Evaluation of

DRUG ABUSE SERVICES PROGRAM

DASP

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SUMMARY

This evaluation of the Drug Abuse Services Program (DASP) was designed to directly assess the extent to which the four specific objectives of the program were attained during the first eight months of operations, and to answer two specific questions concerning the processes by which drug abusing wards became involved with community programs while on parole. The objectives and questions are stated below along with the findings of the evaluation.

1. Maintain the current level of community treatment services for identified drug abusing parolees.

   The program started operations with only half the number of identified drug abusers on parole as had originally been anticipated from the levels of previous years. As a result, the total number of service involvements dropped to about half that of the previous period (September 1, 1976-January 31, 1977). In terms of the number of identified abusers in each period, however, the proportions receiving services were about the same--13.1% of the DASP parolees received services compared to 15.1% and 12.1% in the two previous comparison periods.

2. Determine if length of stay and type of service in a community treatment program correlates with decreases in violation status and recidivism of parolees receiving community-based services.

   For the sample of 138 drug abusers used in the follow-up study, only one of the 29 program-involved wards had failed at the end of six months from release to parole. Fifteen of the 109 wards who were

not involved with a program failed within the same time. The respective failure rates are 3.4% and 13.8%. The low failure rate for program-involved wards and the short follow-up period did not allow any analysis of differential effectiveness by type of service or length of stay. An attempt to study program effectiveness in terms of violation, local custody, employment status, drug usage, peer associations, and parole agent's evaluation of parole adjustment did not reveal any statistically significant differences between program-involved and non-involved wards, except for the parole agent evaluation, which is subject to considerable bias.

3. Increase the Department's knowledge of which type of community-based treatment program is most cost effective in reducing recidivism and the number of wards in violation status.

It was not possible to differentiate cost effectiveness by type of program for the reasons given in 2. above. An attempt was made to examine general cost effectiveness by reviewing expenditures using a "ward/month saved" framework. It was estimated that if as few as six of the wards for whom services expenditures were made during the first eight months of the program were retained on parole rather than being revoked or dishonorably discharged for one year longer than anticipated as a result of those expenditures, then the program would be cost effective for that period.

4. Increase by 15% the use of existing approved community drug treatment resources by the end of the project year.

"Approved" programs were those on the Department of Health's list of drug programs eligible to receive federal funds. Thirty-eight wards were involved with approved programs during the study period. Although actual data for the previous periods were not available, for the above

objective to be achieved, no more than 33 wards would have received approved services during any one of the previous comparison periods. However, it was judged highly likely from the total number of program involvements in the previous periods that at least 33 wards would have been with approved programs in each period. It was therefore felt that this objective was not achieved.

5. Does involvement with drug program services while in an institution motivate wards to become involved with community drug programs following release to parole?

No relationship was found between the two types of drug program involvement.

6. Do staff recommendations on placement or referral reports and Board Orders have any influence on whether a ward becomes program involved or not?

Of the wards who became program involved on parole, 79.2% had staff and/or Board recommendations compared to only 33.3% of the non-involved who had recommendations. The difference was highly statistically significant. There was also an indication that the more specific the recommendation or order, the more likely it was to be followed, although the data were not statistically significant.

It is recomended that the data for 2. and 3. above be re-examined after the sample has had the possibility of at least 18 months on parole in order to see if any differentiation of effectiveness by type of program or length of involvement emerges.

Taking an overview of the Youth Authority's experience with drug programs during the past six years it was concluded that:

1. The concept of contracting with community drug treatment agencies to provide services for Youth Authority wards has proven eminently practical and successful.

2. The greatest success was found where the emphasis was on providing direct drug related services: chemotherapy, residential treatment, psychotherapy and drug counseling to wards characterized as older, "hard-core" users with longer delinquent histories.

3. When the programs have shown significant impact on the parole performance of program-involved wards they have been highly cost effective in terms of actual purchase-of-service expenditures. It is when excessive administrative expenditures are added that the overall cost-effectiveness of the programs declines.

EVALUATION OF DRUG ABUSE SERVICES PROGRAM (DASP)

The California Youth Authority's Drug Abuse Services Program (DASP) came into being June 15, 1977, through funding from the State Office of Narcotic and Drug Abuse. The program aims at identifying "hard-core" abusers of opiate, depressant, stimulant, and hallucinogenic drugs within the Youth Authority population and at providing treatment and rehabilitative services for them following their release to parole. It was designed as an interim replacement for the previous Community-Centered Drug Program (CCDP) and is a direct descendant of the latter program. It is, therefore, desirable to look at the background from which DASP was developed in order to understand both the problems which the program encountered during its formative stages and the limitations and implications of the data which will be examined in this report.

The Community-Centered Drug Program

The CCDP was launched in August 1972, after nearly a year's intensive planning by Youth Authority task forces in the North and in the South. The pooled findings of the planning groups resulted in a proposal to develop a large-scale statewide program of contracting with community drug treatment facilities to provide services to Youth Authority wards.

The plan envisioned a structure of two drug program administrators, North and South, nine Drug Resource Specialists based in each regional parole office and coordinating institutional programs, and a cadre of Drug Resource Aides attached to each parole office and institution. Special Drug Diagnostic and

Planning Units were to be established at both the Northern and the Southern Clinics. A special pre-release unit was to be developed at Metropolitan State Hospital for both male and female wards. These personnel and special units were to identify drug abusing wards within the Youth Authority population, work with community programs in making wards aware of, and motivating them to make use of, the wide range of drug treatment resources available to them in the community, and to arrange payments to those community programs for provision of services to Youth Authority wards who wished to avail themselves of those services.

The proposal was accepted by the Law Enforcement Assistance Administration through the California Council on Criminal Justice. The first year grant was for $1.5 million. The total project period was to be three years with grants of $1.6 million and $1.3 million respectively for the second and third year. It was initially envisioned that the program would be funded directly by the State thereafter.

The CCDP became operational in December 1972. The original aim of the program was to focus on the "hard-core" drug abuser. Thus, the identification and provision of services to marijuana and alcohol abusers were not stressed in the early years. By early 1974, however, marijuana and alcohol abusers were being identified in increasing numbers and by 1976 they accounted for more than two-thirds of all wards identified into the program (Roberts, 1977).

Earliest indications, based on successive samples, suggested that the CCDP was rather strikingly successful in maintaining drug-abusing wards on the streets. The data are shown in Table 1.

TABLE 1

COMPARISON OF PAROLE OUTCOME RATES FOR THREE CCDP SAMPLES

Program Involvement	Sample 1		Sample 2		Sample 3	
	Number	Percent Fail	Number	Percent Fail	Number	Percent Fail
TOTAL	163	35.0	372	24.5	323	30.3
Involved	35	22.8	85	18.8	64	26.6
Not Involved	128	38.3	287	26.1	259	31.3
Difference in Percentage Points:		15.5		7.3		4.7
Significance: Chi-Square[a] (one-tailed)		.048		.084		.231

[a]Chi-square (χ^2) is a statistical test which measures the variation of actual frequencies from calculated expectancies within the data. A significant variation in this report is one in which the difference shown would be expected to occur by chance less than five times in a hundred repetitions.

For the first sample of drug-identified wards, released to parole during the first seven months of 1973, those who took advantage of available drug treatment services while on parole failed[1] at only 22.8% as compared to a rate of 38.3% for those who did not become involved with community drug programs--a difference of 15.5 percentage points (Roberts, 1976). For the second sample of wards, those identified at reception center-clinics prior to February 1974, the difference in failure rates had declined to 7.3 percentage points--much less than the difference for the first sample. By the third sample (wards

[1]Failure was measured by revocation, recommitment or discharge while on violation status for an offense committed during the first 12 months on parole.

released to parole in the last half of 1974) the difference had declined to only 4.7 percentage points. This relative decline in impact was initially attributed to the increasing number of marijuana and alcohol abusers introduced into the population. The initial data seemed to show that the older "hard-core" drug abusers were those most amenable to treatment efforts and that the generally younger marijuana and alcohol abusers were less amenable to treatment. It was argued that as increasing numbers of the latter were brought into the program, the overall level of effectiveness was thereby reduced (Roberts, 1977).

The above hypothesis was not supported when parole outcome was analyzed for successive release cohorts of the total drug abuser population, rather than the samples discussed above. This is shown in Table 2. Again, the difference in failure rates between involved and non-involved wards for the first six cohorts is substantial. By 1975, however, the differences decreased and parole outcome for the final two cohorts actually reversed slightly, with the involved wards showing a higher failure rate than the non-involved.

TABLE 2

PAROLE FAILURE RATES FOR SUCCESSIVE RELEASE COHORTS OF IDENTIFIED DRUG ABUSERS IN THE CCDP, BY INVOLVEMENT OR NON-INVOLVEMENT WITH COMMUNITY DRUG TREATMENT SERVICES

Release Cohort	Number in Cohort	Percent of Cohort Failing on Parole at 12 Months From Release to Parole	Significance Between Group Difference
TOTAL	8,070	28.2	
Involved	1,509	17.8	.001
Non-involved	6,561	29.3	
January-June 1973	1,436	29.9	
Involved	238	14.7	.001
Non-involved	1,198	32.9	
July-December 1973	1,299	31.4	
Involved	253	15.4	.001
Non-involved	1,046	35.3	
January-June 1974	990	29.3	
Involved	226	13.7	.001
Non-involved	764	33.9	
July-December 1974	1,065	26.5	
Involved	243	16.9	.001
Non-involved	822	29.3	
January-June 1975	1,046	25.6	
Involved	218	19.3	.016
Non-involved	828	27.3	
July-December 1975	1,090	23.2	
Involved	189	24.3	.500+
Non-involved	901	23.0	
January-June 1976	1,144	22.9	
Involved	142	24.6	.500+
Non-involved	1,002	22.6	

The pattern shown in Table 2 was repeated when the data were controlled for a number of background and personal characteristics variables, including

the major drug of abuse as shown in Table 3.

Thus, marijuana and alcohol abusers show variations in failure rates over successive cohorts similar to hard drug users and other segments of the drug-identified population. Except for the hallucinogens, each of the major drug groups is initially characterized by high significance levels (less than .05) indicating lower failure rates for the program-involved wards than the non-involved wards. In later cohorts, the difference disappears, or even reverses in some instances, to where, in the last two cohorts, no significant differences were found for any drug group.

TABLE 3

SIGNIFICANCE[a] OF THE DIFFERENCE IN PAROLE FAILURE RATES BETWEEN PROGRAM-INVOLVED AND NON-INVOLVED WARDS IN SUCCESSIVE SIX-MONTH COHORTS, BY MAJOR DRUG OF ABUSE

	Major Drug of Abuse						
Release Cohorts	Opiates	Depressants	Stimulants	Hallucino-gens	Marijuana	Alcohol	Volatile Substances
January-June 1973	.001	.005	.011	>.500	.007	>.500	-[b]
July-December 1973	.001	.001	.005	.356	>.500	.022	.017
January-June 1974	.002	.002	.013	>.500	.003	.279	.010
July-December 1974	.009	.024	>.500	.150	.375	.184	.238
January-June 1975	.442	>.500	.285	.015	.146	>.500	.197
July-December 1975	>.500	>.500	.075	>.500	>.500	>.500	.054
January-June 1976	.285	>.500	.245	.465	.268	>.500	-[b]

[a]Significance determined by Chi-square.

[b]Could not be computed.

The more fruitful explanation for the decline in impact of the CCDP seemed to be simply that at the end of the initial three-year project period, indecision concerning its continuance led to a decline in staff morale and in the resultant delivery of services to wards. The specialized pre-release unit at Metropolitan State Hospital was discontinued in 1974. By January 1975, it was increasingly clear that although the program could show a significant difference in failure rates between involved and non-involved wards, that difference was not sufficient to warrant the increasing costs of the program. Moreover, fourth year funding from the Office of Criminal Justice Planning was approved only weeks before the project was due to terminate. In the fourth year, the program was united under a single administrator.

By early 1976, it was clear that if the program was to be continued, its funding would be at a much lower level than previously and there would be drastic reductions in personnel. Many staff began looking for other job assignments as early as January 1976. Fifth year funds were obtained from OCJP and the State Office of Narcotic and Drug Abuse. At the end of June 1976, the Drug Resource Specialists were removed and in December of that year the Drug Resource Aides were removed. At that point, a staff of more than 85 persons had diminished to only one administrator and his secretary and a three-person research unit. By early 1977, the number of wards being identified into the program had dropped from a prior average of 167 wards per month[2] to only 40 wards per month. The data suggest that because of the reductions in program resources and personnel, the parole offices reoriented their position to one of continuing to provide services to those wards already involved in program activities, extending services to new emergency cases who appeared, but less

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[2]Based on 1974 and 1975 identifications.

actively directing newly released wards into involvement with community programs. This was especially practical because it was not anticipated by administrators that any drug program funds would be made available in the future.

In April 1977, however, it appeared that some funds would be available from the State Office of Narcotics and Drug Abuse (SONDA), although not in the amounts previously expended. A proposal for utilization of these funds was developed by the Youth Authority and accepted by SONDA. In June 1977, DASP was created from what was left of its predecessor--inheriting all the problems left by the latter's slow demise.

The Drug Abuse Services Program

DASP was planned to focus only on parolees and was limited to "hard-core" abusers of opiates, depressants, stimulants, and hallucinogens.[3] Marijuana and alcohol abusers were systematically excluded from receiving services. As with CCDP, the emphasis was on the utilization of existing community services for the treatment of Youth Authority wards. The available funds allowed for one program manager, one research manager, and one secretary for the project. These were subsequently augmented by two CETA workers and a student assistant paid from other sources. Some $230,000 were available for purchase of drug treatment services.

During the first half-year of DASP the major thrust of work for the program staff was that of reestablishing the service delivery and identification systems. Since no specialized staff were attached to DASP, most of the work formerly performed by parole aides was left to the individual parole agents.

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[3]Hereafter, in this report, the term "drug abusers" will refer only to users of these types of drugs.

This required an intensive effort by DASP staff to train agents in the identification process and to make them aware of the various drug treatment services which were available through DASP. Relations with the various community services had also to be reestablished and their service potentiality assessed. This eventuated in the development of a community services resource guide for each parole office. Fiscal and contract procedures for reimbursing community services and preventing duplication of payments (some services were also receiving funds directly from SONDA) had to be implemented and explained to the various office managers.

Perhaps the most difficult task was the rebuilding of the identification process. The lapses in drug identifications during the last months of CCDP had left a large number of unidentified drug abusers in institutions or on parole. DASP staff reviewed nearly all unidentified ward files in early 1978 attempting to locate those missing cases. The necessity for reestablishing the entire distracted DASP staff from fully concentrating on maintaining service delivery. To a considerable extent the program did not become operational until after September 1977, and was not fully functional until after January 1978.

Four specific program objectives were stated in the proposal:

1. Maintain the current level of community treatment services for identified drug abusing parolees.

2. Determine if length of stay and type of service in a community treatment program correlates with decreases in violation status and recidivism of parolees receiving community-based services.

3. Increase the department's knowledge of which type of community-based treatment program is most cost effective in reducing recidivism and number of wards on violation status.

4. Increase by 15% the use of existing approved community drug treatment resources by the end of the project year.

The evaluative research design for the program addresses itself primarily to those four objectives. Data for the first and the fourth of the objectives were obtained through parole agent interviews and ward file searches and recorded on special forms. For the other two objectives, a special sample of wards was followed up for a six-month interval to determine parole outcome and the ward's adjustment while on parole. At the same time data were obtained from files and interviews concerning 1) involvement with drug treatment programs while the ward was in an institution, and 2) the nature of the ward's pre-release parole plans. These latter data were used to answer two specific questions concerning the effectiveness of institutional programs or pre-release recommendations in motivating wards to become program involved when on parole.

Under DASP, each ward entering one of the Youth Authority's four reception centers is screened for evidence of prior drug abuse through application of a Substance Abuse Referral System (SARS) questionnaire (see Appendix A). All wards with scores of 32 or more on the questionnaire are identified as drug abusers. Some wards scoring less than 32 may also be identified as drug abusers at the caseworker's discretion. This identification process may also be applied at any time a youth counselor in an institution or a parole agent in the field feels that a ward might be in need of drug abuse treatment services following release to parole.

Wards usually spend three to four weeks at the reception center and are then sent to an institution. The stay there averages slightly less than one year. While in the institution the identified drug abuser might be placed in one of the special drug units at the Youth Training School, Preston School of Industry, or Nelles School, or they might be exposed to one of the visiting

programs at some schools, where drug treatment program staff from community organizations conduct group or individual counseling sessions to educate and motivate wards to become involved with community drug treatment programs on release to parole.

When a ward is ready to leave an institution on release to parole, his or her case is reviewed by staff, and parole planning and placement recommendations are made for Board consideration. These are frequently translated into Board Orders or Conditions of Parole. For drug abusers, these orders might direct him into a particular community drug treatment program or generally suggest a particular mode of treatment.

When the ward is released on parole, his parole agent is ready to assist the ward in becoming involved with a community program if he wishes. Particularly if the parole agent feels that the ward has started using drugs again, he might coercively direct him into a program as an alternative to revocation. The parole agent might also insist that the ward undergo periodic urinalysis testing to detect any reversion to drug abuse.

Drug Abuse Service expenditures may be made on behalf of any identified drug abuser as long as he is on parole--until he is either revoked, recommitted, or discharged.

Population Movement and Characteristics

At the end of June 1976 there were 1,730 identified abusers of "hard-core" drugs in the Youth Authority's parole population. Since there was little reason to believe that drug abuse among youth had waned in the intervening year, it was anticipated that about the same number of drug abusers should be available

on parole for DASP services at the end of June 1977--at the start of the DASP program. The actual number turned out to be 1,388, a decrease of 342 wards from the previous year. By the end of September 1977, the number had fallen to 985 wards--nearly half the number anticipated. A low of 940 wards was reached at the end of January 1978. At the end of March 1978, the total had risen only slightly to 960 wards.

The decline in the number of drug abusers on parole appears directly related to the dwindling of identifications during the last years of the CCDP. The number of hard-core abusers identified into CCDP and DASP each month between January 1973 and February 1978 is shown in Table 4.

As has been noted, most drug abusers are identified while in one of the reception centers. Following that, nearly all spend an average of 11 months in an institution before being released to parole. Thus, most of the wards identified since July 1977, when DASP started, had not been released to parole by the end of the project year. During its first year of operation, then, the only wards on parole that DASP had available to work with were those identified during the previous years.

TABLE 4

NUMBER OF WARDS IDENTIFIED AS DRUG ABUSERS
BY MONTH OF IDENTIFICATION,
JANUARY 1973-FEBRUARY 1978

Month	Year					
	1973	1974	1975	1976	1977	1978
Monthly Mean	148[a]	36	61	54	39	-
January	119	55	63	69	31	35
February	338	46	28	54	48	48
March	445	41	35	69	38	-
April	129	33	50	66	34	-
May	113	42	39	66	23	-
June	84	37	53	52	36	-
July	109	42	115	50	31	-
August	146	32	82	59	39	-
September	57	27	66	51	48	-
October	51	36	89	36	43	-
November	137	17	60	30	48	-
December	52	24	49	50	46	-

[a]The high Monthly Mean for 1973 reflects the initial push during that year to identify all drug abusers on parole and in institutions.

The first row of Table 5 shows the dramatic drop in the total drug abuser population between June 30, 1976 and June 30, 1977 from 1,730 to 1,388 wards in 12 months. Changes in the personal and background characteristics of the drug abuser population over the four-year period are also shown in Table 5. Some of the changes reflect basic differences occurring within the general

Youth Authority population, such as the decrease in female wards, the greater number of "Persons Crime" offenders, the fewer narcotic and "other" offenders and the growing proportions of criminal court commitments. Others are unique to the drug abuse population, however. For example, as of June 30, 1977, only half of the wards in the general population on parole were criminal court commitments (CYA, 1977), compared to nearly two-thirds among the drug abusers. While 35.5% of the general parole population were Black, only 20.7% of the drug abusers were Black. Similarly, about two-thirds of the general parole population were less than 21 years of age, but only 44.2% of the drug abusers were in the younger age bracket. On admission status, 35.5% of the drug abusers had prior commitments while only 21.5% of the general parole population had been committed before. Wards in the drug abuse population, then, seem to be older and with more extensive delinquent histories than do the wards in the general population.

TABLE 5

PERSONAL AND BACKGROUND CHARACTERISTICS OF
IDENTIFIED DRUG ABUSERS ON PAROLE,
AS OF JUNE 30, 1974-1977

Characteristics	1974		1975		1976		1977	
	No.	%	No.	%	No.	%	No.	%
TOTAL	1,894	100.0	1,866	100.0	1,730	100.0	1,388	100.0
Sex								
Male	1,591	84.0	1,622	86.9	1,569	90.7	1,269	91.4
Female	303	16.0	244	13.1	161	9.3	119	8.6
Race								
White	1,075	56.8	1,026	55.0	904	52.2	709	51.1
Spanish Surnamed	409	21.6	414	22.2	407	23.5	369	26.6
Black	369	19.5	387	20.7	384	22.2	287	20.7
Other	41	2.1	39	2.1	35	2.1	23	1.6
Age at Parole								
Less than 21	701	37.0	736	39.4	659	38.1	614	44.2
21 and over	1,193	63.0	1,130	60.6	1,071	61.9	774	55.8
Commitment Offense								
Narcotic/Drug	461	24.3	332	17.8	246	14.2	174	12.5
Persons Crime	480	25.3	644	34.5	704	40.7	604	43.5
Property Crime	567	29.9	596	31.9	596	34.5	496	35.7
Other	386	20.4	294	15.8	184	10.6	114	8.3
Admission Status								
First Admission	1,197	63.2	1,210	64.8	1,131	65.4	896	64.5
Prior Admission	697	36.8	656	35.2	599	34.6	492	35.5
Court of Commitment								
Juvenile	845	44.6	799	42.8	625	36.1	488	35.2
Criminal	1,049	55.4	1,067	47.2	1,105	63.9	900	64.8
Area of Commitment								
Southern California	1,162	61.3	1,102	59.1	1,073	62.0	882	63.5
Bay Area	414	21.9	407	21.8	342	19.8	249	17.9
Other	318	16.8	357	19.1	315	18.2	257	18.6
Major Drug of Abuse								
Opiates	640	33.8	627	33.6	628	36.3	584	42.1
Depressants	826	43.6	742	39.8	573	33.1	417	30.0
Stimulants	251	13.2	279	14.9	276	16.0	192	13.8
Hallucinogens	177	9.4	218	11.7	253	14.6	195	14.1

For the first ten months of DASP (July 1, 1977 through April 30, 1978),

the number of identified drug abusers released to parole or identified while on parole and the number of wards removed from the program each month are shown in Table 6.

TABLE 6

IDENTIFICATION AND REMOVALS OF DRUG ABUSERS,
JULY 1977 THROUGH APRIL 1978

Month	Identification	Removals[a]	Difference
1977			
July	49	72	-23
August	62	104	-42
September	74	86	-12
October	72	73	1
November	67	48	19
December	78	76	2
1978			
January	59	56	3
February	62	37	25
March	232[b]	53	179
April	132[b]	37	95

[a]Removal could be by revocation, recommitment, or discharge.

[b]These abrupt increases in intake were due to a special effort in February and March 1978 to review ward files to identify those drug abusers on parole who had been missed during the latter months of the CCDP program.

It is apparent from the data that the decline in numbers of identified drug abusers on parole had started some time before the advent of DASP, which was just getting into full swing at the bottom of that decline on October 1977.

The situation facing DASP, then, at its start was: 1) a much lower-than-anticipated population of drug abusers on parole with whom to work, 2) a barely functioning identification system, 3) no specialized field staff, and 4) no consistently defined system for delivering drug abuse services to wards on parole. It is within this context that DASP's first year must be evaluated.

EVALUATION OF PROGRAM OBJECTIVES

The remainder of this report examines the extent to which each of the four major objectives of the program were met and analyzes the data to seek answers to several questions concerning the procedures through which wards become involved with community programs.

Objective 1: Maintain the current level of community treatment services for identified drug abusing parolees.

With only half of the estimated number of identified drug abusers on parole with whom to work and a much smaller staff and limited financial resources for purchase of services, in retrospect it would have been highly unlikely that DASP in its first year could maintain the same levels of service delivery as in previous years under CCDP.

Data on service delivery levels in previous years was available from the CCDP evaluations. These were complete for the total population only from September through January each year from 1974 through 1976.[4] These are the months during which DASP was just reorganizing, beginning to rebuild its population and developing a service delivery system. It was not until January

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[4]For the early years of CCDP program involvement data were gathered only on specific wards in special study samples. Program involvement data were gathered more generally starting in September 1974, but only through the following January in anticipation of the termination of the program, leaving time for analysis and report writing. In 1975 and 1976 data were gathered only during the same intervals for the same reasons and because meaningful comparisons could only be made between the same months each successive year.

that every parole office had become fully involved with the new program.

What can be compared between these periods is both the number of drug abusers who became involved with a community resource during each period and the total number of such involvements--any one ward may have had several such involvements. To be counted as an "involvement" a ward must have remained in a residential program at least two weeks or have attended an outpatient clinic or "drop-in" center (including methadone maintenance clinics and vocational training programs) at least four times within a four-week period. Testing must have been on a regularly scheduled basis of at least four times a month to be included. Any complete detoxification service was counted regardless of duration.

Table 7 shows the total number of wards who became involved with community drug programs during each period and what proportion they were of the total of identified drug abusers on parole during that period.

TABLE 7

WARDS RECEIVING DASP SERVICES DURING FOUR COMPARISON PERIODS

	Comparison Periods			
	9/1/74-1/31/75	9/1/75-1/31/76	9/1/76-1/31/77	9/1/77-1/31/78
Total wards served	209	342	213	134
Total identified drug abusers on parole	2,530	2,271	1,761	1,226
Percent of drug abusers on parole served	8.3%	15.1%	12.1%	13.1%

The number of identified drug abusers on parole during the 1977-78 period,

under DASP, was less than half the number for the 1974-75 period, yet nearly two-thirds as many wards became program involved. In comparison with the 1975-76 period, the high point of service delivery activity under CCDP, the proportion of identified drug abusers involved with community programs in the 1977-78 period was only slightly lower, 13.1% compared to 15.1%. It would appear, then, that considering the severely reduced population of identified drug abusers on parole, the level of service delivery under DASP was at least proportionately on a par with previous years, even though in actual numbers fewer wards were served.

Table 8 shows the number of involvements by type of service for each of the four study periods. A number of points are shown in Table 8. First, it is clear that the largest number of drug service involvements was in 1975-76. Yet, that is the very period, as has been described, of declining staff services and program effectiveness. It seems likely that this high point in service delivery is a consequence of the momentum of the previous three years of growth of the CCDP. Some indication of the nature of that growth is shown in that in both the 1975-76 and the 1976-77 periods, although the total number of wards served was greater than in 1974-75, the proportion of involvements in residential treatment and counseling declined, while urinalysis more than doubled.

If one restricts "treatment" to residential, counseling and chemotherapy services, then the levels of these treatment service involvements dropped over the first three periods from 74.0% of the total to 47.7% of the total treatment service involvements in the 1976-77 period. It is interesting to speculate that the decrease in involvements is in some way associated with the declining effectiveness of CCDP during that period, but the data are not sufficient to

support that hypothesis. More likely, as the CCDP began to slow down, parole staff found it more convenient, in the absence of drug specialists, to administer those types of services, such as urinalysis, vocational training, and transitional services which were not in the main line of direct drug treatment, but with which they were more familiar.

TABLE 8

WARD PROGRAM INVOLVEMENTS BY TYPE OF SERVICE DURING FOUR COMPARISON PERIODS

	Comparison Periods							
	9/1/74-1/31/75		9/1/75-1/31/76		9/1/76-1/31/77		9/1/77-1/31/78	
Type of Service	No.	%	No.	%	No.	%	No.	%
Total Involvements	322	100.0	520	100.0	333	100.0	161	100.0
Detoxification	12	3.7	21	4.0	4	1.2	6	3.7
Chemotherapy	9	2.8	15	2.9	10	3.0	6	3.7
Residential Treatment	82	25.5	108	20.8	51	15.3	56	34.8
Religious Programs	11	3.4	6	1.2	5	1.5	2	1.2
Psychotherapy	25	7.8	30	5.8	8	2.4	6	3.8
Counseling	111	34.5	158	30.4	85	25.5	48	29.8
Vocational Training	14	4.3	20	3.8	20	6.0	14	8.7
Urinalysis	53	16.5	145	27.9	135	40.5	23	14.3
Transitional Services	5	1.6	17	3.3	15	4.5	0	0.0

Interestingly, the pattern of service delivery in the 1977-78 period, under DASP, again emphasizes residential and various counseling services, with the percentage of total services for those types of treatment plus chemotherapy, once more reaching the 73.3% level.

Objective 2: Determine if length of stay and type of service in a community treatment program correlates with decreases in violation status and recidivism of parolees receiving community-based services.

It was originally planned that the selection of a sample cohort of drug abusers released to parole during the period May through August 1977, and followed for six months, would provide approximate information on this objective. A total of 172 identified drug abusers were released during that period. Wards who were placed out-of-state or who were otherwise potentially unable to complete at least three months of active parole (died within three months of release, missing, and AWOL more than three months, etc.) were removed from the sample cohort, leaving 138 wards in the sample. Of these, 29, or 21.0% of the sample, became involved with a community program. The summary outcome statistics for these sample wards are shown in Table 9.

TABLE 9

PAROLE OUTCOME AT SIX MONTHS FOR DRUG ABUSE SERVICES PROGRAM SAMPLE, PROGRAM-INVOLVED AND NOT INVOLVED WARDS

	Total		Success		Failure[a]	
Program Involvement	Number	Percent	Number	Percent	Number	Percent
TOTAL	138	100.0	122	88.4	16	11.6
Program-Involved Wards	29	100.0	28	96.6	1	3.4
Not Involved Wards	109	100.0	94	86.2	15	13.8

[a]Failure is defined as removal from parole by revocation, recommitment, or discharge while on violation status or as a result of a new offense committed within six months of release to parole.

Due to the small numbers, the difference in failure rate between the involved and the non-involved wards is not statistically significant. The data do, however, continue to reflect trends found during the first 30 months of CCDP, as was shown in Table 2 (page 5)--wards who became involved with community

programs failed at much lower rates than wards who did not become involved.

Other indices of parole adjustment were applied in an attempt to differentiate between the program-involved and non-involved wards in the sample. These included violation data, parole agents' judgments of the wards' behavior on parole, job status, drug use, and social stability as evidenced by living arrangements and peer group involvement. The data are shown in Table 10.

TABLE 10

PAROLE ADJUSTMENT AT SIX MONTHS FOR DASP SAMPLE, BY PROGRAM INVOLVEMENT

	Parole Program Involvement					
	Total		Involved		Not Involved	
Parole Adjustment	No.	%	No.	%	No.	%
TOTAL	138	100.0	29	100.0	109	100.0
Violations						
None	92	66.7	21	72.4	71	65.1
One or more	46	33.3	8	27.6	38	34.9
Local Custody						
None	111	80.4	25	86.2	86	78.9
Some	26	19.6	4	13.8	22	21.1
Employment Status						
Full-time	52	37.7	14	48.3	38	34.9
Intermittent/none	86	62.3	15	51.7	71	65.1
Current Drug Usage						
None/light/unknown	120	87.0	28	96.6	77	70.6
Heavy	18	13.0	1	3.4	32	29.4
Peer Associations						
Non-/moderate delinquency	94	68.1	24	82.8	70	64.2
Highly delinquent	44	31.9	5	17.2	39	35.8
Parole Agent's Evaluation of Parole Adjustment						
Adequate	83	52.9	20	69.0	53	48.6
Poor	65	47.1	9	31.0	56	51.4

For only one of the above indicators of parole outcome, the parole agent's evaluation, do the differences between the involved and non-involved wards achieve statistical significance at the .05 level. Two, however, are within the 10.0% range: Current Drug Usage and Peer Associations. All three items are parole agentjudgments and probably reflect his or her feelings concerning the ward. If he has had problems with the ward and has had to revoke or discharge him, then it would seem likely that he would react with negative assessments on these items. Nevertheless, across all indicators the program-involved wards consistently show more positive parole adjustment than do the non-involved wards.

It had been hoped that the data would provide some information on the differential effectiveness of involvement with different types of programs or for varying length of program involvement. Since only one ward among the program-involved wards "failed" parole within the follow-up period, however, and he was only involved in urinalysis, one can only say that for the remaining 28 wards, the different types of programs appeared to be equally effective.

The types of programs utilized by the 29 program-involved wards in the sample are shown in Table 11. Of the program-involved wards in the sample, 25 became involved within their first four months on parole. Twelve wards were still involved with their programs at the end of the six-month follow-up period. Three of the sample wards were involved with two programs during the period, and one of them with three programs. For all program involvements, by definition, the minimum allowable length of involvement was two weeks and the follow-up period was 26 weeks. Mean length of involvement was 9.6 weeks.

TABLE 11

TYPES OF PROGRAMS UTILIZED BY DASP
SAMPLE WARDS DURING THEIR FIRST SIX MONTHS ON PAROLE

Program Type	Number	Percent
TOTAL	29	100.0
Chemotherapy	2	6.9
Group Counseling	1	3.4
Individual Counseling	4	13.8
Residential Treatment	16	55.2
Urinalysis	6	20.7

In general, the data simply do not allow any definitive declaration relative to Objective 2. Continued follow-up at one year or 18 months may allow some distinctive patterns to emerge from the data, but for the small sample available for use here and with a follow-up period of only six months any differences are still too nebulous.

Ojective 3: Increase the Department's knowledge of which type of community-based treatment program is most cost effective in reducing the number of wards in violation status.

The original intention had been to apply cost figures to the findings from the sample of Objective 2 and develop comparative cost-effectiveness ratios from them. However, with no way of determining relative effectiveness between different types of treatment, no real cost-effectiveness analysis can be conducted.

A review of the available information relative to costs, however, might be useful in providing a general overview. The original project budget allowed $230,000 for purchase of services during the 1977-78 fiscal year. By the end of January 1978, $41,531.01 had been expended. These expenditures had been made in the various categories as shown in Table 12.

TABLE 12

CUMULATIVE GRANT EXPENDITURES FOR DASP SERVICES,
BY TYPE OF SERVICE, JULY 1977 THROUGH JANUARY 1978

Type of Service[a]	Cumulative Expenditure	Percent of Total Expenditure
TOTAL	$41,531.01	100.0
Medical Care	3,270.05	7.9
Counseling/Classification	18,720.18	45.1
Residential Placement	15,362.05	37.0
Vocational Education	164.36	0.4
Transitional Services	4,014.37	9.7

[a]For fiscal purposes different service categories are used than for service involvement monitoring. "Medical care", for instance, includes both chemotherapy and psychiatric services.

The above funds provided for 77 program involvements out of a total of 176 involvements during the period. The balance of the involvements were funded through Youth Authority general funds, directly through SONDA, or through individual county agencies, or were otherwise not charged against the project's budget. (See Appendix B for listing of programs.) Seventy-two wards were the recipients of the grant-funded services; 73 other wards received services funded from other sources.

At this point, the problem arises of attempting to place some cost estimate on the non-grant funded services. Since financial data are not available, a best estimate would simply be to double the expenditures in Table 12 under the assumption that for nearly the same number of wards during the same time period the general costs should be about equal for both groups. Using this assumption, it would be estimated that about $83,000 was expended for program services for some 145 program-involved wards during the first seven months of DASP. That averages some $572 per ward.[5]

[5]These expenditure estimates consider only direct service costs and do not include the costs of program administration, research, or administrative overhead.

Following program involvement, the 145 program-involved wards showed a failure rate of 3.4% after six months on parole, while 311 non-involved wards showed a failure rate of 10.3% during the same period as shown in Table 13.

TABLE 13

PAROLE OUTCOME AT SIX MONTHS FOR TOTAL DASP POPULATION[a], BY PROGRAM INVOLVEMENT

	Parole Outcome					
	Total		Success		Failure	
Program Involvement	No.	%	No.	%	No.	%
TOTAL	456	100.0	419	91.9	37	8.1
Program Involved	145	100.0	140	96.5	5	3.4
Not Involved	311	100.0	279	89.7	32	10.3

(Chi-square=9.51, $p<.01$)

[a]Includes all wards released to parole 1/1/77 through 10/31/77, and any pre-1977 parole releases who received program services under DASP in 1977.

If we assume that program involvement had something to do with the difference in failure rates between the two groups, then we would have to expect that 10.3% of the 145 program-involved wards would likely have failed if programs had not been available, that is, 15 wards. Since only five actually failed, it could be argued that the availability of program services helped retain some 10 wards on parole. Mean time on parole following the initiation of program involvement was nearly four months. Within the period, roughly 40 ward/months were "gained" by not having to return those wards to any institution. Institutionalization costs are presently estimated at $1,500 per month.[6] Using a figure

[6]Derived from institutional costs in the Governor's 1978-79 budget.

of $1,500 x 40, an estimated savings of $60,000 was realized at a cost of $83,000.

The problem with this estimate is that not only does it not take into account a number of other real and intangible costs but also it looks only at the short-time effects. What needs to be examined is the outcome over longer periods of time. Expenditures in the present do not only have benefits in the present but also, it is hoped, in the future.

Using the above estimates and projecting for a 12-month follow-up, one might expect failure rates of 6.8% for the program-involved wards and 20.6% for the non-involved wards. At that point one could expect 30 of the involved wards to have failed if they had no program involvement while only 10 would have actually done so, for a retention of 20 wards at an average stay on parole of 11 months following program involvement. This would be a "gain" of 220 ward/months. Applying the institutional cost estimate to that, the saving would be $330,000. This would be without necessarily increasing drug abuse service expenditures for that group.

One could take another approach and ask how many ward/months would need to be "saved" in order to break even. That is, $83,000 divided by $1,500 equals 55.3 ward/months. That is only 15.3 ward/months more than the 40 already served. Thus, of the initial 10 "saves" in the short term follow-up, if as few as five wards can be maintained on parole for an additional three months following initial involvement, then a positive cost/benefit could be claimed. This would allow a 66% failure rate within the initial group of 15 wards within eight months, a much higher rate than is ordinarily experienced with Youth Authority wards.

The above is, of course, highly speculative. More precise values and probabilities need to be determined. The underlying assumptions need testing: Can the differences in failure rates realistically be attributed to program involvement? Or is there a self-selection factor in operation in which the type of ward more likely to stay out on parole is also the one more likely to take advantage of community services? The data do not allow any test of that question. If, however, the assumption is sustained and the differences in failure rate remain consistent with successive samples or cohorts, then it would seem likely that the funds expended for community treatment services for drug-abusing wards is money well spent as long as the cost levels remain within reasonable range of the anticipated ward/month savings.

Objective 4: Increase by 15% the use of existing approved community drug treatment resources by the end of the project year.

Youth Authority wards became involved with 101 different community programs during the seven-month period from July 1, 1977, through January 31, 1978 (see Appendix B). Twenty-eight of these programs were on the approved list of the Department of Health's Substance Abuse Division. Services were delivered to 38 different wards by the 28 programs. To meet the requirements of Objective 4, no more than 33 wards would have been involved with such approved programs during a previous comparison period.

The data for the previous periods do not allow the differentiation of approved programs from other programs of the same type. Essentially, however, the approved projects are those featuring methadone maintenance, residential treatment, and counseling (but not involving religious or psychotherapy programs). Referring to Table 8 (page 20), the totals for those types of program involvements can be extracted for each period, as shown in Table 14.

TABLE 14

WARD PROGRAM INVOLVEMENTS BY TYPE OF SERVICE
DURING FOUR COMPARISON PERIODS
(SPECIFIC DRUG TREATMENT ONLY)

Type of Service	Comparison Periods			
	9/1/74-1/31/75	9/1/75-1/31/76	9/1/76-1/31/77	9/1/77-1/31/78
Total Involvements.....	202	281	146	110
Methadone Maintenance	9	15	10	6
Residential Treatment	82	108	51	56
Counseling	111	158	85	48

It would be difficult to believe that from the total involvements in each of the first two periods that at least 34 of those involvements were not with approved programs. They would constitute 16.8% of the involvements in the first period and 12.1% in the second period. For the third period the 34 approved program involvements take a larger slice of the total involvements--23.3%. For DASP, the actual approved program involvements are 33.6% of the total program involvements in the three categories.

If either of the first two periods are taken as the base period for comparison, then it seems fairly certain that DASP did not increase by 15% the use of approved programs. If the final period (September 1976-January 1977) is used as the base, then there is a slim possibility of increased usage of approved programs. Unfortunately, the data do not allow any more concise analysis.

MOTIVATION FOR PROGRAM INVOLVEMENT

During the course of the CCDP, several questions had arisen concerning the efficacy of different methods of approach in motivating wards to become involved with community programs. DASP was seen as a way of examining these approaches in greater detail; so several questions were incorporated into the basic data-gathering instruments in order to explore those areas. The data and comments are shown below.

Institutional Program Involvement and Subsequent Parole Program Involvement

During CCDP and DASP, it was felt that drug-abusing wards could best be helped and motivated to become involved with community programs if they were made aware of those programs or were brought into contact with them prior to release to parole. It was also felt by some that wards who were exposed to drug counseling while in an institution would be more motivated to involvement with a drug program following release. This was generally managed in two ways: 1) two institutions established their own living unit programs which provided treatment and counseling services to wards in those units, and 2) most institutions had contracts with community agencies to come into the institution and counsel wards on a regular periodic basis. For the wards in the May-August 1977 sample of parole releases, their involvement within either type of drug program in institutions prior to release was recorded and compared with their subsequent involvement with drug programs while on parole. The data are shown in Table 15.

TABLE 15

INSTITUTIONAL DRUG PROGRAM INVOLVEMENT BY SUBSEQUENT PAROLE DRUG PROGRAM INVOLVEMENT FOR WARDS RELEASED TO PAROLE, MAY THROUGH AUGUST 1977

	Parole Program Involvement					
	Total		Involved		Not Involved	
Institutional Program Involvement	No.	%	No.	%	No.	%
TOTAL	138	100.0	29	21.0	109	79.0
Y.A. Living Unit Programs	31	100.0	9	29.0	2	71.0
Community Counseling	28	100.0	7	25.0	21	75.0
No Involvement	79	100.0	13	16.5	66	83.5

(Chi-square was not significant)

Although it does appear from the table that wards who were involved with a drug program while in an institution were more likely to become involved with a drug program when released to parole, the lack of statistical significance does not permit generalization of that notion. We cannot definitely state that there is any causal relationship between the two types of program involvement.

Parole Release Recommendations and Subsequent Parole Program Involvement

For about a third of the drug abusers released to parole some recommendation concerning subsequent drug treatment placement is made, usually in the Board Order, the Placement Report, or the Pre-Release Referral Report. Often the recommendation in one or the other of the latter two reports is incorporated in the Board Order. These may make a very specific recommendation or order such as: "The ward is to be released to Impact House in Pasadena and he is not to leave there without the parole agent's authorization." Or the recommendation/order might be quite general, such as: "The ward is to become involved in drug

counseling per his parole agent's instructions." A question was raised concerning the usefulness of such recommendations and the extent to which they were followed.

Table 16 shows subsequent parole program involvement within three months from release to parole for wards in the May-August sample for whom drug program recommendations were made and those with no drug program recommendation at release.

TABLE 16

DRUG PROGRAM RECOMMENDATION AT RELEASE TO PAROLE AND SUBSEQUENT DRUG PROGRAM INVOLVEMENT FOR WARDS IN THE MAY-AUGUST 1977 RELEASE COHORT

	Parole Program Involvement					
	Total		Involved		Not Involved	
Parole Program Recommendation	No.	%	No.	%	No.	%
TOTAL	135[a]	100.0	24	100.0	111	100.0
Recommendation	56	41.5	19	79.2	37	33.3
No Recommendation	79	58.5	5	20.8	74	66.7

[a]Data were missing for three wards. (Chi-square=16.9<.001)

It would seem that the presence of a documented recommendation for treatment services at the time of release to parole had a stimulating effect on wards' actually becoming involved with community drug treatment services. One explanation was, however, that where the Board has ordered a ward into a specific program the parole agent could hardly ignore it, but that where it was left to the parole agent's discretion with simply a general recommendation the ward was less likely to get involved. This argument is tested in Table 17.

TABLE 17

SPECIFIC VERSUS GENERAL RECOMMENDATIONS, BY SUBSEQUENT PAROLE PROGRAM INVOLVEMENT

Type of Parole Program Recommendation	Parole Program Involvement					
	Total		Involved		Not Involved	
	No.	%	No.	%	No.	%
TOTAL	56	100.0	19	33.9	37	66.1
Specific Program Recommendation	32	100.0	13	40.6	19	59.4
General Program Recommendation	24	100.0	6	25.0	18	75.0

(Chi-square was not significant)

Although a larger proportion of the specific program recommendations was likely to be followed, the difference is not statistically significant. Thus, any generalization that a specific recommendation generates a more positive response than a general recommendation is not warranted from the data. It would seem probable that simply the inclusion of a recommendation serves to bring to the parole agent's attention a need which would otherwise not be noticed until the ward started to act out on parole. It appears that the more specific the content or the recommendation, the more likely the parole agent is guided by it.

An additional possibility is that such recommendations are made as a result of the institutional caseworker or the parole agent having discussed possible program involvement with the ward prior to release and that such wards are therefore more motivated to initiate and maintain involvement as a result.

CONCLUSION

The conditions faced by the Drug Abuse Services Program at its beginning were in a greater state of disorganization than had been anticipated. The termination of the previous CCDP had disrupted most of the identification and service delivery system. As a consequence only half the anticipated number of identified drug abusers were available on parole and only limited services were being made available to them. In this context it would not be reasonable to expect that DASP could recover and maintain the same numerical levels of service delivery as in previous years. However, by April 1978, it did appear that it had managed to approximate the proportionate levels of previous years. That is, the percentage of involvements relative to the number of identified drug abusers available on parole was similar to the previous comparison periods.

The low level of parole failure at six months for the May-August cohort who became program involved did not allow comparisons of effectiveness between different types of programs or varying lengths of stay in programs. In looking at other indicators of parole adjustment, only the parole agent's judgements were statistically significant and that could easily have been due to judgmental bias.

For the reasons cited above, no cost benefit differentials could be determined between different types of community programs. However, the data did suggest that, overall, if the differences in failure rate at six months indicated

a true difference in parole adjustment between involved and non-involved wards, the program as a whole was cost-effective relative to the alternative of reincarceration.

Due largely to the low number of drug abusers on parole during the first seven months of DASP, the program was not able to attain a 15% increase in the use of approved community drug treatment resources in comparison with previous years.

No strong indication was forthcoming that ward involvement in institutional drug programs was more likely to lead a ward to become involved in community drug programs following release to parole. Even though wards in both living unit programs and community counseling programs in institutions showed higher rates of parole program involvement than did wards with no institutional drug program involvement, the difference was not statistically significant.

It would appear, however, that where a recommendation for program service was incorporated in the Board Order or Placement Plans for a ward at the time of his release to parole he was much more likely to become involved with a community program following release than if no such recommendation was present. The recommendation seemed somewhat more effective if it was specific rather than general in nature.

All in all, it would appear that DASP, during its first year of operation, has made considerable progress in reactiviating both the identification and the service delivery systems which had slowed down during the last year of CCDP. Follow-up time at this report is still too short to look for differential effectiveness between different types of service deliveries. Perhaps this can be considered at some point in the future when the wards in the sample cohort will have had greater time since release to parole.

In the longer view, looking at the accumulated experience of the Youth Authority in providing drug treatment services to its wards during the past six years--under both CCDP and DASP, several quite important points are beginning to emerge which can be expected to have implications on future drug programming activity. These are:

1. The concept of contracting with community drug treatment agencies to provide services for Youth Authority wards has proven eminently practical and successful. The data presented herein on DASP support this. For the first six CCDP cohorts and for the DASP sample, drug abusers who became involved with community drug programs show significantly better adjustment on parole than do those who were not involved. Why that is so cannot be determined from the available evidence. Only a rigorous experimental comparison under controlled conditions could provide that answer. Nevertheless, it seems clear that the fact of having community services available for utilization results in lower failure rates and greater mean months on parole for those who take advantage of them.

2. The extent to which the above holds true seems conditioned by at least two factors:

   a. <u>The nature of the programs utilized</u>. The decline in program effectiveness during the latter years of CCDP was accompanied by decreasing use of direct drug related services: chemotherapy, residential treatment, psychotherapy and drug counseling, and increased use of urinalysis detection, vocational training and cultural/recreational activities. Under DASP, direct drug services were once more emphasized and the effectiveness levels once more increased.

b. The nature of the wards available for treatment. Under CCDP it was demonstrated that program effectiveness was maximized within a subgroup of drug abusers defined as older, "hard-core" users with longer delinquent histories. As greater numbers of younger less delinquent, marijuana and alcohol users were introduced into the population, overall effectiveness declined. With DASP the target population was again the older, hard-core user, and effectiveness increased.

The exact interaction and relative strengths of these two factors on program effectiveness cannot be determined from the available data, but that they do have an important influence on program effectiveness seems well supported by the data.

3. When the programs do show significant impact on the parole performance of program-involved wards, they are highly cost-effective in terms of the actual purchase of services expenditures. Variation in overall cost-effectiveness ratios

administrative cost. CCDP's lack of cost effectiveness was related in large part to its administrative costs far exceeding the benefits realized from its operations. In CCDP's second year, for instance, funds for direct services to wards accounted for only 25% of the total budget; personnel costs accounted for nearly 60%. Under DASP nearly 70% of the budgeted funds were for ward services while less than 20% were for personnel services. It would seem likely that an important task in the future will be to determine the optimum effectiveness ratio between administrative and ward service expenditures.

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E R R A T A

Page 37: Final paragraph, second sentence should read:

Variation in overall cost-effectiveness ratios depends to a great extent on the size of administrative costs.

State of California
DEPARTMENT OF THE YOUTH AUTHORITY

SUBSTANCE ABUSE REFERRAL

YA 3.302 (3/1/78)

APPENDIX A

I. INFORMATION

Wards Name	YA Number	Age	Sex (Circle One) Female Male
Name of Interviewer	Location		Date (Month - Year)

II. SUBSTANCE ABUSE INDEX

A. PRIMARY DRUG INFORMATION	CHECK ONE	SCORE
1. Primary Drug of Abuse	___ Opiates (12) ___ Depressants or PCP (8) ___ Alcohol (8) ___ Stimulants (6) ___ Hallucinogens (4) ___ Marijuana (2)	___
2. Method of Use	___ Injection (6) ___ Oral/Nasal (4) ___ Inhale/Smoke (2)	___
3. Typical Effect, Primary Drug	___ Coma (10) ___ Amnesia (8) ___ Intense Euphoria (6) ___ Intoxication (4) ___ Slight High (2)	___
B. TOTAL DRUG HISTORY INFORMATION		
1. Other Drugs of Abuse	___ Opiates (6) ___ Depressants or PCP (4) ___ Alcohol (4) ___ Stimulants (3) ___ Hallucinogens (2) ___ Marijuana (1)	___
2. Frequency of Use, Drugs: Days Per Week	___ Seven (8) ___ Five-Six (6) ___ Three-Four (4) ___ One-Two (2)	___
3. Duration of Drug Involvement	___ 4+ Years (10) ___ 2-4 Years (8) ___ 1-2 Years (6) ___ 6-12 Months (4) ___ 0-6 Months (2)	___
4. Reason for Using Drugs	___ Maintenance (8) ___ Relieve Anxiety (6) ___ Social Facilitation (4) ___ Peer Group Pressure (2) ___ Experimental/Other (1)	___
5. Abstinence, Effect, Drugs	___ Withdrawal, DTs (8) ___ Severe Anxiety/Depression (6) ___ Confusion/Disoriented (4) ___ Jittery/Mild Hangover/Dizzy	___

If the score is 32 or greater, ward should be identified; 31 or less, ward should not be identified unless for casework reasons, as indicated in the Instruction Manual.

TOTAL SUBSTANCE ABUSE SCORE ___

APPENDIX B

COMMUNITY PROGRAMS UTILIZED BY DASP WARDS

Name	Type of Service	Location
Ray Huffaker	Counseling	Sacramento
Anaclin Laboratories Reference Laboratories Pharm - Chem Laboratories	Urinalysis Testing	Statewide
West Covina Community Health Clinic	Methadone Maintenance	Los Angeles
Sons of Watts	Counseling	Los Angeles
Gesner L. Martin	Foster Home/Counseling	Los Angeles
Impact House	Residential Treatment	Los Angeles
Pat Weaver	Counseling	San Diego
Dr. Robert Keim	Psychiatry	Sacramento
Jefferson-Grand Medical Group	Detoxification	Los Angeles
West Los Angeles Drug Treatment Program	Methadone Maintenance	Los Angeles
Casa Blanca Community Treatment Center	Counseling	Los Angeles
Michael Mauer	Counseling	Alameda
Narconon	Residential Treatment	Alameda
Straight Ahead	Residential Treatment	Orange
Dr. Charles Head	Counseling	Orange
Athena House	Residential Treatment	Alameda
Seventh Step	Counseling	Sacramento
Lorraine Ellinger	Group Home/Counseling	Orange
Dr. Ken Johnson	Psychiatry	Sacramento
Sacramento Peer Counseling	Counseling	Sacramento
Retract Center	Residential Treatment	Riverside
Professional Human Services	Detoxification	San Diego

APPENDIX B (Con't)

Name	Type of Service	Location
Narconon	Detoxification	
Hope Mental Health Clinic	Counseling	Los Angeles
Central City Bricks	Counseling	Los Angeles
Pathways	Counseling	Santa Clara
Stockton Half-way House	Residential Treatment	San Joaquin
Center House	Residential Treatment	Sacramento
LaVey's Group	Counseling	Santa Clara
Allied Welding School	Job Training	San Joaquin
Seventh Step Group Home	Residential Treatment	Sacramento
John Adams	Counseling	San Joaquin
Woodruff Group Home	Residential Treatment	Los Angeles
Lawrence Jackson Group Home	Residential Treatment	Los Angeles
ITSP Group Home	Residential Treatment	San Joaquin
Park Centre	Residential Treatment	San Diego
SPACE	Residential Treatment	Los Angeles
Soccoro Group Home	Residential Treatment	Los Angeles
Harper House	Residential Treatment	Alameda
Heuropsychiatric Institute--Aptos	Residential Treatment	Santa Cruz
Jeff Barker Group Home	Residential Treatment	San Jose
Seventh Step Group Home	Residential Treatment	Alameda
WERC Project	Residential Treatment	San Diego
Dr. Keith	Psychiatry	San Diego
Gloria Longiden	Counseling	San Diego
California Rehabilitation Center	Residential Treatment	San Bernardino

APPENDIX B (Con't)

Name	Type of Service	Location
John Handy Group Home	Residential Treatment	Los Angeles
New Hope Saloon	Counseling	Alameda
Dean House	Psychiatric Residence	Alameda
Project Eden	Residential Treatment	Alameda
Jock Rosberg Foster Home	Residential Treatment	Los Angeles
Freedom House	Residential Treatment	Santa Cruz
Strickland Home	Residential Treatment	Santa Cruz
Thornton Group Home	Residential Treatment	Los Angeles
Hill House	Residential Treatment	Kern
Midway Center	Residential Treatment	Los Angeles
Educational Cultural Complex	Counseling	San Diego
Annadale Welding School	Job Training	Tulare
Prison Ministries	Residential Treatment	Sacramento
Narcotics Prevention Program	Counseling	Los Angeles
Project Total Push	Residential Treatment	Los Angeles
Fremont Adult School	Job Training	Los Angeles
Narcotic Education League	Residential Treatment	Alameda
M^2 Sponsors	Job Training	Sacramento
Community Youth Program	Job Training	Sacramento
SAEOC	Job Training	Sacramento
SYEDA	Job Training	Sacramento
Police Athletic League	Recreation	Sacramento
Alcoholics Anonymous	Counseling	Statewide
Volunteers in Parole	Counseling	Statewide
WIN	Job Training	Sacramento

APPENDIX B (Con't)

Name	Type of Service	Location
ALPHA Program	Counseling	Sacramento
Conception	Counseling	Sacramento
Sacramento Women's Center	Counseling	Sacramento
Project DARE	Counseling	Santa Clara
Catholic Community Services	Counseling	Imperial
Metropolitan State Hospital Drug Program	Residential Treatment	Los Angeles
COTA	Counseling	Santa Barbara
North Valley Occupational Center	Job Training	Los Angeles
Drug Alternative Counseling	Counseling	Sacramento
West Oakland Methadone Maintenance Clinic	Methadone Maintenance	Alameda
Yolo Co. Manpower	Job Training	Yolo
Alcohol Rehabilitation Center	Counseling	Los Angeles
Los Angeles Co. Drug Diversion	Counseling	Los Angeles
Orange Co. Mental Health Clinic	Counseling	Orange
Santa Clara Co. Alcohol Program	Counseling	Santa Clara
Yolo Co. Mental Health Clinic	Counseling	Yolo
Riverside Co. Mental Health Clinic	Counseling	Riverside
Kern Co. Drug Diversion Project	Counseling	Kern
Tulare Co. Mental Health Clinic	Counseling	Tulare
Desert Drug Treatment Clinic	Counseling	Riverside
Sacramento Co. Mental Health Clinic	Methadone Maintenance	Sacramento
Sacramento Co. Mental Health Clinic	Counseling	Sacramento

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