used in community settings after the client leaves the correctional institution; and 5) to provide a linkage with significant adults involved in the client's life.

In the skill training phase of Project ADAPT, case management focuses on relationship development, skill reinforcement, assessment, and reentry planning. The case manager assesses the client's functioning and needs in the following areas: 1) home or placement, 2) school and/or work, 3) social skills, 4) relationships, 5) social activities, and 6) services in the community. Case managers coordinate efforts in these areas and work to foster their clients' willingness to become involved in improving these areas of their lives.

In the aftercare phase of Project ADAPT, case management facilitates the implementation of the client's personal re-entry plans, by monitoring the client's progress in previously established goal areas, intervening in client and family crises, and building community supports. Case management decreases in intensity and frequency over a six month period. The case manager meets with the client in the client's environment, usually at home or school, and maintains contact with the client's family, friends, and service providers during this time.

Specific case management activities may include having the client check in with a school counselor on a regular basis, helping the client join a peer helper program at school, accompanying the client to fill out job applications, or transporting him/her to job interviews. Case managers often assist clients to obtain and maintain additional services from youth service bureaus or mental health centers. The case manager acts as a resource to both the client and the client's family, to aid in solving problems that arise.

The case manager works to change the adolescent's reward structure in three ways: by providing tangible and social rewards for positive changes in the client's behavior; through continuing to provide skill practice and coaching until skill levels are such that rewards are forthcoming from

the client's environment; and through teaching parents, teachers and others to reward positive attempts on the part of the client. Over time, the emphasis of case management shifts to empowering the youth and his/her significant others to seek out help from resources and sources of support around them.

This intensive and coordinated program requires a high level of commitment, and time by skill trainers and case managers. A full-time case manager carries a caseload of six to eight clients. A low staff/client ratio is required to provide some of the unique aspects of this program, including a relationship which bridges the transition from institution to community, intensive contact in the community, skill maintenance, and coordination of services.

Project ADAPT has produced significant skill changes in experimental subjects. Levels of social and problem solving, self-control, drug avoidance and consequential thinking skills have been shown to increase on a post-test among experimental subjects who were compared to control subjects. The long-term effectiveness of the project's interventions are being evaluated through follow-up interviews which examine recidivism and relapse rates at 6 and 12 months after subjects return to the community.

In summary, Project ADAPT's purpose is to provide assistance and skills to incarcerated juveniles to reduce

drug use and criminal behavior following their release to the community. By providing a combination of skill training and comprehensive case management services, the program attempts to address the multiple factors that place these youth at risk for continued criminal and drug involvement.

FOOTNOTES

1. Osborn & West, 1980; Weideranders, 1983.

2. Hunt, Barnett, Branch, 1971; Catalano, Howard, Hawkins & Wells, 1988.

3. Simpson & Sells, 1979; Hubbard, Cavanaugh, Craddock, & Rachal, 1985.

4. Catalano & Hawkins, 1985.

5. Briar & Piliavin, 1965; Hirschi, 1969.

6. Akers, 1977; Bandura, 1977.

7. Catalano & Hawkins, 1985.

8. Elliot et al., 1985.

9. Kaplan, 1985; Hundleby, 1986; Elliott et al., 1985.

10. Hawkins & Catalano, 1985; Jenson, Hawkins, & Catalano, 1986.

11. Freudenberger & Carbone, 1984.

12. Marlatt & Gordon, 1985.

13. Jenson, Hawkins, & Catalano, 1986.

14. Bandura, 1969, 1973; Bandura & Walters, 1963; Rosenthal & Bandura, 1978.

15. Janis & Mann, 1965; McFall & Marston, 1970.

16. Pentz, 1983.

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EVALUATION RESEARCH
FOR ADMINISTRATORS OF SUBSTANCE ABUSE PROGRAMS

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EVALUATION OF SUBSTANCE ABUSE PROGRAMS

During the past three decades, an increasing demand has been placed upon human service organizations to perform systematic program evaluations, for such purposes as: fulfilling a funding resource requirement, improving service to clients, assessing the impact of a program, or testing the feasibility of a planned intervention. This demand has given rise to a growing body of methodological material known as evaluation research. This form of research is generally "a means of supplying valid and reliable evidence regarding the operation of social programs or clinical practices - how they are planned, how well they operate, and how effectively they achieve their goals."[1] This section clarifies key evaluation research issues to provide the administrator with guidelines for designing and implementing substance abuse program evaluation.

PURPOSES OF EVALUATION AND RELATED ISSUES

There are three major reasons for conducting evaluation research: administrative analysis, impact assessment, and testing new practice approaches.[2] First, an in-place program may be evaluated for the administrative purpose of assessing efficiency of operation. Goals for administrative analysis normally include achieving a smooth delivery of services with an optimum balance of benefits and cost. The prime criterion

here is "accountability." The value of a program is essentially determined by a net economic gain or loss due to the provided services. Direct costs of most programs are relatively easy to determine. However, it is often difficult to monetize benefits. This is particularly true for substance abuse treatment programs, where the purposes of program intervention are to change deviant attitudinal and behavioral patterns contributing to the abuse of substances. Successful treatment related outcomes, such as abstinence from drug use, enhanced self-esteem, reduced anxiety, and improved socialization patterns (i.e., regular school attendance) are also difficult to convert into monetary benefits. Nonetheless, such outcomes may be important program goals, and administrators must seek to define their utility in measurable terms.

Some benefits of successful treatment can be clearly translated into economic values. These include reduced costs of criminal behavior associated with drugs, and reduction of judicial and correctional costs incurred by continued contact with criminal justice authorities. Estimating these benefits requires an understanding of the economic costs of drug related criminality, and entails the capacity to measure the impact of treatment beyond the subject's time in the program. This suggests that cost efficient intervention cannot be divorced from impact assessment.

It is important to note that an administrative analysis of the structure and operation of a program is the critical first step to effective evaluation. An administrator should carry out a thorough review of a program's components, expected results, and the connections between the two. Moreover, this review should encompass the program as it is structured in theory, as well as how it is actually implemented. Differences in the designed delivery of a program and its real operation may explain a program's success or failure. For example, a programmatic review of a group counseling program in a correctional system revealed poorly trained and unmotivated counselors were working with clients whose participation was largely driven by the desire to reduce time on their sentences. Given an understanding of this client-staff relationship, the program's failure to reduce recidivism was not surprising.[3]

An administrative program review consists of developing a model of the program, identifying each element and the linkage between them. It should also identify which aspects of the program are to be evaluated. Evaluation areas are identified for two reasons. First, identifying elements or goals to be evaluated enables one to specify and measure variables that are indicators of those elements or goals. Second, a key element of evaluation research is assessment of the intended outcome(s) of a program. Outcomes may be

identified as behavioral or attitudinal, single or multi-dimensional, short- or long-term, and so forth. Some outcomes may be so general they are practically impossible to measure. The goal of changing a juvenile substance abuser into a capable and functioning adult may be a commendable purpose that is beyond the scope of measurement. In such situations, outcomes may be redefined as proximate goals. These are goals that can be realized and measured in the short-term, and that are related to the accomplishment of goals that are long-term.[4]

Another important reason for identifying aspects of evaluation is the practical issue of examining the proper areas of interest to concerned program or sponsoring bodies. Various interest groups may make up the audience for evaluation results, and a consensus over the desired product cannot be assumed. Careful consideration of evaluation outcomes will increase the usefulness of the research, and avoid the production of irrelevant results that are not among the program's priority of interests.

Impact assessment speaks directly to the goals of a program. As noted above, it is helpful to stress the need for identifying program objectives.

> The first task for the evaluator is to develop clear and consistent statements of goals in consultation with planners, project managers, and policy makers. It bears emphasis that unless goals can be clarified and objectives operationalized, it is unlikely that adequate evaluation can be attempted.[5]

However rational and straightforward this may seem, it is not normally a simple matter to define goals for evaluation purposes. Pitfalls exist in: the discrepancy between official and operative goals; the multiplicity of goals and disagreement over their hierarchy of importance; the instability of goals as an organization changes over time (this is subject to a changing environment of service needs and community expectations); and the capacity to translate goals into operational terms that accurately reflect the purposes of the program.

Several other factors affect the determination of criteria for evaluating program goals. To the extent that the assessment of an organization effects its survival and growth, the determination of goals and selection of evaluation criteria are, in part, political decisions.[6] Interest groups, whether internal or external to the program, will attempt to influence the determination of a program's goals and will want measurements to be in accord with their objectives.

The politics of evaluation, much like the personal values that any practitioner brings to his or her job, is an issue better openly acknowledged than harbored. All stages of evaluation, from the conceptualization of assessment goals to the interpretation of findings, are subject to political influence. To illustrate, program staff who place favorable

evaluation above realistic assessment may limit their client population to those who are most amenable to treatment. The practice of "creaming" is one of accepting only those clients who are good risks for improvement, to favorably demonstrate the effectiveness of a program. Further, an evaluation study that excludes those who have failed to complete a treatment program may selectively study a population whose members are the most successful cases.

Covert political considerations that compromise a rigorous program evaluation may buttress short-term survival, while, ultimately, undermining a viable service program. External political influence, once recognized, can be used to clarify the domain in which a program operates; thus administrators may better define their program's provision of desirable services and demand necessary resources. More pragmatically accurate feedback, particularly if it is negative, enables an organization to correct operational deficiencies, which can be critical to its survival.[7] In short, an impact assessment that is politically structured to demonstrate only strengths can endanger the program's capacity to function.

Another dilemma of impact assessment stems from the common problem of measuring treatment effectiveness. "Effectiveness" refers to the degree to which a program is achieving its goals.[8] A correctional program designed to

reduce further criminal behavior is effective inasfar as recidivism rates are lowered. In this instance, the match between an intended goal and a measurable outcome appears to be clear; however, it may be difficult to isolate those programmatic variables which affect clients' behaviors. The procedures used to transform clients' attributes are often not determined, and the ways to effect outcomes are not fully understood. Moreover, counseling programs typically involve several components that are loosely coupled, and the relationship between elements is not sufficiently understood. Therefore, it is difficult to provide satisfactory information about cause and effect relationships between specific treatment components and behavioral outcomes.

Added to the dilemma of indeterminate treatment procedures is the complex and variable nature of clients' attributes and behaviors. People respond differently to treatment interventions, and do so for reasons that are frequently unknown. Clients are also subject to factors extraneous to program services, so external variables may account for outcomes. In sum, the composition of client characteristics can have an enormous impact on program outcomes, irrespective of treatment delivery. Specifying and measuring relevant characteristics is thus critical to assessing the contribution of program components.

The difficulties associated with accurate impact assessment prompt some organizations to displace effectiveness criteria with more manageable indicators of program efficiency. Accounting of resource use, charting the timely progress of clients as they move through treatment phases, and the gathering of staff and client testimonials on program satisfaction are means of demonstrating efficient operation. However inherently valuable, these forms of information say little about the effectiveness of a program. When efficiency criteria displace effectiveness, the evaluation results are not a valid indication of a program's impact. Furthermore, such displacement may lead an organization to treat efficiency measures as true indicators of effectiveness.[9]

Indicators of organizational efficiency are attractive criteria for evaluation to program managers and staff. They are self enhancing measures, and the records of data are controlled by the organization. An evaluation that is internally determined by an organization commonly confirms the expectations of that organization. The evaluation will be subject to biases that may overlook quality of services, as performance measures will tend to be selected according to 1) the availability of records (sources that are naturally consistent with efficiency) and 2) their promotion of the program's continuance.

The resistance to external evaluation is not surprising, particulary when "most programs, when properly evaluated, turn out to be ineffective or, at best, marginally accomplishing their set aims."[10] The demand for self-evaluation can be based in the logical argument that practitioners are most capable of assessing the quality of their services. For example, the long-standing resistance of police departments to evaluation by civilian review boards is based largely on the belief that civilians are naive about the realities of police work. The position is that only the police are capable of understanding, and evaluating policing.

It can be assumed that managers and staff are generally committed to their programs, and that this organizational location effects their view of service issues and their interpretation of program outcomes. This does not necessarily imply paranoia exists towards evaluation. However, the relationship between external evaluators (who are typically academic research scholars), and the personnel of an organization that is the subject of evaluation, is often uneasy. Two points are made in considering a better balance of such relationships. First, administrators place greatest importance on evaluations that provide explicit recommendations for practicable and implementable courses of action, and they prefer findings that support existing beliefs and

program operations.[11] Evaluation researchers are most concerned with sound methodological practice when they design and implement an assessment.[12] These points of interest may be mutually reinforcing. The quality of an evaluation study is important to credibility in the eyes of decision-makers; thus the expertise of a researcher striving for rigor and objectivity is valuable to program objectives. From the other perspective, an organization is interested in generating policy recommendations based on feasible program goals and expected evaluation outcomes. Put differently, the academic interest in the "best" scientific evaluation must be tempered by the practicality of information provided by a study.

The second point in considering an independent evaluation is the tendency for a study to be perceived as a "trial" of a program, that is designed to uncover the faults and failures of its delivery of services. The classical assumption of statistical tests performed on hypothesized program impacts is one of "no effect." The burden is upon the program to demonstrate an effect exists.[13] Given the many dilemmas of precisely assessing impact, clear positive findings are not usually demonstrated. Taking account of the complex nature of intervention programs, it is realistic to expect that findings will not usually be unambiguous, and

that the absence of uniformly positive results is not synonymous with program failure. The utility of an evaluation lies in its capacity to provide sound feedback about the nature of a program's services to identify organizational strengths and weaknesses. Summary judgments of a program's viability are not likely to be apparent from evaluation results, and are thus generally unwarranted.

The dilemmas of conducting an impact assessment have been presented to sensitize administrators to problematic issues of carrying out such an evaluation. Substance abuse treatment programs will, like other types of service organizations, vary in their capacity to effectively address key issues of assessment. Given this caveat, there are four questions that should bear on the design of an impact assessment.[14]

1) Is the organization reaching its target population?
2) Is it providing mandated services?
3) Are the services effective?
4) Are the services being provided efficiently?

Some specific issues concerning these questions will be raised later. While formulating impact assessment, these questions can be taken as a guide for evaluating performance.

The final reason for evaluation research is to test hypotheses or practice approaches, often in anticipation of new intervention strategies. Such evaluation may test

specific components of a program, such as the effectiveness of educating substance abuse clients on relapse prevention. Another purpose is to expand social scientific knowledge about an intervention approach that is new and largely unexplored. A planned program should benefit from an evaluation if it conceives of its treatment intervention as an experimental stimulus within a research design that encompasses isolated methodological variables. The capacity to conceptualize and examine treatment effects is the most powerful tool that an experimental study can draw upon. However, there may be barriers to conducting such an evaluation, as the following section suggests.

EVALUATION RESEARCH DESIGN AND METHODOLOGICAL ISSUES

The most powerful research design is the experimental method which uses at least two randomized equivalent groups- one will receive the treatment and the other will serve as a control group. Experimental design assumes a cause and effect relationship between program intervention (stimulus) and behavioral outcome (response). This is subject to controlled isolation and measurement. The key to this research design is the random assignment of subjects to either group. However, random assignment, and the control over other sources of variation, are subject to impediments.

Random assignments of prospective clients to either receive or deny program services can be blocked by ethical or legislative demands to provide treatment to all persons who meet eligibility requirements. Substance abuse programs normally receive clients by mandate of court order or social service referral, so that random allocation to experimental design groups may not be possible. Moreover, staff may resist the idea of denying services to some for the purpose of composing a control group if all clients are perceived as needing, and deserving services.

The above impediments to randomization are but a few of the factors that enter into evaluation experiments conducted in a field setting. Most evaluations take place in the setting where the program is administered and this setting is subject to varying conditions that cannot be controlled. Though many practical problems may arise, the field setting is an important context for evaluation, as it provides for a true test of services within the realistic environment of program administration. This is critical when addressing how a program be can best implemented.

When random assignment of subjects is not possible, a variety of alternatives to experimental design may be considered sufficient for evaluation. Several quasi-experimental designs have been frequently used in evaluation,

however it is important to recognize the weaknesses of these methods.[15]

The choice of a research design, much like the formulation of the research question(s), is crucial to the development of meaningful evaluation results. Program administrators should familiarize themselves with basic principles and issues of research design so that informed input to evaluation decisions can be made.[16]

Some evaluation issues that may be relevant to substance abuse programs, such as identifying multiple components of treatment, have been noted. Three issues of particular interest to substance abuse evaluation are: 1) attrition of clients from a program, 2) the validity of information derived from clients, and 3) the measurement of program effectiveness.

The loss of clients prior to completion of a program may occur. It is important to carefully monitor the nature of attrition, as the characteristics of client losses bear on program implementation and effectiveness. Clients who are removed from treatment may be poorly motivated to respond to program goals; and may, in fact, be among those who are most in need of substance abuse counseling. If such persons are a high risk for repeat substance abuse, it is necessary to determine why treatment was unsuccessful, and what course of action would be most appropriate for such clients. This is a

key source from which negative feedback may be generated for the benefit of program improvement.

Another reason for attrition lies in misclassification of clients who do not belong in a substance abuse program. Court-ordered placement of juvenile offenders who maintain a connection between their offenses and substance abuse (such as stealing to pay for drugs) may make inappropriate recommendations, either because of misinformation or insufficient availability of resources in certain treatment programs. Misclassification, and the subsequent failure of clients to fulfill treatment expectations, is a problem that may be erroneously attributed to program ineffectiveness.

Revealing the character of client attrition contributes to understanding the target population of program services. This should allow for any needed redefinition of that group. Evaluation should include a conscious plan for studying client attrition. A treatment program may not accurately be reflected by information gleaned from those persons who complete all of its phases.

Where the effectiveness of a program depends upon data provided by clients, the validity of information must be considered. The accuracy of clients' self-reports may be undermined if there is motivation to manipulate information. A basis for self-interest in reporting positive information

can be perceived by clients, or they may perceive a desirability to produce favorable outcomes.

Another methodological concern lies in the validity of questionnaires for assessing clients' cognitive states. There is a strong emphasis on the use of questionnaires to measure cognitive constructs, such as values, behavioral intentions, self-image, and so on. As client responses to questionnaires are not necessarily reflective of cognitive processes underlying their behavior,[17] direct assessment of behavior, though more complex than questionnaire analysis, should be attempted in the measurement of treatment impact.

A third issue of information validity concerns post-treatment follow-up of clients. Aftercare research is complex and consuming in the best scenarios, and substance abuse programs undoubtedly pose a particularly difficult population of participants for follow-up study. Response bias is likely to be very high if follow-up information depends upon the initiative of former clients to comply with data requests. A careful examination of the relationship between program objectives and the capacity to generate reliable data on client behavior after program completion, should be made during the conceptualization of the research questions.

Finally, no issue is more important than the need for clearly specified operational criteria of a program's

impacts. Too often, the effectiveness of treatment intervention is couched in the vague and subjective impressions of staff members' faith in the operation and objectives of their program, and/or their belief in the transformation of client attributes or behavior. There is little use to an evaluation that is based on such information. Nor are critics of an intervention approach likely to accept evaluations that do not meet scientific standards for empirical research.

USE OF PROGRAM EVALUATIONS

Though the demands for carrying out program evaluations have recently risen, the results of evaluations are rarely put to much use. In an evaluation of a counseling program in the correctional setting cited earlier, careful research uncovered few positive effects of the intervention.[18] However, the reaction of the Department of Corrections was to expand the program, with no changes, to every prison in the system.

It is a contention of this report that under-utilization of evaluations is partly due to careless research conceptualization and implementation. Vague findings based upon impressionistic indicators of treatment effects offer no practical course of action; thus it is hardly surprising that such studies are effectively ignored. Program administrators have an interest in drawing upon the methodological expertise

of social science research for conducting evaluation. This is a direct reason for devising a study that identifies specific program strengths and weaknesses that recommends ways to improve treatment effectiveness and efficiency. An indirect reason would be to satisfy political critics and revenue sources with a meaningful review process.

A better marriage between program administrators and outside evaluation researchers would overcome poor communication of results on the part of evaluators. Use is defied when the technical procedures and language of researchers is not clearly stated within the operative terms that are used by program staff and management. Just as evaluation should demand an accountability of the program in question, administrators should demand an accountability of research utility from evaluators.

Evaluation utility must also draw upon increased willingness of program administrators and policymakers to put research results to use. Existing procedures for conducting program intervention become customary and resistant to question. The extensive bureaucracy of linkages between policymakers and program implementors tends to thwart innovative action. However, these barriers to research are apparently on the decline, as the necessity of serious evaluation in an environment of finite resources grows larger, and the tools of scientific research methodology

become more exact. There is an encouraging prospect for the role of evaluation research in developing more effective treatment programs.

FOOTNOTES

1. Monette, Sullivan & Cornell, 1986.
2. Race & Freeman, 1982.
3. Kassebaum, Ward, & Wilner, 1971.
4. Weiss, 1972.
5. Rossi, Freeman, & Wright, 1979, p. 63.
6. Weiss, 1975.
7. Hasenfeld, 1976.
8. Campbell, 1977.
9. Hasenfeld, 1983.
10. Rossi, 1978.
11. Weiss & Bucuvalas, 1980.
12. Cain & Hollister, 1972.
13. Cain & Hollister, 1972.
14. Rossi, 1978.15.
15. Cook & Campbell, 1979.
16. Campbell & Stanley, 1963; Spector, 1981.
17. Nisbett & Wilson, 1977.
18. Kassebaum, et al., 1971.

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LEARNING THE ROPES OF ADVENTUROUS, EXPERIENTIAL EDUCATION

by

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LEARNING THE ROPES OF ADVENTUROUS, EXPERIENTIAL EDUCATION

INTRODUCTION

Sociologist James S. Coleman of the University of Chicago contrasts modern urban life with the rural/small town lifestyle of 100 years ago. In those times, much of a child's learning experiences had meaning, purpose and relevance to this/her economic survival and to the survival of his/her family. Home and school, in partnership, had the job of passing on the attitudes, values, and behavioral skills for successful living. Young people were prepared for adulthood through a clear and concrete set of experiences, expectations and challenges.

Lacking such value forming experiences, most youth today come into rehabilitation programs under the cloud of some identity myth: They are considered to be "delinquent," "conduct disordered," "learning disabled," "alcoholic," "substance-abusers," or "victims." Usually they fall under some combination of these categories.

Experiential education programs give substance abusers the opportunity to transcend these labels and, perhaps, to write themselves new life scripts. Experiential-based programs involve participants in activities which tap their strengths and talents while compelling them to learn intellectual and social skills. All of this is catalyzed when the young substance abusers are immersed in a new and challenging environment.

The activities inherent in ropes/challenge courses, wilderness programs and community life skills challenges present opportunities for them to surpass socially and self imposed limits. "Rise to the occasion!" "Go for it!" and "You can do it!" become the directives which often provide the bases of a new self-definition. This concept is particularly effective with chemical abusers who deny their problem. The process avoids their denial and attacks the cause.

Experiential educators approach adolescents as individuals who have not had the opportunities to develop a strong set of prosocial values. Given exposure to a group survival experience, they develop self-worth, personal responsibility, and a sense of connection to society and others. This connection alone helps them re-evaluate their chemical abuse. Typically, participants are given tasks which cannot be accomplished without group interaction,

cooperation and organization. They are given tasks such as scaling a sheer cliff, constructing a group shelter, putting on a play, or even finding their way from point A to point B in the middle of Manhattan. During these activities the peer group becomes the primary vehicle for setting of standards and goals, solving of problems and forming bonds of trust and communication.

Experiential educational programs can include working ranch, community service, vocational skills, flight training, urban skills and even performing arts programs. These programs seem particularly well suited to the learning styles of adolescents for whom peer group acceptance is so important. All have been very effective in the field of corrections/substance abuse. Ropes/challenge courses and wilderness expeditions are two forms of adventure-based experiential programs. They will be the primary focus of this paper although other experiential programs are recognized as important too.

There are numerous examples of wilderness programs which have worked primarily with delinquent youths, some examples are the Santa Fe Mountain Center in New Mexico, Outward Bound's Project STEP in Florida, Project SPRITE in Wisconsin, Eckerd Youth and Family Alternatives, now offered in seven states, Associated Marine Institutions in Florida and the

Underway Program in Illinois. Operating on extended wilderness expeditions, adolescents participate in such activities as hiking, camping, mountaineering, canyoneering, canoeing, rock-climbing community activities and even caving. Programs do not teach these specialized skills as ends in themselves, but rather, they teach through them. A wilderness adventure context is an excellent stage upon which staff can draw attention to the coping mechanisms of participating clients.

The number of wilderness programs is limited due to their set-up costs, the need for high levels of specialized staff training, the secure nature of many correctional commitments, and the lack of proximity to suitable wilderness terrain. As a result, other programs, such as ropes/challenge and team/life skills courses, have been developed. These programs provide innovative solutions to the above constraints for chemical abusers which can be used in conjunction with other substance abuse treatment programs.

A ropes course consists of a series of obstacles made with ropes, platforms, and ladders built in tall, hardwood trees or telephone poles. Metaphorically, the ropes/challenge course brings the "rocks," "rivers," and "mountains" to the institution. Courses can be built in urban settings in areas as small as 250 square feet.

A challenge lab usually consists of a series of team problem-solving tasks that parallel the types of obstacles a group might encounter in the wilderness. A series of low events offer incremental success and confidence building. The high ropes course contains challenges of heroic and mythic proportions. Built 40 to 50 feet off of the ground, the high ropes course requires a summoning of courage and commitment while the person is in the context of a supportive small group.

While often frightening to behold, the high ropes course is a highly controlled, physically safe environment. The participant will perceive it as highly dangerous, but the real risk, in fact, is minimal. However, it provides an atmosphere that can act as a powerful catalyst for growth.

A community challenge laboratory can also consist of a series of assignments which develop general social and coping skills in an urban environment. Assignments can be designed to be practical hands-on life-skills training courses.

Issues of trust, confidence, commitment, responsibility, empathy and support are experienced directly in adventure-based education. Ropes/challenge programs and wilderness expedition programs are action oriented, behavioral approaches. They use unfamiliar environments to develop close, cooperative, small group processes. Also, both

program success to alter self-limiting perceptions of their participants which will be transferred to other life contexts and experiences.

ACTION

The use of adventure experiences as a therapeutic tool stands in sharp contrast to traditional substance abuse treatment which is primarily introspective and analytical. Most therapeutic approaches presuppose a verbal ability that is often absent in delinquent youths. Experiential educators believe that positive experiences which result in new perceptions of capability, power and significance can be of more therapeutic value than many cognitive or analytical talking approaches. Instead of conceptualizing and processing abstract concepts, experiential educators attempt to design real life situations which provide manageable challenges that, in fact, are do-able, but which will seem to the individual to be more than he/she can meet.

These situations are engineered to be opportunities. The youths will be given activities which will provide the groundwork for understanding, teaching and therapy. They give the chemical abuser the opportunity to feel high naturally from their accomplishments. The counseling agenda helps the individual understand and learn from his or her behavior and actions.

In summary, the experiential education approach attempts to meet youth "on their own turf," in the world of action. This hands-on approach reduces therapeutic resistance, quickens the building of rapport, and facilitates more genuine engagement in the program.

NOVEL ENVIRONMENT

Ropes/challenge courses and wilderness expeditions thrust participants into new and uncomfortably novel environments. This jolts them from false securities they would feel in familiar settings, and enables them to gain new perspectives on their old patterns and assumptions. New activities can also be enticing and fun. Thus, the young person enters an inherently stimulating situation in which he/she will be driven to use new problem-solving and coping techniques.

This approach is dramatically different from that of a conventional correctional institution or treatment program, where the usual adult roles are those of authorities and reinforcers of behavior. In such a traditional setting, the youths become programmed to function according to rules designed by someone else. They seldom have opportunities to exercise their own problem-solving skills or personal initiatives in meaningful situations. By contrast, in an

adventure-based setting, rules are natural, rather than arbitrary. The outdoor environment and the accompanying challenges dictate that an individual respond flexibly and adaptively.

In the wilderness environment, lessons emphasize responsibility rather than conformity. If one neglects to put up a shelter, one is miserable when it rains. And, on a ropes course, the rule that one must always wear a helmet and back up each safety knot makes practical sense.

Most chemical abusing youths view their lives as hopeessly complex. The isolation and simplicity of the out-of-doors helps to bring them back to basics and into a more manageable sense of the world.

A COOPERATIVE COMMUNITY

Group process lies at the core of adventure education. Since personality is formed and shaped largely through our contact and involvement with others, it can be reshaped through this same intimate contact. Group process becomes a way of life, not just a therapeutic tool. The group decides what needs to be done and organizes it. Guided group discussion is used to settle problems, to give individuals feedback, and to evaluate group and individual performance. When an adolescent has a problem, it is dealt with in the

immediate context and with the help of the group. All the group members are effected, and therefore all have a stake in the resolution of problems. It is in the repeated use of the group process that an adolescent develops his/her greatest insights.

The attainment of personal comfort and security in the wilderness requires a cooperative community structure and an effective group process. A wilderness expedition involves living interdependently. Fulfilling physical needs, healing, personal growth, and even physical triumphs are experienced in relation to, and with the support of, others. This sense of mutual dependence and trust is highly therapeutic. Adolescents need to feel that they matter and that their existence is significant. In the wilderness, individuals who may never have felt important to others discover that the group depends upon them.

Ropes course experiences are specially designed to create cooperative behavior and trust. Since each individual feels vulnerable when confronting fear, novelty and discomfort, group social bonding and group identity is intensified. Challenge programs force participants to quickly develop intimate relationships.

In all adventure programming, group cohesion promotes honest emotional expression and sharing. After each

significant experience group members discuss their successes and failures and resolve problems. Group counseling sessions become extremely candid after bonds have developed. The group learns that anger, frustration, fear and anxiety are universal human feelings and genuine acts of kindness, friendship and compassion become the norm. This helps reduce the natural defensiveness of abusers.

The attention to outside observers is quickly drawn to the dramatic nature of the activities which characterize adventure education. Personal empowerment, however, does not automatically result from the dramatic components of the activity; rather it arises from the way such problems are structured. Walsh and Golins (1976) have identified six characteristics of problem-solving tasks:

1. The problems are planned, prescribed and managed. Each problem situation is designed by the staff to fit the needs and capabilities of the learner.
2. The problems are incremental so that skills development will parallel the graduated difficulty of tasks. Confidence is developed through successive achievement and the accumulation of an increasing repertoire of skills.
3. The problems are concrete. Success and failure stand out in bold relief. The tasks have clear beginnings and ends.

4. The problems are manageable. While they can be solved, success is not guaranteed. When a student cannot simply dismiss a problem as impossible and yet when the problem's successful resolution is uncertain, maximum motivation is achieved.

5. The problems offer real consequences. Success or failure is readily apparent. Feedback to the learner is immediate. Because the outcomes are consequential, each individual learns to assume responsibility for his/her actions and choices.

6. Problem resolution requires that students draw on the full complement of their physical, emotional and cognitive resources. For example, to climb a mountain or complete the ropes course, one must cognitively plan the route, develop the necessary emotional commitment to attempt the challenge, and to exert the physical stamina to succeed at the task.

The intentional use of stress is central to the change process of adventure education. The anxiety which results from the dramatic nature of adventure activities sets the stage for a potentially transforming experience. When a failure-oriented substance abuser summons the courage, discipline and resolve to master a difficult task, he/she changes self-definition as well. The successful resolution

of anxiety and the mastery of a challenge that appears beyond one's capabilities results in increased sense of self-worth and potency.

Thus, experiential education seeks to replace self-defeating attitudes and perceptions, which have lead to delinquency and substance abuse, with feelings of empowerment, perseverance and confidence.

TRANSFER OF EXPERIENCE

Self-efficacy theory (Bandura, 1977) suggests that when one's accomplishments are perceived to be of great magnitude they tend to be broadly generalized to other situations. Adventure educators have paid particular attention to the issue of transfer or generalizability of experience. Indeed, one might argue that the behavior one observes in an adventure setting is more indicative and generalizable as well as more useful to life after release than institutional conformity. Adventure experiences demand flexibility and adaptability which are necessary traits for success in the real world.

The high stress inherent in wilderness or ropes course experiences is similar to the stresses that lead to delinquent acts and substance abuse. How a substance abuser responds to ambiguity becomes an excellent predictor of their emotional and behavioral readiness for a less structured

setting. The behaviors, feelings and thoughts manifested in the adventure context are representative of the typical strategies a youth will employ in his home environment. Staff have the critical responsibility of helping participants to understand the profound implications of their program experiences.

In the role of therapeutic guide, staff members act as translators between the youth and the teachable moments of the adventure experience. They have a crucial responsibility for helping abusers to see the daily life implications of their experiences.

SUMMARY

Experiential programs dramatically demonstrate areas of power and competency to those identified as chemical abusers, where other programs merely concentrate on the individual's failures and deficiencies. For many, this formula can be a giant first step on a therapeutic journey.

While research efforts conducted by adventure education programs around the United States clearly demonstrate positive therapeutic change on a host of variables, program administrators would be well-advised not to over sell the long-term behavioral effects of experiential programs. It is recommended the changes that have come about through these

programs be supported and developed after wilderness participants graduate. Some experiential programs place their graduates in transitional classroom-based learning groups. In the transitional classroom, the youths can transfer and solidify learnings from their experience-based programs to more traditional educational settings. This will help them to strengthen competencies in basic skills areas and to participate in lessons which more closely approximate those learned in a regular classroom. Some invite their alumni to return to re-participate in wilderness experiences as graduates feel they need to, or periodically when alumni weekends are sponsored. Both are designed to strengthen and renew their graduates. Others place clients in transitional treatment programs which use a variety of additional experiential components such as work, ranch, horse braking, community service, vocational skills, flight training, sailing, urban skills and performing arts programs.

Learning by doing offers much therapeutic potential for the substance abuser, whether fully addicted or in the experimental or moderate stages of abuse. For many chemical abusers, these approaches have brought about significant changes which will have value and meaning throughout their lives.

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TREATMENT SERVICES FOR THE CHEMICALLY DEPENDENT YOUTHFUL OFFENDER AND IMPLICATIONS FOR THE FUTURE

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TREATMENT SERVICES FOR THE CHEMICALLY DEPENDENT YOUTHFUL OFFENDER AND IMPLICATIONS FOR THE FUTURE

To treat chemical dependency one needs to understand it. For many young people drug or alcohol use involves experimentation and/or situational use. They, by themselves or with appropriate assistance, will minimize or eliminate chemicals from their lives. For many, however, the problem is more complex, resistive to intervention and almost impossible to resolve. This is the group that usually ends up on a correctional system.

Of significance is the ability or lack of ability to separate the truly drug dependent youth from the moderate experimenter or the occasional drug user. Many correctional drug treatment programs are superficial and treat all participants with a bland education/threatening approach that is of little value. It is, therefore, necessary to improve the diagnostic process to separate drug users into different groups, depending upon their degrees of dependency to drugs and/or alcohol.

Most experts have come to the conclusion that chemical dependence is a disease. It cannot be cured, only controlled by abstinence. Chemical dependence is progressive. It is characterized by increased tolerance, where the person needs

to consume more to get the same effect. Use becomes not only a way to get high, it becomes a way to get by.

The inability to stop using chemicals has predictable characteristics. It becomes a preoccupation. Most of the addict's thoughts and activities will focus on drugs or alcohol. They will become fascinated by the drug/alcohol culture and will change their friends to drug/alcohol users. They will develop a strong dependence upon their dealer and will panic when their supply is threatened.

Loss of control occurs as the disease progresses. Marked behavior changes will occur in the individual, such as temper outbursts, assaultive behavior or withdrawal from friends and family. School involvement will deteriorate and poor grades will ensue. Suspensions and expulsions are common. As use becomes uncontrolled, morals and values will be abandoned. At this point, the individual's risks for overdose, withdrawal complications, suicidal gestures and criminal behavior will increase.

Delusional thinking permeates the chemically dependent. The person's perspective will narrow and become highly resistant to change, despite numerous and harsh consequences. Problems will be denied or minimized. Perceptions of self become distorted and the person will come to view him/herself with increased power, self-esteem, and invulnerability.

If the youthful offender has many of these symptoms, he/she can be considered chemically dependent. It will be very difficult to stop their usage and their problems will escalate with the resultant perception that continued use will be their only solution. The type of chemical consumed may become irrelevant. The chemically dependent youth, when given the opportunity, usually uses whatever is available until it is entirely gone. Forced abstinence will not solve the problem, it only postpones it.

Successful treatment becomes a formidable challenge. For years chemical abuse was either ignored or punished. The prevailing attitude was that drug use was the result of self indulgent adolescent tendencies, or the need to escape the realities of one's life. Interventions, if any, consisted of education, counseling, surveillance or threats. The failures were frequent and the successes few.

Practitioners have learned from these experiences that there are no shortcuts or magical cures. The problem will not go away. Treatment, to be effective, needs to be intensive, multidimensional and provided over a long period of time.

There are several options available to correctional decisionmakers as they seek solutions and workable answers:

A) Status Quo - They can continue on the same course with the same level of services. For many systems

this will consist of varying degrees of education, counseling, confrontation and persuasion that will be inconsistently applied. Some drug offenders will positively respond to these efforts. The chemically dependent offender will not. Although these attempts satisfy the need to provide a substance abuse treatment program, they do little to provide meaningful services.

B) Voluntary treatment - Systems without resources for new services can provide, at little cost, an Alcoholics Anonymous/Narcotics Anonymous, 12-step program in their facilities. Staff or volunteers who are in recovery may organize and coordinate this effort. AA/NA is confidential and voluntary. While it is a volunteer, self-help program, it is the program which has been most effective. However, AA/NA by itself, does not guarantee sobriety. It does educate the offender to the issues of addiction and dependence, provide a source of support and encouragement and present an alternative for a drug-free lifestyle. Agencies that have introduced AA services into their facilities speak positively of its effects.

C) Continuum of Care Services - For systems that have the commitment and the resources, a more

comprehensive, intensive intervention is recommended. It is generically referred to as the continuum of care model. Based on several operating assumptions that have been developed over time, it reflects the collective wisdom of practitioners who have struggled with this problem. Its assumptions include:

1. Treatment, to result in sobriety and a commitment to recovery, initially has to be primary and exclusive. It cannot be a part of another treatment model or treated as a secondary issue.
2. The preferred focus of treatment is the AA/NA 12-step model. It is geared to personal responsibility and total abstinence and it can provide a lifetime of support for all chemically dependent youths who choose to remain sober.
3. Chemically dependent youth with the proper support and structure can be motivated to make a commitment to a drug-free lifestyle.
4. It is recognized that drug usage is intricately enmeshed in other issues inherent in the lives of troubled youth, these include low self-esteem, social and emotional dysfunction,

family conflict and personal development deficiencies. These issues will need to be resolved or, at least, minimized for recovery to be maintained.

The continuum of care model spans secure institutional care, residential placement and supervised community living. It usually lasts twelve to twenty-four months. Progression and/or regression is permitted along the continuum based on the offender's response to treatment. Ideally residents will move sequentially through each phase and placed strategically in certain phases based on previous treatment experiences.

This model has four phases which are described herein:

. **Phase I/Assessment:** Assessment begins in a separate living unit in a secure component of a correctional facility. Residents have been screened and assessed as chemically dependent. They should be compliant if not cooperative with the program and have minimal, if any, interest in stopping their drug usage after discharge.

The environment must be drug-free and convey a preferred way of living. Integrated into the staffing pattern are persons who are in recovery, knowledgeable of the 12-step process and committed to sober lifestyles. The content includes, in

addition to the regular program, AA/NA meetings, study groups, education on chemical dependency issues and group/individual counseling focusing on personal responsibility and positive lifestyles.

The purpose of this phase is threefold: 1) to introduce the concept of sobriety, present positive role models of people in recovery; 2) to provide encouragement and support for the client to consider giving up drugs; and 3) to assess the degree of resistance and denial and to determine the youth's potential for continuing in the program.

The length of this phase is 1 to 2 months.

Phase II/Primary Care (this also could be levels three or four of Phase I): Designed for those youth who have expressed or demonstrated some interest or commitment to recovery. Twelve-step work will be the primary focus, with successful completion of the first three steps being a requirement for advancement. The educational component will concentrate on chemical dependency issues and their consequences. Counseling will be primarily confrontive to deal with denial, resistance and minimization. The environment should continue to be free from external

influences, with on-site visits from family and friends being the only outside contact.

The purpose of this phase is to get the residents to commit to recovery, understand and accept their dependency, develop an initial understanding of their disease and provide a foundation for their continued sobriety.

This phase can be contracted with a private facility or continued in the correctional setting. It does not need to be physically secure. Opportunities for going AWOL should be made available to test participants' commitment to the program.

Phase III/Transitional Care: Provides for reintegration services in a residential setting for youth who have completed primary care.

The extended care program addresses all functions that may contribute to and are covered by the young person's chemical dependence. The therapeutic model identifies four primary components for treatment:

a) Recovery - Sobriety for the client is still delicate. Treatment is designed to maintain and enhance the success of an inpatient program. AA meetings, 12-step progression (4-12), educational and chemical dependency

groups are the primary components of this tract.

b) Psychological/Emotional Issues - Many offenders harbor destructive and dangerous feelings, such as anger, rage and depression, and they have residuals of pain from abusive and neglected childhoods. Their feelings will be identified, shared, clarified and resolved through individual and group counseling.

c) Family Dysfunction - Multifamily groups and individual family treatment is intensified. The focus is on resolving or minimizing the issues that may be causing alienation and distrust to reinstate the family, whenever possible, as a source of support and comfort.

d) Personal Development - Youths with histories of delinquency and chemical dependence may possess limited social skills. They may be unable to communicate effectively, and many have had an accumulation of negative experiences in school and employment, and most have minimal interests and use their leisure and recreational time poorly. A variety of activities are designed to correct these

deficiencies and to provide each of them with the tools for more mature and fulfilling lives.

- Psycho/educational modules. Self-esteem, values clarification, decision-making, sexuality, legal rights, stress management and conflict resolution.
- Education/employment preparation. Job development skills, GED, tutorial activities, school re-entry, vocational and employment preparation/maintenance. Knowledge of transportation systems.
- Recreation, leisure-time development. Designed to introduce more productive enjoyable free time activities, exposure to sports, hobbies, and physical fitness. Knowledge of community resources, library, YMCA/YWCAs, community/recreational centers, museums, etc.

This phase requires a nonsecure community-based setting, either through contract with a private provider or by using a community corrections facility.

Phase IV/Supervised Community Living: Participants in this phase will live in the community (home, group home or independent housing), under the close supervision of their parole officers. They are expected to maintain drug-free lifestyles while attending school, work or day treatment. They are required to continue in a recovery program which includes, at a minimum, AA meetings and 12-step study, aftercare groups, active participation with a sponsor and other support services determined by the parole officer and discharging agency.

The primary purpose of this phase is to give the youth opportunities to gain experience and confidence with a drug-free lifestyle.

This model is a comprehensive, intensive and expensive approach to the problem of chemical dependency. However, commitment to this process will result in progress and success in treatment of chemically dependent offenders. Anything less will probably maintain the status quo. Of primary

importance is the need to reintegrate the adolescent into the community and allow for relapses and retraining within a program. An institutional program that lacks this trial and error phase in the community has little chance of success.

Some systems and institutions will resist the change in their programs and their attitudes. Others will see it as an opportunity for progress and improvement. To date, continuum of care appears to be the only viable course to take.

Other promising strategies for adolescent chemical abusers lie in the development of self-enhancement activities, either mixed with other treatment approaches or used separately. Particularly for the juveniles that are in early experimentation or moderate stages of drug/alcohol use, the concept of providing successful living activities which give them legitimate feelings of accomplishment, rather than a false high, has merit. These strategies center around work, vocational, education and experiential, or problem solving, education. See our chapter on experiential education for further information.

Every correctional program, whether residential or not, can facilitate its success by training and strictly enforcing a standard model of behavior relative to chemical use for its staff. Many staff members will talk of their alcohol and

substance uses and abuses, giving nonverbal and verbal signals which approved of chemical use. The reduction of these behaviors and attitudes will diminish the double standard that now is offered to juveniles in our care.

The future of substance abuse treatment in juvenile correctional programs depends on further development of techniques to successfully treat chemical abusers. At the present time, no one has the absolute answer, and we unfortunately, will pass many juvenile chemical users and abusers onto adulthood.

Nonetheless, we need to treat chemical dependency as a primary problem that must to be treated before other interventions are introduced. Treatment is a process which takes place over a broad span of years. All programs have their share of failures. Relapses are common. Quick cures, while desirable, are not really feasible in this field. Ultimately, being patient and persistent is critical to long-term success.

Very importantly, innovative approaches need to be encouraged and their effectiveness meaningfully measured and compared against other treatment approaches. Solutions which will effectively break through the denial of adolescent substance abusers in correctional programs is an area in which development could be pioneered. To date, it has been a major obstacle to the treatment of these youngsters.

The number of chemically dependent persons currently needing treatment far exceeds the number of available treatment slots in the country. Some waiting lists for entry into publicly supported treatment programs are as long as nine months. As addiction rates seem to be increasing, we can expect an even greater demand for treatment resources.

Many treatment programs are being funded on the basis factors not related to the success of their programs. In many cases, the clamor for treatment slots outstrips the concern for accountability. Quantity of service recipients, not effectiveness at stopping drug use, is too often the main criterion by which communities measure success. During the recent White House Conference for a Drug Free America it was strongly recommended that funds only be allocated to programs that have been proven effective.

Developing standardized objective methods for determining the success of drug treatment is essential for our accountability and, now it seems, accountability may be essential for continued funding.

ADDENDUM:

BACKGROUND INFORMATION AND RESEARCH

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ADDENDUM: BACKGROUND INFORMATION AND RESEARCH

Drug use has been strongly linked to criminal recidivism. Drug use prior to adjudication[1] and after treatment[2] has also often been associated with high rates of recidivism and violent offending.[3]

Drug using delinquents are responsible for a disproportionate amount of all crimes.[4] High rates of relapse and recidivism have led researchers, practitioners and policy makers to ask who is at risk for return to drug use and criminal activity, following treatment. By isolating factors associated with recidivism and relapse, it is hoped that steps can be taken to identify those at risk and to develop interventions that will reduce these risks.

There is extensive literature on factors which predict relapse among adults.[5] The evidence assembled to date suggests that post-treatment factors appear to be most important in determining a person's return to drug use.[6]

In designing aftercare and transition programs, the goal is to maintain treatment gains and prevent a return to drug using and delinquent behaviors. The fundamental premise of this chapter is that to prevent relapse and recidivism, programs must seek to reduce factors that are associated with these behaviors. The chapter will identify factors related to relapse and recidivism, identify how these factors might

be addressed by treatment programs, and describe a model program we have developed which we feel will address these factors.

PREDICTORS OF POST-TREATMENT RELAPSE TO DRUG USE

While there are many descriptions of adolescent drug abuse treatment approaches, few studies of post-treatment outcomes exist.[7] Four studies of adolescent drug treatment outcomes have been cited in the literature. All of these studies used nationwide data collection systems.

Sells and Simpson (1979) reported on data collected from 5,405 black and white clients under age 20, who entered into drug treatment in the years 1969-73. The subjects were admitted to drug treatment centers that participated in a Drug Abuse Reporting Program (DARP). The researchers additionally reported on a four- to six-year follow-up of 587 subjects from the 1969-72 cohorts.

Hubbard et al. (1985) analyzed data gathered from a sample of 375 clients. All clients were under the age of 20. Subjects were selected from 1979-80 admissions to programs in a Treatment Outcome Prospective Study (TOPS).

The most recent published adolescent drug treatment results we cite were found in five articles.[8] All used data which were derived from the National Institute of Drug Abuse

(NIDA)-CODAP statistical information system. Subjects were 5,789 clients, under age 20, admitted in 1979-80 to drug treatment programs.

A fourth study looked, not at drug abuse treatment, but at the impact of delinquency treatment on adolescent delinquents' drug abuse behavior. Braukman, and associates (1985) examined the effects of group treatment on delinquents' drug use. In this study, 91 clients in Teaching Family group homes using social learning theory, behavior modification, skill teaching, self-government, motivation, relationship development and youth advocacy interventions, were compared with 150 clients in non-Teaching Family group homes.

All these studies attempted to describe treatment outcomes and identify predictors of outcome for adolescent subjects. Together they did not provide conclusive evidence concerning the effectiveness of adolescent drug abuse treatment, as they all had flaws in their sample selections and designs. Only two studies[9] used an untreated control group. While one used a treated control group, the subjects were not randomly assigned to the treatment group. One study used only discharge data to assess outcome, and did not provide long-term follow-up to see if changes were maintained.[10] With the exceptions of Friedman and Braukman, data gathered was not particularly youth-oriented, rather subjects were

primarily adolescents who had been placed in adult treatment settings.

In spite of these methodological flaws, the four studies do provide information about rates and prediction of post-treatment drug use. Predictors of post-treatment relapse included the pre-treatment variables of: pre-treatment drug use, education, employment, criminality, age, race, psychiatric symptoms, and variables measuring treatment experiences, such as treatment environment scales, time in treatment, and treatment modality.

Pre-Treatment Factors

In the TOPS (Treatment Outcome Prospective Study) study all subjects were under 20. The clients who were under age 18 faired better on a variety of outcome measures. In the DARP (Drug Abuse Reporting Program) study, outcome was predicted by a combination of age and race. Although all groups evidenced favorable changes for opioid and nonopioid use, employment, and criminality, older whites showed the greatest positive change in outcome indices. Younger blacks showed the least favorable outcomes.

Friedman and his colleagues found that pre-treatment variables were weak predictors of outcome. Psychiatric symptoms explained only 2% - 3%,[11] pre-treatment marijuana

use accounted for 4%, race accounted for 1%, and number of other pre-admissions factors accounted for 1% of the variance in during-treatment drug use reduction.[12]

It appeared that the pre-treatment factors of race, age, and severity of drug use and psychiatric symptoms accounted for a relatively small amount of the variance in post-treatment outcomes. As most of these pre-treatment factors are relatively fixed characteristics, there is little that programs can do to change them and thus, reduce post-treatment relapse. However, these factors might be used to identify those who are slightly higher than normal risks. For example, the fact that psychiatric symptoms can be a predictor suggests that post-treatment planning might provide access to mental health services to clients who have these symptoms.

Treatment Factors

Treatment Modality

All treatment modalities have been associated with reductions in heavy use of every drug but marijuana and alcohol. Sells and Simpson (1979) found decreases from pre-treatment to four- to six-year follow-ups in daily opioid use among adolescents. The percent of subjects using opioids daily decreased from 28 to 4 in outpatient, 44 to 1 in Therapeutic Community (TC), 86 to 7 in methadone maintenance,

61 to 2 in alcohol detoxification (detox), and 35 to 10 in intake-only. Decreases in daily nonopioid use occurred in all but the intake-only group.

The percentage of subjects using marijuana daily remained at 18 for outpatients and increased from 22 to 24 in TC, 10 to 21 in methadone maintenance, from 14 to 22 in detox, and from 26 to 29 in intake-only. Heavy alcohol use also increased or remained the same, in all but outpatient subjects, where the percentage decreased from 18 to 7.

Treatment was associated with increased rates of abstinence from all drugs but marijuana, whose rate of use showed little change. (Data on total abstinence from drug use are not available from the DARP study. Results were reported separately for each drug.) The percent of subjects abstinent from opioids increased from 7 in the two months prior to treatment, to 66 in the two months before follow-up in methadone maintenance, 24 to 91 percent in TC, 51 to 85 percent in outpatient, 24 to 72 percent in detox and 16 to 75 percent in the intake-only group. The percent abstaining from marijuana decreased from 52 to 29 percent in the methadone maintenance group, showed little change (from 34 to 33 percent) in TC treatment, increased slightly from 30 to 34 percent in outpatient treatment, and decreased from 38 to 31 in detox, and from 29 to 18 in the intake-only group.

The large increase in usage of marijuana in the methadone maintenance group may be due to substitution of marijuana for opioids. The overall increase may also reflect the increasing acceptance of and increasing use of marijuana in the general population between 1969-72 and 1975-76, when follow-up was completed.

In general, treatment is associated with reductions in the use of opiates. These are the drugs which are typically addressed in adult drug treatment programs. However, treatment was not associated with reductions in the use of marijuana or alcohol, the drugs more typically used by adolescents.

Residential and outpatient treatment for young persons (age 17 and younger) and for young adults (age 18 to 19) were compared in the TOPS study.[13] For clients remaining in treatment three months or longer, greater declines in use were seen in residential than in outpatient groups at one- and two-years' follow-ups. For example, for adolescent clients, daily marijuana use decreased from 79 to 12 percent in residential treatment. In outpatient programs, daily marijuana use increased from 48 to 54 percent.

While residential treatment clients appeared to fair better in the TOPS study, outpatient clients faired slightly better in the DARP study. In the NIDA-CODAP cohorts,[14] frequency of use of each drug was reduced by one-half in the

time between treatment admission and discharge. However, no post-treatment follow-up data were gathered, so it is not known whether these changes were maintained.

In the Braukman et al. (1985) study of group home treatment for delinquents, Teaching Family youths reported less alcohol use and abuse, and more prosocial behavior during treatment than did non-Teaching Family youths. Drug and alcohol use did not differ at post-treatment, but prosocial behavior was greater in the Teaching Family group at post-treatment.

Other Treatment Factors

In two studies, time in treatment was related to post-treatment success. In the TOPS study, clients who remained in treatment for at least three months did better on several outcome measures. Friedman found that time in treatment accounted for 1 to 2 percent of reduced during-treatment drug use. Staff and client ratings of outpatient program environments accounted for between 9 and 25 percent of variance in reductions in during-treatment drug use.[15]

In another study of treatment factors, measures of five categories of program variables were entered into separate regression equations to predict reductions in drug use during treatment.[16] Factors measured included size, special services, staff training, therapy method, and perceptions of

treatment environment. All variables, except those pertaining to treatment environment perception, were then collapsed into scales and entered simultaneously.

The provision of special services accounted for between 10 and 17 percent, therapy method between 2 and 4 percent, and the size of the program between 0 and 3 percent of the variance, depending on outcome year examined. The most important variable related to reduction of drug use during treatment appeared to be the provision of special services, specifically, school, recreational, vocational, and contraceptive services.

In Friedman's studies, program variables seem to account for a larger amount of variance than pre-treatment factors in drug use reduction during treatment. These results should be interpreted with caution, however, since the dependent variable was a change score[17] and drug use from admission to discharge was all that was examined.

From the results of studies examining during-treatment factors, it is unclear whether inpatient or outpatient treatment is likely to be more effective in reducing the risk of relapse. Group home programs based on behavioral principles are more successful, than other group home programs, in reducing drug use during treatment. However, additional services appear to be needed to maintain these reductions

after treatment. Such special services as school, recreational, vocational and contraceptive services, when provided, seem to reduce risk of relapse among adolescents during treatment.

Post-Treatment Factors

In Braukman et al.'s (1985) study, pre-treatment and during-treatment variables were combined to account for 28% of the variance in subjects' alcohol use, 38% for marijuana use, 31% for other drug use, and 30% for prosocial behaviors during treatment. These same variables accounted for 19%, 38%, 20% and 12%, of the variance, respectively, in the corresponding post-treatment outcomes. With the exception of marijuana use, pre-treatment and during-treatment variables did not predict post-treatment functioning as well as they predicted during-treatment functioning. This suggests that other variables may have a significant impact on post-treatment outcome. Braukman et al. (1985) suggested that "effective post-group home environments may need to be developed," and that treatment strategies, such as "family therapy, teaching functional skills to the youth for refusing peers, for making new nondrug-using friends or for obtaining access to systems of reinforcement contingencies that discourage irresponsible drug and alcohol use" be attempted to reduce post-treatment relapse.[18]

A number of adult post-treatment drug use relapse studies have been conducted.[19] In these studies, pre-treatment factors accounted for 10-20% of the variance in post-treatment relapse,[20] and treatment factors accounted for 15 to 18%.[21] Post-treatment experiences seem to be particularly important to the relapse process, accounting for roughly 50% of the variance in drug treatment outcome,[22] which is more than the combined amount of variance explained by pre- and during-treatment factors.

The following post-treatment factors have been shown to be associated with adult relapse: absence of a strong prosocial interpersonal network, including family and peers[23] use or pressure to use;[24] social isolation;[25] lack of involvement in productive roles, such as work or school;[26] lack of involvement in active leisure activities;[27] negative emotional states, such as depression or anxiety;[28] negative physical states, such as chronic pain or withdrawal states;[29] and skill deficits.[30] For adolescents, it appears to be important to provide a broad range of services during the post-treatment period which: increase clients' social, stress coping, problem solving, and drug refusal skills; provide opportunities for them to strengthen their network of prosocial, nondrug-using friends and family; increase their involvement in work or school; and increase their involvement in active leisure activities.

FACTORS RELATING RECIDIVISM TO DELINQUENCY

In the past 20 years, studies have attempted to identify pre-treatment, during-treatment and, to some extent, post-treatment factors which would allow accurate prediction of who would and who would not return to delinquent behavior following adjudication. Although none of these studies has succeeded in the goal of accurate prediction, a number of predictive factors have been identified which may be helpful in targeting promising treatment approaches.

Rates of Recidivism

It is recommended that investigators working in the delinquency field attempt to arrive at a standard definition of recidivism. Failing that, they should at least describe the population, the follow-up period, and the definition of recidivism that is used.

In the studies we examined, we found a wide range of reported recidivism rates. The recidivism of delinquents ranged from 15[31] to 77 percent.[32] Variation in the way these data were collected and on whom they were collected probably accounts for this wide variability in rates. Studies have defined recidivism in three ways, as reconviction,[33] as reinstitutionalization[34] or as rearrest.[35] Follow-up periods during which recidivism data were collected also varied from

six months[36] to 10 or more years.[37] The age of subjects was variable, ranging from juveniles[38] to young adults.[39] Studies also differed in the populations they selected to study, e.g., first time probationers,[40] detainees,[41] or all referrals to a given court system.[42] However, almost all investigations made use of official records and did not depend on self-reports to determine the incidence of recidivism.

Pre-treatment Factors and Offender Characteristics

By far, the greatest attention in the prediction of recidivism has been devoted to the study of offenders' backgrounds. There are three reasons these factors have been studied so extensively: 1) they are often readily available from court or institution records; 2) with the exception of court data on reconviction, studies which use pre-treatment predictors do not require expensive follow-up data collection; and 3) a main goal of recidivism prediction has been to develop methods by which institutions or court systems could make sentencing or release decisions regarding young people for whom they are currently responsible. In examining these predictors, our focus will be on developing programs which would prevent delinquent and drug-involved delinquent youth from recidivating once they are returned to the community.

Offense-Related Predictors

A number of offense-related variables have been found to be related to recidivism. The younger a youth's age at his/her first conviction the more likely he or she is to be reconvicted.[43] The type of offense involved is also a predictive. Felons and status offenders are more likely to be recommitted than youth who have committed misdemeanors.[44] Several situational characteristics of the offense are related to repeated offending.[45] The variables include: whether the crime involved injury or theft, the amount of damage involved, the victim-offender age discrepancy, and whether the crime occurred outdoors.

Youths who commit crimes alone and who have previous criminal justice contacts are likely to recidivate.[46] Osborn and West (1978) found they could correctly identify 70 percent of recidivists based on the number of their previous convictions. Having a previous offense record received the highest weighting among six variables in a prediction model developed by Brundage (1984). Similarly, other investigators report that previous convictions predict reconviction.[47]

Demographic Characteristics

The demographic characteristics of gender[48] and socio-economic status[49] are predictors. Being female decreases and

low socioeconomic status increases the likelihood of recommittment. It should be noted that these are fairly isolated findings. Few studies of recidivism actually included females, and few have examined socioeconomic status as a predictor.

Personal Characteristics

Many studies have examined personal characteristics, such as intelligence, personality, and interpersonal functioning as predictors of recidivism. Low IQ is associated with reconviction.[50] One study found no difference between recidivists' and nonrecidivists' IQs,[51] however, it employed a nonverbal test of intelligence. Other investigators have noted that a large discrepancy between verbal and performance IQ scores is related to recidivism.[52]

While the demographic and personal characteristics discussed above may be useful for identification of potential recidivists, most are not amenable to change. Several more mutable characteristics have been identified which suggest promising directions for treatment and aftercare program development.

Personality factors associated with recidivism include impulsivity,[53] extraversion,[54] antisocial personality[55] and poor social adjustment before arrest.[56] McGurk et al. (1978) found that youth reconvicted within two years of release from

juvenile detention scored higher on projected hostility, suspiciousness, and social nonconformity and lower on conscientiousness than juveniles who were not reconvicted. Also in an attempt to validate the Jesness Inventory as a delinquency prediction instrument, Saunders and Davies (1976) found that five scales predicted recidivism for both detention releasees and probationers: social maladjustment, value orientation (on a scale which measured empathy), alienation, manifest aggression, and denial. Some of these personality characteristics may be viewed as underlying "traits" which are not likely to change with intervention. Characteristics that reflect the youth's interpersonal style may be amenable to change through skill training. These include impulsivity, poor social adjustment, aggressiveness, and lack of empathy. Cognitive skill train- ing has been effective in reducing impulsiveness[57] and aggressiveness.[58]

Ollendick et al. (1980) found that external focus of control (the belief that outcomes are outside one's own control) was associated with recidivism among previously incarcerated delinquents. The authors suggested that interventions attempt to "'move' the externally-oriented youth into an internally oriented direction so that he can accept responsibility for his behavior and not attribute it to luck, fate or chance."[59] Lack of social skills, interpersonal effectiveness, and social maturity have also been

implicated in recidivism.[60] After finding differences in social maturity between recidivists and nonrecidivists, Davis and Copley (1976) stated, "Youngsters of low interpersonal maturity may well need a lengthy period of treatment during which they can develop basic social skills, [and] the ability to see the relationship between causes and effects..."[61]

Other Problem Behaviors

Early problem behaviors of lying, aggression, and stealing, are not only related to the development of delinquent behavior, but are also related to its repetition.[62] A history of drug use is also related to recidivism,[63] suggesting that drug use and other antisocial behavior patterns ought to be addressed in both treatment and aftercare programs for delinquent youth.

School Factors

A history of poor school behavior and truancy are related to repeated offense behaviors[64] and recidivists demonstrate lower levels of pre-treatment school achievement than do nonrecidivists.[65] Delinquent youths returning to the community who have a history of school problems are particularly high risks for reoffense. This suggests that school factors are particularly important predictors of recidivism and

transition programs should provide complete academic assessment, appropriate school placement, and assistance in academic performance.

Family Factors

The pre-treatment family environment of juvenile offenders is linked to being reconvicted of crimes. Family variables related to recidivism include the general "quality" of home conditions,[66] a "negative atmosphere" in the home,[67] parent criminality and the presence of delinquent siblings in the home.[68] Molof (1970) found that recidivists had a greater number of previous foster home placements than nonrecidivists. Larger families were more likely to produce persistent recidivism.[69]

Contradictory evidence exists concerning whether growing up in a one- or two-parent family affects a young person's tendency to repeat criminal acts. Some studies have found more "broken homes" among recidivists.[70] The age at which a person's family composition changes appears to be a variable, though the results concerning age are not consistent. Kelly and Baer (1969) found that 39 percent of juveniles recidivated whose fathers left their family before they were seven years of age. In contrast, 12 percent of delinquents whose fathers remained in the home, and 10 percent of those whose fathers left when they were seven or greater, recidivated.

Virkunnen (1976) investigated death of a parent and divorce among families of delinquent youths. Recidivists' fathers were more likely to have died during the subject's adolescence. A larger proportion of nonrecidivists gained stepfathers after their fathers had died.

In a study[71] of female delinquents the relationship between family composition and recidivism was reversed. The highest frequency of recidivism was in the group who had lived with both natural parents. This was followed by those who had lived with foster parents, and then by those who had lived with a single parent.

Although it is not possible to change what has already occurred, the above findings indicate the importance of environmental factors, and in particular, the family, in promoting or preventing recidivism. As documented in a later section, these family factors are also important in young person's post-treatment environment, and need to be addressed in transition and aftercare programs.

Peer and Community Factors

Recidivists report they have delinquent friends in their pre-treatment environment more often than do nonrecidivists.[72] Because there are high levels of drug use among other delinquent youths,[73] their former peer network pressures delinquents to return to drug use after treatment.

A low neighborhood educational level has also been associated with recidivism.[74]

The vast majority of studies of recidivism have been devoted to examination of factors which are not easily amenable to change. Their primary importance may be in the provision of criteria by which potential recidivists may be identified, so that appropriate services can be offered to them. Brundage (1984) describes one such effort in a Michigan county. A system which identified potential recidivists using pre-treatment factors in a prediction model, was able to reduce recidivism in the county. Intensive parole services, including lower probation caseloads and frequent unscheduled contact, were provided to the highest risk youth.

Important targets of transition services are also suggested by some of these pre-treatment factors. Programs which provide training in social- and self-control skills, internal attribution, and which address drug use, school problems, and family problems, offer the most promise in reducing continued crime.

Treatment Factors

Treatment Modality

Interventions to treat delinquency have been used at four points in the juvenile justice system: (a) diversion prior to

formal system processing, (b) community-based treatment following court adjudication, (c) residential or institutional treatment, and (c) aftercare following release from treatment. Since the central focus of this paper is upon transition services, this review of evaluations of treatment modality will focus on evaluations of residential programs.

The Teaching Family Model has been compared to other group home models. Participants in the Teaching Family Model committed significantly fewer offenses during treatment.[75] However, this model has not demonstrated any greater success than other group home models in one- or three-year follow-ups.[76] Early evaluations of guided group interaction approaches reported positive effects on recidivism,[77] however, more recent evaluations of this technique reveal no significant effects on recidivism.[78] Jesness (1971) found improvements in institutional discipline problems but no differences at 15 and 24 months post-institutional stay for those subjects who received special assessment-tied treatment, compared to those receiving regular treatment services. Cavior and Schmidt (1978) found similar recidivism rates (58%) three years after treatment for institutional groups exposed to behavior modification, individual and group counseling, reality therapy, or transactional analysis. However, Jesness (1975) reported fewer parole violations for

those exposed to behavior modification and transactional analysis compared to those receiving regular treatment.

Promising results have been produced with cognitive-behavioral skills training approaches in residential settings. In a meta-analysis of 111 treatment studies conducted with delinquents in residential settings, Garrett (1985) found that cognitive behavioral approaches appeared to be the most successful in reducing subsequent delinquency. Other approaches which showed positive effects were life skills training, contingency management, and family-focused interventions. Individual and group counseling interventions did not produce significant reductions in delinquent behavior following treatment. In another meta-analysis of community based interventions in residential and nonresidential settings, Gottschalk and associates (1987) found that behavioral interventions and programs that included behavioral components produced the largest number of positive results.

This review of the effects of treatment modality on recidivism has demonstrated that although several modes of treatment have produced positive changes while youths were in residential treatment, few show long term effects on reducing post-treatment recidivism. Promising results have been produced by cognitive-behavioral, behavioral, and family interventions; however, the differences in recidivism between

the experimental and control subjects were modest and not always consistently demonstrated. It is recommended that future studies using these methods pay careful attention to experimental design and description of treatment methods so that the inconsistencies and the strength of results for these promising treatment approaches can be further examined.

Other Treatment Factors

Only a few studies have examined more general dimensions of the treatment process as they relate to recidivism. Length of incarceration was one of ten items which differentiated between recidivists and non-recidivists.[79] Recidivists tended to be incarcerated for longer lengths of time.

Youths' own predictions of their chances of parole success are highly correlated with their actual success.[80] One study examined behavior during incarceration and found that delinquents who had fewer disciplinary transfers while incarcerated and who did not belong to youth gangs while institutionalized had a greater chance of success in the two years which followed incarceration.[81]

These factors suggest several treatment processes which might be effective in reducing recidivism. Programs that enhance youths' motivation to succeed may increase positive predictions of their chances of success. Programs that focus

on reducing youth gangs in institutions have promise for reducing recidivism. Programs based on enhancing motivation and expectations of treatment success have been developed in the drug abuse treatment field[82] and might be applied to juvenile corrections.

Programs that teach youth skills to meet their goals, without resorting to aggressiveness or other antisocial activities in the institution, are also promising. For example, interventions that teach negotiation, compliance, social and problem solving skills, have been shown to change skill levels[83] and hold promise for reducing problem behavior.

Post-Treatment Factors

Only a few studies have examined post-treatment factors related to recidivism. Involvement in productive roles appears to be an important protective factor in the post-treatment period. Programs which help reintegrate youths into school and jobs are promising. Two studies found employment in the post-treatment period was positively related to success.[84] Wiederander's (1983) study of parole success concluded that school attendance was related to success.

Several environmental factors appear to influence recidivism. Zarb (1978) found that parents' willingness to

have their child return home accounted for a large proportion of the variance in recidivism. Buikhusen and Hoekstra (1974) found that those youths who moved to a different address than the one they had lived in before incarceration were more successful. However, this variable accounted for only a small portion of the variance. Having nondelinquent friends and associates in the post-treatment environment[85] to whom one is attached[86] is an important predictor of post-treatment success.

From these data, one can infer that delinquent youth need a stable family environment to which to return. However, the associates present in their community environment may influence them to return to crime. Both relocating and having prosocial attachments are helpful in reducing recidivism. To the extent that 1) families can be helped to deal with the returning offender, 2) the offender is helped to develop non-delinquent alternatives, and 3) the young person avoids delinquent associations after release, the likelihood of their recidivism declines.

Several problem behaviors are associated with reconviction. Young persons who use drugs and alcohol after participating in a treatment program[87] and who become involved in fights[88] are likely to continue criminal activities. Programs, which reduce drug and alcohol use, and which

teach delinquent adolescents to deal with provocation without fighting, are sorely needed.

These findings suggest the importance of involving youth in productive roles, and altering their post-treatment environments. The young person needs an environment which is supportive of positive change, provides opportunities for association with nondelinquent peers, reduces opportunities for drug and alcohol use, teaches skills to deal with anger and provocation, and helps him/her to avoid former associates or to refuse involvement with them in delinquent activities.

Interpretation of Studies of Recidivism

The studies discussed above have a number of methodological problems. First, they rely largely on official records of recidivism, and, therefore, miss youths who reoffend without being caught. Thus, while identified variables are valid predictors of reinvolvement in the criminal justice system, they may not be valid predictors of reoffending. Second, many of the studies examine the relationship between one variable and recidivism, failing to control for the effects of other variables. Without controlling for other variables, it is difficult to determine the relative strength of various predictors. Third, studies often do not adequately describe the actual measures they

use, such as the definition of recidivism, leaving it unclear as to what is being predicted by which independent variable.

In some studies significant predictors of recidivism explain only a small percentage of the variance in outcome. For example, Molof (1970) began with 54 variables and reduced the number to five variables which were most predictive. However, together the five pre-treatment variables accounted for only six percent of the variance in recidivism.

One study which illustrates the power of avoiding these problems[89] combined a post-treatment variable (parent willingness to have the delinquent return home) and an environmental variable (number of nondelinquent best friends in the pre-treatment environment) with during-treatment assessment of the juvenile's interpersonal skill level. Together these variables accounted for 72 percent of the variance in delinquent acts. In this study, the measure of recidivism included both officially recorded acts and acts known by the aftercare officers that were not part of the official record. It can be seen from these results that when pre-treatment, during-treatment and post-treatment variables are observed and clearly documented, and when acts committed that do not result in conviction are reported, the accuracy of prediction improves.

We recommend that services which target the post-treatment period be given a high priority. The findings that

many treatment programs produce positive changes during treatment which are not maintained after-treatment suggest that transition and aftercare services could play a valuable role in the reduction of juvenile delinquents' return to crime and drug use. This hypothesis is supported by the success of cognitive behavioral treatment interventions which have provided youths with specific skills to deal more effectively with their post-treatment environments.

Zarb (1978) in a summary of the results of her study stated,

> ...the most effective approaches for dealing with property offenders would be characterized by: (1) an environment in which the parenting figures demonstrate a willingness to stick by the boy in spite of anticipated difficulties and personal hardships; (2) a setting or type of treatment intervention that increases exposure to nondelinquent peers and decreases exposure to delinquent peers; and (3) a setting or treatment program that provides an opportunity for the boy to improve his skill in dealing with interpersonal situations involving parents, teachers, and nondelinquent peers.[90]

To these suggested program components, we would also add interventions which: (4) teach the young person to attribute outcomes to his/her own behavior; (5) help him/her to integrate into productive roles with which he/she may have had difficulty in the past; (6) teach him/her skills to avoid drug use and drug using peers; (7) teach skills to enhance self-control to reduce impulsivity and aggressiveness; and (8) provide opportunities for him/her to become involved in nondrug related leisure activities.

FOOTNOTES
(References cited on page 161)

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APPENDICES

APPENDIX A

GLOSSARY OF TERMS

AA (Alcoholics Anonymous) - an anonymous self-help group of men and women recovering from alcoholism. AA is the originator of the Twelve-Step program, which is the model other self-help recovery groups, such as Narcotics Anonymous.

Abstinence - total avoidance of a substance, particularly a food, alcoholic drink, tobacco, or other drug.

Abuse - to use in an improper or harmful manner.

Abuse Potential - tendency for a certain percentage of individuals taking a drug to abuse it; or the tendency of a particular drug to be abused.

Accreditation - certification or licensing of a program or organization by a government or professional group.

Addiction - An obsessive physical or psychological need.

Adolescent - usually defined as between the ages of 13-16 or 13-18.

Aftercare - services provided to a person after they have been discharged from residential treatment. It may include regularly scheduled group therapy or individual meetings which may be held for varying session lengths and frequencies.

Al-Anon - anonymous self-help group for relatives and friends of alcoholics. Al-Anon believes that alcoholism is a family sickness, and that changed attitudes of all involved can aid recovery.

Alateen - anonymous self-help group for children of alcoholics and substance abusers.

Alcoholism - a term with a wide range of meanings. It often refers to alcohol abuse, or to any drinking problem. Often viewed as a chronic and progressive disease, it is characterized as physical and/or psychological in origin.

Alternatives - a prevention approach to drug abuse, developed in the last decade. The alternatives approach assumes that use becomes less compelling to individuals who are involved with constructive activities of their own.

Behavior Modification - a method of changing human behavior through systematic use of reward and punishment.

Behavior Therapy - application of learning principles and techniques to the treatment of behavior disorders. Symptoms, rather than the history of the problem, are studied and treated.

Codependency or Coalcoholism - refers to the dynamics of the relationship of individual family members or the entire family to the substance abuser.

Crisis Intervention - the process of diagnosing and treating a crisis, such as a panic reaction or a drug overdose.

Cross Dependence - condition where the substitution of one drug for another can prevent or ease withdrawal. For example, the use of tranquilizers or marijuana to cushion withdrawal from alcohol.

Cross Tolerance - a condition which develops when increasing amounts of more than one drug are taken to achieve the same effects. For example, a person who needs to drink more and more alcohol may find he/she needs more marijuana than someone else to achieve the same effect.

Denial - ability to be aware of the symptoms and effects of substance abuse and/or behavior disorders and believe or say they are not occurring or are not significant.

Dependence, Drug - an emotional and/or physical need for a drug.

Detoxification - withdrawal from alcohol or other substances.

Diagnostic and Statistical Manual of Mental Disorders (DSM III) - official manual of mental disorders published by the American Psychiatric Association.

Dirty Urine - positive test results for the presence of drugs in a urine specimen, indicating drug use by the subject.

Disease - refers to addiction as a genetically transmitted, incurable, progressive illness that is potentially fatal if not treated.

Drug Abuse - drug use that is considered excessive, dangerous or undesirable for the individual or those around them.

Drug Education - a program designed to provide information on substance abuse and/or to change attitudes and behavior.

Dual Diagnosis - diagnosis of two or more primary problems, e.g., substance abuse and behavioral disorders. The two problems may be related or independent.

EAP - an acronym for Employee Assistance Programs, which are designed to assist employees whose job performance is hindered by personal problems, including alcohol and/or drug abuse.

Ex-Addict - this term implies the person is abstaining from a substance to which they have had a history of abuse. Their abstinence has been for an unspecified length of time and they have experienced a change in their lifestyle. A more proper description would be "recovering alcoholic/addict."

Experiential Education - (also called Adventure Education, Wilderness Education and Problem Solving Education) A treatment technique used to develop teamwork, self-confidence, responsibility, self-awareness, and stress tolerance which uses "hands on" experience connected to learning.

Experimental Drug Use - short-term, unpatterned trial of one or more drugs. Experimentation is generally motivated by curiosity or the desire to experience new feelings or moods.

Family Disease - Treating an addiction as the causal factor of a disorder in a family.

Family Therapy - treatment of more than one family member in the same session; or treatment of the entire family where one of family members is considered the identified patient. This form of therapy considers that an individual's behavior and recovery is dependent upon family interaction.

Group Therapy - treatment of patients in groups. Often group members have similar experiences or problems. This form of therapy may or may not be used in conjunction with individual therapy.

Halfway House - a program or facility which provides supervised living in the community. Halfway houses can promote a smooth transition from more structured therapeutic settings to the general community. Many individuals living in halfway houses attend school and/or are employed.

History, Drug - a history taken usually at the time of admission to document a client's experience with drugs. It may involve verbal or written responses to questions about types, dates, duration and quality of drug experiences, etc.

Inpatient Program - a program where patients reside in the treatment facility, which may be a hospital or a therapeutic community.

Intake - the process of admitting a client into treatment. Intake usually involves gathering demographic information and medical history, a medical examination, an explanation of the program, and, in certain cases, detoxification.

Intervention - a process by which families, friends and professionals confront a substance abuser concerning his/her drug use and its results.

Medical Models - explanatory theories that define drug abuse/addiction in medical, not social terms. Drug abuse is seen as a chronic disease, possibly with hereditary components, that is usually progressive and which may be fatal.

Minnesota Multiphasic Personality Inventory (MMPI) - a standardized personality test that distinguishes certain psychopathological syndromes as well as normal characteristics. The MMPI is widely used, often in conjunction with other tests, as a screening tool and counseling aid by schools hospitals, employers, and the military.

Narcotic - A drug which relieves severe pain, induces euphoria and induces dependence with repeated use.

Narcotics Anonymous (NA) - a nonprofit self-help group which meets regularly to provide support to its members in their recovery from addiction.

Outpatient Program - patients reside outside the treatment facility, usually in their own homes, while participating in a treatment program.

Paraphernalia, Drug - assorted equipment and materials used to store, make or administer illicit drugs or to make the effects of the drug more intense.

Patterns of Drug Use - sequence of drug-using behavior by an individual or group.

Peer Culture - subculture of a certain class of equals in society, such as teenagers, other persons of the same age, or persons in a given occupation.

Physical Addiction - often refers to alcohol or drug addiction which has physiological effects and may require medical supervision or treatment for withdrawal and recovery.

Polydrug Use - use of more than one drug, including alcohol, with or without a strong preference for any particular drug.

Prevention Models - a mixed bag that may include education, alternatives to drug use, and/or intervention programs.

Prevention, Primary - a program that anticipates a disorder and tries to promote optimal health. Such programs are primarily educational rather than clinical and are oriented toward increasing their clients' capacities for dealing with crises and enables them to take steps that will improve their lives.

Prevention, Secondary - a program directed at persons who are or have been experimenting with drugs or alcohol.

Primary Diagnosis - The causal factor of an individual's mental or behavioral disorder.

Psychodrama - a form of therapy, usually provided in a group setting, where the clients/participants dramatize their life situations. Members of the group often will play act the roles of significant others in a client's life.

Psychological Model of Substance Abuse - stresses that abusers are psychologically, rather than primarily medically motivated, and that psychological and/or psychiatric therapy will help enable them to abstain from the use of drugs and/or alcohol.

Psychosocial Model of Substance Abuse - this theoretical model assumes that abusers are reacting to psychological as well as social and environmental stress.

Psychotherapy - the treatment of mental or emotional disorder or of related bodily ills by psychological means. This usually involves talking to a therapist in a group, family or individual setting.

Recovering - a lifelong process of maintaining sobriety for a person who has been chemically dependent.

Recreational Drug Use - drug use that occurs among friends or acquaintances. Unlike experimental use, social or recreational use tends to be more patterned in frequency, intensity, and duration.

Referring Agency - counselor, therapist, guidance counselor, judge, organization, etc., who recommends drug or alcohol treatment.

Relapse - reversion to old habits of aberrant or substance abuse behavior following a period of rehabilitation.

Residential Treatment - a program in which the patient resides in the treatment facility, especially a hospital or therapeutic community.

Self-Help Groups - groups of people who share the same problem(s) and meet to provide support and practical help to one another. These groups are generally nonprofit and charge no fees.

Sobriety - the condition of being temperate or abstinent from the use of alcohol and/or other substances when one is recovering.

Sociological Models of Substance Abuse - explanatory theories which attempt to identify those factors within society that promote drug and alcohol use.

Spirituality - in AA, NA, and other Twelve-Step programs, the idea that "a power greater than ourselves" exists to help members overcome their addictions. Each person's personal concept of "God" becomes his or her spiritual foundation while they are in the program.

Sponsor - An AA, NA, and other self-help group member who is recovering and who agrees to help a newcomer through the 12-steps as well as to act as a friend and/or mentor.

Subculture, Drug - a subgroup whose members share norms legitimating the use of drugs.

Substance Abuse - Use of any drug, including alcohol, prescription drugs, street drugs, household or industrial chemicals in such a way as to cause harm to oneself.

Synanon - a therapeutic community for the rehabilitation of drug addicts established in 1959 in California. When it was originally established, members stayed as long as they liked and were discouraged from leaving until they were judged capable of remaining drug free. Synanon has developed into a lifestyle movement for both addicts and nonaddicts who live there today.

Therapeutic Community - a term originally used by Maxwell Jones who advocated use of all aspects of the hospital environment as a therapeutic tool. The term has become associated more with nonhospital residential programs for the treatment of substance use disorders which stress self-help and abstinence and reinforce drug-free behavior through intense interaction with others who have had experience with drug abuse. The interaction is heightened by the fact that the members of the community are living together, and firm rules of conduct are stringently enforced by group confrontation.

Tolerance - decrease in response to a drug dose that occurs with continued use, thus a person will take larger doses to obtain comparable results.

Treatment, Drug-Free - treatment that calls for complete abstinence from drug use of any kind.

Treatment Modalities - treatment methods or techniques. Drug treatment modalities might include therapeutic communities, residential centers, drug-free treatment clinics, detoxification, or methadone maintenance clinics. Modalities also refers to the processes used in treatment, such as group therapy, individual counseling, family therapy, and psychopharmacological agents.

Treatment Outcome - refers to the success of a given treatment program in achieving its goals, usually defined in terms of continued abstinence from the use of the drug for which the client is being treated, but also for such factors as increased employment and decreased criminality.

Treatment Providers (Service Providers) - facilities with treatment programs for alcoholism and/or drug addiction.

Treatment, Substance Abuse - may be classified as drug-free or maintenance; residential or ambulatory; medical or nonmedical; selective or nonselective; voluntary or involuntary. In practice, treatment programs can and do offer virtually any combination of these methods.

Twelve-Step Program - an aspect of AA, NA and other self-help programs which uses 12 action steps as a means to recovery.

Urinalysis - in its more comprehensive medical meaning, this consists of a group of techniques for providing information on a urine specimen on a broad range of biochemical and biomedical health indicators, such as the pH level, presence of sugar, and germ count. In the drug abuse field, however, urinalysis has come to be used synonymously with testing for the presence of illicit drugs.

Withdrawal Syndrome - characteristic reactions and behavior, sometimes fatally severe, which occur upon abrupt cessation of a drug upon which the body has developed physical dependence.

APPENDIX B
DIRECTORY OF ALCOHOL AND DRUG ABUSE RESOURCES

NATIONAL ASSOCIATIONS, INSTITUTES, ORGANIZATIONS AND GOVERNMENT AGENCIES

A.A. World Services, Inc.
468 Park Avenue, South
New York, NY 10016
(212) 686-1100

AA publishes literature about the twelve-steps program of Alcoholics Anonymous and distributes it to the public for a nominal fee.

Al-Anon Family Group Headquarters
Madison Square Station
PO Box 182
New York, NY 10010
(800) 356-9996
(212) 529-1604 in NY and Canada

This Al-Anon headquarters provides printed materials specifically aimed at helping families deal with the problems of alcoholism.

Alcohol and Drug Addiction Treatment Center
Scripps Memorial Hospital - McDonald Center
9904 Genesee
La Jolla, CA 92137
(800) 382-4357

McDonald Center provides referrals to local facilities for adolescents and adults.

Alcohol and Drug Problems Association of North America
444 North Capitol Street, NW, Suite 706
Washington, DC 20001
(202) 737-4340

This association provides symposiums, meetings and conferences to members and professionals in the field. Its goal is to improve services that are provided to persons who are alcohol and/or drug dependent.

Alcohol, Drug Abuse and Mental Health Administration (ADAMHA)
5600 Fishers Lane, Room 12105
Rockville, MD 20857
(301) 443-4797
(800) COCAINE

ADAMHA conducts research to reduce and prevent alcohol, drug addiction and mental illness in the United States.

Alcoholism Report, Inc.
1511 K Street, NW, Suite 708
Washington, DC 20005
(202) 737-7342

A bi-weekly newsletter that covers policy developments in the field of alcoholism.

Alcohol Research Information Service
1120 East Oakland Avenue
Lansing, MI 48906
(517) 485-9900

This information service publishes a quarterly journal and bi-weekly newsletter that cover issues, events, and opinions about alcohol and substance abuse.

American Civil Liberties Union (ACLU)
132 West 43rd Street
New York, NY 10036
(212) 944-9800

This union publishes materials on alcohol and drugs.

American College of Sports Medicine (ACSM)
P. O. Box 1440
Indianapolis, IN 46206
(317) 637-9200

ACSM publishes a quarterly newsletter and a monthly journal. Both take a stance on steroids and alcohol in sports.

American Correctional Association
4321 Hartwick Road
College Park, MD 20740
(301) 699-7600

A multidisciplinary organization of correctional professionals, individuals, agencies and organizations involved in the entire spectrum of correctional activities, which include studies of alcohol and substance abuse.

American Council for Drug Education (ACDE)
204 Monroe Street, Suite 110
Rockville, MD 20850
(301) 294-0600

ACDE publishes materials concerning the health hazards of marijuana, cocaine, alcohol, and other drugs.

American Jewish Communal Affairs Committee
165 East 56th Street
New York, NY 10022
(212) 751-4000

This committee distributes pamphlets on alcohol and drug abuse to the public.

Association of Halfway House Alcoholism Programs of North America
786 East 7th Street
St. Paul, MN 55106
(612) 771-0933

A referral service for halfway houses and treatment centers in North America, Canada, and Europe which sends publications to members and to the public on request.

B'nai B'rith CVS
1640 Rhode Island Avenue, NW
Washington, DC 20036
(202) 857-6580

This organization publishes material that is made available to the public regarding alcohol and substance abuse.

Center for Science in the Public Interest
1501 Sixteenth Street, NW
Washington, DC 20036
(202) 332-9110

A nonprofit public health organization that focuses on health and nutrition. The Alcohol Policy Project within the organization focuses on public policy issues concerning alcohol consumption.

Committees of Correspondence
57 Conant Street, Room 113
Danvers, MA 01923
(617) 774-2641

A drug education/resource group that publishes a monthly newsletter.

Council on Alcohol Policy
c/o The Trauma Foundation
San Francisco General Hospital, Building 1
San Francisco, CA 94110
(415)-821-8209

A nonprofit organization that does research on alcohol and publishes articles in medical and public health journals. It also offers workshops for college students and professionals in the field.

Consumer Federation of America
1424 16th Street, Suite 604
Washington, DC 20036
(202) 387-6121

A lobbying group concerned with consumer and public policy issues.

Distilled Spirits Council of the United States (DISCUS)
1250 Eye Street, NW, Suite 900
Washington, DC 20005
(202) 628-3544

A trade association of the distilled spirits industry, which monitors federal and state policies concerning alcohol consumption and provides information to members and other interested organizations.

Do It Now Foundation
P.O. Box 5115
Phoenix, AZ 85010
(602) 257-0797

A nonprofit organization that publishes materials on drug and alcohol abuse and other health topics.

Drugs Anonymous
PO Box 473, Ansonia Station
New York, NY 10023
(212) 874-0700

A self-help group for those with chemical dependencies.

Drug Enforcement Administration (DEA)
1405 I Street, NW
Washington, DC 20537
(202) 633-1000

A government agency in charge of enforcing the substance abuse laws of the United States on a worldwide basis which publishes material made available to the public regarding substance abuse.

Emotions Anonymous (EA)
PO Box 4245
St. Paul, MN 55104
(612) 647-9712

A self-help support group for persons with emotional or living problems.

Hazelden Foundation
Box 11
Center City, MN 55012
(612) 257-4010

A multi-purpose drug resource center, which runs many alcohol and drug programs, a primary youth rehabilitation program, a health promotions program, and a comprehensive educational materials division.

House Select Committee on Narcotics Abuse and Control
3287 House Office Building, Annex 2
2nd and D Street, SW
Washington, DC 20515
(202) 226-3040

A 25-member oversight committee that holds hearings on drug abuse and serves as a resource for Congress. This is the only Congressional committee with exclusive jurisdiction over all aspects of drug abuse.

International Commission for the Prevention of Alcoholism and Drug Dependency (ICPADD)
6830 Laurel Street, NW
Washington, DC 20012
(202) 722-6729

An educational organization that holds congresses, classes, and workshops concerning drug abuse and publishes a quarterly journal.

The Johnson Institute
7151 Metro Boulevard
Minneapolis, MN 55435
(612) 944-0511
(800) 231-5165

A multi-purpose organization that publishes and sells materials, in addition to offering consultation and training on all aspects of alcohol and substance abuse.

Mothers Against Drunk Driving
669 Airport Freeway, Suite 310
Hurst, TX 76053
(817) 268-6233

The world headquarters for this nonprofit group educates the public on the dangers of alcohol abuse. Publications are made available to the public on request.

Narcotics Anonymous (NA)
PO Box 9999
Van Nuys, CA 91409
(818) 780-3951

The world headquarters and publications center for Narcotics Anonymous, a nonprofit self-help group.

Narcotics Education, Inc.
6830 Laurel Street, NW
Washington, DC 20012
(202) 722-6740

A nonprofit organization that distributes drug prevention and educationl materials to groups and associations.

Narcotics Educational Foundation of America
5055 Sunset Boulevard
Los Angeles, CA 90027
(213) 663-5171

A nonprofit organization that distributes educational materials on narcotics abuse and prevention throughout the nation and overseas.

National Association of Drug Abuse Problems (NADAP)
355 Lexington Avenue
New York, NY 10017
(212) 986-1170

A nonprofit organization that helps to place addicts in jobs and training programs.

National Association of State Alcohol and Drug Abuse Directors 444 North Capitol Street, NW, Suite 520
Washington, DC 20001
(202) 783-6868

A nonprofit organization of the directors of state alcoholism agencies whose purpose is to support alcohol and drug abuse prevention and treatment programs throughout all states. It distributes information to state administrators, professionals and volunteers in the field.

National Center for Voluntary Action
1111 North 19th Street, Suite 500
Arlington, VA 22209
(202) 276-0542

An organization that promotes volunteerism around the country. Over 350 local volunteer centers around the country act as referral groups for specific problem areas.

National Clearinghouse for Alcohol and Drug Information (NCADI)
P.O. Box 2345
Rockville, MD 20852
(301) 468-2600

A public agency which provides information and publications to the public in all 50 states, as well as to those who live in foreign countries. The NCADI data base and library contain information on alcoholism, alcohol abuse, illicit drug use, and prevention programs. The agency provides a library of printed materials, searches of several data bases, tours of their library, films and videotapes plus information to statewide networks and clearinghouses.

National Council on Alcoholism, Inc.
12 West Twenty-First Street, Suite 700
New York, NY 10010
(212) 206-6770

The headquarters for this nationwide voluntary health organization provides education and advocacy to alcoholics and drug-dependent individuals. This organization has 200 affiliates around the country who provide information and referral to individuals seeking help for alcoholism.

National Council on Alcoholism
1511 K Street, NW, Suite 320
Washington, DC 20005
(202) 737-8122

The government relations office for this nationwide voluntary health organization provides education and legislative advocacy for alcoholics and other drug-dependent individuals and their families.

National Drug Institute
112 Sladen Street
Dracut, MA 01826
(617) 957-4442

A consultant group that trains supervisors and managers in private industry and public schools to develop drug training and control programs.

National Federation of Parents for Drug Free Youth (NFP)
8730 Georgia Avenue, Suite 200
Silver Spring, MD 20910
(301) 585-5437

A nonprofit group that distributes free educational and prevention materials concerning alcohol and substance abuse. They also have a networking program and sponsor youth seminars.

National Foundation of the March of Dimes
1275 Mamaroneck Avenue
White Plains, NY 10605
(914) 428-7100

A voluntary health group that distributes materials about specific problems associated with alcohol/drug abuse (i.e., birth defects, heart diesease, etc.).

National Highway Traffic Safety Administration
Alcohol Programs Division
400 Seventh Street, SW
Washington, DC 20590
(202) 366-9581

An agency whose programs on highway safety include alcohol and drug abuse prevention and treatment.

National Organization for the Reform of Marijuana Laws (NORML)
2001 S Street, NW, Suite 640
Washington, DC 20009
(202) 483-5500

A group that lobbies for the legalization of marijuana. It holds conferences and distributes a free magazine.

National Parent Resource Institute for Drug Education (PRIDE)
100 Edgewood Avenue, Suite 1216
Atlanta, GA 30303
(404) 651-2548
(800) 241-7946

PRIDE sets up prevention programs with school systems, works with parent groups, and develops community action plans. They publish materials which are made available to the public, some free and some for a fee. They give drug information and provide referrals to treatment centers around the nation.

New York State Division of Alcoholism and Alcohol Abuse
194 Washington Avenue
Albany, NY 10023
(518) 474-3377

This state agency offers direct services in 13 rehabilitation centers; supervises over 500 other treatment/education programs; and coordinates programs with state, local and federal agencies, especially substance abuse programs in correctional facilities.

Phoenix House
164 West 74th Street
New York, NY 10023
(212) 595-5810

A large multi-service drug abuse agency that offers adolescents residential treatment and outpatient treatment, as well as drug education and prevention services.

Potsmokers Anonymous
208 East 18th Street
New York, NY 10009
(212) 254-1777

This organization, which started in 1978, offers a 9-week course to help people stop smoking marijuana.

Prevention Research Center
2532 Durant Avenue
Berkeley, CA 94704
(415) 486-1111

A federally funded nonprofit organization that produces educational materials primarily on the prevention of alcohol abuse which are published in medical and psychiatric journals.

Rutgers University Center of Alcohol
Smithers Hall, Busch Campus
Piscataway, NJ 08854
(201) 932-2190

This major research center studies the causes and treatments for alcoholism. The center has more than 125,000 alcohol-related documents in its library.

Wine Institute
165 Post Street
San Francisco, CA 94108
(415) 986-0878

A group that publishes educational materials and holds seminars on the etiquette of drinking alcoholic beverages.

Women for Sobriety, Inc. (WFS)
PO Box 618
Quakerstown, PA 18951
(215) 536-8026

The national headquarters for this self-help group, has 200 chapters around the country. WFS meets one or more times per week to address the needs of women with alcohol problems. They publish a monthly newsletter which is available to the public.

CLEARINGHOUSES FOR ALCOHOL AND SUBSTANCE ABUSE

Alabama

Alabama Department of Mental Health
Division of Mental Health and Substance Abuse Community Programs
200 Interstate Park Drive
PO Box 3710
Montgomery, AL 36193-5001
(205) 271-9246

Alaska

Alaska Council on Prevention of Alcohol and Drug Abuse, Inc.
7521 Old Seward Highway, Suite A
Anchorage, AK 99502
(907) 323-2077

California

Information Clearinghouse
Department of Alcohol and Drug Programs
111 Capitol Mall, Room 160
Sacramento, CA 95814
(916) 323-2077

Colorado

Mile High Council on Alcoholism
1776 South Jackson
Denver, CO 80210
(303) 759-5555

Connecticut

Connecticut Alcohol and Drug Abuse Commission
999 Asylum Avenue
Hartford, CT 06105
(203) 566-2089

Delaware

YMCA Resource Center
11th and Washington Streets
Wilmington, DE 19801
(302) 571-6975

District of Columbia

Washington Area Council on Alcoholism and Drug Abuse, Inc.
1232 M Street, NW
Washington, DC 20005
(202) 783-1300

Florida

Florida Alcohol and Drug Abuse Association
1286 North Paul Russell Road
Tallahassee, FL 32301
(904) 878-2196

Georgia

Community Resource Development Unit of Mental Health/Mental Retardation
878 Peachtree Street, NE, Suite 322
Atlanta, GA 30309-3999
(404) 894-4204

Hawaii

Alcohol and Drug Abuse Branch
State Department of Health
PO Box 3378
Honolulu, HI 96801
(808) 548-4280

Illinois

Prevention Resource Center
901 South Second Street
Springfield, IL 62704
(217) 525-3456

Indiana

Greater Indianapolis Council on Alcoholism, Inc.
2511 East 46th Street, Building S
Indianapolis, IN 46205
(317) 542-7128

Iowa

Iowa Substance Abuse Information Center
500 First Street, SE
Cedar Rapids, IA 52401
(319) 398-5133
(800) 247-0614

Kansas

SRS/Alcohol and Drug Abuse Services
Biddle Building
2700 West Sixth Street
Topeka, KS 66606
(913) 296-3925

Kentucky

Drug Information Services for Kentucky
Division of Substance Abuse
Bureau of Health Services
275 East Main Street
Frankfort, KY
(502) 564-2880

Louisiana

Office of Prevention and Recovery from Alcohol and Drug Abuse
2744-B Wooddale Boulevard
PO Box 53129
Baton Rouge, LA 70805
(504) 922-0721

Maine

Maine Alcohol and Drug Abuse Clearinghouse
State House Station #11
Augusta, ME 04333
(207) 289-5393

Maryland

State Prevention Office
201 West Preston
Baltimore, MD 21201
(301) 444-4172 or
(301) 356-2164

Massachusetts

Division of Drug Rehabilitation
Department of Public Health
150 Tremont Street
Boston, MA 02116
(617) 727-8614

Michigan

Michigan Substance Abuse Information Center
925 East Kalamazoo Street
Lansing, MI 48912
(517) 482-9902

Minnesota

Minnesota Prevention Resource Center
2829 Verndale Avenue
Anoka, MN 55303
(612) 427-5310

Mississippi

Student Information and Intervention Program
Interdisciplinary Alcohol and Drug Studies Center
Jackson State University
PO Box 17054
Jackson, MS 39217
(601) 968-2094

Missouri

Division of Alcohol and Drug Abuse
Department of Mental Health
20002 Missouri Boulevard
Jefferson City, MO 65102
(314) 751-4423

Nebraska

Alcohol and Drug Information Clearinghouse
Alcoholism Council of Nebraska
215 Centennial Mall South, Room 412
Lincoln, NE 68508
(402) 474-0930

Nevada

Education Component
Nevada Bureau of Alcohol and Drug Abuse
Capitol Plaza, Room 500
505 East King Street
Carson City, NV 89710
(702) 885-4790

New Hampshire

Office of Alcohol and Drug Abuse Prevention
Health and Human Services Building
6 Hazen Drive
Concord, NH 03301
(603) 271-4638

SOLVE, Inc.
10 Conleyn Road
PO Box 157
Atkinson, NH 03811
(603) 898-1516

New Jersey

Drug Information Clearinghouse
New Jersey Health Department
Trenton, NJ 08625
(609) 292-4002

New Mexico

Drug Abuse Bureau
New Mexico Health and Environment Department
PO Box 968
Santa Fe, NM 87504-0968
(505) 827-2668

New York

Narcotic Drug Research, Inc.
New York State Division of Substance Abuse Services
116 Nassau Street, 10th Floor
New York, NY 10038
(212) 406-7270

North Carolina

Alcohol and Drug Treatment Center
Albemarle Building, 11th Floor
325 North Salisbury Street
Raleigh, NC 27611
(919) 733-4555

Ohio

Information Services
Ohio Bureau of Drug Abuse
170 North High Street, 3rd Floor
Columbus, OH 43215
(614) 466-7893

Oklahoma

Oklahoma Department of Mental Health
Reach-Out
4545 North Lincoln Boulevard
Suite 100, East Terrace
Oklahoma City, OK 73105
(405) 521-0044

Oregon

Oregon Drug and Alcohol Information Center
Metropolitan Hospitals, Inc.
235 North Graham Street
Portland, OR 97227
(503) 280-3673

Pennsylvania

Office of Drug and Alcohol Programs
Department of Health
Health and Welfare Building, Room 929
PO Box 90
Harrisburg, PA 17108
(717) 787-9761

Rhode Island

Rhode Island Department of MHMR
Division of Substance Abuse
Substance Abuse Administration Building
Medical Center
Cranston, RI 02920
(401) 464-2091

South Carolina

Marion County Drug and Alcohol Abuse Program
103 West Court Street
Marion, SC 29571
(803) 423-5610

South Dakota

Northeastern Prevention Resource Center
900 Skyline Drive
Watertown, SD 57201
(605) 886-7522

Tennessee

TAADC Clearinghouse
250 Venture Circle, Room 204
Nashville, TN 37228
(615) 244-7066

Texas

Texas Commission on Alcohol and Drug Abuse
1705 Guadalupe
Austin, TX 78701-1214
(512) 463-5510

Vermont

Office of Alcohol and Drug Abuse Programs
103 South Main Street
Waterbury, VT 05676
(802) 241-2178

Virginia

Prevention, Information, and Training Office
Department of Mental Health and Mental Retardation
PO Box 1797
Richmond, VA 23214
(804) 786-3909

Washington

Washington Bureau of Alcohol and Substance Abuse
Mailstop OB-44W
Olympia, WA 98504
(206) 753-3203

West Virginia

Division on Alcoholism and Drug Abuse
1800 Washington Street
East Charleston, WV 25305
(304) 348-2276

Wisconsin

The Wisconsin Clearinghouse
1245 East Washington Avenue, Suite 274
Madison, WI 53703
(608) 263-2797

Wyoming

Alcohol and Drug Abuse Programs
Division of Community Programs
Hathaway Building, 3rd Floor
Cheyenne, WY 82002
(307) 777-7115

NATIONAL CLEARINGHOUSES

Data Center & Clearinghouse for Drugs and Crime
1600 Research Boulevard
Rockville, MD 20850
(301) 251-5388
(800) 666-3332

National Clearinghouse for Alcohol and Drug Information
PO Box 2345
6000 Executive Boulevard
Rockville, Md 20852
(301) 468-2600

National Criminal Justice Reference Service
PO Box 6000
Rockville, MD 29850
(301) 251-5500
(800) 732-3277

National Drug Information Center of Families in Action
2296 Henderson Mill Road, Suite 204
Atlanta, GA 30345
(404) 934-6364

DISTRIBUTORS OF FILMS/VIDEOS ABOUT ALCOHOL AND OTHER DRUGS

AIMS Media
6901 Woodley Avenue
Van Nuys, CA 91406
(800) 367-2467

Barr Films
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PO Box 5667
Pasadena, CA 91107
(800) 423-4483

Churchill Films
662 North Robertson Boulevard
Los Angeles CA 90069-5089
(800) 334-7830

Cinemed, Inc.
PO Box 311
116 C Street
Ashland, OR 97520
(503) 488-2805

CompCare Publishers
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Skokie, IL 60077
(800) 227 9100

FMS Productions
PO Box 4428
520 E. Montecito Street
Santa Barbara, CA 93140
(800) 421-4609

Hazelden Educational Materials
Pleasant Valley Road
Box 176
Center City, MN 55012-0176
(800) 328-9000

Health Communications, Inc.
1721 Blount Road, Suite #1
Pompano Beach, FL 33069
(800) 851-9100

Lucerne Media
37 Ground Pine Road
Morris Plains, NJ 07950
(800) 341-2293

Motivision, Ltd.
#2 Beechwood Road
Hartsdale, NY 10530
(914) 684-0110

New Day Films
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Wayne, NJ 07470-3191
(201) 633-0212

Parkside Publishing Corporation
205 West Touhy Avenue
Park Ridge, IL 60068
(800)221-6364

Southerby Productions, Inc.
PO Box 15403
5000 East Anaheim
Long Beach, CA 90815
(213) 498-6088
(800) 243-3456

APPENDIX C

ANNOTATED BIBLIOGRAPHY

Presented is a list of readings recommended by the National Criminal Justice Reference Service, the National Clearinghouse for Alcohol and Drug Information and chosen experts in the field of drug/alcohol abuse treatment of incarcerated youth. This bibliography is by no means exhaustive or complete.

Akers, R.L., Krohn, M.D., Lanza-Kaduce, L., & Radoseuich, M. (1979, August). Social learning and deviant behavior: A specific test of a general theory. American Sociological Review, 44:636-655.

A social learning theory of deviant behavior is tested. Survey data is correlated with adolescent drinking and drug behavior. The authors believe the study demonstrates that central learning concepts are amenable to questionnaire measurement.

American Bar Association. (1986, March). American Bar Association Policy Recommendations on Youth Alcohol and Drug Problems. Washington, D.C., 1-224.

Outlined is a twenty item model policy for dealing with youth who have alcohol and drug problems. Each policy item is discussed in detail and supported by facts and statistics.

American Correctional Association. (1987, April). Juvenile Corrections Newsletter, 1(3):1-4.

This issue of the newsletter addresses the relationship between drug abuse and delinquency. Areas included are risk factors, promising treatment and control approaches, and treatment interventions. The last two pages describe two treatment programs: Project Adapt (University of Washington School of Social Work) and Moultrie Chemical Dependency Program (South Carolina Department of Youth Services).

American Justice Institute, National Juvenile Justice System Assessment Center. (n.d.). Serious juvenile crime. In Crime Control: State of the Art. Rockville, MD., 54-63.

A summary of major findings and recommendations of a study which examines serious juvenile crime, focuses on offender and offense characteristics, substance abuse, legislation, jurisdiction, confidentiality of juvenile records, programs, and their economic impact.

Beachy, G.M., Petersen, D.M., & Pearson, F.S. (1979). Adolescent drug use and delinquency. Journal of Psychoactive Drugs, 11(4):313-316.

This study tests the hypothesis that abstainers have a lower level of delinquency than alcohol or marijuana users. Five hundred sixty-eight students, aged 9-12, were interviewed. Delinquency scores of marijuana/alcohol use and abstention were assigned and correlated with criminal behavior.

Belair, R., & Cooper, G. (1983). Criminal Justice Information Policy - Privacy and Juvenile Justice Records. Washington, D.C.: U.S. Department of Justice Bureau of Justice Statistics.

This is a third article in a series which describes the development of the juvenile justice system and the underlying assumptions of a separate juvenile justice system. Legislative provisions intended to protect the confidentiality of juvenile records are described and their possible impacts are considered.

Bellassai, J.P. (1977). Protecting the confidential communications of substance abusers in pretrial programs: The Board mandate of federal law. In National Conference on Pretrial Release and Diversion, Conference Resource Book, No. 12.

Federal law and regulations governing the confidentiality of records of alcohol and drug abusers are summarized. Emphasis is given to confidentiality requirements that apply to pretrial programs for substance abusers.

Beschner, G.M., & Friedman, A.S. (1986). Teen Drug Use. Lexington, MA: D.C. Heath & Co.

A collection of articles is compiled to address adolescent drug use, its history, effects, services, treatments, consequences, and impacts on abusers' families. The book is primarily intended for adolescents and their families.

Beschner, G.M., & Friedman, A.S. (1979). Treating adolescent substance abuse. Youth Drug Abuse. Lexington, MA: D.C. Heath & Co.

A survey of drug treatment programs for adolescents is summarized, giving current statistics on adolescent drug use and drug treatment effectiveness.

Braukmann, C.J., Bedlington, M.M., Belden, B.D., Braukmann, P.D., Husted, J.J., Ramp, K.K., & Wolf, M.M. (1985). Effects of community-based group-home treatment programs on male juvenile offenders' use and abuse of drugs and alcohol. American Journal of Drug and Alcohol Abuse, 11(3/4):249-278.

The comparative effects of community-based, group-home delinquency treatment programs in Kansas are examined. Self-report measures of drug/alcohol use and prosocial behaviors are used to determine treatment effectiveness.

Breed, A.F. (1975, November-December). California's Youth Authority reports successful program for chronic drug abusers. American Journal of Correction, 8-9.

California's Youth Authority's drug programs are examined. Programs providing for motivated serious drug abusers are detailed. Treatment given at four facilities in 24-hour secure, intensive institutions, with carefully structured aftercare, is described. Treatment effectiveness is measured.

Brower, K.J., & Anglin, M.D. (1987). Adolescent cocaine use: Epidemiology, risk factors, and prevention. Journal of Drug Education, 17(2):163-180.

Epidemiological studies of adolescent cocaine use are critically reviewed, risk factors are identified, and implications for prevention are discussed.

Brown, P.M. (1987). Patterns of marijuana and alcohol use attitudes for Pennsylvania 11th graders. The International Journal of Addictions, 22(6):567-573.

A six-year longitudinal study is described which measures, among other things, beer and marijuana use among 11th graders in Pennsylvania's public schools.

Buck, C.R. (n.d.). Drug Abuse Administration's Regulations Governing Drug Abuse Treatment. State of Maryland Department of Health and Mental Hygiene, Title 10, Subtitle 23, 1467-1497.

This publication offers guidelines for methadone detoxification programs, program maintenance in penal institutions, and certification information for inpatient and outpatient drug free treatment/rehabilitation programs.

Burg, B., Antonelli, P.R., & Heit, D.S. (1984, September 6-7). Abraxas: A Successful Alternative to Incarceration for Young Offenders. Presented at the Practitioners' Conference on Juvenile Offenders with Serious Drug, Alcohol and Mental Problems. Washington, D.C.

Abraxas Foundation operates treatment programs for juvenile offenders in five facilities in Pennsylvania. The program's participants and their treatment process are described.

California Department of Youth Authority, Office of Criminal Justice Planning. (1986). Alcohol, Drugs and the Teenage Driver. Sacramento, CA.

This publication, based on a 1985 workshop, provides descriptions of school-based and inter-agency programs aimed at alcohol/drug abuse prevention for the teenage driver in California. Three school-based models are detailed.

California Department of Youth Authority, Office of Criminal Justice Planning. (n.d.) Violence in the Community-Prevention and Intervention Strategies for High Risk Families and Youth. Sacramento, CA.

A summary is provided of a workshop on violence in the family and community, which was held in San Diego, CA in December 1984. A keynote address examines the relationship between violence and alcohol/drug abuse; school performance and academic achievement; institutional racism, socioeconomic factors, and child abuse. Descriptions of eight violence prevention and treatment programs elucidates efforts to target juvenile delinquency, child abuse, wife battering, chemical dependency, school conflict, and family crisis.

Carmody, D. (1982, January 7). Phoenix House Project teaching 7th graders and up to shun drugs. New York Times.

New York State's drug treatment program for adolescents at Phoenix House is described, and questions that parents typically ask are answered.

Carpenter, C., Glassner, B., Johnson, B.D., & Loughlin, J. (1988). Kids, Drugs and Crime. Lexington, MA: Lexington Books.

The book emphasizes understanding drug use and delinquent behavior from the user's point of view. Research examining the drug-crime-consequences link is summarized.

Catalano, R.F., Howard, M.O., Hawkins, J.D., & Wells, E.A. (1987). Relapse in the Addictions: Rates, Determinants, and Promising Prevention Strategies. Seattle, WA: Center for Social Welfare Research, School of Social Work, University of Washington.

This paper very thoroughly examines rates of relapse, predictors of relapse and relapse prevention strategies for substance, alcohol and tobacco use. Within a literature search, weaknesses in previous research are noted and strategies for conducting further studies are suggested.

Citron, P. (1978, Spring). Group work with alcoholic polydrug-involved adolescents with deviant behavior syndrome. Social Work with Groups, 1(1):39-52.

A federally funded experiment, Drinking and Driving Intervention Program, provided services to adolescents arrested repeatedly for deviant behavior while under the influence of alcohol or drugs. The effectiveness of these services is measured and summarized.

Clayton, R.R. (1981). The delinquency and drug use relationship among adolescents. In D.J. Lettieri & J.P. Lodford (Eds.), Drug Abuse and the American Adolescent. Rockville, MD: National Institute of Drug Abuse.

Literature which studies the crime-drug link among adolescents is reviewed. Criteria of causality, as outlined by Hirschi and Selvin, are critically examined.

Clayton, R.R. (1986, December 10 & 11). Drug Use among Children and Adolescents. Paper prepared for Office of Juvenile Justice and Delinquency Prevention Workshop, Annapolis, MD, 1-77.

Studies are reviewed that have been conducted on youth substance abuse. The strengths and weaknesses of the studies are discussed.

Clayton, R.R., & Tuchfeld, B.S. (1982, Spring). The drug-crime debate: Obstacles to understanding the relationship. Journal of Drug Issues, 12:153-166.

The lack of consensus in the literature regarding the crime-drug relationship and definitions of causality are discussed at length. A model of causality is presented and a crime-drug research agenda is suggested.

Cohn, M.J. (1987). Substance abuse. In Marla R. Barassard, et al. (Eds.), Psychological Maltreatment of Children and Youth. Elmsford, NY: Pergamon Press, Inc.

This paper discusses definitions, the extent of substance abuse among juveniles of various ages, the psychological effects of juvenile substance use, and prevention strategies for juvenile substance abuse. Recommendations are given which cover research, treatment, and community action.

Collins, J.J., & Allison, M. (1983, December). Legal coercion and retention in drug and alcohol treatment. Hospital and Community Psychiatry, 34(12):1145-1149.

This study looks at the effects of clients' legal involvement on treatment retention. Use of legal threat as an approach to deal with drug abusers is examined.

Cory, B. (1986). New York State Juvenile Justice System: A Report on the Fifth Annual Retreat of the Council on Criminal Justice. New York: New York City Bar.

This report focuses on trends in the New York juvenile justice system, particularly those which pertain to serious juvenile offenders, juvenile delinquency factors, and issues in juvenile case processing.

Court of Common Pleas of Allegheny County. (n.d.). Juvenile Court Drug/Alcohol Education/Assessment Program, 1-6.

A history of the development of a substance abuse program in Allegheny County, Pennsylvania is given. The program's target population, guidelines for referral and forms that are used during the program are described.

Czajkoski, E.H. (1982, November). Why confidentiality in juvenile justice? Juvenile and Family Court Journal, 5(33):49-53.

The impact of confidentiality on juvenile offenders is examined.

Dalton, H.L., & Burris, S. (1987). Intravenous drug abusers. In C. O'Neill, (Ed.), Aids and the Law: A Guide for the Public. New Haven: Yale University Press, 253-280.

Related to acquired immune deficiency syndrome (AIDS), the following are examined: past and present drug users, those involved in drug abuse treatment, confidentiality, reporting of conflicts, and the "clean needles" issue.

Dawkins, R.L., & Dawkins, M.P. (1983). Alcohol use among black, white, and Hispanic adolescent offenders. Adolescence, 18(72):799-810.

The connection between drinking and criminal behavior among juveniles is examined. Questionnaires administered to residents of a public juvenile facility are analyzed and summarized.

DeFazio, T. (1985, November). Program Development, Program Description, Current Status. Presented to the National Conference of ACHSA in New York City, NY.

This paper describes components of the Shuman Center Juvenile Detention Home's alcohol and drug program. Included are their assessment instruments, relationship to Alcoholics Anonymous, and use of urinalysis.

Delaney, J.J. (1979). Records and Confidentiality. In Juvenile Justice Standards Symposium, 924-987.

A symposium presentation and subsequent discussion focuses on the principles and problems involved in establishing, maintaining and using of juvenile records. These principles are related to proposed standards on the subject.

Dembo, R., Washburn, M., Getreu, A., Browskowski, A., & Berry, E. (1986, March). Development and Evaluation of an Innovative Approach and Substance Abuse Treatment Services at Entry into Secure Detention. Paper presented at Sciences, Orlando, FL, 1-19.

This paper describes a model of assessment and service linkage in the treatment of adolescents that was piloted in Florida. Emphasis is placed on a thorough assessment including the use of volunteer urinalysis, confidentiality, and appropriate referrals.

Dembo, R., Washburn, M., Wish, E., Yeung, H., Getreu, A., Berry, E., & Blount, W. (1987, January-March). Heavy marijuana use and crime among youths entering a juvenile detention center. Journal of Psychoactive Drugs, 19(1).

A collaborative effort of the Department of Criminology at the University of South Florida, the Northside Community Mental Health Center and the Florida Department of Health and Rehabilitation Services is described. These three agencies designed an approach to identify youth who need mental health/substance abuse treatment at the time they enter a secure detention facility. The project includes voluntary screening interviews and voluntary urinalysis.

Department of Health and Human Services, Alcohol, Drug Abuse, and Mental Health Administration. (1988, April 11). Mandatory guidelines for federal workplace drug testing programs; final guidelines; notice. Part IV. Federal Register.

The adopted scientific and technical guidelines for federal drug testing programs and standards for certification of laboratories engaged in urine drug testing for federal agencies is defined and clarified.

Department of Health and Human Services, Public Health Service. (1987, June 9). Confidentiality of alcohol and drug abuse patient records; final rule. Federal Register, 42 CFR, Part 2.

Regulations pertaining to confidentiality of alcohol and drug abuse patient records are discussed.

Department of Social and Health Services, Office of Research. (1977, July). A Study of Drug/Alcohol Use among Residents of Washington Correctional Facilities.

A study of 371 residents at four adult corrections facilities, examines past and current involvement in drug/alcohol treatment, as a variable in recidivism.

Department of Social and Health Services, Program Services Unit, Division of Juvenile Rehabilitation. (1985, July). Treatment of Drug/Alcohol Abuse among Juvenile Offenders: A Review of the Literature. Olympia, WA.

An annotated review of literature is synthesized that pertains to the assessment and treatment of drug and alcohol abusers in criminal justice systems. The efforts of the Division of Juvenile Rehabilitation are outlined and implications for the development of the Division's programming are drawn.

Devine, A. (1984, September 6-7). Adolescent substance abuse and the juvenile court. In Lucas County Court of Common Pleas, Juvenile Division, Drug Abuse, Mental Health, and Delinquency: Summary of Proceedings of Practitioners' Conference on Juvenile Offenders with Serious Drug, Alcohol, and Mental Problems. Washington, D.C.

The Chemical Abuse Reduced through Education and Services (CARES) Program, developed in Toledo, Ohio in 1982, has several committees to address aspects of substance abuse among teens. Committee activities in Lucas County, Ohio are described.

Drug Abuse, Mental Health, and Delinquency: Summary of Proceedings of Practitioners' Conference on Juvenile Offenders with Serious Drug, Alcohol, and Mental Health Problems. (1984, September 6-7). Sponsored by the Office of Juvenile Justice and Delinquency Prevention and the Alcohol, Drug Abuse, and Mental Health Administration, Washington, D.C.

This 1984 conference, covers the topics of treatment/rehabilitation, parents' groups, student assistance programs, prevention models, and implications for federal policymakers.

Dunn, A. (1986, Winter). Juvenile court records: Confidentiality vs. the public's right to know. American Criminal Law Review, 5(23):388-401.

Competing policy concerns regarding confidentiality of juvenile records are identified and examined.

Elliott, D.S., Knowles, B.A., & Canter, R.J. (1981, June). The Epidemiology of Delinquent Behavior and Drug Use among American Adolescents. National Youth Survey Project Report No. 14. Boulder, CO: Behavioral Research Institute.

The National Youth Survey was given a five-year grant, beginning in 1975, by NIMH. The survey's focus was the origins and causes of delinquency among America's young people. Findings were based on exhaustive correlations between delinquency, drug use, and characteristics of the individual, family and demography. Analyses provide a comprehensive picture of the proportions of youth who are involved in delinquency and drug use.

Fagan, J., & Hartstone, E. (1984, April 17-18). Dilemmas in Juvenile Corrections: Treatment Interventions for Special Problem Youth. Paper presented at the National Institute of Justice, Alcohol, Drug Abuse and Mental Health Administration Conference on State-of-the-Art Research on Juvenile Offenders with Serious Drug Abuse, Alcohol and Mental Health Problems, Rockville, MD, 1-63.

The authors describe treatment approaches to youths who have special problems, including substance abuse and mental disorders. They discuss the scope of these problems and current correctional efforts to remedy them. Several treatment programs are described in detail and improvements are recommended.

Feldman, H.W., Mandel, J., & Fields, A. (1985). In the neighborhood: A strategy for delivering early intervention services to young drug users in their natural environments. In A.S. Friedman & G.M. Beschner (Eds.), Treatment Services for Adolescent Substance Abusers. Rockville, MD: National Institute on Drug Abuse, 112-128.

The concept of neighborhood-based early drug use intervention is promoted, and particular programs are described.

Feldman, H.W., Michael, A., & Beschner, G. (Eds.). (1979). Angel Dust: An Ethnographic Study of PCP Users. Lexington, MA: Lexington Books.

The book describes several ethnographic studies of PCP use in several major U.S. cities.

Formalized Substance Abuse Program. (1987, January). State of California Department of Youth Authority.

This guide to substance abuse treatment programs in the state of California includes program standards, with a brief description of institutional treatment programs and Youth Conservation Camps.

Frazier, C., & Potter, R.H. (1982, Winter). Alcohol and drug offenders in the juvenile justice system: Are there differentials in handling? Journal of Drug Issues, 89-101.

This study focuses on two questions: 1) Do juvenile drug/alcohol offenders receive more severe dispositions than those charged with equally serious offenses? and 2) Are drug/alcohol offenders more likely to be placed in compulsory treatment programs than to be released without further action?

Friedman, A.S., & Beschner, G.M. (Eds.). (1987). Treatment Services for Adolescent Substance Abusers. Rockville, MD: National Institute on Drug Abuse, U.S. Department of Health and Human Services.

A collection of papers presents an array of approaches to the treatment of adolescent drug/alcohol abusers.

Goldstein, P.J. (1985, Fall). The drugs/violence nexus: A tripartite conceptual framework. Journal of Drug Issues. 15:493-506.

Drug use and drug trafficking are correlated with incidence of violence. Drugs and violence are seen as being related psychopharmacologically, economically and systemically. Each of these relations is examined. National crime data is used for explication.

Gottesman, R. (Ed.). (1982, January/February). Juvenile records: Who should have access? Children's Legal Rights Journal, 5(3):9-14.

The article examines competing interests of parents, agencies, and children with respect to access to educational, medical, social services and juvenile justice records. A summary of the standards on information collection is provided. Recommendations are suggested.

Gropper, B.A. (1984, November). Probing the links between drugs and crime. National Institute Journal, 4-8.

Findings are summarized from research which examined the nature and extent of drug-crime links. It is suggested that treatment and education programs target the most frequent and intensive drug users.

Guze, S.B., & Cantwell, D.P. (n.d.). Alcoholism, Parole Observation and Criminal Recidivism: A Study of 116 Parolees. (No cite).

The authors conducted a psychiatric and social study of 223 convicted felons to determine the prevalence and types of psychiatric disorders, and to note associations between psychiatric illness and family history, parental home experience, delinquency, etc.

Hague, J.L. (1983). Virginia Juvenile Law and Procedure for the Law Enforcement Officer. Honolulu, HI: Hawaii State Law Enforcement and Juvenile Delinquency Planning Agency.

Presented is Virginia's codified rights and procedures for juveniles, especially as they affect Virginia's law enforcement personnel. Attention is given to jurisdiction of the juvenile, the district court and policy for the investigative process.

Hall, B. (1985, September 11). A place where teenagers in trouble learn "to deal with themselves." Education Week.

The Phoenix House's residential program located in Westchester County, New York, which serves adolescents with drug and alcohol problems, is described.

Hartstone, E., & Hansen, K.V. (1984). The violent juvenile offender: An empirical portrait. In Robert A. Mathias, Paul Demuro & Richard S. Allinson (Eds.), Violent Juvenile Offenders: An Anthology. San Francisco, CA: National Council on Crime and Delinquency, 83-112.

Juvenile offenders, adjudicated for violent crimes, were randomly assigned to experimental and control groups as part of a large scale survey in 1982-83. Data obtained from official records and interviews is summarized in this chapter.

Hawkins, J.D., & Catalano, R.F. (1986). A Reentry/Aftercare Program for Institutionalized Delinquents at Risk for Drug Abuse. Center for Social Welfare Research, School of Social Work, University of Washington, 1-2.

A brief description is provided of a reentry/aftercare program conducted by the Center for Social Welfare Research at the University of Washington's School of Social Work, funded by the National Institute on Drug Abuse.

Hawkins, J.D., & Catalano, R.F. (n.d.). From ADAPT Grant Literature Review. Center for Social Welfare Research, University of Washington.

The relationship between drug and alcohol use and delinquency is examined in a review of the literature and in a survey of residents in a Washington State juvenile institution, Echo Glen.

Hawkins, J.D., Lishner, D.M., Jenson, J.M., & Catalano, R.F. (1986, July 16-17). Delinquents and Drugs: What the Evidence Suggests about Prevention and Treatment Programming. Paper presented at the NIDA Technical Review on Special Youth Populations, Rockville, MD, 1-47.

Literature connecting adolescent delinquency and drug use is reviewed. Research suggesting that adolescents will profit from social, problem-solving and stress-coping skills training programs is discussed.

Heck, R.O., Pindur, W., & Wells, D.K. (1985, Summer). Juvenile serious habitual offender/drug involved program: A means to implement recommendations of the National Council of Juvenile and Family Court judges. Juvenile and Family Court Journal, 36(2):27-42.

Ways that the Serious/Habitual Offender/Drug Involved Program (SHODI) can implement recommendations endorsed by the National Council of Juvenile and Family Court Judges (NCJFCJ) which pertain to the handling of serious juvenile offenders, are highlighted. SHODI's history is discussed, and NCJFCJ and SHODI are described.

Holden, R.T. (1987, January). Rehabilitative sanctions for drunk driving: An experimental evaluation. Journal of Research in Crime and Delinquency, 55-71.

A study of how effective alcohol treatment programs had been at reducing criminal behavior, used 4,126 persons who had been arrested for drunk driving. Findings are discussed.

Inciardi, J.A. (1987, Fall). Beyond cocaine: Bazuco, crack and other cocoa products. Contemporary Drug Problems, 14(3):461-493.

The author gives a brief social-use history of cocaine, Bazuco, crack and other cocoa products and then gives current statistics in Miami, Florida, and considers their implications.

Inciardi, J.A. (1981, November). The Impact of Drug Use on Street Crime. Presented at the American Society of Criminology, Washington, D.C.

The study, funded by the National Institute of Drug Abuse, tested whether criminal histories generally preceded drug use. Interviews were conducted between 1978 and 1981 in five cities.

Inciardi, J.A., Pottieger, A.E., & Faupel, C.I. (1982). Black women, heroin and crime: Some empirical notes. Journal of Drug Issues, 12(3):241-250.

A study of black female heroin users in Miami, Florida correlates heroin use and criminal behavior.

Jensen, G.F., & Brownfield, D. (1983, November). Parents and drugs: Specifying the consequences of attachment. Criminology, 21(4):543-554.

Pros and cons of Hirschi's social control theory, outlined in Causes of Delinquency, are debated and compared to other sociological theories. Survey data collected from high school students in Tuscon, Arizona in 1977 is analyzed and theoretical implications are considered.

Jenson, J., Hawkins, J.D., & Catalano, R. (1986). Social support in aftercare services for troubled youth. Children and Youth Services Review, 8:323-347.

The authors evaluate programs in which social support strategies are used in aftercare. The importance of social support in the success of an adolescent's community re-entry is stressed.

Johnson, B.C., Wise, E., & Huizinga, D. (1983, August 17). Executive Summary. The Concentration of Delinquent Offending: The Contribution of Serious Drug Involvement to High Rate Delinquency, VIIII-VIII4.

The results of a 1979 survey of self-reported involvement in drug use and delinquency are analyzed. The survey was administered to a national, representative sample of youths between the ages of 14 and 20.

Johnson, R.E., Anastasios, C.M., & Bahr, S.J. (1987, May). The role of peers in the complex etiology of adolescent drug use. Criminology, 25(2):323-340.

Self-reports of alcohol, cigarettes, marijuana, amphetamine and depressant use were administered to a group of adolescents. Results were analyzed by integrating differential association and situational group pressure concepts with propositions derived from social bond theory.

Johnston, L.D., O'Malley, P.M., & Bachman, J.G. (1987). National Trends in Drug Use and Related Factors among American High School Students and Young Adults, 1975-1986. Rockville, MD: National Institute on Drug Abuse, U.S. Department of Health and Human Services.

The findings of a survey conducted between the years 1975 and 1986 on high school seniors and followed-up high school graduates are presented. Drug use, attitudes and beliefs are apprised to assess the prevalence and trends of drug usage in U.S. teenagers and young adults.

Johnston, L.D., O'Malley, P.M., & Bachman, J.G. (1987). Use of Licit and Illicit Drugs by America's High School Students 1975-1984. Rockville, MD: National Institute of Drug Abuse, United States Department of Health and Human Services.

The two major topics treated in this report are the prevalence of drug use among American high school seniors and the trends in their drug use since 1975. The grade when drugs were first used, trends in use at earlier grade levels, intensity of drug use, attitudes and beliefs among seniors concerning various types of drug use and their perceptions of relevant aspects of their social environments was also gathered.

Kandel, D. (1980). Drug and drinking behavior among youth. Annual Review of Sociology, 6:235-285.

The article reviews the research on adolescent and young adult use of alcohol and drugs. Presented is the epidemiology of drug behavior from a life span approach, then prevalence and trends of drug use are studied. Last, four theoretical frameworks are described and applied to predicting drug usage.

Kandel, D., Kessler, R., & Margulies, R. (1978). Adolescent initiation into stages of drug use: A sequential analysis. In Denise Kandel (Ed.), Longitudinal Research on Drug Use: Empirical Findings and Methodological Issues. New York: Hemisphere-Halstead, 73-97.

Data from two major sources of influence upon adolescents, parents and peers, was obtained and their impacts upon drug usage were assessed over time.

Kandel, D., Simcha-Fagan, O., & Davies, M. (1986, Winter). Risk factors for delinquency and illicit drug use from adolescence to young adulthood. Journal of Drug Issues, 16(1):67-90.

The study looks at the interrelationships and predictors of delinquent behavior and illicit drug use. Over a nine year period, adolescents and young adults (15-25) who had been formerly enrolled in New York State's schools are examined.

Katz, D. (1983). Grim reality of open juvenile delinquency hearings. New York Law School Review, 28(1):101-122.

Trends are documented in the treatment of confidentiality of juvenile records and their use in juvenile court hearings.

Kelly, C.J., & MacNeur, J.B. (1982). Treatment Alternatives for Juvenile Alcohol and Drug Abusers: A Six-State Survey. Sacramento, CA: Center for the Assessment of the Juvenile Justice System, American Justice Institute.

This special report primarily examines existing treatment and prevention alternatives for juvenile alcohol and drug abusers. A six-state sample, balanced for geographic and population factors, is used. Findings are discussed.

Ladouceur, P., & Temple, M. (1985). Substance abuse among rapists: A comparison with other serious felons. Crime and Delinquency, 31:269-294.

The article uses data collected in the 1979 Survey of Inmates in Correctional Institutions to: a) assess the relationship between substance use and crime for rapists; b) compare this relationship with that for offenders whose crimes have involved varying levels of sex and violence; c) examine the extent to which race, age and social context effect this relationship; d) compare substance use at the time of the offense with the offender's typical use patterns; e) place findings in a theoretical context; and f) suggest directions for future research.

League of Women Voters of Illinois. (1985). Who Cares for Kids? Overview of Services. Chicago, IL.

This description and assessment of Illinois' services for children and youth focuses on child abuse and neglect, missing children, early childhood education, mental and physical health services, permanency planning in the placement of children, the juvenile justice system, child support, drug abuse, and teenage pregnancy and parenthood. An historical perspective to these services is also provided.

Leone, P.E., Trickett, E.J., Greenberg, J.M., Foley, K., Gould, J., & O'Neil, J. (1987, January). The Adolescent Directory: A Guide to Alcohol and Drug Abuse Treatment and Special Education Services for Adolescents in the Washington Metropolitan Area. College Park, MD: Department of Special Education, University of Maryland.

This guide to alcohol/drug abuse treatment and special education services for adolescents in the Washington, D.C. metropolitan area includes a treatment selection checklist, a list of treatment providers, educational and informational resources and a glossary.

Leukfeld, C.G., & Clayton, R.R. (1979). Drug abuse and delinquency: A study of youths in treatment. In George M. Beschner & Alfred S. Freidman, Youth Drug Abuse. Lexington, MA: D.C. Heath & Co.

A national youth polydrug study was designed to provide information on the correlates of drug use/abuse among users in treatment. A total of 2,750 adolescents, drawn from 97 youth drug abuse treatment programs, were studied. The association between drug use and criminality is analyzed.

Lissner, A., Gilmore, J., & Pompi, K. (1976). The dilemmas of coordinating treatment with criminal justice. American Journal of Drug and Alcohol Abuse, 3(4), 621-628.

This article describes how Abraxas' therapeutic community treatment program, responded to what treatment staff viewed as courts' intrusion. Abraxas sensitized their staff to the courts' role, formulated uniform policies, and emphasized coordination of treatment with court officials. The results of these changes are discussed.

Little, A.D. (1983). Confidentiality of Juvenile Offense Histories: A Statutory Review. Washington, D.C.: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

Juvenile codes from 50 states and the District of Columbia are examined as they apply to confidentiality used for juvenile law enforcement and court records.

Little, A.D. (1984). Innovative Juvenile Law Enforcement Programs. Alexandria, VA: American Society for Public Administration, Criminal Justice Administration.

The document identifies 26 innovative juvenile law enforcement programs designed to address alcohol and drug abuse, group violence, status and minor offenses, major and repeat offenses, crime in schools, and vandalism. A national survey of law enforcement agencies' findings are discussed.

McCord, J. (1981). Alcoholism and criminality - Confounding and differentiating factors. Journal of Studies on Alcohol, 42(9):739-748.

The relationship of criminal behavior and alcoholism is studied by collecting and reviewing the life histories of men who had participated in the Cambridge-Somerville Youth Study.

Mieczkowski, T. (1986, November). Greeking up and throwing down: Heroin street life in Detroit. Criminology, 24(4):645-666.

A field study of fifteen street-level heroin dealers located in Detroit, Michigan revealed that Detroit's dealers did not conform to the traditional "hustling" model. Differences are discussed.

Miller, F.W., Dawson, R.O., Dix, G.E., & Parnas, R.I. (1985). Juvenile Justice Process. Third Edition. Mineola, NY: Foundation Press.

State juvenile codes and court decisions bearing on juvenile conduct and juvenile justice processing, as of 1984, are described. A review of the legal and philosophical bases for maintaining separate juvenile and adult justice systems is followed by a examination of the two systems' differences.

Miller, R.E. (1984, Spring/Summer). Inmate drug education programming. Journal of Prison and Jail Health, 4(1):33-39.

The paper presents information about community health education programming for drug offenders. Community resources are described. Although the article's emphasis is drug education, it is suggested that this modality should complement inmate drug counseling and treatment services.

Mio, J.S., Nanjundappa, G., & DeRios, M.D. (1986). Drug abuse and adolescent sex offenders: A preliminary analysis. Journal of Psychoactive Drugs, 18(1):65-72.

The role of substance abuse in youthful sex offenders is investigated. All subjects (seven white male sex offenders) but one, had been convicted of incest. The circle of relationships linked to substance abuse and sexual abuse, as well as emotional neglect, are considered.

Missouri Juvenile Justice Review Committee. (1981). Confidentiality: A Review of the Provisions Relating to Youth in Missouri - Executive Summary. Jefferson City, MO.

The paper surveys the issue of confidentiality and the role it plays in Missouri's juvenile justice system; it then recommends specific changes in the statutes to protect the privacy of juveniles.

Moberg, D.P. (1986). Social control of deviance: Intervention with adolescent alcohol and other drug users. Dissertation Abstracts International, 46(11):3494-A.

Two studies, using formal social control on adolescent alcohol and other drug users, are analyzed. The first study compares formal control processes in a professional urban county with those in a rural county. The second is a quasi-experimental outcome of two adolescent intervention programs.

Murray, D.M., Perry, C.L., O'Connell, C., & Schmid, L. (1987). Seventh grade cigarette, alcohol and marijuana use: Distribution in a North Central U.S. metropolitan population. The International Journal of Addictions, 22(4): 357-376.

Results are given of a study that measured tobacco, alcohol and marijuana use among 7th graders who attended a school in Minnesota. Demographic variables included were age, gender, race, family structure, and parents' occupations. A combination of self-report and biological testing was used.

Myers, J.P. (1986). National Directory of Hotlines and Crisis Intervention Centers. Mullica Hill, NJ: Evaluation Research Associates.

Using information from a mail survey, this directory provides a listing of hotlines and crisis intervention centers in the U.S. The 1,067 programs described are listed alphabetically by state, and city within each state. Major service areas include general, alcohol/drug abuse, child physical and sexual abuse, domestic violence, suicide, and youth services.

National Clearinghouse for Alcohol Information. (1986, February). Alcohol and Crime. Rockville, MD, MS 326, 1-8.

In an effort to link alcohol and crime, this pamphlet discusses the results of a 1983 Department of Justice survey, associating prior alcohol use with criminal behavior. A selected list of resources is included.

National Clearinghouse for Alcohol Information. (1983, Summer). Alcohol Health and Research World. Rockville, MD.

This journal issue is dedicated to alcohol use among youths. Articles cover strategies to reach youths, facts about alcohol use and abuse, treatment approaches, treatment program profiles, psychological effects of alcohol and the genetics of alcoholism.

National Commission of Correctional Health Care. (1986). Standards for Health Services in Jails. Chicago, IL.

Standards for the qualitative and quantitative measurement of prison health care delivery are described.

National Commission of Correctional Health Care. (1986). Standards for Health Services in Prisons. Chicago, IL.

Revised qualitative and quantitative measurements of prison health care delivery systems (July 1979) are discussed.

National District Attorney's Association. (1979). Juvenile Justice Standards Symposium. Alexandria, VA.

Described is 1978-79 Juvenile Justice Standards Symposium Project. Sixteen critical essays cover the topic of juvenile justice standards.

National Institute of Drug Abuse. (1986). Treatment Services for Adolescent Substance Abuse. Treatment Research Monograph Series, Chapters 3-6.

These three chapters discuss: methods of treating adolescent substance abuse (i.e., detoxification, rehabilitation, aftercare, etc.), assessment instruments, and guidelines for choosing an appropriate treatment program.

National Institute of Justice. (1987, March/April). Drugs and crime. NIJ Reports, SNI 202, 1-14.

This issue of NIJ Reports includes information on drug abuse policy, current research, and a list of resources.

Newcomb, M.D., Maddahian, E., & Bentler, P.M. (1986, May). Risk factors for drug use among adolescents: Concurrent and longitudinal analyses. American Journal of Public Health, 76(5):525-531.

Associations are examined between risk factors and substance use in a sample of high school students.

New Jersey Prosecutor's Officer. (n.d.). Prosecutor's Handbook for School Administrators in Union County. New Jersey.

A review of juvenile court procedures and practices is followed by a delineation of school responsibilities and limitations in the areas of student interrogation, search and seizure, evidence control and custody, substance and child abuse, and records confidentiality. The first section describes police diversion, juvenile detention, juvenile intake, and available dispositional options. Access to and use of court records by school administrative proceedings are also covered.

North Dakota Plan for Alcohol and Drug Abusing Children and Adolescents at Risk. (1986, January). Prepared by the Chemical Dependency Subcommittee of the Governor's Commission on Children and Adolescents at Risk.

This paper defines the scope of the problem in North Dakota, defines terms used to describe resources across the state (i.e., inpatient vs. outpatient), and defines the Subcommittee's plan of action and recommendations to address substance abuse among children and adolescents.

Oetting, E.R., & Beauvais, F. (1986, September). Peer cluster theory: Drugs and the adolescent. Journal of Counseling and Development, 65, 17-22.

Several theories of adolescent drug use are discussed as background for the development of a drug use survey instrument. The instrument is designed to determine the underlying characteristics that are related to adolescent drug use. The results of this study led to the authors' "Peer Cluster" theory, whose focus is on the strength of peer influence.

Ostby, F.P., Jr., Leahy, F.J., Jr., & Robotham, R.F. (1969). Records Systems Procedures Manual for the Youth Services Division of the New Haven Police Department. Hartford, CT: Travelers Research Corporation.

The manual describes operating procedures and forms to be used when the records system for the Youth Services of the New Haven Police Department was to be revised. Primarily, the manual deals with the preparation, filing, and purging of records on juvenile offenders.

Pascal, C.B. (1987). Revised Regulations to Protect Confidentiality of Alcohol and Drug Abuse Patient Records: Overview and Summary. Rockville, MD: Alcohol, Drug Abuse and Mental Health Administration, Department of Health and Human Services.

Regulations pertaining to confidentiality of alcohol and drug abuse patient records are described.

Polich, P.L., Ellickson, P.R., & Kahan, J.P. (1984, February). Strategies for controlling adolescent drug use. In Treatment of Adolescent Drug Abusers. Santa Monica, CA: Rand Corporation, Chapter 4.

Research on the treatment of adolescents for drug and alcohol abuse is reviewed. Treatment programs are described and their effectiveness is debated.

Pompi, K., & Resnick, J. (1986, July 24). Retention of Court-Referred Adolescents and Young Adults in the Therapeutic Community. Submitted to AJDAA, 1-15.

The treatment program at Abraxas is compared to nine other therapeutic communities. This study focuses on retention of youth for treatment purposes.

Resource Inventory of Needs and Gaps for Alcohol and Drug Abusing Children and Adolescents at Risk. (1986, January). Prepared by the Chemical Dependency Subcommittee of the Governor's Commission on Child and Adolescents at Risk.

A compilation of results from two surveys sent to over 130 individuals in North Dakota by the Subcommittee, this report offers information on the gaps, weaknesses and barriers to service of both direct service providers and referral agencies. Each area is broken down further (i.e., in-patient, out-patient, private, and public) and discussed.

Rohrer, G.E., Elliott, J.R., & Geer, N.L. (1984). An alcohol education and traffic safety program for institutionalized juvenile offenders. Journal of Alcohol and Drug Education, 29(2):40-43.

This article describes a preventive educational program on alcohol and traffic safety conducted in Ohio's largest correctional institution for juveniles. Pre- and post-tests are compared.

Safer, D.J. (n.d.). School Programs for Disruptive Adolescents. Baltimore, MD: University Park Press.

This text discusses serious student misconduct in junior and senior high schools, examines general intervention and behavioral management issues pertinent to such misconduct, and lists funding sources for programs for disruptive youth.

Santo, Y., Hooper, H.E., Friedman, A.S., & Conner, W. (1980). Criminal behavior of adolescent non-heroin abusers in drug treatment programs. Contemporary Drug Problems, 9(3):301-325.

The article compares characteristics of three groups of adolescents entering a drug program. Characteristics include involvement in: non-drug related criminal offenses; strictly drug related criminal offenses; and no criminal offenses. A link between criminality and drug use is examined.

Schneider, A.L. (1984, March). Juvenile Justice System Response to Drug and Liquor Violations. Paper prepared for the National Research Conference on Juvenile Offenders with Serious Alcohol, Drug Abuse, and Mental Health Problems.

Data collected in Seattle showed how changes in juvenile justice policy has affected intake and sentencing decisions for drug and alcohol offenders. Current policy options are considered for juvenile justice and mental health systems.

Schneider, J.J. (1984, September 6). Practitioner's Conference Manuscript. Presented to the Practitioner's Conference on Juvenile Offenders with Serious Drug, Alcohol and Mental Health Problems, Washington, D.C.

This manuscript offers a detailed description of Lincoln Hills School Substance Abuse Program for delinquent youth, located in Irma, Wisconsin. The program's description includes admission requirements, rules, daily schedules and methods of discipline.

Segal, B., Cromer, F., Hobfoll, S.S., & Wasserman, P.Z. (1982). Reasons for alcohol use by detained and adjudicated juveniles. Journal of Alcohol and Drug Education, 28(1):53-58.

Results are presented of a study designed to examine reasons for alcohol use by detained and adjudicated juveniles. Subjects were taken from participants of McLaughlin Youth Center.

Seyko, R.J. (1985, Spring). Future trends in juvenile justice. PAPPC Journal, 4(1):44-49.

Trends in juvenile justice are examined. Supreme Court decisions are reviewed, proposed legislation and general attitudes are discussed and future trends are predicted.

Siegal, R. (1982, October-December). Smoking cocaine. Journal of Psychoactive Drugs, 14(4):271-355.

The journal dedicates an entire issue to the topic of cocaine, its physical properties and its historical use, abuse, hazards and treatments.

Simonds, J.F., & Kashani, J. (1980). Specific drug use and violence in delinquent boys. American Journal of Drug and Alcohol Abuse, 7(3&4):305-322.

Delinquent boys committed to a training school were interviewed. Drug abuse scores derived from 13 categories were correlated with crime offense categories. A high score for marijuana was the most predictive for membership in a person offending group.

Skager, R., Fisher, D., & Maddahian, E. (1986, May). Report to Attorney General John K. Van de Kamp: A Statewide Survey of Drug and Alcohol Use among California Students in Grades 7, 9, and 11. Sacramento, CA: Office of the Attorney General, California Department of Justice.

A survey of 87 California schools drew 7,379 students from grades 7, 9, and 11. Self-reports regarding drug use, age of first use, attitudes and sources of knowledge about drugs, where drugs are obtained, reasons for use or non-use, and attitudes towards alcohol/drug prevention classes given in their school, were collected and the findings summarized.

Smith,D., Levy, S.J., & Striar, D.E. (1979). Treatment services for youthful drug users. In George M. Beschner & Alfred S. Friedman, Youth Drug Abuse. Lexington, MA: D.C. Heath & Co.

A national survey designed to define and assess treatment services provided to adolescents with drug abuse problems is presented.

State of Maryland, Department of Health and Mental Hygiene. (1985, October). Code of Maryland Regulations 10.47.01, Certification of Alcoholism and Alcohol Abuse Facilities, Title 10, Subtitle 47, 1875-1876.

This booklet defines terms used to describe the process of certification in the State of Maryland. It then moves onto describe certification eligibility and procedures for obtaining state certification for alcohol treatment facilities.

Stayton, S.E., & Diener, R.G. (1979). Personality characteristics of juvenile delinquent heroin users. Internal Journal of the Addictions, 14(4):585-587.

Measures of self-concept, IQ and reading grade level were collected from a population of incarcerated delinquents who were predominantly from urban, minority backgrounds. Those with histories of heroin use were compared to those without.

Syracuse/Onondaga County Youth Bureau. (1984). Onondaga County Interagency Coordination Project - Alternatives for Youth at Risk. Final Report, Recommendations and Community Plan. Syracuase, NY.

The history of Onondaga County's project and its attempts to develop an integrated approach to policy development and service delivery for Persons in Need of Supervision (PINS), youths at risk, and juvenile delinquents is reported. The purposes of the four project committees are explored. The State Interagency Planning Report is attached, as are appendices which provide forms for PINS, comparisons of appellate court rules for guardian panels, and results of alcohol and drug use surveys.

Thornton, W.E. (1981, September). Marijuana use and delinquency; A reexamination. Youth and Society, 13(1):23-37.

This paper explores the relationship of self-reported marijuana use to other types of self-reported delinquency.

Tinklenberg, J.R., Murphy, P., Murphy, P.L., & Pfefferbaum, A. (1981, July-September). Drugs and criminal assaults by adolescents: A replication study. Journal of Psychoactive Drugs, 13(3):277-287.

A study of reported drug use and violent crime among incarcerated male juveniles in California is summarized and discussed.

Tjaden, C.D., Wanberg, K.W., Garrett, C.J., & Embree, J. (1986). The Relationship between Drug Use, Delinquency, and Behavioral Adjustment Problems among Committed Juvenile Offenders. A report presented to the Colorado Alcohol and Drug Abuse Division by the Colorado Division of Youth Services.

The Colorado Division of Youth Services (DYS) developed a survey instrument which could be used to provide descriptive information on drug/alcohol use, delinquency involvement, history of physical/sexual abuse, and sexual perpetration. The survey instrument was used on a sample of 303 youths in residence at five DYS institutions. The resulting statistics are compared with 1982 National Institute on Drug Abuse statistics and the National Youth Survey.

Tyson, L.P. (1984, September 6-7). Treatment alternatives to street crime: A case management model for juvenile offenders with alcohol/drug/mental health problems. In Drug Abuse, Mental Health, and Delinquency: Summary of Proceedings of Practitioners' Conference on Juvenile Offenders with Serious Drug, Alcohol, and Mental Problems. Washington, D.C.

The Treatment Alternatives to Street Crime (TASC) programs were created in 1972 by the White House Special Action Office for Drug Abuse Prevention to counter increasing drug abuse and related crime. This article describes in detail eight TASC programs designed to serve juveniles.

United States Congress Senate Committee on the Judiciary. (1983, July 19). Confidentiality of Juvenile Court Records: Hearing before the Senate Committee on the Judiciary. Washington, D.C.

Three witnesses testify on the laws prohibiting access to juvenile records. Committee members discuss the issue of confidentiality.

United States Department of Health and Human Services, Alcohol, Drug Abuse, and Mental Health Administration. (1980). Guidelines for Responding to Law Enforcement Requests for Alcohol and Drug Abuse Patient Records. Rockville, MD.

Federal confidentiality regulations and the authorizing legislation, accompanied by an interpretative letter, provide guidance for responding to police requests for alcohol and drug abuse patient records.

United States Department of Health and Human Services, National Institute on Drug Abuse. (1986). Communities - What You Can Do about Drug and Alcohol Abuse. Rockville, MD.

This booklet outlines several strategies that communities, parents, schools and businesses could adopt to prevent drug and alcohol abuse.

United States Department of Health and Human Services, National Institute on Drug Abuse. (1984). Adolescent Maltreatment-Issues and Program Models. Washington, D.C.

This text provides an overview of issues and selected research findings on adolescent maltreatment service models. Problems inherent in defining adolescent maltreatment are surveyed. Projects in Missouri, California, New Jersey and Maine that provide services to maltreated youth are described.

United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention. (1984, September 6-7). Drug Abuse, Mental Health and Delinquency: Summary of Proceedings of Practitioners' Conference on Juvenile Offenders with Serious Drug, Alcohol, and Mental Health Problems.

Conference presentations cover such issues which pertain to the treatment of juvenile drug and alcohol abusers: treatment and rehabilitation, treatment alternatives, parents groups, student assistance programs, and prevention models. Implications for federal policymakers based on two conferences are discussed and summarized.

United States Department of Justice, Bureau of Justice Assistance. (1983). Prisoners and Drugs. Washington, D.C.

Drug use and criminal behavior is examined by using the 1979 Survey of Inmates of State Correctional Facilities, a national survey involving 12,000 state prison inmates. Conclusions are discussed.

United States National Institute on Drug Abuse. (1981). Drug Abuse Treatment in Prisons. Washington, D.C.: U.S. Government Printing Office.

A national survey was conducted of correctional institutions. Correction administrators in each state were contacted to obtain current information about services they provided. Findings are summarized.

Van Horne, L. (1987, April). Delinquency prevention success in Virginia. Corrections Today, 49 (2).

An independent evaluation of Virginia's Delinquency Prevention Program compares statistics over a three year period, 1980-1983. The results are statistically significant. This article briefly describes the results of the evaluation and the success of the programs.

Vigdal, G.L., et al. (1981). Skills training in a program for problem-drinking offenders: A one-year follow-up evaluation. Journal of Offender Counseling, Services and Rehabilitation, 5(2):61-73.

A correctional program located in Wisconsin which treats problem-drinking offenders is evaluated. The program incorporates a functional social learning perspective to deal with abusive drinking associated with criminal activity.

Watters, J.K., Reinarman, C., & Fagan, J. (1985, Fall). Causality, context and contingency: Relationships between drug abuse and delinquency. Contemporary Drug Problems, 351-373.

This article critically reviews studies that have examined the relationship between drugs and crime. The importance of context, and motivation of drug use and crime is emphasized. Recommendations are made to address conceptual and methodological limitations of previous research.

Weissman, J.C. (1987, March). The criminal justice practitioner's guide to the new federal alcohol and drug abuse confidentiality regulations. Quarterly Journal of Corrections, 11-18.

The Code of Federal Regulations which pertains to confidentiality of alcohol and drug abuse patient records was passed on August 1, 1975. The effects of these regulations upon the operation of the criminal justice system are identified and examined.

Welte, J., & Barnes, G.M. (1987). Alcohol use among adolescent minority groups. Journal of Studies on Alcohol, 48(4):329-335.

This study compares different aspects of drug and alcohol use (i.e., frequency, quantity, and relationship to social problems) by race. A sample of minority students in New York is used.

White, A.G. (1982). Privacy/Confidentiality: The Criminal Justice System: A Recent Source List. Monticello, IL: Vance Bibliographies.

Approximately 120 publications are cited on the issue of privacy and confidentiality which date from 1973 to 1981.

White, H.R., Robert, J.P., & LeGrange, R.L. (1987, August). Longitudinal predictors of serious substance abuse and delinquency. Criminology, 25(3):715-740.

Longitudinal data on 441 male and 441 female adolescents is analyzed. The validity of a common-cause model for serious substance use and serious delinquent behavior is tested. Implications for theory development and policy implementation are discussed.

Wylen, J.C. (1984). Descriptive Study of Juvenile Offenders Released to State Parole Supervision. Albany, NY: New York State Division of Parole.

This report summarizes data collected by the New York State Division of Parole. Included are background characteristics, experiences, and recidivism rates of all juvenile offenders released on parole, 1978 through 1983. Provisions of the Juvenile Offender Law are explained.

Yoast, R. (1981). What You Can Do. Madison, WI: Wisconsin Clearinghouse.

Step-by-step instructions are given for organizing a community action group intended to work toward prevention of alcohol/drug, mental health, and youth problems.

Zinberg, N.E. (1984). Drug, Set and Setting: The Basis of Controlled Intoxicant Use. New Haven: Yale University Press.

The author examines the differences between illicit drug users who maintain control and those who lose control of drug use. He then interviews 153 users (subcategorizing them as controlled, marginal and compulsive) and charts the effects drug usage had on the subjects, over time.

APPENDIX D

DEVELOPMENT AND SUBSTANCE ABUSE RESOURCE GUIDE: NEEDS ASSESSMENT

To develop a substance abuse resource guide which would address the needs of juvenile correction agencies, ACA would like you to answer the following questions. For the purpose of this questionnaire, the term substance abuse will refer to both alcohol and drug use.

Name_____ Position_____

Address_____

_____ Telephone ( )_____

1. Please indicate how your agency has responded to juvenile substance abuse.

____ Gathering of Statistics
____ Using Assessment Instruments
____ Staff Training
____ Education/Prevention Programming
____ Treatment Programing
____ Establishing of a Referral Network
____ Contracting With Private Providers to Provide Treatment Services
____ Other _____

2. Describe or enclose a description of any substance abuse treatment services offered by your agency, and the name of a contact person who could provide us with more information.

3. Do you have any type of cooperative agreement(s) with any state agency or other resource(s) to provide substance abuse education and/or treatment for juveniles? If so, please describe.

4. Check the items which describe the type of assistance you would find useful. Information concerning:

_____ Treatment Methods
_____ Model Treatment Programs
_____ How to Develop a Treatment Program
_____ Post-Treatment Care/Reintegration
_____ How to Evaluate a Treatment Program
_____ Staff Training
_____ Sample Assessments Instruments
_____ Intra/Interagency Service Collaboration
_____ Information on Funding Sources
_____ Available Resources
_____ Other _____

5. Indicate below any treatment program(s) which you consider to be especially effective.

Program_____

Contact Person_____

Address_____

_____Telephone ( )_____

6. Comments/Suggestions:

Please return to ACA by November 13, 1987.

APPENDIX E

ALCOHOL/DRUG TREATMENT PROGRAM PROFILE

April, 1988

DATA SHEET

FACILITY:

ADDRESS:

CONTACT PERSON/TITLE:

PHONE NUMBER: ( )

ACA STAFF/CONSULTANT:

DATE OF SITE VISIT:

COMMENTS:

I. Philosophy

A. View of chemical dependency

1. illness (physical)
2. mental health problem (psychological)
3. primary or secondary problem

B. What is the program's philosophy as to why kids use drugs?

C. How do you view the treatment of involuntary clients? How does that differ from voluntary clients?

D. With what types of clients do you believe your program is most successful? Least successful? How do you measure success?

II. Demographics/Facility Design

A. Percentage of clients by:

1. age
2. sex
3. race
4. drug abuse pattern
5. geographic origin

B. Facility description:

1. number of beds
2. average number of clients
3. accessibility to disabled
4. other location
5. within correctional/detention facility or separate

C. How long has the program been in existence?

D. To what extent, if any, is there community involvement?

III. Eligibility/Admission Criteria

A. Do you accept involuntary clients?

B. What criteria are used for admission of clients to your program? What evidence do you look for in client records? Do you do independent interviews or tests?

C. What types of clients are not appropriate for your program?

D. Does your facility treat clients with problems other than substance abuse? If so, are substance abuse clients mixed with other clients?

E. Who makes the final admission decision? Do you reserve places for clients from specific agencies or organizations?

IV. Program Structure

A. Level of substance abuse treatment available at your facility:

1. prevention/education
2. crisis intervention
3. detoxification
4. residential/in-patient
5. out-patient
6. aftercare

B. What do you do for clients in need of detoxification?

C. Do you consider your treatment program to be drug free? If not, what medications are used?

D. What is the average length of treatment?

E. Are adolescents/adults treated separately? If so, how does treatment differ?

F. What procedure is followed in a medical emergency?

G. Does the program use volunteers? If so, what are their roles? What are the required qualifications for volunteers? and, how are volunteers trained?

H. What disciplinary procedures are utilized by your program? Under what circumstances is a client removed from the treatment program? (i.e. failure to comply with rules, not remaining drug free)

I. What are the consequences of not following the treatment program?

J. What is the criteria for program completion?

K. If you have a multiphase program, what are the criteria to move from one phase to the next? How long does each phase last? What % of clients move to each phase?

L. What relationship does your program maintain with the court or office responsible for client placement? Is it an ongoing relationship or a one-time report? What client information is shared and how often?

M. Is there someone who does case management and coordination of aftercare service planning?

V. Treatment

A. In what intervention areas do you assess clients at the onset of treatment (i.e. mental health, family, social, educational)?

B. What specific areas do you treat? Do you offer referrals in those areas that you do not treat?

C. How is treatment progress measured? (negative and positive)

D. How often is each client re-assessed for appropriateness of treatment and treatment plan, and progress within the program?

E. How is the treatment program structured? Describe a typical session, day and week.

F. What types of therapy are included in the structure of your treatment program?

1. individual
2. small group
3. large group
4. family
5. multi-family
6. psychodrama
7. peer counseling
8. play therapy
9. art therapy
10. psychological testing
11. medical testing
12. legal services
13. services for special populations
    a. females
    b. minorities
    c. handicapped/disabled
14. other

F. Is involvement in self-help groups encouraged and/or incorporated into the treatment program?

G. Does the program include other components such as:
   1. recreation
   2. occupational education
   3. health
   4. nutrition

H. Is urinalysis or another drug testing method used pre/post/during treatment?

I. What referral sources are used during the course of treatment (including outside consultants)? How are these sources evaluated to ensure proper care and coordination of service?

J. Do you have any contracts/agreements with other facilities?

VI. Education

A. What, if any, educational (academic) services are provided within your treatment program? Do these services include special education? How are these services incorporated into the total treatment program? Who teaches the classes that are offered (ie. qualifications, work experience)?

B. Can academic credits be earned and transferred to other schools? Can a GED certificate be earned?

C. Is the educational program accredited? If so, by whom and what date?

D. Does your program have any relationship with local school districts?

VII. Aftercare

A. Describe the aftercare component of your program.

   1. When do you start planning it?
   2. How long does it typically last?
   3. Is it organized in individual or group sessions?
   4. What percentage of clients are referred during/following aftercare:
      a. to a halfway house
      b. to long term treatment
      c. to out patient treatment
      d. other _____

B. To what extent do staff have both residential and aftercare responsibilities? To what extent do aftercare counselors get involved in treatment?

C. To what extent are probation/parole officers involved in aftercare treatment?

D. How do you ensure a continuum of care from start to finish, including post-aftercare programs?

VIII. Family Involvement

A. Is the client's family involved in the treatment, recovery/aftercare process? If so, how? Are self help groups recommended for family members?

B. Is there a particular staff member who specifically deals with family members' concerns?

IX. Staff

A. What and how do staff know about drug abuse?

B. What is the staff/client ratio at your facility?

C. What are the qualifications of your staff (ie. education, training, experience)? Does the staff include those who are recovering themselves? Are there specific issues you want them to know about?

D. What is the average length of time staff members have been working in the program? Do you rotate staff in different functions? Can clients reasonably expect to have the same therapists/counselors throughout treatment and aftercare?

E. Is continuing education available and/or required of the staff?

F. What hours do staff work on a regular basis? What is your night staffing pattern? Are program activities run in the evening?

X. Finances

A. What is the cost of treatment? Are there additional costs? (ie. aftercare, medications)

B. Can you estimate what % of money is allocated for in-patient treatment versus aftercare treatment?

C. What is your fee structure for court referred versus private clients? Are fees paid on a per diem basis for both types of clients? Is there a differential for private patients?

D. Is the program qualified to receive insurance payments (ie. Medicaid, Blue Cross/Blue Shield)?

E. Does the program have a sliding fee scale or other form of financial assistance?

F. How is your treatment program funded? By whom?

G. Is the program as a whole accredited? If so, by whom?

XI. Administration

A. Do you have written policies and procedures? Do staff receive a copy of these policies and procedures? Is the staff trained in policies and procedures?

B. Do you do any type of employee drug testing? What do you do as a result of staff drug/alcohol use?

C. Have you experienced any problems with malpractice and liability insurance (i.e. accelerated costs)?

XII. Evaluation

A. Internal
Do you have a method to internally evaluate the effectiveness of your program and quality of treatment? If so, please describe.

B. External
Have you ever been evaluated by a third party? If so, could you provide us with a copy?

C. Do you ever do/or participate in research?

XIII. How is your program unique?

APPENDIX F

AMERICAN CORRECTIONAL ASSOCIATION
SURVEY OF SUBSTANCE ABUSE TREATMENT PROGRAMS
FOR ADJUDICATED YOUTH
BY STATE

Question	Inpatient Treatment	Outpatient Treatment	Other
1. # of substance abuse programs used statewide			
Contracted/private	_____	_____	_____
State run	_____	_____	_____
2. Usual length of treatment	_____	_____	_____
3. # of females treated statewide	_____	_____	_____
4. # of males treated statewide	_____	_____	_____
5. Who does the state treat?			
a) Ages	_____	_____	_____
b) Types of offenses	_____	_____	_____
c) Personality types	_____	_____	_____
d) IQ	_____	_____	_____
e) Other	_____	_____	_____
6. Who does the state not treat?			
a) Offenses	_____	_____	_____
b) Behavioral risks	_____	_____	_____
c) IQ	_____	_____	_____
d) Personality types	_____	_____	_____
e) Other	_____	_____	_____

Question	Inpatient Treatment	Outpatient Treatment	Other
7. How many programs assess clients':			
a) Drug use/dependency	_____	_____	_____
b) Psychological makeup	_____	_____	_____
c) Educational needs	_____	_____	_____
d) Medical problems & needs	_____	_____	_____
8. How many of your programs provide:			
a) 12-steps programs	_____	_____	_____
b) Education curriculum	_____	_____	_____
c) Journal writing	_____	_____	_____
d) Drug education	_____	_____	_____
e) Vocational training	_____	_____	_____
f) Social skills training (i.e., indep. living skills, social problem solving, self-esteem enhancement & life skills)	_____	_____	_____
g) Recreation/exercise programs	_____	_____	_____
h) Wilderness/ropes courses	_____	_____	_____

Question		Inpatient Treatment	Outpatient Treatment	Other
8.	How many of your programs provide:			
	i) Medical services	_____	_____	_____
	j) Drug testing	_____	_____	_____
	If so, how often?	_____	_____	_____
	k) Strip searches	_____	_____	_____
	l) Community outreach	_____	_____	_____
	m) Family outreach	_____	_____	_____
	n) Mental health services	_____	_____	_____
	o) Family counseling	_____	_____	_____
	p) Group/peer counseling	_____	_____	_____
	q) Individual counseling	_____	_____	_____
	r) Drug crisis counseling	_____	_____	_____
	s) Other	_____	_____	_____
9.	Therapeutic models and approaches used:			
	a) Disease concept	_____	_____	_____
	b) Family disease concept	_____	_____	_____
	c) Therapeutic Community	_____	_____	_____
	d) Other	_____	_____	_____

	Inpatient Treatment	Outpatient Treatment	Other
10. Methods of behavioral control			
a) Staff run	_____	_____	_____
b) Peer run	_____	_____	_____
c) Other	_____	_____	_____
d) Types of consequences:	_____	_____	_____
11. How many provide aftercare?			
a) Administered by the treatment program	_____	_____	_____
b) Administered by another agency	_____	_____	_____
c) Overseen by sponsors	_____	_____	_____
d) Overseen by probation	_____	_____	_____
e) Other	_____	_____	_____

	Inpatient Treatment	Outpatient Treatment	Other
12. Research			
a) How many have conduced self evaluations?	_____	_____	_____
b) How many have conduced independent evaluations	_____	_____	_____
c) # to have conducted other types of research	_____	_____	_____