Process Evaluation of a Residential Substance Abuse Treatment Program for State Prisoners

The W.J. Maxey Boys Training School

February 21, 2000

Summary Report
by

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This report summarizes the findings from the evaluation of a Residential Substance Abuse Treatment (RSAT) Program intended to reduce substance abuse and recidivism among youth placed at Maxey Boys Training School. The purposes of the evaluation were to describe the activities of the RSAT Program and the relationship between program participants and success in the new program. There are five primary evaluation questions: 1) Are the participants appropriate? 2) Is the staff trained to deliver the planned services? 3) How does service delivery vary over time? 4) Do the participants make timely progress? 5) What organizational factors change service delivery and participant progress?

Information on service delivery, treatment services, program progress, RSAT staff, and staff training were collected. In addition, information from youth in the RSAT and comparison groups was collected through surveys, focus groups, and observation. Residents were admitted to the RSAT Program and its comparison group on the basis of three criteria: 1) the resident was not a sex-offender; 2) he had a known substance abuse history; and 3) he was expected to be released within one year. Youth in the RSAT program underwent intensive substance abuse psycho-education and relapse prevention in addition to the treatment provided in the Maxey Model.

Maxey implemented two RSAT programs: one on Sequoyah E (SEQ E) which houses medium security residents with substance abuse problems and the other on Green Oak Center (GOC G) which houses high security residents. The comparison group included youth housed in different wings of Sequoyah and Green Oak Center. Intake data from the Family Independence Agency Information System was used to determine if significant differences existed between the RSAT and comparison groups. Statistical analysis revealed no significant differences in race, county of residence, committing offense type, marital status of parent at time of placement, number of truancies, number of previous placements, and number of arrests for the two groups. The evaluation team also compared the two RSAT locations to determine if differences in the location and security status of the two programs were important. GOC was found to have a significantly larger proportion of youth with a class one committing offense, unmarried parent, and more than three previous placements. GOC youth were also significantly more likely to be

African American or Latino and residents of Wayne County. The evaluation team found no significant differences between the RSAT and comparison group within each center.

Three sources of data (Maxey Treatment Activity Monitoring Forms, RSAT substance abuse counselors' monthly time sheets, and observations of group sessions and daily interactions) were analyzed to provide information regarding the diversity, quality, and quantity of services provided in the RSAT and comparison groups as well as between Sequoyah and Green Oak Centers. Two types of group counseling services were analyzed. The first, general Maxey Model treatment services, include group, individual, and family sessions that are facilitated by a group leader/social worker. RSAT program treatment services, the second, include all groups, individual, and family sessions that are facilitated by the substance abuse consultants in addition to the services provided in the Maxey Model.

Ninety-minute groups meetings, which are scheduled to occur four times per week, are the fundamental component to the general Maxey Model Treatment Services. Family and individual sessions, although not required, supplement this work. None of the wings involved in this evaluation met expectations for the number of weekly group sessions. The low number of group sessions indicates a need for enforcement of already established procedures. Family and individual sessions were also low; however, family sessions rely on family commitment to a youth's treatment and individual sessions are conducted by the youth's advocate and are not required to be documented. No significant differences in the number of group sessions were found between the RSAT and comparison groups. However, there was a statistically significant difference in the number of individual sessions conducted within each center. Sequoyah residents (both RSAT and comparison) had more individual sessions than GOC, 7.06 and 2.1 average sessions per week respectively. This is due largely to the fact that the GOC psychologist and psychiatrist are the main facilitator of individual counseling whereas youth advocates are more likely to direct individual counseling sessions in Sequoyah.

Compilation of the service delivery data revealed problems in records collection and great variability in the wings, indicating a need for greater reporting accountability. For many weeks

throughout the year, the number of sessions was not reported. This varied greatly based on the wing.

In addition to the services provided in the general Maxey Treatment Services, three substance abuse consultants provided additional individual, family, and group sessions. While the substance abuse consultants on each wing (two in GOC G and one in SEQ E) worked independently of each other, they did share the same tools, worksheets, and resources each had developed which were later standardized for all treatment teams. The Substance Abuse Consultants were contracted to provide three group sessions per week and no standards were set for individual or family sessions. The average number of group sessions is less than the three group sessions specified in the consultants' contracts. On average, the consultants spent eight hours per week providing direct service. The amount of service provided varied considerably between the three consultants. SEQ E had more than twice as many family sessions as either of the other groups and had a higher number of group sessions. GOC group 1 had twice as many individual sessions as the other two groups. Each group session is required to be 90 minutes in duration and there were no significant differences in the session length across consultants.

Observations of group sessions revealed variation in the structure of the groups. In some groups, facilitators insured that everyone participated, set a clear group focus, balanced participant needs and provided closure. In other cases, disruptive and disrespective behavior went without consequence, monopolization of time by a few people occurred, or sessions lacked focus and closure. The evaluation team piloted an observation form that if implemented would provide evaluation criteria for group facilitators and encourage greater clinical supervision and accountability.

Focus groups were conducted in each of the four wings (RSAT and comparison), revealing problems youth had with the Maxey Model and Maxey services in general rather than the RSAT Program alone. Program participants expressed their desire for a connection to the outside community and an increase in individual and family counseling as well as a more challenging educational program. The young men, particularly those in GOC G, expressed concern about staying clean in the community and appreciated the attention to substance abuse treatment in the

RSAT program. RSAT participants also expressed some frustration over their progress in the program. This related to both staff implementation of the RSAT program and the young men's perceptions of the program.

One of the most challenging problems identified by the youth was the behavioral control method of the Maxey Model and its effect on insincerity in treatment. It seems to create mistrust and power imbalances between youth and negatively affect their relationships with staff.

Sixty-five participants completed the client survey, which included questions that evaluated youth satisfaction with services, and their predictions for success once released. Youth were asked to rate different aspects of the Maxey treatment program as "excellent," "good," "okay," "not good," or "terrible". Statistical analysis revealed only one statistically significant difference between the RSAT and comparison groups. The RSAT groups rated the quality of their group sessions more highly than the comparison group. Because there were no significant differences in any of the service areas between the two locations, greater satisfaction with the group sessions is attributable to the presence of the RSAT program.

While a large majority of the young men viewed the quality of school, family sessions, and family visits quite favorably, less than half viewed Maxey overall as very positive. The findings suggest some strengths of the Maxey program and indicate that the quality of food, group sessions, and staff interactions with youth could be improved. The analysis indicates some interesting differences between the SEQ and GOC locations. Overall, SEQ residents rated the quality of the school significantly higher than the GOC residents. GOC youth do not attend the main school building that all other Maxey residents do and have more learning disabilities and educational challenges as well. Young men on the Sequoyah wings also viewed the hall staff more favorably.

Participants were also asked to rate whether they felt staff, peers, teachers, the police and the judges who sent them to Maxey treated them fairly. Overwhelmingly, the majority of youth felt that staff, peers, teachers, and judges treated them fairly while their opinion of the police is more mixed. Statistical analysis revealed a significant difference in the reporting of police treatment

with the RSAT group reporting that the police treated them fairly more often than the comparison group did. Analysis by center revealed a significant difference in the number of youth who felt that teachers treated them fairly with Sequoyah residents reporting that teachers treated them fairly most or all of the time. Interestingly, the young men reported that staff, peers, and teachers treat them fairly most or all of the time, which is a sharp contrast from data gathered from the youth in the focus groups.

There were no statistically significant differences in the frequency of several risk and protective factors between the RSAT and comparison groups. Most participants in both groups report that abuse of alcohol, drug use, drug selling and violence is frequent in their neighborhoods. The number of youth reporting these activities occurring frequently in their neighborhoods is higher than the frequency for their families, possibly because youth are less willing to reveal more negative information about their families. Youth also rated the frequency of people in the neighborhood listening to, caring about or helping them as low compared to how they rated their families. Analysis by center revealed many statistically significant differences in the frequency of risk and protective factors for the youth. GOC residents reported that someone in their family listened to them and helped them be good "a lot of the time" or "almost always" whereas SEQ residents reported someone in their family was drunk or violent "a lot of the time" or "almost always." GOC residents reported greater frequency of people in their neighborhood listening to them and caring about them. Conversely, SEQ residents reported that people in their neighborhood were drunk, using drugs and violent frequently.

It is surprising that GOC, the high security center, residents report a greater amount of family and community support and less violence and substance abuse. To further understand this relationship, residents in the drug treatment program were compared with the residents not in drug treatment. While analysis was somewhat problematic due to the small sample size, the evidence points to several things. Participants in the non-substance abuse wing report greater frequency on five questions: neighborhood listened, neighborhood cared, family listened, family cared and family helped. Surprisingly, there are no significant differences between the two groups in most areas related to substance abuse. The substance abuse treatment group only

reported greater frequency in family violence and the number of people in the neighborhood who are drunk.

Overall, the survey section indicates the need to connect the young men with positive (drug-free, crime-free, and violence-free) support systems, jobs and good schools when they re-enter the community in order to help them remain clean.

Length of time on each level of the Maxey Model and total length of time in the RSAT program are measures used to indicated timely progress through the RSAT program. The first measure of progress proved to be problematic, as Maxey does not record level promotions or demotions. Even with complete data, its meaning would have been complicated by the fact that the level systems in GOC and SEQ were structured differently and the level systems in both halls were revised during the evaluation period. However, the length of time it took young men to complete the program provided an indication of timely progress. While youth were supposed to complete the program within six to twelve months, only 38.7 percent of the young men did so. A larger number of young men, 51.6 percent, did not complete the program within twelve months in part, no doubt, because Maxey itself does not have absolute control over release dates and transition facilities are crowded. In the court proceedings, the state-appointed delinquency worker makes recommendations about release dates to the judge. However, the judge makes the final decision and is under no obligation to follow these recommendations. Further investigation into why young men did not complete the program within the prescribed time period is necessary.

Two program managers from SEQ E and GOC G were interviewed, and information was analyzed on ten staff at SEQ E and fourteen staff at GOC G, including both the substance abuse consultants and the regular Maxey staff, regarding staff experience with substance abuse treatment, the number of staff in recovery, education levels, gender and ethnicity. Most staff turnover occurred at the beginning and near the end of the first year. During the first year, three staff left GOC G and four left SEQ E.

Three Maxey staff had previous experience working in substance abuse treatment and all three substance abuse consultants had worked in the field for several years. The majority of staff in

both RSAT wings were male and white. GOC G had three Masters level staff whereas SEQ E had two staff with a Masters degree in a related filed. There was a nearly even mix of staff with Bachelors degrees, some college experience and no college training. Approximately the same number of staff were in recovery on both wings. In addition, three staff from each wing were Certified Addiction Counselors by the State Board of Addiction Professional via RSAT program training.

Given the limited knowledge of substance abuse treatment of the majority of staff, substance abuse training was essential. Program staff received over 100 hours of substance abuse and relapse prevention training in three separate weeks. Substance abuse consultants reported they provided some additional training in staff team meetings The Brighton Hospital Relapse Prevention training ran five days. The topics covered included: Gorski's Relapse Prevention Model, the Franklin Reality Model, group process intervention, 12-step milieu management, motivating adolescents to recovery, therapeutic tools and shame/grief/attitudes related to chemical dependency and criminal behavior. Overall staff rated the training positively with 86.2 percent of staff reported that the topic(s) were "very much" or "pretty much" useful to them, although the evaluation team's observation of the first week of substance abuse training were otherwise. Some observed issues were that the training did not engage staff attention, did not provide a well-organized, comprehensive foundation on substance abuse issues and substance abuse treatment, did not contain up-to-date information, and did not provide tools relevant to Maxey's specific population.

The CENAPS Corporation training on relapse prevention lasted for three days and included staff from the original RSAT groups as well as staff new to the expanding RSAT programs. The topics included: developing a relapse prevention counseling plan, abstinence and treatment contracts, relapse intervention plans, identifying and personalizing high-risk situations, therapeutic models, and managing high risk situations. Overwhelmingly, staff praised the workshop and felt their skill level improved noticeably with 100 percent of staff rating the overall effectiveness of the workshop as "very good" or "excellent."

The conclusions of this report are summarized in the context of the original research questions: 1) Are the participants appropriate? 2) Is the staff trained to deliver the planned services? 3) How does service delivery vary over time? 4) Do the participants make timely progress? 5) What organizational factors change service delivery and participant progress?

Are the participants appropriate?

There have been improvements in the process of choosing participants for the RSAT program during the evaluation period. Initially, participants entered the program after staff assessed youth from other Sequoyah and GOC wings through examination of their client files or direct knowledge of the youth. The original participants of the RSAT program had substance abuse problems and, therefore, were appropriate for the program. Over the course of the evaluation, assessment of youth for the RSAT program became more systematic. Youth placed on the new RSAT wings and new youth for the original RSAT wings completed the substance abuse assessment instrument, the PEI, prior to placement.

Is staff trained to deliver the planned services?

Initial training and planning for the RSAT program was extensive. Maxey hired substance abuse consultants with extensive knowledge of and experience in substance abuse treatment. The consultants spent considerable time developing the details of the program and support materials. Staff received over 100 hours of training within the first year and reported being satisfied with the training. This provided a sound introduction for the staff working in the RSAT at that time.

How does service delivery vary over time?

Examination of service delivery highlighted some areas of concern for Maxey as a whole and some areas specific to the RSAT program. For Maxey as a whole, reporting accountability is a serious issue. Information regarding the provision of clinical service in general was incomplete. The percentage of missing data from the Treatment Activity Monitoring Form indicates a need for greater accountability in reporting practices. Supervision of clinical services requires accurate information of what services are being delivered on each wing.

The RSAT program service delivery improved over time. By February 1998, quarterly reviews of the substance abuse consultants' case files began. Regular reviews provided needed supervision to consultants and improvements in their individual treatment planning. Clearer expectations and accountability for number of hours and frequency of direct service by substance abuse consultants must be established. The evaluation team recommends the establishment of guidelines for the number of hours and frequency of services that will increase the amount of individual and family counseling sessions as well as standardize the amount of group time. This will contribute to the consistency of service delivery to each program participant and across all wings participating in the RSAT program.

By March 1998, the separate work done by the original substance abuse treatment consultants was synthesized into a unified program. The documents were then distributed to the current RSAT and the new RSAT program wings. Ongoing supervision to ensure the consistent implementation of the program on each wing is necessary.

Agencies and individuals from the community have been included in the RSAT program. These contacts create an important link for the young men to a community of recovering individuals and agencies who can provide support for them once they are released from Maxey. The RSAT program in Sequoyah E included attendance at 12-step meetings in the community and, for a time, some community outings. This is a vital connection for the young men, and it is recommended that increasing the regular involvement of outside agencies and individuals on all RSAT wings may be beneficial. This would include inviting agencies to provide presentation, recovering speakers, more AA/NA meetings facilitated by outsiders and community outings, when appropriate.

Conversations with program participants reinforced their desire for a connection to the outside community and an increase in individual and family counseling, but brought to light some new concerns. Young men in the program expressed some frustration over their progress through the RSAT program. They felt they were repeating work they had done prior to RSAT placement. This relates both to staff implementation of the RSAT program and young men's perceptions of

the program. It will be helpful to better clarify the integration and separation of RSAT work and Maxey Model work in order to improve satisfaction with the RSAT program for the young men. Perhaps the most challenging problem that came out in conversations with the young men was the behavioral control method of the Maxey Model and its effect on insincerity in treatment. It seems to create mistrust and power imbalances between youth as well as negatively affect relationships with staff. The RSAT program might consider altering this part of their program.

Do the participants make timely progress?

Maxey experienced some difficulty with timely progress. Over half the youth did not exit the program within the stated twelve-month time frame. Maxey does not have complete control over youth release date. The court system makes the final decision for release dates. Knowing this, Maxey should investigate ways to work more closely with the court system in order to increase the number of youth who complete the program within twelve months. A greater sense of urgency in the completion of treatment tasks is necessary for the young men to feel that their time at Maxey is well-spent and will impact on their lives once they leave residential care.

During their time at Maxey, youth in the program have learned assertive communication skills. Their focus group participation demonstrated that they have useful, critical feedback for program improvement and will express this when given the opportunity. Their feedback should be incorporated into RSAT functioning to improve outcomes and satisfaction with length of time in RSAT and Maxey.

The RSAT program paid particular attention to establishing outcomes of program participation. The RSAT program now uses a pre and post-test PEI to measure the effectiveness of the RSAT program on youth. In addition, University of Michigan staff complete follow-up surveys in the community at six months and one year after release. This outcome evaluation will lead to ongoing improvements to the RSAT program.

What organizational factors change service delivery and participant progress?

Organizational changes in RSAT provided improved supervision and service delivery. Maxey staff are interested in substance abuse treatment and committed to helping the young men in the

program succeed once released. To build effectively on their motivation, team cohesion, and a unified vision of how to get the job done, clinical supervision and accountability must occur. The addition of a grant manager solved some significant RSAT supervision and accountability problems. Yet, some improvements are needed. Improved reporting accountability, additional clinical supervision and communication between all members of the team: program managers, group leaders, social workers, youth specialists, the grant manager and other clinical services, will be effective in addressing these problems.

In sum, the process of delivery of the RSAT funds and program has improved over time. Some serious issues were found in the intersection between the Maxey Model and the RSAT program. As is typical in many such facilities, the youth report some dissatisfaction. More in-depth evaluation of the agency and Maxey Model as a whole is suggested to clarify these issues. Ongoing process and outcome evaluation is strongly suggested.

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Final Report
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This implementation evaluation was guided by five questions: 1. Are participants appropriate? 2. Is the staff trained to deliver the planned services? 3. How does service delivery vary over time? 4. Do the participants make timely progress? 5. What organizational factors change service delivery and participant progress?

Description of Maxey Training School

The W.J. Maxey Boys Training School is the most secure facility in the system of private and public residences for adjudicated male delinquents in the State of Michigan. The Michigan Family Independence Agency, Office of Juvenile Justice operates the facility. It houses over 500 state wards. The average length of stay is about twenty months. Five centers comprise the facility: Huron, Sequoyah, Summit, Green Oak and Olympic. Each center has several wings typically housing approximately twenty youth. Huron Center and Green Oak Center are high security placements and the remainder are medium security settings. The Maxey Model provides a comprehensive treatment structure for the whole campus. The model is a hybrid of cognitive behavioral treatment, behavioral modification and trauma resolution. It includes a bi-directional system of levels that the youth move through during their placement to recognize progress. Within each level are different treatment tasks and privileges.

Description of the RSAT and Comparison Groups

Maxey implemented two Residential Substance Abuse Treatment (RSAT) programs one on Sequoyah E (SEQ E) and Green Oak Center G (GOC G). Initially, SEQ E had twelve residents and GOC G had eighteen residents. The young men in the RSAT program reside in the same center as other youth, but the RSAT youth are confined to one wing. The comparison group, included one wing from both Sequoyah and Green Oak Center. SEQ F had 20 residents and GOC E had 20 residents. As stated above, Sequoyah houses medium security residents with substance abuse problems and Green Oak Center houses high security residents. Staff assessed youth with substance abuse histories from other wings at Green Oak Center to determine who would be included on the RSAT wing. What distinguished these 30 beds in the RSAT program from the others was the intensive work that the youth did with substance abuse psycho-education and relapse prevention. In addition substance abuse consultants were hired to facilitate additional treatment groups, supervise staff, train staff and provide individual and family counseling in conjunction with current program staff.

Admission to RSAT Program

Staff chose initial Sequoyah E-wing participants from other Sequoyah substance abuse treatment wings or young men who were relatively new to Maxey who had a substance abuse history. Young men chosen were expected to be released from Maxey in six months to one year. Staff chose initial GOC-G wing participants from other GOC wings using three criteria: 1) the resident was not a sex-offender; 2) he had a known substance abuse history; and 3) he was expected to be released within one year. Eleven of the twenty residents who were already on GOC G qualified for the program. Initially, staff had two means for determining a substance abuse history: client files which indicated a history of drug or alcohol use and the Minnesota Multiphasic Personality Inventory (MMPI).

MMPI

The Minnesota Multiphasic Personality Inventory (MMPI) measures various levels of psychological distress. The MacAndrews scales are three sub-scales of the MMPI associated with substance abuse. All residents complete the MMPI within the first 30 days of treatment and before release. In some cases, young men are released before the MMPI is conducted the second time. Maxey staff looked for scores of 65 or higher on the MMPI MacAndrews scales for youth they wanted to refer to the RSAT program. A score of 65 or higher indicates severe alcohol and/or drug use (Appendix B).

Personal Experience Inventory

The Personal Experience Inventory (PEI) is an adolescent assessment tool for alcohol and/or drug use and abuse. (Appendices A and B) It measures substance use, problem severity, quantity, frequency and psychosocial and environmental correlates of adolescent drug and alcohol use. Maxey has two goals related to the use of the PEI. One is to test all youth who enter Maxey and identify youth appropriate for RSAT programs and secondly, re-test youth prior to release to measure progress. Maxey was not able to implement this system for the initial group of RSAT participants, therefore, this data is not available for the analysis. However, this system is now in place for youth entering and exiting Maxey. The initial implementation difficulties have been corrected. This system of testing has been revised and PEIs are being completed at a much higher rate.

Implementation History

January 1997	Program grant began.
January-April 1997	Maxey staff received initial substance abuse and relapse prevention training.
March 1997	Evaluation grant began.
April 1997	Three substance abuse consultants hired to begin group, individual and family counseling.
May 1997	Substance abuse group counseling began.
June 1997	All staff from both of the program wings attended 40 hours of substance abuse training. Brighton Hospital, a local residential substance abuse treatment facility, provided this training.
July 1997	All staff from Sequoyah E-wing received an additional 40 hours of training from Brighton Hospital.
August 1997	All staff from Green Oak Center G-wing received an additional 40 hours of training from Brighton Hospital.
August 1997	A contracted agency began Personal Experience Inventory (PEI) assessments of Maxey residents. (Appendices A and B)
September 1997	Sequoyah E-wing introduced its residents to the new treatment program that integrated previous expectations of the Maxey Model with new substance abuse treatment tasks.

September 1997	Green Oak Center G-wing began using a new self-evaluation form for residents. Sequoyah E-wing began using a new peer evaluation form for residents. See Appendix C.
October 1997	Green Oak Center G-wing introduced its residents to a new treatment program that integrated previous expectations of the Maxey Model with new substance abuse treatment tasks. See Appendices D through G).
November 1997	Grant manager hired for RSAT program.
December 1997	Current and future RSAT program staff received 24 hours of training on Relapse Prevention from the CENAPS Corporation.
January 1998	Social worker from Sequoyah E goes on medical leave. Another group leader takes over groups temporarily.
February 1998	File review system implemented quarterly.
February 1998	Follow-up CENAPS training.
February 1998	Substance abuse consultants from Sequoyah E and GOC G meet to discuss integration of programs.
March 1998	RSAT campus curriculum implemented.
March 1998	Substance abuse consultant from Sequoyah E transfers to another RSAT site. New substance abuse consultant hired.
May 1998	One of the substance abuse consultants from GOC G resigns. This consultant is not replaced.
June 1998	New consultants hired to administer PEI.

Narrative

The RSAT program became operational in May, 1997, when the substance abuse consultants began to run their substance abuse treatment groups. Although the grant was awarded in January 1997, the employee union contested the contracts for the substance abuse consultants. This caused a delay of two months. By September, 1997, the substance abuse consultants introduced staff and residents to new goals and expectations, which added substance abuse treatment to the Maxey Model. Each wing, Sequoyah E and GOC G, had somewhat different expectations and approaches to substance abuse treatment. GOC G integrated substance abuse treatment into the Maxey Model more fully than Sequoyah E. For example, GOC G has had two multi-session, special-topic seminars, which included both substance abuse consultants and the wing staff. The differences and delays in implementing revised goals and expectations hampered the RSAT program. The residents needed to know what the program and its expectations were upon entry.

By March 1998, staff synthesized the various program elements developed in Sequoyah E and GOC G into uniform treatment tasks and objectives, a leader's manual and resource book. Maxey has copyrighted this work and shares it with other juvenile facilities statewide to assist them with their current programming. The treatment tasks and objectives combine the work of substance abuse and criminal behavior treatment (see Appendix D). The leader's manual included information staff need before beginning their work in the RSAT program (see Appendix E). The resource manual provides activities, questions and worksheets relevant to the treatment tasks and objectives (see Appendix F). As new wings were added to the RSAT program in the early part of 1998, these resources became available to the new RSAT staff.

Through the course of implementation, significant improvement to the RSAT program has occurred. The grant manager, hired in November 1997, made a considerable difference in the management of the RSAT program. The grant manager assisted in the development of treatment tasks and objectives and a leader's manual and resource book. In addition, she implemented the collection of relevant data, revised pre and post testing practices, and supervised the substance abuse consultants and RSAT expansion in its second year. Substance abuse training opportunities were regularly available to all staff during the grant period.

For the majority of the evaluation period, staff turnover was low. However, on Sequoyah E in 1998, two key staff left the program. First, their social worker was on a medical leave of absence for five months, and then the substance abuse consultant for the wing transferred to another wing. These people played different but important roles in treatment for the young men.

Intake Data Comparison

We obtained intake data for 95 young men from the Family Independence Agency's management information system and examined seven key demographic variables: race, county of residence, committing offense type, marital status of parent at time of placement, number of truancies, number of previous placements, and number of arrests. Statistical analysis of the RSAT and comparison group demonstrated no significant differences in seven variables between the two groups. The percentages within each variable are listed in Table 1.

Table 1: Intake Data of RSAT and Comparison Groups

African American or Latino	64.9%	73.7%
Wayne county resident	81.6	75.4
Committing offense class 1[1]	39.5	40.4
Unmarried parent	48.6	47.4
1 or more previous truancies	34.2	28.1
More than 3 previous placements	51.4	45.6
More than 2 previous arrests	51.4	62.5

The separate locations and the difference in security status of the two RSAT programs present some difficulties in drawing conclusions between the comparison and RSAT groups. To determine if location was important, the evaluation team analyzed seven key demographic variables by site: GOC versus Sequoyah. Table 2 shows the comparison between the two locations. This analysis revealed significant differences in five of the seven key areas. Variables that have statistically significant differences are marked with an asterisk. Some of these differences are predictable when put in the context of high security (GOC) versus medium security (Sequoyah). The percentage of youth from Wayne County, the county that includes Detroit and 27.8% of the population of the state, was significantly higher in GOC than in

Sequoyah. GOC had more youth with a class one committing offense[1], and they had significantly more placements. These figures are anticipated considering GOC is a high security setting. However, there was no significant difference in the number of arrests between the two groups. It would be expected that youth in a high security setting would have a greater number of arrests. Another unexpected difference was that more African American and Latino youth were placed at GOC than at Sequoyah. In addition, GOC had a higher percentage of youth from unmarried households.

Table 2: Intake Date for GOC versus Sequoyah Groups

African American or Latino*	46.5%	90.2%
Wayne county resident*	65.1	88.5
Committing offense class 1*	9.3	68.4
Unmarried parent*	37.2	56.9
1 or more previous truancies	23.3	36.5
More than 3 previous placements*	37.2	56.9
More than 2 previous arrests	56.1	60

*Items with an asterisk had statistically significant differences

There were no significant differences between the RSAT and comparison group within each center. There was a higher proportion of young men in the RSAT group who are white than in the comparison group at GOC. However, the sample is not of sufficient size for a formal statistical test.

Table 3: Intake Date for Sequoyah RSAT, Sequoyah Comparison, GOC RSAT and GOC Comparison

African American or Latino	60.0%	46.4%	81.8%	96.6%
Wayne county resident	60.0	67.9	95.7	82.8
Committing offense class 1	6.7	10.7	60.9	69.0
Unmarried parent	33.3	39.3	59.1	55.2
1 or more previous truancies	20.0	25.0	43.5	31.0
More than 3 previous placements	26.7	42.9	68.2	48.3
More than 2 previous arrests	42.9	63.0	57.1	62.1

[1] Examples of offense class one includes: murder I, murder II, assault with intent to murder, attempted murder, criminal sexual conduct I, armed robbery, car jacking, violation of controlled substances act, kidnapping, arson of a personal dwelling, escape from a secured facility.

Service Delivery

Analysis of service delivery data from May 1,1997 - April 30, 1998 provided data regarding the diversity, quality, and quantity of services provided in the RSAT and comparison groups, as well as, between Sequoyah and Green Oak Center. Three sources of information were used. First, Maxey Treatment Activity Monitoring Forms, which reports the frequency of clinical services including the number of group, individual and family sessions. The program manager on each hall is responsible for completion of the forms. RSAT substance abuse consultants' submit monthly time sheets. Included on the time sheets are the date, type of service and to whom the service was provided. Observation of group sessions and daily interactions was the last source of information. During observations of group sessions, a structured group observation form was piloted. (Appendix P) The form was designed to be used with all types of group sessions. The frequency of sessions, length of sessions and clinical observations of content were examined. Data in this section does not include youth participation in 12-step meetings, work with their youth advocate (line staff), psychologists and/or psychiatrists.

Two types of group counseling were examined: the general Maxey treatment services and the RSAT program treatment services. Due to the data coming from two incompatible sources, a total of all treatment services on each of the comparison and group wings cannot be provided. The general Maxey treatment services include group, individual and family sessions that the group leader/social worker facilitated. The RSAT treatment services are *in addition* to the general Maxey treatment services and include all group, individual and family sessions that the substance abuse consultants facilitated.

General Maxey Treatment Services

A social worker or group leader provides the majority of treatment on each wing. The responsibilities include weekly group sessions, individual and family counseling. Additional responsibilities include but are not limited to updating treatment plans, court appearances and preparation for aftercare. The ninety-minute group meeting is scheduled to occur four times per week. These group sessions are the key treatment component. During group meetings, young men discuss topics relevant to making progress through the Maxey Model treatment tasks, in addition to, any daily concerns or behavioral issues that arise. Family and individual sessions, although not required, supplement this work. Family session should occur monthly; however, this relies on the family's commitment to a youth's treatment. Individual sessions are scheduled at the discretion of the social worker/group leader. However, most individual sessions are conducted by the youth's advocate. Each youth is assigned an advocate, a line staff who talks individually. These sessions are not documented in the Treatment Activity Monitoring Form. In addition, each center has a psychologist and a psychiatrist responsible for individual assessment and counseling.

Data for Table 4 is taken from the Maxey Treatment Activity Monitoring Form. Table 4 shows the weekly averages by wing and indicates that none of the wings involved in this evaluation are meeting expectations for the number of group sessions. Family and individual sessions appear to be low; however, as previously stated, family sessions rely on family commitment, and individual sessions are generally conducted by advocates thus not recorded. The low number of groups sessions indicates a need for enforcement of already established expectations.

Table 4: Weekly Average of Individual, Family and Group Sessions By Wing

Group	3.48	3.14	2.75	3.77
Individual	7.88	6.24	.01	4.18
Family	1.24	1.08	1.2	1.8

A comparison of the average number of group, individual and family sessions held shows no statistically significant differences in the number of sessions between the RSAT and comparison groups (Table 5). The weekly averages represent services to approximately 30 young men in the RSAT group and 40 young men in the comparison group. The slightly higher average of weekly group sessions in the comparison group is probably because the RSAT group and general Maxey group was combined for some sessions and the groups were recorded as RSAT groups not general Maxey groups. The substance abuse consultants and group leader/social worker combined some of their groups during this period to co-facilitate special workshop series, for example, GOC G had a month-long grief and loss series, as well as a month long series on the criminal thinking and the criminal mind.

Table 5: Weekly Average of Individual, Family and Group Sessions by RSAT and Comparison

Group	3.11	3.45
Individual	3.94	5.21
Family	1.22	1.44

Although individual sessions are not required, there was a statistically significant difference in the number of individual sessions conducted within each center. Table 6 shows the averages by center. Sequoyah residents (RSAT and comparison) have more individual sessions. This is due largely to the fact that the GOC psychologist and psychiatrist are the main facilitator of individual counseling.

Table 6: Weekly Average of Individual, Family and Group Sessions by Center

Group	3.31	3.26
Individual*	7.06	2.1
Family	1.16	1.5

Compilation of the above information revealed problems in records collection. For many weeks throughout the year, the number of sessions were not reported. This varied greatly based on the wing. The percentage of missing data is listed in Table 7. The large amount of information not reported indicates a need for greater reporting accountability. Clearly some program managers are more diligent in their reporting than others.

Table 7: Number of Weeks of Missing Data for Weekly Treatment Activity Monitoring Forms (out of 56 weeks)

Sequoyah E	(RSAT)	29	55.8
GOC G	(RSAT)	5	9.6
Sequoyah F	(comparison)	0	0
GOC E	(comparison)	14	26.9

RSAT Program Services

In addition to the rates of services discussed above, the three substance abuse consultants provided additional individual, family and group sessions. Sequoyah E had one consultant, whereas, GOC G had two consultants, one for each group of 10 youth on each wing. These sessions were generally independent of the other treatment sessions, and the other hall staff were always not present. Substance abuse consultants on Sequoyah E and GOC G worked independently of each other, but they did share the tools, worksheets, resources each had developed which were later compiled into one set of standardized materials for all treatment teams. They were contracted to provide three group sessions per week. No standards were set for individual or family sessions. Data in this section comes from the substance abuse consultants' time sheets. The time sheets reported the number and length of sessions each consultant provided.

Table 8 indicates the total number of sessions and hours of direct service the substance abuse consultants provided. Substance abuse consultants spent an average of eight hours per week in direct service or about 20% of their time. Substance abuse consultants spent the remainder of their time in team meetings, documentation, supervision, development of program components and training.

Table 8: Number and Hours of Substance Abuse Treatment Session

RSAT Group	343	643.7
Individual	479	431.5
Family	97	119.5
Other	27	63.25

Table 9 is a compilation of information regarding the differences in treatment by treatment group. It reveals the amount of service provided varied greatly between the three consultants. SEQ E hall had more than twice as many family sessions as either of the other groups and had a higher average number of group sessions. GOC group 1 had twice as many individual sessions as the other two groups. The substance abuse consultant on Sequoyah E also provided 27 additional treatment groups. These groups included off-grounds activities, day-long retreats and group meetings to discuss family visits. There are few family sessions provided. The average number of groups is less than the three group sessions specified in the consultants' contracts. This is due in part to other activities by the consultants and the aforementioned combined group meetings.

Table 9: Weekly Average Number of Session by RSAT Group

RSAT Group	2.58	2.08	2.27
Individual	2.69	5.25	1.48
Family	1.35	.15	.46

Table 10 shows the average length of the sessions for each consultant. The differences between the length of each session are not significant. Each group is required to be 90 minutes in duration.

Table 10: Average Length of Session by RSAT Group (in hours)

RSAT Group	2.01	1.13	1.88
Individual	1.09	.76	1.09
Family	1.15	1.25	1.44

Several group sessions were observed by evaluation staff of each facilitator, both the substance abuse consultants and the other Maxey staff. In some cases, facilitators insured that everyone participated, set a clear group focus, balanced participant needs and provided closure. In other cases, disruptive and disrespectful behavior went without consequence, monopolization of time by a few people occurred, or sessions lacked focus and closure. The observation form which we piloted, if implemented, would provide evaluation criteria for group facilitators and encourage greater clinical supervision piloted (See Appendix P). Training on group facilitation skills would assist with some inconsistencies, but it will not be effective unless ongoing supervision and accountability increases. The examination of delivery of key components of treatment highlighted the need for greater clinical supervision and consistency.

Youth Surveys, Focus Groups and Observation

Evaluation staff gathered information directly from the young men in three ways: 1) observation; 2) focus groups; and 3) a client survey. Each method revealed differing facets of the strengths and challenges of the RSAT program.

Focus Groups

Focus groups occurred in each of the four wings- RSAT and comparison. Maxey staff were not present during the focus groups. The discussion with each wing is summarized in bullets. In some cases, direct quotes are included. All information that could link a comment with a particular youth has been changed. Although each group had some distinctions, there were several overriding themes of the focus groups. Many of the problems the RSAT youth discussed related to the Maxey Model and Maxey services in general rather than the RSAT program.

- The young men would like more individual counseling time, family visits and family therapy. Some young men felt isolated from their families because siblings over twelve and under five are not allowed to visit.
- The young men felt that the educational program was too limited in scope and not challenging, and they want to learn more. They seemed to recognize that good education affects their success in the community as much as their ability to use different coping skills.
- They also thought there was too much time spent sitting around and not enough to do to keep their minds and bodies occupied.
- The sharing, cohesion and sense of belonging that the Maxey Model is intended to create is not always accomplished. While this is more manifested in GOC, Sequoyah was more critical of Maxey's behavior management methods. As a consequence, some youth tend to mistrust group and group methods.
- There appears to be a lack of urgency about progress of treatment that may be a consequence of Maxey's lack of control over release dates. This is evident in the youths' discussion about wasting time and just doing their time.
- RSAT has been helpful and provided learning tools. The young men have appreciated the attention to substance abuse treatment. More so than GOC G, Sequoyah E expressed concern about staying clean in the community.
- Participants expressed realism bordering on cynicism regarding the imposed responsibility each group member had for each other both therapeutically and as behavior control method.

One of the most interesting and vexing questions facing the treatment staff at Maxey, as well as, those interested in determining the efficacy of any treatment, is the degree to which the youth participate in treatment with sincerity. The problem of assessing sincerity is inherent to the nature of treatment in any context. It is not always clear that people in treatment are internalizing everything that they are told. In addition to the extent they feel strongly about, or participate sincerely in activities and strategies that are involved in their treatment. This problem, however, is significantly compounded in secure mandated residential settings such as Maxey.

At Maxey, youth receive clinical treatment from people whose responsibilities also include determining and enforcing sanctions for misconduct. As part of behavior management at Maxey, as part of the Maxey Model, the young men are expected to "check" each other if someone is not behaving properly. Checking refers to holding another youth accountable for his actions. Youth have suggested that there are numerous instances where people will be "checked for doing nothing wrong." This can interfere with effective group treatment in that it fosters mistrust and suspicion among the youth.

Comments from several youth are suggestive of problems stemming from attempts to integrate treatment and behavior management. Each paragraph indicates a paraphrase excerpt from one youth.

I'd rather be in jail than be here. I was in jail before. And there, at least they leave you alone. You can say what you want ...you don't need to pretend to be something that you're not. I mean everybody here is fronting. And then they give you shit for fronting, but they're fronting too. And you know that they are fronting but they still give you shit when you're fronting. And if

you're honest, then you get shit for not being compliant. So now, I just go through the shit, and I don't tell nobody. I just want to get my levels so that I can get out of here, and the only way that I can get out of here is to keep fronting.

I have one person I trust here. Someone I knew before I came here. I say I don't trust anyone here. No, 'cause they're going to turn on you. You know when you think that they're on your side, or that they back you up---then they'll check you. I don't think anyone here as my friend. And I don't trust any of them.

Watching the youth interact on the wing, it appeared they are close to one another, and seem to manage the intense interpersonal and emotional demands of residential treatment well. Indeed, they understand that in order to get along well at Maxey, they need to present themselves as sincerely engaged in treatment. However, their private comments state otherwise. Because the youth are expected to disclose all of their concerns and troubled pasts, the lack of trust among youth may inhibit treatment progress. This is a difficult issue to assess, and it is a challenge to residential treatment facilities. Youth are reluctant to discuss their distrust of one another for the possibility that they will be seen as 'fronting'. Fronting is when a youth presents himself in a fashion that is not inherently true. There are two realities at Maxey, one the youth present for the benefit of the staff and another that reflects the more genuine and unsurprising (given the legally mandated nature of this treatment) feelings of the youth, including their animosity toward one another, the treatment team, and toward Maxey.

Client Survey

The survey included questions that evaluated youth satisfaction with services, and their predictions for success once released. (Appendix Q) Sixty-five young men completed the survey between August 1997 and October 1997. The young men completed the survey without Maxey staff present.

The young men were asked to rate different aspects of the Maxey treatment program "excellent," "good," "okay," "not good," or "terrible," the quality of school, food, group sessions, hall staff, family sessions, family visits and Maxey overall. Statistical analysis revealed only one statistically significant difference between the RSAT and comparison groups. The RSAT group rated the quality of their group sessions more highly than the comparison group. Since there were no statistically significant differences in any of the service areas between the two locations: GOC and Sequoyah, the greater satisfaction with groups is attributable to the presence of the RSAT program.

Table 11 shows the percentage of young men who rated the services as good or excellent. A large majority of young men viewed the quality of school, family sessions and family visits quite positively. The quality of food provided is overwhelming viewed as poor. There was more difference in opinion on the quality of hall staff and Maxey as a whole. Over 50% of the young men viewed the hall staff favorably and less than half viewed Maxey overall very positive. These numbers demonstrate some strengths of the Maxey program and indicate that some attention and improvements can be made to the quality of group sessions, staff interactions with youth, and food served to the youth.

Table 11: Percentage Rating Various Services at Maxey as "Good" or "Excellent"

School	75.9%	70.0%
Food	13.8	7.5
Group sessions*	86.2	57.5
Hall staff	58.6	52.6
Family sessions	75.9	84.2
Family visits	79.3	73.7
Maxey overall	41.4	32.5

*Items with an asterisk had statistically significant differences

Although there was only one significant difference in the RSAT and comparison group's opinions, analysis indicates some interesting differences between the two locations: Sequoyah and GOC. Sequoyah residents rated the quality of the school significantly higher than the GOC residents. GOC youth do not attend the main school building that all other Maxey residents do. GOC youth have more learning disabilities and educational challenges, as well. Instead, some of their classes are held in a classroom on their wing and the rest are elsewhere in the GOC building. Perhaps something in this set-up limits the educational quality offered at GOC.

The difference in rating of hall staff also varied significantly between GOC and Sequoyah. The young men on the two Sequoyah wings viewed their staff more positively. There is not adequate data to account for these differences. It will be important for Maxey to gage the therapeutic alliance of staff and residents in the two centers and, if significant difference is found, to investigate the reasons why.

Participants were asked to rate whether they felt that staff, peers, teachers, the police and the judges who sent them to Maxey treated them fairly. Their choice of answers was "never," "once in a while," "sometimes," "most times" or "all the time." Statistical analysis revealed only one significant difference between the RSAT and comparison group. The RSAT group reported the police treated them fairly more often than the comparison group did. Table 12 shows the percentage of youth who said that the different groups treated them fairly "most of the time" or "all of the time." Staff, peers, teachers and judges are overwhelmingly rated as having treated them fairly while their opinion of the police is more mixed. It is interesting to note that the young men feel the judges, who sentenced them to a secure facility, treated them fairly. The high rating of fair treatment on the part of staff is in some contrast to their overall rating of hall staff which shows a more mixed opinion of staff and of Maxey overall.

Table 12: Percentage Who felt they were treated fairly "most or all of the time" by RSAT and comparison

Staff	93.1%	95.0%
Peers	96.6	95.0

Teachers	93.1	95.0
Police*	55.2	34.2
Judges	89.7	79.5

*Items with an asterisk had statistically significant differences

Analysis by center indicates there was a significant difference in the number of youth who felt teachers treated them fairly. Sequoyah residents reported their teachers treated them fairly "most of the time" or "all of the time." This is consistent with the feedback from the focus groups in which GOC residents were more critical of the educational program. Table 13 shows the percentage of participants who reported they were treated fairly all or most of the time. Overall, the young men report that people associated with Maxey, staff, peers, and teachers, treat them fairly most or all of the time. However, their responses in the focus groups indicated a sharp contrast with this.

Table13: Percentage of youth who felt they were treated fairly "most or all of the time" by Center

Staff	94.3%	94.1%
Peers	94.3	97.1
Teachers*	100.0	88.2
Police	51.4	34.4
Judges	82.9	84.8

*Items with an asterisk had statistically significant differences

Participants were asked about the frequency of several risk and protective factors in their family and community. They chose how often these events occurred as "never," "a few times," "a lot of times," or "almost always." Table 14 shows how the young men view their family and community. Statistical analysis did not show a statistically significant difference between the RSAT and comparison groups. Most participants in both groups report neighborhood abuse of alcohol, drug use, drug selling and violence is frequent. The number of youth reporting these activities occurring frequently in their neighborhoods is higher than the frequency for their families, possibly because youth are less willing to reveal more negative information about their families. Youth rate the frequency of people in the neighborhood listening to, caring about or helping them as low compared to how they rated their families.

Table 14: Percentage who judged risk or protective factors occurring "a lot of the time" or "almost always" in youths' families and neighborhoods by RSAT and Comparison

Neighborhood drank	71.4%	78.9%
Neighborhood used drugs	82.1	83.8
Neighborhood sold drugs	75.0	78.4
Neighborhood was violent	71.4	73.0
Neighborhood listened to me	14.8	23.1
Neighborhood cared about me	32.1	38.5

Neighborhood helped me be good	17.9	15.8
Someone in family was drunk	50.0	56.4
Someone in family used drugs	60.7	57.9
Someone in family sold drugs	48.1	50.0
Someone in family was violent	46.4	38.5
Someone in family listened to me	33.3	47.5
Someone in family cared about me	81.5	81.5
Someone in family helped me be good	40.7	45.0
Jobs available: yes	78.6	63.2
Good schools available: yes	78.6	64.1

*Items with an asterisk had statistically significant differences

Analysis revealed many statistically significant differences in the above mentioned categories when evaluated by center. GOC residents reported that someone in their family listened to them and helped them be good "a lot of the time" or "almost always," whereas Sequoyah residents reported someone in their family was drunk or violent "a lot of the time" or "almost always." GOC residents reported greater frequency of people in their neighborhood listening to them and caring about them. Whereas, Sequoyah residents reported that people in their neighborhood were drunk, using drugs and violent frequently. Table 15 shows the percentage of residents in each center who reported the various events as occurring "a lot of the time" or "almost always."

It is surprising that GOC, the high security center, report a greater amount of family and community support and less violence and substance abuse. In order to better understand this difference, the data were analyzed a third time. In this case, the residents in a drug treatment program which includes the two RSAT wings and Sequoyah F, were compared with the residents not in drug treatment, GOC E. Because of the small sample size for the non-substance abuse treatment, analysis was somewhat problematic.

Table 15: Percentage who judged risk or protective factors occurring "a lot of the time" or "almost always" in youths' families and neighborhoods by location

Neighborhood drank*	91.4%	58.1%
Neighborhood used drugs*	94.3	70.0
Neighborhood sold drugs	82.9	70.0
Neighborhood was violent*	85.7	56.7
Neighborhood listened to me*	11.8	28.1
Neighborhood cared about me*	20.0	53.1
Neighborhood helped me be good	14.3	19.4
Good schools available: yes*	60.0	81.3
Someone in family was drunk*	74.3	31.3
Someone in family used drugs	65.7	51.6
Someone in family sold drugs	51.4	46.7
Someone in family was violent*	57.1	25.0
Someone in family listened to me*	20.0	65.6

Someone in family cared about me	80.0	90.6
Someone in family helped me be good*	25.7	62.5
Jobs available: yes	62.9	77.4

*Items with an asterisk had statistically significant differences

The evidence points to several things. Youth not on substance abuse wings reported greater frequency of family and neighborhood support. On five questions: neighborhood listened, neighborhood cared, family listened, family cared and family helped, participants in the non-substance abuse wing report greater frequency of these actions. Quite unexpectedly, in most areas related to substance use, there does not seem to be a statistically significant difference in the two groups. The substance abuse treatment group reported greater frequency only in the frequency of people in the neighborhood who are drunk. The substance abuse group also reports greater frequency of family violence. This analysis indicates the statistical differences seen in Table 16 may speak more to the kind of family factors that are causative or concomitants of substance abuse.

Table 16: Percentage who judged risk or protective factors occurring "a lot of the time" or "almost always" in youths' families and neighborhoods by substance abuse treatment and non-substance abuse treatment

Neighborhood drunk*	80.4%	60.0%
Neighborhood used drugs	86.3	71.4
Neighborhood sold drugs	76.5	78.6
Neighborhood was violent	76.5	78.6
Neighborhood listened to me*	14.0	37.5
Neighborhood cared about me*	27.5	62.5
Neighborhood helped me be good	15.7	20.0
Someone in family was drunk	58.8	37.5
Someone in family used drugs	62.7	46.7
Someone in family sold drugs	48.0	53.3
Someone in family was violent*	51.0	12.5
Someone in family listened to me*	28.0	82.4
Someone in family cared about me*	80.0	100.0
Someone in family helped me be good*	32.0	76.5
Good schools available: yes	68.6	75
Jobs available: yes	62.9	77.4

*Items with an asterisk had statistically significant differences

Overall, the survey section indicate the need to connect the young men with positive (drug-free, crime-free, violence-free) support systems, jobs and good schools when they re-enter the community in order to help them remain clean.

Progress Through the Program

Measures which indicate timely progress through the RSAT program include 1) length of time on each level and 2) total length of time in the RSAT program. The first measure of progress proved problematic. Maxey does not record level promotions or demotions, so accurate data on promotion dates for each level did not exist. The level system is based on performance in treatment and behavior. Even with complete data, its meaning would have been complicated by the fact the level systems in GOC and Sequoyah were structured differently and the level systems in both halls were revised during the evaluation period. The level systems, in part, are different because of the high and medium security status of each center. This problem indicates a need for a standardized measure of progress throughout the agency.

The length of time it took young men to complete the program provided an indication of timely progress. As stated in the original RSAT grant, youth were supposed to complete the program within six to twelve months. Table 17 indicates that 38.7% of the young men completed the RSAT program within 12 months. A larger number of young men, 51.6%, did not complete the program within 12 months in part, no doubt, because Maxey itself did not have direct control over release dates and transition facilities are crowded. In the court proceeding, the state-appointed delinquency worker makes recommendations about release dates to the judge based on progress in the program. However, the judge is under no obligation to follow these recommendations and makes the final decision. Further investigation of why young men did not complete the program within the prescribed period of time is necessary. It may be that some young men were transferred to the RSAT program too early in their stay at Maxey. In this case, revision to the selection procedure is necessary. It may also be that the RSAT program needs to be restructured in order to insure that young men are making timely and significant progress. In examining solutions to this problem, it will be important to insure that youth are not moved out of the program to comply with timelines but that they have accomplished their treatment goals. It is also critical to insure that the program does not get used as a means for keeping youth in the system longer.

Table 17: Length of Time in the RSAT Program

Completed in 6-12 months	38.7%	12
Incomplete, more than 12 months	51.6%	16
Released in less than 6 months	9.7%	3

RSAT Staff

Staff profiles

Two program managers from Sequoyah E and GOC G were interviewed to gather information regarding staff experience with substance abuse treatment, the number of staff in recovery, education levels, gender and ethnicity. They reported on ten staff at Sequoyah E and fourteen staff at GOC G. Table 19 profiles the staff. It includes both the substance abuse consultants and the regular Maxey staff. Most staff turnover occurred at the beginning and near the end of the first year.

During the first year, three staff left GOC G and four left Sequoyah E. The substance abuse consultant from Sequoyah E was transferred to another wing and replaced 8 months into the program and one of the substance abuse consultant from GOC G left the program 13 months into the program. He was not replaced.

Three Maxey staff had previous experience working in substance abuse treatment. All three substance abuse consultants had worked in the field for several years. The majority of staff on both wings was male and white. GOC G had three Master's level staff whereas Sequoyah E had two staff with a Masters degree in a related field. There was a nearly even mix of staff with Bachelor's degrees, some college experience and no college. Approximately the same number of staff were in recovery on both wings. In addition, three staff from each wing were Certified Addiction Counselors by the State Board of Addiction Professionals via RSAT program training.

Table 18: Profile of RSAT program staff

Turnover	4	3	7
Previously worked in substance abuse treatment	4	4	8
In recovery	5	4	7
Male	7	10	17
African-American	4	3	7
Education			
Master's in a related field	3	4	7
BA	3	2	5
Some college	3	3	6
No college	1	2	3
Unknown	1	3	4
Total	**11**	**14**	**24**

Staff Issues

Some tension between recovering and non-recovering staff was observed early in the program. Staff tended to focus either on criminal history or substance abuse issues as the core problem. This dichotomy created professional tensions that evaluation staff and program participants observed.

RSAT Staff Training

Given the limited substance abuse treatment knowledge of the majority of staff, substance abuse training was essential. Program staff received over 100 hours of training in three separate weeks on substance abuse and relapse prevention. Substance abuse consultants reported they provided some additional training in staff team meetings. Evaluation staff attended portions of all three weeks of training to supplement the staff evaluations of the training. Attendance at two of the

three weeks of training was high. Maxey did an excellent job of assuring attendance for RSAT program staff.

Table 19: Substance Abuse Training Attendance

Brighton Hospital Relapse Prevention Training-Week One	unavailable	unavailable
Brighton Hospital Relapse Prevention Training-Week Two	90	96
CENAPS Relapse Prevention Training	90	86

Overall, staff rated the quality of this training as high. The evaluation team's observation of the first week of substance abuse training were otherwise. Some observed issues were that it did not engage staff attention, it did not provide a well-organized, comprehensive foundation on substance abuse issues and substance abuse treatment, did not contain up-to-date information, and did not provide tools relevant to their specific population.

The Brighton Hospital Relapse Prevention training ran five days. Brighton Hospital is a local substance abuse treatment facility that works with both adolescents and adults. The facility includes residential bed and family counseling. The topics covered included: Gorski's Relapse Prevention Model, the Franklin Reality Model, group process intervention, 12-step milieu management, motivating adolescents to recovery, therapeutic tools and shame/grief/attitudes related to chemical dependency and criminal behavior. The staff appeared engaged in the interactive workshops. Maxey staff developed the training evaluation tool. Respondents could answer: "very much," "pretty much," somewhat," "not really," or "not at all." Staff rated the training positively. Table 20 summarizes the results.

Table 20: Staff rating of Brighton Hospital's relapse prevention training-week two

Topic was useful to me: very much or pretty much	86.2
Speaker's presentation was clear: very much or pretty much	92.6
I would want to listen to this speaker again: very much or pretty much	87.2

The CENAPS Corporation training on relapse prevention lasted for three days. Staff from the original RSAT groups, as well as, staff new to present and expanding RSAT programs. As the program expanded the number of staff attending the training in December 1997 increased. The training covered numerous topics including: developing a relapse prevention counseling plan, abstinence and treatment contracts, relapse intervention plans, identifying and personalizing high-risk situations, therapeutic methods, and managing high risk situations. Throughout the training, staff appeared engaged and enthusiastic about the workshop. At the end of the three days staff completed an evaluation which reflected their opinions of the workshop and their self-reported knowledge of skill areas before and after the training. On each question staff could answer: "excellent," "very good," "good," "fair," or "poor." Overwhelmingly, staff praised the workshop

and felt their skill level improved noticeably. An abbreviated summary of their ratings appears in Table 21.

Table 21: Staff rating of CENAPS relapse prevention training

Ability to help clients prevent relapse before training: very good or excellent	15
Ability to help clients prevent relapse after training: very good or excellent	85.2
Presenters knowledge and skills: very good or excellent	100
Overall effectiveness of the workshop: very good or excellent	100

In addition to these training that nearly all RSAT staff attended, other substance abuse training has been available for a limited number of staff to attend. Other trainings during the evaluation period included: Understanding the 12 Steps, Treating substance abusing criminal offenders; trauma resolution; Eye Movement Desensitization and Reprocessing; and Culturally sensitive substance abuse treatment.

Conclusions

Conclusions are summarized in the context of the original research questions: 1. Are participants appropriate? 2. Is the staff trained to deliver the planned services? 3. How does service delivery vary over time? 4. Do the participants make timely progress? 5. What organizational factors change service delivery and participant progress?

Are the participants appropriate?

There has been improvements in the process of choosing participants for the RSAT program during the evaluation period. Initially, participants entered the program after staff assessed youth from other Sequoyah and GOC wings through examination of their client files or direct knowledge of the youth. The original participants of the RSAT program had substance abuse problems and, therefore, were appropriate for the program. Over the course of the evaluation, assessment of youth for the RSAT program became more systematic. Youth placed on the new RSAT wings and new youth for the original RSAT wings completed the substance abuse assessment instrument, the PEI, prior to placement.

Is staff trained to deliver the planned services?

Initial training and planning for the RSAT program was extensive. Maxey hired substance abuse consultants with extensive knowledge of and experience in substance abuse treatment. The consultants spent considerable time developing the details of the program and support materials. Staff received over 100 hours of training within the first year and reported being satisfied with this training. This provided a sound introduction for the staff working in RSAT at that time.

How does service delivery vary over time?
Examination of service delivery highlighted some areas of concern for Maxey as a whole and some areas specific to the RSAT program. For Maxey as a whole, reporting accountability is a serious issue. Information regarding the provision of clinical service in general was incomplete. The percentage of missing data from the Treatment Activity Monitoring Form indicates a need for greater accountability in reporting practices. Supervision of clinical services requires accurate information of what services are being delivered on each wing.

The RSAT program service delivery improved over time. By February 1998, quarterly reviews of the substance abuse consultants' case files began. Regular reviews provided needed supervision to consultants and improvements in their individual treatment planning. Clearer expectations and accountability for number of hours and frequency of direct service by substance abuse consultants must be established. The evaluation team recommends the establishment of guidelines for the number of hours and frequency of services that will increase the amount of individual and family counseling sessions, as well as, standardize the amount of group time. This will contribute to the consistency of service delivery to each program participant and across all wings participating in the RSAT program.

By March 1998, the separate work done by the original substance abuse treatment consultants was synthesized into a unified program. The documents were then distributed to the current RSAT and the new RSAT program wings. Ongoing supervision to insure the consistent implementation of the program on each wing is necessary.

Agencies and individuals from the community have been included in the RSAT program. These contacts create an important link for the young men to a community of recovering individuals and agencies who can provide support for them once they are released from Maxey. The RSAT program in Sequoyah E included attendance at 12-step meetings in the community and, for a time, some community outings. This is a vital connection for the young men, and it is recommended that increasing the regular involvement of outside agencies and individuals on all RSAT wings may be beneficial. This would include inviting agencies to provide presentations, recovering speakers, more AA/NA meetings facilitated by outsiders and community outings, when appropriate.

Conversations with program participants reinforced their desired for a connection to the outside community and an increase in individual and family counseling, but brought to light some new concerns. Young men in the program expressed some frustration over their progress through the RSAT program. They felt they were repeating work they had done prior to RSAT placement. This relates both to staff implementation of the RSAT program and the young men's perceptions of the program. It will be helpful to better clarify the integration and separation of RSAT work and Maxey Model work in order to improve satisfaction with the RSAT program for the young men.

Perhaps the most challenging problem that came out in conversations with the young men was that of the youth-led behavioral control methods of the Maxey Model and its effect on insincerity in treatment. It seems to create mistrust and power imbalances between youth, as well as

negatively affecting relationships with staff. The RSAT program might consider altering this part of their program.

Do the participants make timely progress?
Maxey experienced some difficulty with timely progress. Over half the youth did not exit the program within the stated twelve-month time frame. Maxey does not have complete control over youth release date. The court system makes the final decision for release dates. Knowing this, Maxey should investigate ways to work more closely with the court system in order to increase the number of youth who complete the program within twelve months. A greater sense of urgency in the completion of treatment tasks is necessary for the young men to feel that their time at Maxey is well-spent and will impact on their lives once they leave residential care.

During their time at Maxey, youth in the program have learned assertive communication skills. Their focus group participation demonstrated that they have useful, critical feedback for program improvement and will express this when given the opportunity. Their feedback should be incorporated into RSAT functioning to improve outcomes and satisfaction with length of time in RSAT and Maxey.

The RSAT program had paid particular attention to establishing outcomes of program participation. The RSAT program now uses a pre and post-test PEI to measure the effectiveness of the RSAT program on youth. In addition, University of Michigan staff completes follow-up surveys in the community at six months and one year after release. This outcome evaluation will lead to ongoing improvements to the RSAT program.

What organizational factors change service delivery and participant progress?
Organizational changes in RSAT provided improved supervision and service delivery.
Maxey staff is interested in substance abuse treatment and committed to helping the young men in the program succeed once released. To build effectively on their motivation, team cohesion, a unified vision of how to get the job done, clinical supervision and accountability must occur. The addition of the grant manager solved some significant RSAT supervision and accountability problems. Yet, some improvements are needed. Improved reporting accountability, additional clinical supervision and communication between all members of the team: program managers, group leaders, social workers, youth specialists, the grant manager and other clinical services, will be effective in addressing these problems.

In sum, the process of the delivery of the RSAT funds and program has improved over time. Some serious issues were found in the intersection between the Maxey Model and the RSAT program. As is typical in many such facilities the youth report some dissatisfaction. More in depth evaluation of the agency and Maxey Model as a whole is suggested to clarify these issues. Ongoing process and outcome evaluation is strongly suggested.

APPENDICES

A: Personal Experience Inventory (PEI)
B: PEI Six Month Follow Up
C: Peer Evaluation
D: Treatment Levels and Tasks
E: Treatment Tasks Check List
F: Leader's Manual
G: Samples of Curriculum
H: Initial Assessment Form
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N: Release of Information Form
O: Activity Monitoring Form
P: Group Session Obeservation Form
Q: RSAT Survey Form

APPENDIX A

PLEASE DO NOT MARK IN THIS AREA

77358

IMPORTANT: Enter this number on Transmittal Form when submitting for scoring.

Personal Experience Inventory (PEI)

Ken C. Winters, Ph.D. and George A. Henly, Ph.D.

Published by

WPS WESTERN PSYCHOLOGICAL SERVICES
Publishers and Distributors
12031 Wilshire Boulevard
Los Angeles, California 90025-1251

DIRECTIONS

This booklet contains questions about you and your personal experiences, including some questions about your experiences with alcohol and other drugs. Some concern how often certain things have happened. Others are about how much you agree with a given statement.

First, fill in the background information. Write your identification number in the boxes above the circles and then darken the appropriate circles below. If you haven't been assigned an identification number, ask your examiner. Darken the circles that correspond to your sex, age, and ethnic background.

When you are ready to begin, read each question carefully. Then, mark your answer by filling in the appropriate circle. Make sure you fill in only one circle for each question. When you choose an answer, make dark, heavy marks that fill the whole circle.

CORRECT ● ● WRONG ⊗ ✓ ÷

Use only a No. 2 or softer, black-leaded pencil. Make no stray marks on the booklet. If you change an answer, erase your first answer completely. Make sure you answer every question. Please be open and honest. Your answers will be kept private.

CLIENT INFORMATION

ID Number: 0 1 2 3 4 5 6 7 8 9

Ethnic Background (Optional): White, Black, American Indian, Hispanic, Asian American, Other

Age: 11, 12, 13, 14, 15, 16, 17, 18, 19, 20+

Sex: MALE, FEMALE

GROUP IDENTIFICATION

Group | Subgroup 1 | Subgroup 2

FOR WPS USE ONLY

A-2

PART I

For the questions in this section, please mark one of these answers:
⓪ Never ① Once or twice ② Sometimes ③ Often

How often have you used alcohol or other drugs:

		Never	Once or twice	Sometimes	Often
1.	At home	⓪	①	②	③
2.	With friends your own age	⓪	①	②	③
3.	To feel mellow, calm, or happy	⓪	①	②	③
4.	On school days	⓪	①	②	③
5.	To be like other kids	⓪	①	②	③
6.	When you were bored	⓪	①	②	③
7.	Just before going to sleep	⓪	①	②	③
8.	To feel less shy and make friends	⓪	①	②	③
9.	When you felt tense or uptight	⓪	①	②	③
10.	While driving around or sitting in a car	⓪	①	②	③
11.	To get high	⓪	①	②	③
12.	Even though you had planned not to use	⓪	①	②	③
13.	Before going out	⓪	①	②	③
14.	To build your courage	⓪	①	②	③
15.	To get your mind off your problems	⓪	①	②	③
16.	Soon after getting up in the morning	⓪	①	②	③
17.	To have fun	⓪	①	②	③
18.	In a foreign country (other than Canada or Mexico)	⓪	①	②	③
19.	At school or on school grounds	⓪	①	②	③
20.	To have sexual relationships	⓪	①	②	③
21.	When you were mad or irritated	⓪	①	②	③
22.	To get to sleep	⓪	①	②	③
23.	On weekends, holidays, or days off	⓪	①	②	③
24.	To relieve a hangover or other effects from the night before	⓪	①	②	③
25.	When you were alone	⓪	①	②	③
26.	To feel more relaxed with someone you like	⓪	①	②	③
27.	While driving a race car	⓪	①	②	③
28.	Throughout the whole day	⓪	①	②	③
29.	At teenage parties where your parents or other adults were *not* present	⓪	①	②	③
30.	When you were lonely	⓪	①	②	③
31.	Just before or during school	⓪	①	②	③
32.	To feel better around people	⓪	①	②	③
33.	When you felt sad or depressed	⓪	①	②	③
34.	At places where teenagers hang around	⓪	①	②	③

How often have you:

35.	Used something to get high without knowing what it was	⓪	①	②	③
36.	Avoided family activities so you could get high	⓪	①	②	③
37.	Gotten alcohol or other drugs from friends	⓪	①	②	③
38.	Had thoughts of using or drinking when you should have been thinking of something else	⓪	①	②	③
39.	Made excuses or lied to friends about your alcohol or drug use	⓪	①	②	③
40.	Gotten alcohol or drugs from a teacher or school official	⓪	①	②	③
41.	Avoided straight friends so you could get high	⓪	①	②	③
42.	Kept on using drugs or drinking when you should have stopped	⓪	①	②	③
43.	Used more than one drug at the same time in order to get high	⓪	①	②	③
44.	Looked for people or parties to get high with	⓪	①	②	③
45.	Made excuses or lied to friends about having drugs to make sure you would have enough for yourself	⓪	①	②	③
46.	Gotten alcohol or drugs from a police officer	⓪	①	②	③
47.	Ended up drinking or using more than you had planned without realizing it	⓪	①	②	③
48.	Made plans to be with friends and then cancelled them so you could get high	⓪	①	②	③

When using alcohol or other drugs, how often have you:

49.	Felt hot and sweaty (feverish) or cold and clammy (chills)	⓪	①	②	③
50.	Felt afraid or nervous for no good reason	⓪	①	②	③
51.	Felt more powerful and in control of a social situation	⓪	①	②	③
52.	Gotten into fights or tried to hurt someone	⓪	①	②	③

A-3

When using alcohol or other drugs, how often have you:

	Never	Once or twice	Sometimes	Often
53. Become depressed or really sad	0	1	2	3
54. Felt spacey or out of it	0	1	2	3
55. Felt unable to control your feelings	0	1	2	3
56. Lost your sense of taste for several days	0	1	2	3
57. Been bothered a lot by little things people said or did	0	1	2	3
58. Felt better able to talk about your feelings and thoughts to someone of the opposite sex	0	1	2	3
59. Thought about how you would kill yourself	0	1	2	3
60. Had the shakes (trembling hands, tongue, or eyelids)	0	1	2	3
61. Felt people were watching you or talking about you	0	1	2	3
62. Started out feeling good and ended up feeling bad	0	1	2	3
63. Lost sight in one eye for an hour or longer	0	1	2	3
64. Had sudden outbursts of temper, crying spells, etc.	0	1	2	3

In order to get or pay for alcohol or other drugs, how often have you:

65. Gone without things you wanted or needed	0	1	2	3
66. "Conned" or used people	0	1	2	3
67. Changed other plans you had made	0	1	2	3
68. Taken or sold things that weren't yours	0	1	2	3
69. Done personal favors for people	0	1	2	3
70. Borrowed money or gone into debt	0	1	2	3
71. Sold personal things, like your clothes or jewelry	0	1	2	3
72. Done illegal things other than selling drugs	0	1	2	3

For questions in the next section, please mark one of these answers:

0 Never 1 Once or twice 3 More than once or twice

How many times have you:

	Never	Once or twice	More than once or twice
73. Had an accident or been injured due to using drugs or alcohol	0	1	3
74. Gotten into fights with friends due to using drugs or alcohol	0	1	3
75. Broken promises to yourself or others to limit or cut down your drinking or drug use	0	1	3
76. Had trouble at work due to your drug or alcohol use	0	1	3
77. Had trouble with your teachers or principal due to using alcohol or drugs	0	1	3
78. Committed a crime when using alcohol or drugs	0	1	3
79. Broken promises to yourself or others to quit drinking or using drugs	0	1	3
80. Missed work or gotten to work late due to using drugs or alcohol	0	1	3

For questions in the next section, please mark one of these answers:

Y Yes N No

Please answer the following questions about your experiences:

	Yes	No
81. Once I start using or drinking it is hard for me to stop before I get completely stoned	Y	N
82. It is sometimes hard for me to go on with my work if I am not encouraged	Y	N
83. There have been times when I was quite jealous of the good fortune of others	Y	N
84. I have tried not to think about how much I was drinking or using	Y	N
85. At times I have had doubts about my ability to succeed in life	Y	N
86. If I could get into a movie without paying and be sure I was not seen I would probably do it	Y	N
87. I have felt that my use of alcohol or drugs is a real problem for me	Y	N
88. No matter who I am talking to, I'm always a good listener	Y	N
89. A few times I have given up doing something because I thought too little of my ability	Y	N
90. I feel that my use of alcohol or drugs is normal	Y	N
91. There have been times when I took advantage of someone	Y	N
92. At times I have really insisted on having things my own way	Y	N
93. I can remember "playing sick" to get out of something	Y	N
94. I can stop drinking or using without a struggle after one or two drinks, hits, etc.	Y	N
95. I am always polite, even to people who are unpleasant	Y	N
96. There have been times when I felt like smashing things	Y	N

For questions in the next section, please mark one of these answers:
⓪ Never ① Once or twice ② Sometimes ③ Often

How often have you used each of these chemicals in order to get high:

	Never	Once or twice	Sometimes	Often
97. Beer	⓪	①	②	③
98. Wine	⓪	①	②	③
99. Hard liquor (whiskey, vodka, gin, etc.) or mixed drinks	⓪	①	②	③
100. Shaving lotion, cough medicine, mouthwash, vanilla extract, or anything like that	⓪	①	②	③
101. Marijuana (grass, pot) or Hashish (hash)	⓪	①	②	③
102. Stimulants (uppers, speed, diet pills)	⓪	①	②	③
103. Tranquilizers (Valium, Librium, etc.)	⓪	①	②	③
104. Quaaludes (ludes, soapers) or Downers (reds, blues, yellows, barbs, etc.)	⓪	①	②	③
105. Cadrines (wagon wheels or rails)	⓪	①	②	③
106. Inhalants (gasoline, glue, aerosol sprays), Amyl Nitrate or Butyl Nitrate (poppers, rush, locker room, etc.)	⓪	①	②	③
107. Pills or medicine available at drugstores without a prescription, such as NoDoz, Sominex, cold capsules, etc.	⓪	①	②	③
108. Cocaine (coke, crack, rock)	⓪	①	②	③
109. PCP (angel dust, peace pill), LSD (acid) or other psychedelics	⓪	①	②	③
110. Heroin (horse, smack) or other Opiates (methadone, opium, morphine, codeine, etc.)	⓪	①	②	③

For the next question, please mark one of these answers:
○ Never ○ 1 or 2 times ○ 3 to 5 times ○ 6 to 9 times
○ 10 to 19 times ○ 20 to 39 times ○ 40 or more times

111. How many times have you had alcoholic beverages (including beer, wine, and liquor) to drink: (Fill in one circle for each line.)	Never	1 or 2 times	3 to 5 times	6 to 9 times	10 to 19 times	20 to 39 times	40 or more times
a. In your lifetime	○	○	○	○	○	○	○
b. During the last 12 months	○	○	○	○	○	○	○
c. During the last 3 months	○	○	○	○	○	○	○

For the next question, please mark one of these answers:
○ Never ○ A few of the occasions ○ About half of the occasions
○ Most of the occasions ○ Nearly all of the occasions

112. On the occasions that you drink alcoholic beverages, how often do you drink enough to feel pretty high	Never	A few of the occasions	About half of the occasions	Most of the occasions	Nearly all of the occasions
	○	○	○	○	○

For questions in the next section, please mark one of these answers:
○ Never ○ 1 or 2 times ○ 3 to 5 times ○ 6 to 9 times
○ 10 to 19 times ○ 20 to 39 times ○ 40 or more times

113. How many times (if any) have you used marijuana (grass, pot) or hashish (hash, hash oil) (Fill in one circle for each line.)	Never	1 or 2 times	3 to 5 times	6 to 9 times	10 to 19 times	20 to 39 times	40 or more times
a. In your lifetime	○	○	○	○	○	○	○
b. During the last 12 months	○	○	○	○	○	○	○
c. During the last 3 months	○	○	○	○	○	○	○

114. How many times (if any) have you used LSD ("acid") (Fill in one circle for each line.)	Never	1 or 2 times	3 to 5 times	6 to 9 times	10 to 19 times	20 to 39 times	40 or more times
a. In your lifetime	○	○	○	○	○	○	○
b. During the last 12 months	○	○	○	○	○	○	○
c. During the last 3 months	○	○	○	○	○	○	○

115. How many times (if any) have you used psychedelics other than LSD (like mescaline, peyote, psilocybin, PCP) (Fill in one circle for each line.)	Never	1 or 2 times	3 to 5 times	6 to 9 times	10 to 19 times	20 to 39 times	40 or more times
a. In your lifetime	○	○	○	○	○	○	○
b. During the last 12 months	○	○	○	○	○	○	○
c. During the last 3 months	○	○	○	○	○	○	○

116. How many times (if any) have you used cocaine (sometimes called coke, crack, rock) (Fill in one circle for each line.)	Never	1 or 2 times	3 to 5 times	6 to 9 times	10 to 19 times	20 to 39 times	40 or more times
a. In your lifetime	○	○	○	○	○	○	○
b. During the last 12 months	○	○	○	○	○	○	○
c. During the last 3 months	○	○	○	○	○	○	○

For questions in the next section, please mark one of these answers:

○ Never ○ 1 or 2 times ○ 3 to 5 times ○ 6 to 9 times ○ 10 to 19 times ○ 20 to 39 times ○ 40 or more times

117. Amphetamines can be prescribed by doctors to help people lose weight or to give people more energy. They are sometimes called uppers, ups, speed, bennies, dexies, pep pills, ice, and diet pills. Amphetamines do not include any nonprescription drugs, such as over-the-counter diet pills or stay-awake pills, or any mail-order drugs. How many times (if any) have you taken amphetamines on your own—that is, without a doctor telling you to take them

(Fill in one circle for each line.)

a. In your lifetime
b. During the last 12 months
c. During the last 3 months

118. How many times (if any) have you used quaaludes (quads, soapers, methaqualone) on your own—that is, without a doctor telling you to take them

(Fill in one circle for each line.)

a. In your lifetime
b. During the last 12 months
c. During the last 3 months

119. Barbiturates are sometimes prescribed by doctors to help people relax or get to sleep. They are sometimes called downs, downers, goofballs, yellows, reds, blues, rainbows. How many times (if any) have you taken barbiturates on your own—that is, without a doctor telling you to take them

(Fill in one circle for each line.)

a. In your lifetime
b. During the last 12 months
c. During the last 3 months

120. Tranquilizers are sometimes prescribed by doctors to calm people down, quiet their nerves, or relax their muscles. Librium, Valium, and Miltown are all tranquilizers. How many times (if any) have you taken tranquilizers on your own—that is, without a doctor telling you to take them

(Fill in one circle for each line.)

a. In your lifetime
b. During the last 12 months
c. During the last 3 months

121. How many times (if any) have you used heroin (smack, horse, skag)

(Fill in one circle for each line.)

a. In your lifetime
b. During the last 12 months
c. During the last 3 months

122. There are a number of narcotics other than heroin, such as methadone, opium, morphine, codeine, demerol, paregoric, talwin, and laudanum. How many times (if any) have you taken narcotics on your own—that is, without a doctor telling you to take them

(Fill in one circle for each line.)

a. In your lifetime
b. During the last 12 months
c. During the last 3 months

123. How many times (if any) have you sniffed glue, or breathed the contents of aerosol spray cans, or inhaled any other gases or sprays in order to get high

(Fill in one circle for each line.)

a. In your lifetime
b. During the last 12 months
c. During the last 3 months

For questions in the next section, please mark one of these answers:

○ Never ○ Grade 6 or before ○ Grade 7 or 8 ○ Grade 9 or 10 ○ Grade 11 or after

How old were you when:

124. You first got high on alcohol
125. You started getting high on alcohol *regularly*
126. You first got high on marijuana (pot) or hashish (hash)
127. You started getting high on marijuana *regularly*
128. You first got high on some drug other than alcohol or marijuana
129. You started getting high *regularly* on some drug other than alcohol or marijuana

PART II

In the next section, please decide how much you agree with each statement about you, and mark one of these answers:

(SD) Strongly disagree (D) Disagree (A) Agree (SA) Strongly agree

		Strongly disagree	Disagree	Agree	Strongly agree
1.	I enjoy seeing a good movie	SD	D	A	SA
2.	Some kids I hang around with have trouble at school due to using alcohol or other drugs	SD	D	A	SA
3.	It doesn't matter how my life turns out	SD	D	A	SA
4.	I am sometimes irritated by people who ask favors of me	SD	D	A	SA
5.	I make friends easily	SD	D	A	SA
6.	I would never think of letting someone else be punished for my mistakes	SD	D	A	SA
7.	I have plans for what I'll do after high school	SD	D	A	SA
8.	The kids I hang around with think it's okay for kids to drink alcohol	SD	D	A	SA
9.	It would be better if I were dead	SD	D	A	SA
10.	Someone in my family has touched me in a way that bothers me	SD	D	A	SA
11.	I sometimes wish I had more money	SD	D	A	SA
12.	My parents don't get along well with each other	SD	D	A	SA
13.	I believe there is a spiritual force that can help me with my problems	SD	D	A	SA
14.	Some kids I hang around with use alcohol or drugs before or during school	SD	D	A	SA
15.	Nothing I do seems to turn out right	SD	D	A	SA
16.	I can't remember ever being ill	SD	D	A	SA
17.	I should be allowed to stay out as late as I want	SD	D	A	SA
18.	I don't mind feeling bored	SD	D	A	SA
19.	I am helped by prayer or meditation	SD	D	A	SA
20.	I am unhappy with my parents	SD	D	A	SA
21.	I have a pretty clear idea of what I want out of life	SD	D	A	SA
22.	My family is very close	SD	D	A	SA
23.	I don't forgive myself easily	SD	D	A	SA
24.	I have never strongly disliked anyone	SD	D	A	SA
25.	I don't care about anything anymore	SD	D	A	SA
26.	I enjoy hearing a good joke	SD	D	A	SA
27.	I sometimes feel resentful when I don't get my way	SD	D	A	SA
28.	Some kids I hang around with have trouble with their parents due to using alcohol or other drugs	SD	D	A	SA
29.	There are people who care about what happens to me	SD	D	A	SA
30.	My family has some unpleasant secrets	SD	D	A	SA
31.	I take a positive attitude toward myself	SD	D	A	SA
32.	I like some kids better than others	SD	D	A	SA
33.	It's important for people my age to think about the future	SD	D	A	SA
34.	I sometimes try to get even, rather than forgive and forget	SD	D	A	SA
35.	My table manners at home are as good as when I eat out in a restaurant	SD	D	A	SA
36.	The kids I hang around with think it's wrong for kids to get drunk or high	SD	D	A	SA
37.	I would rather lose a game than win	SD	D	A	SA
38.	I stay away from home as much as I can	SD	D	A	SA
39.	I feel a spiritual force working in my life	SD	D	A	SA
40.	I don't much care how my actions affect others	SD	D	A	SA
41.	It's wrong to skip school	SD	D	A	SA
42.	One of my parents has ruined the family	SD	D	A	SA
43.	On the whole, I'm satisfied with myself	SD	D	A	SA
44.	There have been times when I felt like rebelling against people in authority, even though I knew they were right	SD	D	A	SA
45.	I am working toward some important goals in my life	SD	D	A	SA
46.	It's okay to hang around with kids my parents don't like	SD	D	A	SA
47.	I have had a powerful religious or spiritual experience	SD	D	A	SA
48.	It's stupid to trust other people	SD	D	A	SA
49.	The kids I hang around with think it's wrong for kids to use drugs other than alcohol or marijuana	SD	D	A	SA
50.	I don't like any kind of music	SD	D	A	SA
51.	I'm afraid of someone in my family	SD	D	A	SA
52.	I have given up on school	SD	D	A	SA

In the next section, please decide how much you agree with each statement about you, and mark one of these answers:
(SD) Strongly disagree (D) Disagree (A) Agree (SA) Strongly agree

	Strongly disagree	Disagree	Agree	Strongly agree
53. I like warm, sunny days	(SD)	(D)	(A)	(SA)
54. It's wrong to lie for my friends	(SD)	(D)	(A)	(SA)
55. The kids I hang around with don't use alcohol or other drugs	(SD)	(D)	(A)	(SA)
56. Good luck is more important than planning and hard work for success	(SD)	(D)	(A)	(SA)
57. I'm always willing to admit it when I make a mistake	(SD)	(D)	(A)	(SA)
58. I have faith in a power greater than me	(SD)	(D)	(A)	(SA)
59. I like my parents	(SD)	(D)	(A)	(SA)
60. It's all right for people to have pets	(SD)	(D)	(A)	(SA)
61. I have never felt that I was punished without a good reason	(SD)	(D)	(A)	(SA)
62. It's wrong to take something from a store without paying for it	(SD)	(D)	(A)	(SA)
63. I plan to finish high school	(SD)	(D)	(A)	(SA)
64. My family always seems to be in an uproar about something	(SD)	(D)	(A)	(SA)
65. I have never said something that hurt someone's feelings on purpose	(SD)	(D)	(A)	(SA)
66. It's okay to trade sex for something I want	(SD)	(D)	(A)	(SA)
67. I daydream sometimes	(SD)	(D)	(A)	(SA)
68. No matter how hard I try, it is never good enough for my family	(SD)	(D)	(A)	(SA)
69. I have never been bothered when people expressed ideas very different from my own	(SD)	(D)	(A)	(SA)
70. It's important to have plans for the future	(SD)	(D)	(A)	(SA)
71. I have a parent who needs treatment for alcohol or drug problems	(SD)	(D)	(A)	(SA)
72. It's wrong to copy someone else's schoolwork or answers on a test	(SD)	(D)	(A)	(SA)
73. I am not a religious person	(SD)	(D)	(A)	(SA)
74. When I don't know something, I don't at all mind admitting it	(SD)	(D)	(A)	(SA)
75. The kids I hang around with think it's okay for kids to smoke marijuana	(SD)	(D)	(A)	(SA)

For questions in the next section, please mark one of these answers:
(0) Seldom or never (1) Sometimes (2) Often (3) Almost always

How often do these things happen:

	Seldom or never	Sometimes	Often	Almost always
76. I get upset when people make me wait	(0)	(1)	(2)	(3)
77. Things happen in my family that nobody wants to talk about	(0)	(1)	(2)	(3)
78. I think everything is my fault	(0)	(1)	(2)	(3)
79. My parents are disappointed in me	(0)	(1)	(2)	(3)
80. It bothers me when I break a rule	(0)	(1)	(2)	(3)
81. I have tried to hide how much I was eating from other people	(0)	(1)	(2)	(3)
82. I feel free to talk with friends about my problems	(0)	(1)	(2)	(3)
83. I have a parent who gets drunk or high	(0)	(1)	(2)	(3)
84. I argue with adults about the things they tell me to do	(0)	(1)	(2)	(3)
85. Members of my family get so angry they hit each other	(0)	(1)	(2)	(3)
86. I feel guilty or ashamed	(0)	(1)	(2)	(3)
87. I do things my own way, no matter what others want me to do	(0)	(1)	(2)	(3)
88. I feel like someone else is controlling my mind	(0)	(1)	(2)	(3)
89. I have a brother or sister who uses alcohol or drugs with me	(0)	(1)	(2)	(3)
90. I rely on religion when I have problems	(0)	(1)	(2)	(3)
91. People treat me fairly	(0)	(1)	(2)	(3)
92. I make myself throw up after eating	(0)	(1)	(2)	(3)
93. It's hard for me to tell anyone how I'm feeling	(0)	(1)	(2)	(3)
94. I get mad when I can't have my own way	(0)	(1)	(2)	(3)
95. I feel like a failure	(0)	(1)	(2)	(3)
96. I have a parent whose use of alcohol or other drugs worries me	(0)	(1)	(2)	(3)
97. I like to see how much I can get away with	(0)	(1)	(2)	(3)
98. My mind doesn't seem to work quite right	(0)	(1)	(2)	(3)
99. I have a brother or sister who uses alcohol or drugs before school or during school	(0)	(1)	(2)	(3)
100. I'm proud of the things I do	(0)	(1)	(2)	(3)
101. There is someone I can talk to if I need to	(0)	(1)	(2)	(3)
102. I do the opposite of what people tell me, just to get them mad	(0)	(1)	(2)	(3)

For questions in the next section, please mark one of these answers:

⓪ Seldom or never ① Sometimes ② Often ③ Almost always

How often do these things happen:

103.	I have a brother or sister who uses marijuana	0	1	2	3
104.	I'd like to feel more sure of myself	0	1	2	3
105.	I am bothered by headaches	0	1	2	3
106.	My family acts like I'm in the way	0	1	2	3
107.	I make plans to kill myself	0	1	2	3
108.	It bothers me when someone else gets blamed for what I do	0	1	2	3
109.	I have a parent who uses alcohol or drugs soon after getting up in the morning	0	1	2	3
110.	Other kids seem to like me	0	1	2	3
111.	I have trouble sleeping	0	1	2	3
112.	I am happy to be the person I am	0	1	2	3
113.	When I have a problem, I can count on someone in my family to help	0	1	2	3
114.	I worry about small mistakes	0	1	2	3
115.	I do what I want, even if I think I will be sorry later	0	1	2	3
116.	I am too tired to do anything	0	1	2	3
117.	I have a brother or sister who gets drunk or high	0	1	2	3
118.	It bothers me to lie	0	1	2	3
119.	I get angry and lose my temper	0	1	2	3
120.	I am bothered by strange thoughts	0	1	2	3
121.	I have been afraid that I couldn't stop eating	0	1	2	3
122.	I ignore rules that get in my way	0	1	2	3
123.	I get frightened for no real reason	0	1	2	3
124.	I rush into doing things without thinking about what might happen	0	1	2	3
125.	I throw or break things when I get angry	0	1	2	3
126.	I have a parent who hits me	0	1	2	3
127.	My thoughts are confused or go too fast	0	1	2	3
128.	People complain that I don't listen to them	0	1	2	3
129.	I go on eating binges, where I eat much larger amounts of food than usual (like a whole chicken or a loaf of bread)	0	1	2	3

For questions in the next section, please mark one of these answers:

o Never 1 Once or twice 3+ More than once or twice

130.	Someone in my family has been sexually abused by another family member	0	1	3+
131.	I've taken something from a store without paying for it	0	1	3+
132.	I have used a weapon to get something from somebody	0	1	3+
133.	I have broken into a locked home or building	0	1	3+
134.	Someone in my family has been sexual with me	0	1	3+
135.	I have damaged someone else's property on purpose	0	1	3+
136.	I have been suspended from school	0	1	3+
137.	I have hit a teacher or supervisor	0	1	3+
138.	I have been in trouble with the police	0	1	3+
139.	A brother or sister of mine has had treatment for alcohol or drug problems	0	1	3+
140.	My parents have taken me to a doctor because they were worried about my eating habits or dieting	0	1	3+
141.	I've been in a fight where someone else was seriously hurt	0	1	3+
142.	I've been sent to the principal or counselor for doing something wrong	0	1	3+
143.	I have been arrested for something besides a traffic violation	0	1	3+
144.	A doctor has told my parents that I was hyperactive or something like that	0	1	3+
145.	One of my parents has had treatment for alcohol or drug problems	0	1	3+
146.	A doctor has prescribed a medicine, like Ritalin, to help me control my behavior at school	0	1	3+
147.	I have been sexually abused by someone outside my family	0	1	3+

Printed in U.S.A. M87516.321

APPENDIX B

B-1

Personal Experience Inventory, PEI - 6m Follow-up

(3-month interval)

Direct all correspondence to :

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B-2

PART I.

For the questions in this section, please mark one of these answers:

- Never
- Once or twice
- Sometimes
- Often

DURING THE PAST 3 MONTHS, HOW OFTEN HAVE YOU USED ALCOHOL OR OTHER DRUGS

1. At home
2. With friends your own age
3. To feel mellow, calm, or happy
4.
5
6. When you were bored
7.
8
9. When you felt tense or uptight
10.
11. To get high
12.
13. Before going out
14. To build your courage
15. To get your mind off your problems
16. Soon after getting up in the morning
17. To have fun
18. In a foreign country (other than Canada or Mexico)
19
20.
21. When you were mad or irritated
22.
23. On weekends, holidays, or days off
24. To relieve a hangover or other effects from the night before
25.
26.
27. While driving a race car
28. Throughout the whole day
29. At teenage parties where your parents or other adults were *not* present
30. When you were lonely
31. Just before or during school
32. To feel better around people
33. When you felt sad or depressed
34 At places where teenagers hang around

DURING THE PAST 3 MONTHS, HOW OFTEN HAVE YOU:

35. Used something to get high without knowing what it was
36. Avoided family activities so you could get high
37.
38. Had thoughts of using or drinking when you should have been thinking of something else
39. Made excuses or lied to friends about your alcohol or drug use
40. Obtained alcohol or drugs from a teacher or school official
41. Avoided straight friends so you could get high
42. Kept on using drugs or drinking when you should have stopped
43. Used more than one drug at the same time in order to get high

79.

80.

For questions in the next section, please mark one of these answers:

- **Yes**
- **No**

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR EXPERIENCES DURING THE PAST 3 MONTHS:

81. Once I start using or drinking it is hard for me to stop before I get completely stoned_____

82. It is sometimes hard for me to go on with my work if I am not encouraged_____

83. There have been times when I was quite jealous of the good fortune of others_____

84. I have tried not to think about how much I was drinking or using_____

85. At times I have had doubts about my ability to succeed in life_____

86. If I could get into a movie without paying and be sure I was not seen I would probably do it_____

87. I have felt that my use of alcohol or drugs is a real problem for me_____

88. No matter who I am talking to, I'm always a good listener_____

89. A few times I have given up doing something because I thought too little of my ability_____

90. I feel that my use of alcohol or drugs is normal_____

91. There have been times when I took advantage of someone_____

92. At times I have really insisted on having things my own way_____

93. I can remember "playing sick" to get out of something_____

94. I can stop drinking or using without a struggle after one or two drinks, hits, etc._____

95. I am always polite, even to people who are unpleasant_____

96. There have been times when I felt like smashing things_____

GO TO QUESTION 111

97.

98.

99.

100.

101.

102.

103.

104.

105.

106.

107.

120. Tranquilizers are sometimes prescribed by doctors to calm people down, quiet their nerves or relax their muscles Librium, Valium, and Miltown are all tranquilizers. How many times (if any) have you taken tranquilizers on your own - that is, without a doctor telling you to take them...

a. In your lifetime_____
b.
c. During the last 3 months_____

121. How many times (if any) have you used heroin (smack, horse, skag)...

a. In your lifetime_____
b.
c. During the last 3 months_____

122. There are a number of narcotics other than heroin, such as methadone, opium, morphine, codeine, demerol, paregoric, talwin, and laudanum. How many times (if any) have you taken narcotics on your own - that is, without a doctor telling you to take them...

a. In your lifetime_____
b.
c. During the last 3 months_____

123. How many times (if any) have you sniffed glue, or breathed the contents of aerosol spray cans, or inhaled any other gases or sprays in order to get high...

a. In your lifetime_____
b.
c. During the last 3 months_____

124.

125

126.

127.

128.

129

Please continue on the next page

41. It's wrong to skip school
42 One of my parents has ruined the family
43 On the whole, I'm satisfied with myself
44 There have been times when I felt like rebelling against people in authority, even though I knew they were right
45. I am working toward some important goals in my life
46 It's okay to hang around with kids my parents don't like
47. I have had a powerful religious or spiritual experience
48 It's stupid to trust other people
49 The kids I hang around with think it's wrong for kids to use drugs other than alcohol or marijuana
50 I don't like any kind of music
51 I'm afraid of someone in my family
52 I have given up on school
53 I like warm, sunny days
54 It's wrong to lie for my friends
55 The kids I hang around with don't use alcohol or other drugs
56 Good luck is more important than planning and hard work for success
57. I'm always willing to admit it when I make a mistake
58. I have faith in a power greater than me
59 I like my parents
60 It's all right for people to have pets
61 I have never felt that I was punished without a good reason
62 It's wrong to take something from a store without paying for it
63. I plan to finish high school
64 My family always seems to be in an uproar about something
65 I have never said something that hurt someone's feelings on purpose
66 It's okay to trade sex for something I want
67. I daydream sometimes
68. No matter how hard I try, it is never good enough for my family
69 I have never been bothered when people expressed ideas very different from my own
70. It's important to have plans for the future
71. I have a parent who needs treatment for alcohol or drug problems
72 It's wrong to copy someone else's schoolwork or answers on a test
73. I am not a religious person
74 When I don't know something, I don't at all mind admitting it
75. The kids I hang around with think it's okay for kids to smoke marijuana

For questions in the next section, please mark one of these answers:

- Seldom or never
- Sometimes
- Often
- Almost always

DURING THE PAST 3 MONTHS, HOW OFTEN DID THESE THINGS HAPPEN:

76. I get upset when people make me wait
77 Things happen in my family that nobody wants to talk about
78 I think everything is my fault
79. My parents are disappointed in me
80. It bothers me when I break a rule

128. People complain that I don't listen to them.....

129. I go on eating binges, where I eat much larger amounts of food than usual (like a whole chicken or a loaf of bread).....

For questions in the next section, please mark one of these answers as it applies to the past 3 months:

- **Never**
- **Once or twice**
- **More than once or twice**

130. Someone in my family has been sexually abused by another family member.....

131. I've taken something from a store without paying for it.....

132. I have used a weapon to get something from somebody.....

133. I have broken into a locked home or building.....

134. Someone in my family has been sexual with me.....

135. I have damaged someone else's property on purpose.....

136. I have been suspended from school.....

137. I have hit a teacher or supervisor.....

138. I have been in trouble with the police.....

139. A brother or sister of mine has had treatment for alcohol or drug problems.....

140. My parents have taken me to a doctor because they were worried about my eating habits or dieting.....

141. I've been in a fight where someone else was seriously hurt.....

142. I've been sent to the principal or counselor for doing something wrong.....

143. I have been arrested for something besides a traffic violation.....

144. A doctor has told my parents that I was hyperactive or something like that.....

145. One of my parents has had treatment for alcohol or drug problems.....

146. A doctor has prescribed a medicine like Ritalin, to help me control my behavior at school.....

147. I have been sexually abused by someone outside my family.....

Thank you for completing this inventory.

APPENDIX C

PEER EVALUATION OUTLINE

Group Member Conducting Evaluation_____

Name and Level of Peer Being Evaluated_____

Date of Evaluation_____

Please write about your perceptions of the peer being evaluated within the categories listed below, as well as complete the rating scales. Your perceptions should be based on personal peer observations (i.e., on unit, in school, staff interactions, at 12 meetings, in groups, etc.) and your best judgments.

- **Remember, with perception there is no right or wrong response, considering all observations and feedback are based on truth and honesty.**
- **Any evaluations that are superficial or "BS" will be rejected and you will be asked to do the evaluation over, this time more realistic and accurate.**

ACCEPTANCE OF TREATMENT

Attitude (For instance, not being open to feedback, grandiosity (feeling superior or invincible), arrogance, verbal negativity, placating, non-compliance, resentfulness, non-verbal negativity, feelings of entitlement, not trusting in the process, authority problems, holding grudges, etc.?)

Behavior (For instance, not taking responsibility to confront others, not empowering self to address personal and family problems, acting out, staying stuck in the problem rather than the solution, projecting into the future, defiance and rebellion, poor anger management, close minded, etc.?)

- *Rating System (Please circle appropriate response)*

  ⇒ Treatment Response – Resistance 1 2 3 4 5 6 7 8 9 10 Acceptance
  ⇒ Level of responsibility for own treatment – Low 1 2 3 4 5 6 7 8 9 10 High
  ⇒ Accountability for committing offense and consequences – Low 1 2 3 4 5 6 7 8 9 10 High

C-2

ACCEPTANCE OF SUBSTANCE ABUSE/ADDICTION AND RELAPSE PREVENTION

Belief System (For instance, does peer believe or accept that they are an addict? Do they think they need a recovery program? How much humility do you see in peer? Are they realistic about strengths and limitations? Do you see them relapsing, mentally, while in the program or when they get out?)

Attitude and Thought Process (Specifically, related to impaired thinking & preoccupation/obsession with using drugs or sex; denial, rationalizing, justifying, minimizing consequences, romanticizing old friends and times, glorifying using or selling drugs, harboring resentments, not discussing reservations) Does peer believe they are unique or still slick and cleaver?

Behavior (For instance, self centeredness, sneakiness, dishonesty, engaging in rituals about using or sex, avoidance behavior, not taking care of self and feelings, limited or shacky recovery program, not reaching out to help others, inconsistent behavior, stubom, etc. ?)

Does peer truly accept into their life a power or powers that are greater than themselves? Especially, when struggling with difficult problems or are most decisions still based in self centeredness?

Is your peer applying new principles and tools of recovery in daily program (for example, frustration tolerance, patience, empathy, love, humility, honesty, open minded, acceptance, using the 12 Steps, Praying, calling groups, using 12 step meetings, reading recovery literature, inventory of self, etc.) ?

- *Rating system (Please circle appropriate response)*

Acceptance of addiction and need for recovery

⇒ Denial 1 2 3 4 5 6 7 8 9 10 Acceptance

⇒ Relapse bound 1 2 3 4 5 6 7 8 9 10 Recovery bound

ACCEPTANCE OF CHANGE

What changes have you seen over time in your peer?

Does the person show at his present level positive attributes (i.e., leadership skills, assertiveness, problem solving skills, integrity, decision making skills, etc.) ? For instance, does person empower himself to deal with issues or do they sit on the pity pot, get resentful, or blame others when frustrated.

Does the person appear to be changing and growing which might be reflected in spirituality, increased self esteem and respect, respect for others, expression of feelings, letting go when powerless, etc.? If not, please identify barriers to their recovery that will be necessary for them to remove or deal with?

What do you believe your peer needs to change or improve to move to the next level?

- *Rating System (Please circle appropriate response)*

  ⇒ Acceptance of Change – Resistance 1 2 3 4 5 6 7 8 9 10 Acceptance
  ⇒ Maturity level relevant to age – Immaturity 1 2 3 4 5 6 7 8 9 10 Maturity

POSITIVE STROKES

Give person positive feedback – Remember, there is always some good and strengths in people, so try and identify it?

OVERALL PROGRESS

- *Rating System (Please circle appropriate response)*

Do you believe your peer is scared of success?
⇒ Not at all – 1 2 3 4 5 6 7 8 9 10 – Absolutely

Do you believe your peer has a tendency to sabotage themselves or their treatment?
⇒ Not at all – 1 2 3 4 5 6 7 8 9 10 – Absolutely

Do you believe your peer is scared of failure? Meaning, the best way not to fail is to not take risks?
⇒ Not at all – 1 2 3 4 5 6 7 8 9 10 – Absolutely

Please rate the overall treatment and recovery progress you have observed while your peer has been in treatment?
⇒ Poor 1 2 3 4 5 6 7 8 9 10 Excellent

Overall Comments about your peer:

APPENDIX D

OFFICE OF JUVENILE JUSTICE
MAXEY TRAINING SCHOOL
SUBSTANCE ABUSE TREATMENT CURRICULUM

LEVEL ONE - ACCEPTANCE

A. Drug history
1. complete worksheets
2. present to group, advocate, and family

B. Progression, tolerance, and frequency
1. explain and identify

C. Committing Offense
1. complete worksheet
2. present to group, advocate, and family

D. Personal behavior and criminal history
1. complete worksheets
2. present to group, advocate, and family

E. My environment
1. complete worksheets
2. present to group, advocate, and family

F. Genograms for family drug/alcohol and criminal histories
1. complete worksheets
2. present to group, advocate, and family

G. Ecomaps for personal drug/alcohol and criminal influences
1. complete worksheets
2. present to group, advocate, and family

H. Serenity prayer
1. memorize
2. give examples of personal use in your daily life
3. present to group, advocate, and family

I. Journaling
1. journal daily
2. share with advocate

J. Goal setting
1. set daily goals in the morning
2. journal achievement of goals daily
3. present to group, advocate, and family

LEVEL TWO - WILLINGNESS

A. Personal defense mechanisms

1. complete worksheets
2. memorize and explain defense mechanisms in your own words
3. identify personal defense mechanisms and give examples
4. journal use of defense mechanisms daily
5. present to group, advocate, and family

B. Chemical Dependency and Disease Concept

1. complete readings, worksheets and tests
2. explain disease concept and give personal examples
3. explain principles of addiction and give personal examples
4. complete personal Jellnyck chart and present to group, advocate, and family
5. explain action of drugs on body and mind

C. AA/NA Principles

1. memorize the 12 steps
2. demonstrate understanding of the 12 steps and basic principles
3. memorize selected sayings and ideas and explain
4. present a to c to group, advocate, and family
5. complete readings and worksheets

D. First Step of AA/NA- "We admitted that we were powerless over our addiction and that our lives had Become unmanageable."

1. complete readings and worksheets
2. demonstrate understanding of First Step principles
3. present First Step to group, advocate, and family

E. "Beat the Streets" video series

1. complete worksheets
2. demonstrate ability to connect main ideas of the video to AA/NA Steps and Program

F. Introduction to Relapse Prevention

1. complete worksheets
2. identify personal triggers and trigger events
3. explain and identify warning signs and high risk situations
4. map a high risk situation
5. explain TFUAC (thoughts, feelings, urges, actions, and consequences) cycle and map personal cycle
6. present to group, advocate, and family

G. H.A.L.T. (Hungry, Angry, Tired, & Lonely)

1. memorize, explain, and give personal examples
2. begin developing personal recovery plan using these principles
3. present to group, advocate, and family

LEVEL TWO - WILLINGNESS

H. Changing Your Criminal Mind - based on Stanton Samenow Ph.D., "Commitment to Change: Overcoming Errors in Thinking" video series

1. complete worksheets and readings
2. identify personal criminal thinking errors and examples of their use
3. identify examples of your criminal lifestyle
4. identify thoughts behind criminal behavior and hurtful behaviors toward others
5. socially responsible thoughts and behaviors
6. present to group, advocate, and family

I. Good-bye letters to drugs and the criminal life-style

1. complete letters
2. present to group, advocate, and family

J. Good-bye letters to friends and family members who use drugs or are involved in the criminal life-style

1. complete letters
2. present to group, advocate, and family

K. Second Step of AA/NA - 'We came to believe that a Power greater than ourselves could restore us to sanity."

1. complete readings and worksheets
2. demonstrate understanding of Second Step principles
3. present to group, advocate, and family

LEVEL THREE - WILLINGNESS

A. Third Step of AA/NA - " We made a decision to turn our will and lives over to the care of God *as we understood Him.*"

1. complete readings and worksheets
2. demonstrate understanding of Third Step principles
3. present to group, advocate, and family

B. Fourth Step of AA/NA - "We made a searching and fearless moral inventory of ourselves."

1. Life History
   a. complete written life history
   b. present to group, advocate, and family

2. Victimization Identification
   a. complete readings and worksheets
   b. identify and write out victimization cycle
   c. present to group, advocate, and family

3. Personal Inventory
   a. complete readings
   b. demonstrate understanding of Fourth Step Principles
   c. complete inventory sheets

C. Children of Alcoholics

1. complete readings and worksheets
2. demonstrate understanding of Children of Alcoholics issues
3. identify personal CHILDREN OF ALCOHOLICS issues
4. present to group, advocate, and family

D. Grief and Loss

1. complete readings and worksheets
2. identify personal losses
3. demonstrate understanding of grieving process
4. identify personal grieving needs
5. develop plan to address these needs
6. present to group, advocate, and family

E. Healthy Thinking

1. complete readings and worksheets
2. identify personal unhealthy thoughts
3. develop healthy and constructive thoughts

LEVEL FOUR - TRUST

A. Fifth Step of AA/NA - " We admitted to God, to ourselves, and to another human being the exact nature of our wrongs."

1. complete readings and worksheets
2. demonstrate understanding of Fifth Step principles
3. Present Fifth Step to staff member of his own choosing

B. Sixth Step of AA/NA- "We were entirely ready to have God remove all these defects of character."

1. complete readings and worksheets
2. demonstrate understanding of Sixth Step principles
3. select behaviors and personal traits you are willing to change and explain your choices
4. obtain feedback on list from group, advocate, and family

C. Seventh Step of AA/NA- "We humbly asked Him to remove our shortcomings."

1. complete readings and worksheets
2. demonstrate understanding of Seventh Step principles
3. develop new thoughts and behaviors to replace personal defects of character
4. obtain feedback on changes from group, advocate, and family
5. demonstrate sincerity and commitment in trying new behaviors

D. Eighth Step of AA/NA- "We made a list of all people we had harmed, and became willing to make amends to them all."

1. complete readings and worksheets
2. demonstrate understanding of Eighth Step principles
3. make a list of people harmed and appropriate amends
4. obtain feedback on list from group, advocate, and family following 12 Step principles

E. Ninth Step of AA/NA - "We made direct amends to such people wherever possible, except when to do so would injure them or others."

1. complete readings and worksheets
2. demonstrate understanding of Ninth Step principles
3. make appropriate amends

F. Tenth Step of AA/NA - "We continued to take personal inventory and when we were wrong promptly admitted it."

1. complete readings and worksheets
2. demonstrate understanding of Tenth Step principles
3. develop list of to take daily inventory
4. obtain feedback on list from group, advocate, and family
5. demonstrate sincerity and commitment in taking a daily inventory according to 12 Step principles
6. obtain feedback on list from group, advocate, and family

LEVEL FOUR - TRUST

G. Building a Recovery Plan- Relapse Prevention Techniques

1. complete readings and worksheets
2. complete recovery contract
3. demonstrate understanding or relapse techniques
4. successfully map out and role play two high risk situations and identify the following: triggers, warning signs, high risk situations, and elements of the TFUAC (thoughts, feelings, urges, actions, and consequences) cycle
5. complete recovery plan focusing on the following areas: nutrition, stress management (includes time management and relaxation techniques), exercise, social contacts, and anger management
6. send letters to unsafe individuals including using friends and family members and those involved in the criminal life-style

APPENDIX E

LEVEL ONE: ACCEPTANCE
TREATMENT TASK: ASSINGMENT SHEET

Youth Name: _____

LEVEL ONE YOUTH TREATMENT TASK ASSIGNMENT SHEET

Task	Date Assigned	Date Due	Date Completed	Youth Initials	Staff Initials
Drug History-Written					
Drug History-Presented					
Identify Tolerance, Progression, and Frequency					
Committing Offense					
Problem Behavior History					
Personal Criminal History					
Environment- Using					
Environment-Crime/Hurtful Behaviors					
Genogram					
Eco-map					
Serenity Prayer					
Journaling					
Goal Setting					
Other:					

E-2

LEVELTWO: WILLINGNESS
TREATMENT TASK: ASSINGMENT SHEET

Youth Name: _____

LEVEL TWO YOUTH TREATMENT TASK ASSIGNMENT SHEET

Task	Date Assigned	Date Due	Date Completed	Youth Initials	Staff Initials
Defense Mechanisms					
Disease Concept					
Drugs & Effects					
AA/NA Principles					
Memorize Steps					
Memorize Sayings					
First Step – written					
First Step- presented					
Beat the Streets					
RPT Techniques					
H. A. L.T.					
Samenow Series					
Good-bye letters To drugs & crime					
Good-bye letters To others					
Second Step					
Other:					

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E-3

LEVEL THREE: UNDERSTANDING
TREATMENT TASK: ASSINGMENT SHEET

Youth Name: _____

LEVEL THREE YOUTH TREATMENT TASK ASSIGNMENT SHEET

Task	Date Assigned	Date Due	Date Completed	Youth Initials	Staff Initials
Third Step					
Fourth Step- Life History					
Fourth Step- Victimization Tasks					
Fourth Step- Personal Inventory/ Character Defects					
Fourth Step- Personal Inventory/ Strengths					
Fourth Step- Resentments					
Grief & Loss					
Healthy Thinking					
Other:					
Other:					
Other:					
Other:					
Other:					

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LEVEL FOUR: TRUST
TREATMENT TASK: ASSINGMENT SHEET Youth Name: _____

LEVEL FOUR YOUTH TREATMENT TASK ASSIGNMENT SHEET

Task	Date Assigned	Date Due	Date Completed	Youth Initials	Staff Initials
Fifth Step					
Sixth Step					
Seventh Step					
Eighth Step-					
Ninth Step					
Tenth Step					
Recovery Plan-Contract					
Recovery Plan – Identify triggers					
High risk situations					
Warning Signs					
Mapping					
Role playing					
Letters					
Other:					
Other:					
Other:					
Other:					

APPENDIX F

F-1

OFFICE OF JUVENILE JUSTICE
MAXEY TRAINING SCHOOL

RESIDENTIAL SUBSTANCE ABUSE TREATMENT CURRICULUM

AN INTEGRATED RECOVERY PROGRAM
FOR CHEMICALLY DEPENDENT
AND SUBSTANCE ABUSING JUVENILE OFFENDERS

INTRODUCTION

The Residential Substance Abuse Treatment curriculum integrates the Maxey Model with substance abuse and relapse prevention treatment. A cognitive-behavioral approach serves as the core therapeutic modality. The framework of this treatment approach incorporates the following:

- Disease Concept
- Nature of Addiction
- The 12 steps of Narcotics and Alcoholics Anonymous
- Stanton Samenow's video series on thinking errors and the criminal mind
- Terrance Gorski's Relapse Prevention Model

Goals of this program are to provide a safe and structured environment in which residents can make needed systemic changes in the following domains: cognitive, affective, behavioral, and spiritual.

Residents are provided an explanation and understanding of the dynamics underlying human behavior focusing on chemical dependency, addiction, and the criminal mind. They are given techniques and skills to identify and map high risk situations, warning signs and triggers for various cycles such as offending, manipulating others, and using chemicals, and to build cognitive and behavioral interrupters. The Twelve Step Program is utilized to provide a unifying anchor for various treatment approaches.

IMPLEMENTATION OF THE PROGRAM

The Residential Substance Abuse Treatment Curriculum requires that staff conduct seven groups weekly. The nature of the groups range from psycho-educational to group therapy depending on the treatment focus and presenting group or individual issues.

Two of the aforementioned seven weekly groups follow a psycho-educational model. Information is presented through videos, lectures, and group exercises.

Four weekly groups provide residents an opportunity to present their Drug History, First Step, Committing Offense, Life History. Cycle work and in-depth work on individual issues, group processing are also addressed within this group format.

In addition, a Twelve Step group is held weekly where group issues are discussed within the context of a Twelve Step perspective.

TREATMENT TASKS AND LEVELS

Residents move through the four levels established by Maxey Training School by completing various treatment tasks. The tasks are sequential in design and are contingent upon mastery of the preceding task. Tasks range from:

- Describing behaviors, substance use, their environments and life events.
- Understanding the practical application of new ideas and knowledge.
- Understanding the relationship between cause and effect in their lives and their personal histories.
- Developing an ability to make cognitive and behavioral changes.
- Developing and practicing sound rational thoughts, values, and behaviors.
- Building a comprehensive recovery plan addressing all areas of their lives.

The Maxey Model provides the framework for the sequence of the treatment tasks and incorporates the Twelve Steps.

- Level One tasks are designed to have residents discover the unmanageability in their lives and the resulting consequences of their behavior.
- Level Two tasks expand upon unmanageability by having residents examine their unsound reasoning and repetative behaviors with the anticipation of a different consequencial outcome. The framework for the First Step is established as they are introduced to the concept of powerlessness in their lives.
- Level Three tasks assists residents in making sense of the influence of previous life events on their personality, behaviors and resulting consequences.
- Level Four tasks focus on making cognitive and behavioral changes. Throughout this treatment stage residents are given tools to make changes and build a personalized recovery plan.

In reality understanding and change do not wait until residents reach a certain level. These processes are taking place continually through intervention to address their attitudes and behaviors.

Major Tasks:

Level One *Acceptance* (One Month)	**Level Two** *Willingness* (Four Months)	**Level Three** *Understanding* (Three Months)	**Level Four** *Trust* (Three Months)
1. Short Personal History	1. Personal Defense Mechanisms	1. Third Step	1. Fifth Step
2. Problem Behaviors and Criminal History (including problem list)	2. Chemical Dependency, Disease Concept and Addiction	2. Children of Alcoholics	2. Sixth and Seventh Steps (Behavioral Goal-Setting and Changes)
3. Committing Offense	3. Drugs and Their Effects	3. Fourth Step (including Life History Events, Trauma and Victimization)	3. Eighth and Ninth Steps (inlcuding Empathy and Making Ammends)
4. Drug History	4. AA and NA: The Twelve Step Program	4. Loss and Grief	4. Tenth Step
5. Environmental Influences (including Genograms and Ecomaps)	5. First Step	5. Healthy Thinking Module	5. Building a Recovery Plan (including Relapse Prevention Techniques, Personal Recovery Plan and Contract)
6. Losses	6. Building a Recovery Plan (including Relapse Prevention fundamentals, H.A.L.T. and Managing Stress)		
7. Goal-Setting and Journaling	7. Changing Your Criminal Mind		
	8. Second Step		
	9. Good-Bye Letters		

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F-5

LEVEL ONE: ACCEPTANCE

Resident Goals: Change first requires residents to be honest and take responsibility for their behaviors. Goals for facilitating responsibility include:

- Admit their actions.
- Recognize the consequences of their actions to others and themselves.
- Recognize the influences in their environment on their thoughts, attitudes and behaviors.

Resident Tasks: Residents accomplish these goals by completing the following taks :

1. **Short Personal History**--overview of residents' life year by year to identify strengths, problem areas, and changes in life due to criminal involvement and drug use.

2. **Problem Behaviors and Criminal History**--a chronological history of behaviors: Breaking rules and problem behaviors at home, in school, and in the community; stealing from family and friends; shoplifting; use of force and other hurtful behaviors (emotional and mental abuse); and breaking the law.

3. **Committing Offense**--detailed description of offense and events 24 hours before and after the offense.

4. **Drug History**--chronology of use focusing on mind-set toward drugs prior to use, setting, progression in tolerance and frequency and consequences of use to others and self. Residents should be able to identify and explain progression in tolerance and frequency. In addition residents are encourgaed to engage in affective versus descriptive list of consequences relative to substance use.

5. **Environment**--detailed description of resident's influences in their environment in areas of criminal behavior, use of force and other hurtful behaviors (emotional and mental abuse), and drug use. Genograms and Eco-maps are be completed as part of the above task.

6. **Loss**-- residents list losses to self and others due to their criminal behaviors and use of drugs in addition to loss suffered as a result of drug use and criminal behaviors of significant others in their lives. This task should be be both affective and descriptive.

7. **Goal-setting and Journaling**--begin daily using these techniques as part of their recovery plan.

These tasks will identify areas for further in-depth work such as: attitude toward authority, awareness of cause and effect, responsibility to others, family issues, and victimization. Residents should complete the worksheets concerning their personal behavior and present them in a group meeting prior to starting the Environmental Influences tasks. Residents

need to first focus and take ownership of their behaviors and substance use. Blaming one's environment is a pitfall that may occur if this sequence is not followed.

Milieu Goals: Reporting behaviors and chemical use in group allow residents to see the commonality they share with others. This reporting may decrease shame and embarrassment. Willingness to be honest can be assessed and commented upon by other group members. Residents begin forming a relationship with their advocates as they review the worksheets together

Family work: Family issues and dynamics will be identified through completion of the worksheets and residents' reporting of his behaviors to family members.

Twelve Steps: After reporting on their behaviors and substance use, the concept of unmanageability will be introduced. Residents will be asked if they believe they have managed their lives, taken care of their responsibilities and recognized that their own behavior was out of control. These same questions should be asked regarding their environment. The First Step is not introduced at this point as a subject of study. The goal is for residents to recognize the unmanageability of their lives due to their decisions and behaviors and the influence of others with whom they associated.

LEVEL TWO: WILLINGNESS

Resident Goals: These treatment tasks provide conceptual framework for residents to achieve the following goals:

- Describe and understand their behaviors as a result of their chemical use and other compulsive behaviors.
- Describe and understand the relationship between thoughts, feelings, and actions (cycle work).
- Identify and use interrupters for making changes (cycle work).
- Use the principles of the Twelve Step Program and relapse prevention techniques for making cognitive, affective, and behavioral changes.
- Begin building their own recovery program including nutrition, exercise, stress management techniques, recreational and spiritual activities.

Resident Tasks: residents complete the aforementioned goals by completing these tasks:

1. **Personal defense mechanisms :** Residents will demonstrate an understanding of role of personal defense mechanisms via identifying personal defense mechanisms and providing examples. This is accomplished through memorizing and explaining the various defense mechanisms, journaling personal use of defense mechanisms daily and presenting them to group, advocate, and family.

2. **Chemical Dependency, Addiction, and Disease Concept**: Residents will demonstrate an understanding of the role of brain chemistry in chemical dependency, the Disease Concept and the principles of addiction namely, compulsion, obsession, craving with personal examples. This is accomplished through completion of readings, worksheets and tests. In addition residents will complete their own personal Jellnyck chart, which allows for a visual picture of progression, and present it to group, advocate, and family.

Resources:

- Bill Moyers' video series titled, , the segment " The Addicted Brain".
- Clinical services' brain model, which can be taken apart to show the different parts.

3. **Drugs and Their Effects**: Residents will demonstrate an understanding of the characteristics and properties of specific drugs in addition to synergistic effects. Consequences of drugs on the human body will be identified as well as the concept "your relationship with drugs". Personal examples will be required of residents in all of these componants. To complete these goals, residents will complete readings, worksheets, and tests and memorize definitions of specific drugs, drug classes and their respective properties. Additionally they will be required to memorize effects of drug use and identify personal settings and mind set for use of chemicals. Personal examples should be given including listing the positive outcomes of drug use.

4. **AA and NA: The Twelve Step Program**: Residents will demonstrate a conceptual understanding of the Twelve Step program. Principles (such as acceptance, openness, willingness, serenity, and surrender), the Steps (their function and relationship to one another), and Twelve Step literature will be explored. Application of this knowledge will be associated with one's daily life and recovery. To successfully complete these tasks residents must memorize the Twelve Steps, explain the purpose of each Step and the relationship to other Steps, identify examples of practical application of the Steps in resident's daily life and to memorize program sayings, explain their meanings, and identify areas of personal application. Residents must also complete readings, worksheets, and tests appropriate for this task. This treatment task can provide residents with an understanding of the conceptual framework of the Twelve Steps and how it can lead them from self-awareness and understanding to change.

The Steps help residents take responsibility for their lives and actions. As residents take responsibility for their lives, they regain their self esteem and self-respect. They also begin to find meaning and purpose in their lives. A synergistic process continually takes place. The various concepts of the Twelve Steps are interrelated and interconnected.

The consequences of actions encourage change and growth exponentially This is dramatically seen by examining one of the key concepts providing the underpinning for recovery: serenity. Serenity is relates to everything one does in the Steps. Honesty contributes to serenity. Honesty is necessary for the First Step. When you can admit and accept your powerlessness to drugs or in situations, you can move from struggling and

fighting to finding solutions. Trusting others can give you a feeling of safety and security thereby contributing to your serenity. The connections can go on and on.

Resources::

- "Working the Twelve Steps: Keep It Simple Series by Hazeldon"
- "Pathways to NA",
- Chapters three and four of "Narcotics Anonymous."
- Reading selections from the "Big Book" and the NA book.
- Twelve Steps and Twelve Tradition books.
- Michael Johnson's "Twelve Steps Video Lecture Series"
- "The Twelve Steps: Recovering from Addictions" video series.

5. First Step of AA/NA- *"We admitted that we were powerless over our addiction and that our lives had become unmanageable."*
Residents will demonstrate an understanding of First Step principles as they relate to drug use as well as other areas of their lives. They must further identify areas of denial in respect to drug use. To complete these goals, residents are required to complete readings and worksheets in addition to the First Step which must be presented to group, advocate, and family.

Step One presents an interesting contradiction to residents. For males Step One challenges their ideas about masculinity, power, and victory. In order to recover, they must recognize their powerlessness. In order to recover (or win), they must surrender. What they probably perceive as weakness--powerless and surrender--become their strengths. In order to understand this juxtaposition of concepts, residents need to truly understand the concept of acceptance and the Serenity Prayer.

6. Building a Recovery Plan: In this task residents begin building a day-to-day recovery plan. They are introduced to relapse prevention concepts and techniques. These concepts help them identify high risk situations; warning signs (progression in their behavior) which can lead to acting out or substance use. Residents must identify their thinking errors which they use to justify their behavior and the resulting consequences of their actions and how to map their cycle. This task moves from the didactic to action and is to be done daily. These tasks are holistic in theory and practice and residents will learn about the physical and spiritual aspects of recovery in addition to the cognitive and emotional. They look at nutrition, exercise, stress management techniques including relaxation and meditation, fun, and spiritual activities as integral to a successful recovery.
This task has four parts: Introduction to Relapse Prevention, the "Beat the Streets" video series, H.A.L.T. (Hungry, Angry, Tired, & Lonely), and Managing Stress which includes relaxation and meditation techniques.

A. Relapse Prevention Concepts and Techniques: Residents must be able to identify and explain the concepts "high risk situation", "warning signs", "triggers", "thinking error" and be able to identify personal examples. In addition residents must identify and chart parts of their cycle for behaviors. In addition developing and practicing cognitive and behavioral interrupters through role play and writing rational thoughts to counter thinking errors are appropriate at this level. Residents should be able to map out high risk situations in addition to completing worksheets and presenting material to group, advocate, and family.

Resources:

- The "Beat the Streets" video series.
- "Episode 13: Relapse" in The Twelve Steps: Recovering from Addictions and accompanying worksheets.

B. H.A.L.T. (Hungry, Angry, Tired, & Lonely): In this task, the role of nutrition, exercise, sleep, relaxation, and fun are discussed as integral parts of a successful recovery plan. Residents must demonstrate an understanding of the concepts by applying them to their daily lives through incorporation into daily goals and daily use.

C. Managing Stress: Residents must demonstrate an ability to break down assignments and other responsibilities into realistic componants by creating a workable daily schedule. In addition residents must have the ability to perform relaxation and meditation techniques.

7. **Changing Your Criminal Mind:** Residents must demonstrate an understanding of the relationship between thinking errors and behavior. This can be accomplished by identifying personal thinking errors such as criminal, using, hurting others and self and the consequences of these thinking errors. An understanding of the concept of personality and the ability to identify various criminal and drug using personalities are goals of this task. In addition residents must demonstrate an understanding of the concept "value system" and its relationship to behavior. Through the indentification of a personal value system and the demonstration of the interrelationship between thinking errors, value system, and personality residents wil be able to make cognitive and behavioral changes in these areas.

Residents will complete worksheets and readings, make a list of thinking errors (criminal, using, and hurtful behaviors to others and self) and the consequences of these thinking errors. Furthermore they must describe various parts of personalities and actions, language, and habits that keep these parts of personalities viable. Residents should make a list of street values and socially responsible values residents want to practice in the future.

Resources:

- Stanton Samenow Ph.D., "Commitment to Change: Overcoming Errors in Thinking" video series.
- The workbook that accompanies the series.

8. **Second Step of AA/NA** – *"We came to believe that a Power greater than ourselves could restore us to sanity."*
Residents must demonstrate an understanding of the following concepts: insanity, good orderly direction, trust, and faith as well as how residents use these ideas in their daily lives. These goals are accomplished through completion of readings and worksheets and the memorization of meanings, concepts and ideas in the Second Step. Residents should be able to explain how these ideas operate in their lives.

The Second and Third Steps, the spirituality steps, usually stimulate considerable discussion and debate. We can learn much about our residents when they discuss their ideas about religion and God. Group sessions often become a lesson in practicing tolerance and respect for others.

Because this subject is controversial start with the idea of insanity and sane behavior tying it to their previous work on unmanageability. Continue with a disscussion on the difference between religion and spirituality.

A part of spirituality is living one's value system. Asking residents to list their values, discussing what is right and wrong, and looking at day-to-day behavior helps them seed spirituality in another perspective. This query can be followed with discussions about their Higher Power: how their Higher Power wants them to live; what values their Higher power wants them to have; and how they should treat others and themselves.

The spirituality aspect of the Twelve Steps can be troublesome for some because the literature talks about God although it says a Higher Power of one owns choosing.

9. **Good-bye letters to drugs and the criminal life-style:** At this point in treatment, writing letters can be an emotional experience for residents. Residents might find themselves conflicted over ending their relationship with drugs , alcohol, and their criminal way of life. Although the task says "good-bye letters", the letters should reflect whatever place a resident is at. If a resident cannot say good-bye to a drug, use this for reviewing the First Step and the insanity of the Second Step.

10. **Good-bye letters to friends and family members who use drugs or are involved in the criminal life-style:** At this point the residents do not have to mail these letters to their friends and relatives. Sending good-bye letters should be voluntary or it truly does not have any meaning. Residents may have some friends that they cannot send these letters to because it may cause problems. These letters are really an expression of the residents' inner dialogue and conflict. Saying good-bye to friends and family members and redefining their relationships are also about loss and grief. The ability to give up a close friend or relative is one barometer of a resident's growth and strength in recovery.

Milieu Goals: As residents gain more understanding of the dynamics of addiction and their personal behaviors, the community should be changing to a therapeutic community. Residents should be encouraged to use the knowledge they have gained to describe behaviors. Small Step study groups allow for residents to share their ideas and to help each other. Residents on Levels Three and Four can help new residents complete drug histories and their step work (thereby doing their Twelfth Step.) New residents could be required to have older residents review their Step work and give suggestions before giving the work to their advocates.

LEVEL THREE: UNDERSTANDING

Treatment tasks in this level zero in on residents' understanding of themselves specifically the relationship between events in their lives and how they internalized these events; how they decided who they were and their place in the world; and what the world meant to them. This task deals with self-definition and definition of others and how these definitions then are acted out. This work is really done through treatment. In this tasks, the introspection is more intense. Staff should realize that residents make begin acting out as they touch core personal issues. Although behavior should not be excused, the goal of intervention should be awareness of the connection between this therapeutic work and problems. (Of course, safety for self and others need to be primary.)

LEVEL THREE: TREATMENT TASKS

1. <u>Third Step of AA/NA</u> - " We made a decision to turn our will and lives over to the care of God *as we understood Him."*

Goals:

- Demonstrate understanding of Third Step concepts
- Identify areas of using, criminal life-style, and hurtful behaviors where one wants to hold onto and explain

Tasks:

- Complete readings and worksheets
- Explain in writing and orally the areas of their lives they need direction and to what lengths they believe they are willing to go to take advice in making changes.
- Explain in writing and orally the areas of their lives they are not willing to take advice and direction.
- Demonstrate by their interaction in group and individual sessions and their actions in the community their willingness to take advice and try new ideas and behaviors.

2. Children of Alcoholics (COA)

3. Fourth Step of AA/NA - *"We made a searching and fearless moral inventory of ourselves."*

Goals:

- Demonstrate an understanding of relationship among life events, thoughts about self and others, character traits, and behaviors.
- Demonstrate an understanding of the consequences of these behaviors to self and others.

Tasks:

- Complete readings and worksheets.
- Complete a chronology of life events identifying positives in childhood and adolescence, family problems and issues, individual trauma and victimization, as well as, character traits.
- Identify connections between events, thoughts about self and others, behaviors and resulting consequences.

At this point in treatment residents should be ready--and willing--to discover more about themselves--why they act a certain way. Residents must see how they defined themselves and the world and then acted out these definitions. This work allows them to better understand their character traits and the purpose behind them. As residents move into other steps, they will need to ask themselves some new questions such as:

- "What have been the consequences of keeping myself safe this way?"
- "Do I need to keep myself safe this way now?"
- "What safe and appropriate ways do I have **now** to keep myself safe?"
- "What am I willing to give up and why?"

Residents look at their resentments--the reasons they hold them, what purpose they have served, actions resulting from holding onto these resentments and the consequences to others and self.

Besides looking at their character defects or shortcomings, residents look at their strengths and inner resources. Residents, at this point, should focus on both their strengths and their weaknesses.

4. Loss and Grief

Goals:

- Demonstrate an understanding of the concepts of loss, grief and the corresponding stages of grieving.
- Identify personal grieving needs and begin to develop resources to facilitate one's personal grieving process.

Tasks:

- Complete readings and worksheets.
- List Losses and consequences of losses to self.
- Describe ways of grieveing for these losses, the consequences of their grieving, and their grieving needs.
- Develop a personal plan to address their grieving needs.

Resources:

- Module entitled "Loss and Grief: Helping Us to Cope with Our Losses".
  This module discusses the signs of depression and suicide. Suggestions of how to help those who grieve are given. A list of suggestions for rituals to help residents mourn for their losses and commemorate their losses concludes the module.

5. Healthy Thinking

Goals:

- Demonstrate an understanding of the relationship between thoughts, feelings and actions.
- Demonstrate an understanding of the concept negative thought, irrational thought or thinking error.
- Demonstrate an understanding of the relationship between these thinking errors and resulting behavior.
- Demonstrate an understanding of the process of building positive, rational and healthy thoughts to replace these errors.

Tasks:

- Complete readings and worksheets.
- List personal thinking errors, negative thoughts, irrational thoughts and their consequences.
- Identify and practice healthy positive thoughts and record feelings associated with this positive change.

This module is based on Rational Emotive Therapy. Changing thoughts will not automatically result in internal change, but this conecpt is part of the process of change. What is important is an understanding of the consequences of how thoughts are turned into actions.

Resources:

- "The Complete RET Learning Program" by Art Perlman, Ph.D., a Hazeldon Publication, 1996. Series titles include Understanding, Anger, Perfectionism, Anxiety and Worry, Depression, Shame, Grief, Guilt, and Self Esteem.

LEVEL FOUR: TRUST

Resident's Goals: Steps Five through Ten provide a natural progression of tasks focusing on taking responsibility for behavior, consequences of their behavior, as well as, setting cognitive and behavioral goals. The goals and objectives for these steps are similar. Residents need to achieve the following goals:

- Read the literature.
- Complete all worksheets.
- Discuss the concepts of these goals in group to demonstrate an understanding of the Step.
- Complete the step.

LEVEL FOUR: TREATMENT TASKS

1. **Fifth Step of AA/NA** - *" We admitted to God, to ourselves, and to another human being the exact nature of our wrongs."*

Residents need to choose one staff member they can trust to do their Fifth Step. This step entails discussing what they learned about themselves when they completed Step Four. Doing a Fifth Step with a family member should be voluntary as many issues may exist that have not yet been dealt with by the resident and family member. Forcing disclosure with a family member would be a violation of the spirit and intent of the Fifth Step.

2. **Sixth Step of AA/NA**- *"We were entirely ready to have God remove all these defects of character."*

The advocate or staff member with whom the resident does Step Five helps prepare the way for Step Six. This step is accomplished by identifying character traits, fears and resentments that residents are resistant and afraid to resolve. Reaching out to the community to learn how others prepared themselves to make changes and let go of resentments, behaviors, and fears are goals of Step Six.

3. **Seventh Step of AA/NA**- *"We humbly asked Him to remove our shortcomings."*

Residents write what they are going to change in their lives and how they will accomplish this task. Cognitive and behavioral changes are given for each character defect or shortcoming the resident is willing to change. This is also done for resentments and fears.

4. **Eighth Step of AA/NA**- *"We made a list of all people we had harmed, and became willing to make amends to them all."*

Step Eight demands empathy and requires residents to put themselves in the place of others and experience the ways they have harmed others. Unless they can see all the ramifications of their actions and appreciate the pain of others, they cannot move on to the Ninth Step. After examining the harm they did to others, residents need to look at the harm they did to themselves and discuss this subject in group and with their advocates.

5. **Ninth Step of AA/NA** - *"We made direct amends to such people wherever possible, except when to do so would injure them or others."*

Step Nine emphasizes that residents should make direct amends to those they have harmed in the past. Where direct amends cannot be made then residents should think of alternative ways to make amends. Residents should understand that an individual may refuse to accept their amends and that this is the individual's right. Residents need to find ways to make amends to themselves. Step Nine espouses that changing behavior is a necessary and critical part of making amends to others and oneself.

6. **Tenth Step of AA/NA** - *"We continued to take personal inventory and when we were wrong promptly admitted it."*

Step Ten is a daily reflection of one's behavior towards others and to themselves. Residents examine identified behaviors they wish to change and how they will change them. Journaling is vital when doing this Step. Residents should get daily feedback from the group. Hopefully, residents will make this daily inventory a regular part of their recovery and their lives after they leave placement.

7. Building a Personal Recovery Plan

Residents draw upon knowldege and skills they have aquired throughout participation in the program. Utilizing this knowledge together facilitates the creation of their personal recovery plan. Residents formulate a recovery contract to use in their next placement, which can be submitted to the court as a statement of their commitment to recovery. The contract is also a commitment to themselves.

Tasks:

- Review the consequences of their using, breaking the law and hurtful behaviors toward others.
- State the reasons for maintaining their sobriety and a criminal free life-style.
- Set recovery goals and tasks for the next six months.
- Identify addictive and criminal thinking errors and newly aquired skills and thoughts to counter them.
- Identify High Risk Situations, Triggers, as well as, cognitive and behavioral interrupters they have been practicing while in treatment.
- Identify warning signs and actions to employ as solutions when they arise.
- Role play potential high risk situations including encountering individuals whom with they used and broke the law.

Their contract includes participation in Twelve Step Programs, personal exercise and nutrition plans, use of stress management techniques, work and school commitments besides issues specific to their recovery. Residents should review this contract with the group, advocate, family, and other significant people in their lives.

APPENDIX G

LEVEL ONE ACCEPTANCE
TREATMENT TASK: JOURNALING

COMMITTING OFFENSE: A GUIDELINE

The following questions will be helpful to you in completing your committing offense treatment task. Answer these questions in order. Give a truthful, accurate, and complete account of your committing offense. Use additional paper for this exercise.

1. When did you start thinking about the offense?

2. Where did you get the idea for the offense?

3. Had you ever committed this kind of offense before?

4. What did you think you would get out of doing it?

5. When did you start the actual planning?

6. Describe in detail, including a timeline, all the planning for the offense.

7. Describe your fantasies or pictures you had when thinking about or planning the offense.

8. If you told someone about your plan what did he/she say about the plan.

9. If your plans changed, describe the changes and how they came about.

10. If you had any second thoughts about the offense, describe them and how you dealt with them.

11. Describe your thoughts about the consequences of the offense. What could happen to you or others?

12. Describe in detail and in order the 24 hours before the offense. Describe what and when you took drugs or alcohol.

13. Did you drink or use the 24 hours before the offense? If so what did you drink or use and when?

LEVEL ONE: ACCEPTANCE
TREATMENT TASK: DRUG HISTORY

DRUG HISTORY

You are now going to write out your drug history starting from the first time you used. Do one drug at a time. When you answer the questions, think of the entire year as best you can. If you had changes in your use during the year or grade, write it down. For example, at age 13 during the school year you used 2-3 times a week but in the summer time you used 4-5 times a week. Complete a drug history for each year you used any substance.

DRUG:_____ **AGE / GRADE:**_____

Where you got it? _____

_____

How often? _____

_____

How much? _____

_____

When during the day did you use? _____

_____

How you used? _____

_____

Where? _____

_____

With whom? _____

_____

Cost and how you got the money? _____

_____

Who knew you were using and what they did about it? _____

_____

G-#5

NARCOTICS ANONYMOUS: HOW IT WORKS
CHAPTER FOUR: *STEP THREE*

Pg. 24-25

1. On the streets who or what were your "higher powers?" Explain how you turned your "life and will" over to them.

a. _____

b. _____

c. _____

d. _____

Pg. 25-26

1. The last paragraph starts out "The word decision implies action." What kind of action do you have to take in order to have faith and make a decision to turn your life and will over to a higher power of your understanding? Give examples of action and explain how these examples can help you build faith.

a. _____

_____

b. _____

_____

c. _____

_____

d. _____

_____

LEARNING ABOUT YOUR BRAIN

In order to understand how the various drugs affect you and why you became addicted to a drug or drugs, you must first understand how your brain works. Every thought, emotion, or action you experience involves your nervous system. This system involves your brain, spinal cord, and nerves that extend throughout your body. Your brain is very complex and flexible in order for you to grow, learn, survive, and adapt to what is happening to you every second of your day.

Picture yourself playing basketball: seeing where everyone is on the floor. Figuring out what others are going to do and what you are going to do. Judging the strengths and weaknesses of your opponent. Looking at what kind of defense is set up. Making all kinds of moves. Picture yourself starting to drive toward the basket with one idea in mind then changing your body position and ball handling in a split second and doing something else. How did you do this?

- First, your eyes had to take all the action in--where your man is, how he is guarding you, where others are on the floor, and where the opening is.

- Second, these messages had to be sent to the brain which sorted them to the correct "memory chips" stored in it so you could interpret (figure out) what was happening.

- Third, the brain made a decision about what to do.

- Fourth, the brain had to send these messages back down to your various muscles to give them instructions on what to do. Think of all the muscle movements in dribbling the ball, moving your body from side to side, backing into someone, switching directions, jumping, and shooting the ball.

- Finally, you make that new change in your drive toward the basket. In a split second, your nervous system has done all this letting you score a basket.

The more you play, the more information you store in your brain. The more you make the same moves, the stronger your memory chips become and the faster you can act. You do not have to think before you walk, it has become an automatic movement. Dribbling the ball has become an automatic movement. Whether you dribble between your legs or behind your back when you are making a move depends on the situation in a game. The more you play, the more times you are in situations that require you to dribble the ball differently. Over time these situations are stored in your mind. When you spot the same situation or a situation close to them, your memory selects what you are to do and tells your body what moves to make.

LEARNING ABOUT YOUR BRAIN

The stronger your memory is, the faster you will be able to act. Think of being guarded by someone for the first time. That person has defensive moves you have not seen; he is doing things that shut you down. As the game goes on, you pick these up, make adjustments, try new moves, and eventually are able to score. You had to send all this new information to your brain which had to sort through all your moves and strategy to help you come up with new moves so you could score on this guy. The more times you tried them, the easier it became because your brain was able to tell your body what to do faster and more efficiently. To better understand how this all works, you need to look at what your brain does and how it works.

LEARNING ABOUT YOUR BRAIN

I. PARTS OF THE BRAIN (These are not all the parts of the brain.)

In order for you to play basketball, you had to take in what is going on around you and continually be making adjustments and changes in a blink of an eye or faster. You take in this information and send it to your brain. In turn the brain makes a decision on what to do and sends this order back down to the various muscle groups involved. Information and messages are sent back and forth by your **nervous system.** There are two parts to your nervous system: the **central nervous** system and the **peripheral nervous** system.

The **peripheral nervous system** is made up of the nerves and their branches that run throughout your body. This system takes messages from your eyes, skin, muscles, ears, and tongue. It sends them to the brain (central nervous system) which makes sense of all this information. The brain then sends orders to act to parts of your body. These orders are carried by the peripheral nervous system back to various parts of your body.

The **Cerebellum** controls your balance, body position, and movement in space.

The **Limbic system** regulates body temperature, blood pressure, heart rate, and levels of sugar in the blood. It helps keep a healthy constant balance in these vital functions like a thermostat sending messages to the furnace when a room gets cold. This is called **homeostasis.** The limbic system is strongly involved in the emotional reactions that have to do with survival: feeding, fighting, fleeing, and sexual reproduction.

The **hypothalamus** is the most important part of the limbic system. It is the "brain" of the brain. The size of a pea, it regulates eating, drinking, sleeping, walking, body temperature, chemical balances, heart rate, hormones, sex, and your emotions. The hypothalamus also directs the master gland of the brain, **the pituitary.** The pituitary regulates the body through **hormones,** chemicals made and secreted by special **neurons** in the brain. These hormones are involved in much of your behavior. For example, testosterone is the male hormone involved in both sex and aggressive behavior.

The **hippocampus** receives and processes new information. It selects what information will be permanently stored in the brain so you can recall it. The **amygdala** is connected to the hippocampus. The amygdala helps to produce emotions such as fear and aggression.

LEARNING ABOUT YOUR BRAIN

I. PARTS OF THE BRAIN (CONT.)

The **cerebrum** is the part of the brain where all your decisions are made; where you organize your world; where you store your experiences; where you produce and understand speech, and where you see paintings and hear music. All these things happen in the **cortex,** the surface of the cerebrum. The cortex receives new information, analyzes it, and compares this new information with stored information from your prior experiences and knowledge. Next, the brain makes a decision and sends the message and instructions to the appropriate muscles and glands. This is how you adapt to new situations; how you are able to learn and grow and change; and how you can survive; how you can play basketball.

The cerebrum is divided into two **hemispheres**. Each hemisphere is responsible for the opposite half of your body. The left side of the brain controls movements and receives information from the right side of the brain. The right side of the brain, controls movements, and receives information from the left side of the brain. Each hemisphere is divided into four **lobes.** Each lobe is responsible for different functions.

The **frontal** lobes are the largest of the four lobes. The frontal lobes are connected to the limbic system. The frontal lobes decide whether an event is threatening or dangerous. Other functions include speech, planning, decision making, and purposeful behavior (doing something that makes sense). If these lobes are damaged, you will not be able to express yourselves, carry out the right order of an activity, understand a complex action or idea (such as playing basketball or putting together a meal), or adapt to new situations.

In the **parietal** lobes you put together your world. Your letters come together as words, and words get put together as thoughts. This is where you are able to perceive (judge and understand) things in your environment. You can judge distance and depth from an object and the movement of something toward you; this is called spatial perception. You need this to put on clothes, eat, walk down the street, and play sports to name just a few of your activities. These lobes allow you to connect a speaker to a voice and allow you to make sense of what your skin feels.

The temporal lobes are responsible for your ability to understand what you hear, your ability to write and draw, and to identify what you smell.

The **occipital** lobes are devoted entirely to vision. The eyes send visual information to these lobes so you can recognize and make sense of what you see. If you cannot make sense of what you see, you will not be able to react appropriately. You may see things that are not really there; in other words, have hallucinations. In short, you cannot experience or be conscious of the visible world as it really is. If these lobes are damaged, you can become blind even if there is no damage to your eyes or other parts of your visual system.

LEARNING ABOUT YOUR BRAIN

II. HOW YOUR BRAIN WORKS: THE NEURON

Neurons are nerve cells; they are the main part, the main element that makes all this work. In many ways they are the most remarkable cells in all biology. Neurons are very tiny, no larger than a few millionths of a meter in diameter; there are millions of them in your brain. The basic job of a neuron is to receive and process information, send this information to other neurons in the brain, and finally to generate behavior (make it happen). Each neuron is like a computer all by itself. Each neuron is always on and always receiving information from thousands of other nerve cells and from chemical messengers in the bloodstream and always in communication with other nerve cells.

Think of millions of neurons throughout your brain, spinal cord, and nerves that fan out throughout your body. During each living moment, these neurons are firing messages or "speaking" to each other.

Covering the neuron is the **membrane;** everything must pass through the membrane for the neuron to do its thing. The membrane resembles a soap bubble; it is very thin and consists of fatty acids that also make up the film on a soap bubble. Various **protein molecules** are scattered throughout the membrane, floating in it. Some of these protein molecules stay on the outside, some are in the inside of the cell. These protein molecules have **chemical side chains** that stick out of the membrane. These protein molecules and their side chains are what we call the **chemical receptors** on the cell membrane.

Neurons send messages by using positive and electrical charges and certain chemicals. These chemicals include **neurotransmitters,** also known as **transmitters.** A transmitter is something that sends a message, for example, a telegraph, a telephone, the wires and towers that carry our electricity. Here is what happens when a particular chemical substance is outside the neuron:

1. The molecules of the chemical (we call them messenger molecules) send a message to the receptor molecule.

2. The receptor molecule recognizes these messenger molecules.

3. These messenger molecules then attach themselves to the receptor molecule of the neuron, just like a key fitting into a lock.

4. This action causes various changes in the cell membrane and the neuron itself.

YOUR BRAIN AND DEPENDENCE

You may be wondering, so what does all this have to do with your getting addicted, becoming dependent on a drug. Let us take a look at how your brain works and how dependence (addiction) occurs.

Remember, neurons take in information and process it. As a result, we act or do something. They send these messages by using chemicals such as neurotransmitters. In order for a neuron to receive a message, the messenger molecule has to fit the receptor molecule. Once the messenger molecule is locked into the receptor molecule, the neuron will do things to send the message onto another neuron, and to another one, and so on until the message is delivered to the correct part of the brain. The brain decides what to do and sends the message back down so an action can take place. A neuron sends messages by producing its own chemicals such as neurotransmitters and hormones and by firing electrical impulses.

Here is where drug dependence enters the picture. Drugs made outside the body, either by man or found in nature, can **mimic** the body's natural chemicals. The receptor neuron does not know if a chemical is a true one or a mimic, a "look-alike." The receptor will recognize it and lock it in.

Three things can happen then in the neuron: (1) the neuron may produce what it is supposed to; (2) it may be prevented from producing what it should; or (3) it may undergo a change and produce something the body does not really want.

In extreme cases, the actual building block of our genetic system, the DNA, may be changed. Depending upon the change, our future children may have serious problems. In the 1960's a drug called thalidomide was prescribed in Europe to help people relax and sleep. Pregnant women who took this drug gave birth to children who were badly deformed, especially their arms and legs. Fortunately, this drug was not allowed to be sold in the United States because our government believed it was unsafe. We know that alcohol can cause birth defects, affecting the development of the mind and body. This is called fetal alcohol syndrome.

YOUR BRAIN AND DEPENDENCE

III. NEUROTRANSMITTERS, MOODS, AND DEPENDENCE

1. OPIUM AND THE BRAIN

Opium has a long history. Europeans discovered opium in China where it had been used for years to relieve pain and bring feelings of intense pleasure, two strong forces that drive our behavior. The major active ingredient in opium is morphine, which was purified in the early 1800's and later synthesized (made) in the laboratory. In the late 1800's, morphine was used in many patent medicines in this country. As a consequence, we experienced a high rate of morphine addiction, which led to the passing of the Narcotic Act of 1914.

In the 1950's, researchers discovered that heroin and morphine attach themselves to special opiate receptors on nerve cells in certain parts of the brain. The question they asked was "Why does our brain have the receptors that fit molecules made by poppy plants?" They thought that the brain must be making chemicals whose shapes were similar to those of opiates.

In 1975, scientists in Scotland found the reason: the brain produces a substance called enkephalins (means "in the head"). Enkephalins help you to endure pain. They were able to do this using the brains of 2000 pigs donated by the slaughterhouses in Scotland. They. further discovered that one end of the enkephalin molecule closely resembles one end of the morphine molecule. In other words, the morphine molecule locked into the enkephalin receptor in the brain. The receptor thought that the morphine molecule was enkaphalin.

Since 1975, scientists have found other neurotransmitters in the brain which block pain and induce euphoria, and intense feeling of pleasure. These are called **endorphins.** They are your brain's own painkillers and narcotics. They produce most of the same effects as drugs made from the opium poppy especially reducing pain and producing a feeling of euphoria. These chemicals are produced by the pituitary gland to counter the pain and suffering you experience due to stress.

Some individuals are born with the ability to produce enough endorphins to deal with every day stress, enjoy themselves, and withstand some pain when hurt. On the other hand, some individuals may not have the ability to produce enough endorphins to deal with stress and pain; these individuals may be at high risk to rely on opiates and therefore may become addicted.

YOUR BRAIN AND DEPENDENCE

Science has found that working out can release these endorphins and make you feel good. In fact, long distance joggers report having a strong feeling of joy and euphoria if they jog regularly for long distances. Other "stressful" activities such as skydiving, bungey jumping, mountain climbing, and other risky sports also produce these. When a mother is ready to deliver, the level of endorphins rises dramatically, ten times its normal level, in order to help the mother and infant protect themselves against the pain and stress of childbirth.

When you use opiates such as heroin, codeine, and such opiate-like pain killers as Demerol, your brain begins to rely on these drugs to stop pain and give you feelings of intense pleasure. The body's natural drugs, the endorphins and enkephalins, cannot match the strength and intensity of these opiates. Over time, the body depends on the heroin, the Tylenol 3's with codeine and the Demerol to block pain and feel euphoric. When these drugs wear off, your brain is unable to produce its own painkillers fast enough or strong enough. You have become used to the feeling that a Tylenol 3 with Codeine or heroin gives us. The brain says "I gotta have it!" "Nothing else will do!" Addiction and dependence have now set in.

2. NEUROTRANSMITTERS

From our discussion about opium and the brain, we have seen how important neurotransmitters are to controlling our mood. Here are the various neurotransmitters involved in chemical dependence:

endorphins and **enkephalins** - reduce or block pain and help give you feelings of pleasure and euphoria

dopamine - involved in regulating pleasure, helps gives you feelings of euphoria and satisfaction

serotonin - relaxes and calms you; important in your getting sleep

gamma amino butyric (GABA) - slows down the action of your central nervous system

sex hormones - can be powerful antidepressants

adrenaline and noradrenaline - your natural uppers; gives you a rush, helps you get pumped up.

YOUR BRAIN AND DEPENDENCE

Alcohol and other drugs produce many of their effects by changing the actions of neurotransmitters. Drug use can:

- change the way that neurons produce neurotransmitters;
- change the way that neurons release neurotransmitters;
- change the way that neurotransmitters return to the messenger neuron;
- imitate the effect of a neurotransmitter;
- block the effect of a neurotransmitter; and
- enhance (make stronger) the effect of a neurotransmitter.

When these changes happen in your brain, your moods also change. That is why these are called **mood altering drugs**. They change the way you feel. Many of these neurotransmitters involved in dependence are those that send messages about pain and pleasure.

YOUR BRAIN AND DEPENDENCE

A. THE MESOLIMBIC SYSTEM AND DEPENDENCE

The part of the brain involved in our ability to feel pleasure is called the mesolimbic system. You can find the mesolimbic system by putting one finger just above your nose between the eyebrows and another finger behind the top of one ear. Imagine lines going straight out from each finger. The mesolimbic system is where these lines cross inside your head. "The effects of most addictive drugs will eventually be explained by their actions in the mesolimbic system" (Erickson and O'Neill).

The **hypothalamus** is a major part of the mesolimbic system. The hypothalamus is found at the base of the brain, right above the pituitary gland. As you learned earlier, the hypothalamus has the control centers that govern your survival: eating, drinking, and sexual activity. One of these control centers is called the **pleasure center.** Running through the pleasure center is a major nerve called the **medial forebrain bundle** which we will call the **MFB.** The MFB is known as the "pleasure pathway." If your MFB is stimulated by electricity or chemicals, you feel intense pleasure and a sense of well-being. This is the kind of stimulation produced by mood altering drugs.

Different drugs act on different parts of the MFB:

- Amphetamines, cocaine, and marijuana increase the amount of dopamine released in one part, called the nucleus accumbens;
- Opiates and (perhaps) nicotine primarily affect the ventral tegmental area; and
- Alcohol acts on both of these parts and probably many others of the brain.

Scientists are now focusing on four neurotransmitters: dopamine, serotonin, endorphins, and GABA. One theory is that people with substance dependence may have low levels of these neurotransmitters in the MFB and other areas of the brain. These people use drugs to feel normal that is, to raise the amount and intensity of these neurotransmitters.

YOUR BRAIN AND DEPENDENCE

The MFB actually contains more than one pathway. Several pathways may be involved in the action of a particular drug. One theory is this: When people are genetically prone to dependence or take a drug over and over again, the pathways on which dopamine travels through the pleasure center changes. These people then become highly sensitive to the effects of the drug. According to this theory, there are three pathways in the MFB:

- A "**like**" pathway that leads to euphoria;
- A "**want**" pathway that leads to craving; and
- A "**need**" pathway that is stronger and more basic than the other two.

Some alcoholics report a need for alcohol that comes from the gut almost like an instinct even when alcohol no longer produces a craving or euphoria. Dependence or addiction has been described as an overpowering drive. It works in the same part of the brain that controls your instincts your "gut" that tells you what we need in order to survive.

YOUR BRAIN AND DEPENDENCE

B. DOPAMINE AND CHEMICAL DEPENDENCE

Dopamine is a neurotransmitter that is released when we experience pleasure, joy, euphoria, and satisfaction. Science believes that certain parts of the brain regulate our feelings of pleasure. When you eat a piece of cake, your senses said, " This is good." "I enjoy this." Your eyes liked the dark chocolate color, texture, and icing; your taste buds salivated over the taste of the chocolate and the texture.

Your brain released dopamine, which allowed you to enjoy even more pleasure and store everything about the cake in your memory. That strong feeling of enjoyment lasted for a short time then faded. This is what normally happens when you enjoy something. If your brain did not regulate (control) these feelings of pleasure, you would constantly be in overdrive when it came to feelings of pleasure.

You probably did not eat another piece of cake one hour later then another hour later. The desire for that taste did not influence you to have chocolate cake when you woke up or eat it throughout the day. You would be constantly doing activities that only gave you pleasure. Our brain regulates these strong feelings of pleasure to help us maintain a balance in our emotional life.

Individuals with addiction problems do not have this balance. Their brain does not regulate their flow of pleasure or their demand for the pleasure to repeat itself. Addicts do not really crave the drug. They crave the dopamine rush. (Similar to some individuals craving the adrenaline rush or high when they fight or break the law.)

Some individuals do not take in (or absorb) enough dopamine when the dopamine is produced so they do not experience pleasure like others. Different drugs intensify (make stronger) the affect of dopamine in the brain.

Dopamine shoots into the pleasure center (nucleus accumbens) and leaves an imprint on the brain. The more dopamine our brain produces, the **more likely** we are to enjoy something and **to remember** it. The less dopamine the brain produces the **less likely** we are to enjoy something and **to remember** it. When dopamine floods the cell, the memory of the event is registered (stamped) in the brain. Along with memory comes the motivation to repeat the behavior.

DOPAMINE AND CHEMICAL DEPENDENCE

Cocaine keeps dopamine trapped in the cell longer than is natural so the effect of the dopamine is much stronger. There is a molecule that brings dopamine back out of the cell to regulate your feeling of pleasure. This is what produces the cocaine high. Amphetamines stimulate cells to produce more dopamine.

Nicotine, heroin, and alcohol raise the dopamine level. There is a chemical in tobacco that is also responsible for keeping dopamine in the cells longer.

Cocaine users make bad choices. One major reason is that cocaine damages the prefrontal cortex part of the brain. This part of the brain helps us choose between what is right and wrong. It helps us control impulsive and irrational behavior.

CHEMICAL DEPENDENCE: A DISEASE

In Part Three, you saw how you became addicted or dependent upon a drug by the chemical and electrical processes in your brain, specifically in the brain's pleasure center. Any drug which gives you pleasure can cause you difficulties in your life. You can become addicted to it. Experimenting with any drug is like gambling (like playing roulette), you will never know if you will become addicted.

Your family history may give you a clue if you are at risk. Scientists believe that you may inherit the potential to become dependent just as you can inherit the potential to have other diseases, such as, diabetes, heart disease, and cancer. Your genetic make-up inherited from your parents, their parents, and generations back may determine if you will become addicted.

Several studies involving children of alcoholics who were adopted by families where alcoholism was not present supports this theory. Adopted male children with alcoholic fathers were three times more likely to become alcoholic than children who did not have alcoholic fathers. Adopted males were nine times more likely to become alcoholics; adopted daughters, three times. As children, you may learn about alcohol from your parents and people around you. You may drink because you see others drink. As these studies show, you are at a higher risk to become alcoholic if alcoholism is in our family.

I. Dependence

Let us look at the word **dependent**. It comes from the word **depend** which means to **rely upon.** You are usually dependent upon your family growing up. You cannot defend yourself when you are young; you cannot teach yourself to walk, to read, to eat with a fork, to put a roof over your head, or to put food on the table. You have to **rely upon** your family.

Chemically dependent people come to rely on a drug or drugs to do things for them. What starts out as using drugs to feel good, to have a good time and to get a buzz or high changes to using to maintain these feelings. **Chemically dependent people** repeatedly use despite experiencing negative consequences.

CHEMICAL DEPENDENCE: A DISEASE

II. Certain processes always take place in dependence:

A. Tolerance. An increase in the amount you use in order to get what you want out of the drug. The amount you were using does not change your mood; it cannot affect your brain like it use to. You need more of the drug to get the same change you had earlier.

B. Reinforcement. You become addicted to these drugs because they work on the brain to **reinforce** your using them. If you want your dog to sit, you reinforce his behavior by giving him a treat every time he sits. The dog connects the tasty treat with his sitting and continues to sit to get the treat. In the addictive person, drugs produce feelings and thoughts in your brain that say "Do it again!" Over a period of time, this message begins taking control and you use despite negative consequences happening to you. This reinforcement is one key part of chemical or drug dependence.

C. Preoccupation is thinking about drugs and getting high when you should be doing something else. Your minds are being occupied with these thoughts. Sometimes the thought of using distracts you from what you are supposed to be doing at school or work. Or you are thinking about using when you are with your family or at a event where there are not any drugs. You may think about, daydream, and fantasize about getting high or drinking with your friends after school, or about the party later on, or just anticipate feeling good when you are going to use. Sometimes you spend time thinking about how you are going to get money to buy your beer, liquor or weed.

D . Loss of Control. Your use has a will of its own. Your use takes charge of itself. Things happen without your being aware of them. Things continue to happen even when you try to change them.

1. Did you sit down and say / next week I am going to smoke a blunt instead of a couple joints; drink more beer or gin or Henessey?

   _____

   _____

   _____

2. Did you know how much you were going to use every time you did? Explain.

   _____

   _____

   _____

CHEMICAL DEPENDENCE: A DISEASE

8. Get into fights? Not come home? Break the law? Explain.

_____

_____

_____

9. Use Visine, cologne, or breath mints regularly to hide your use? Explain.

_____

_____

_____

If you answered yes to any of these questions, you experienced loss of control.

CHEMICAL DEPENDENCE: A DISEASE

III. The Four Stages of Drug Use.

A. Stage One: Experimentation and First-Time Use.

1. Think back to when you first smoked a cigarette. What happened? Did you cough? Wheeze? Eyes burn? List what happened to you. _____

_____

_____

2. Think back to when you first drank beer or liquor. List what happened.

_____

_____

_____

3. Think back to when you first smoked marijuana. List what happened.

_____

_____

_____

Despite what happened when you first used--probably you did not like these effects--you continued to use. Let us look at the reasons why. Give examples.

4. What did other people tell you to help you continue using? _____

_____

_____

5. Did peer pressure play a role? _____

_____

_____

6. Why do you think you continued to use? _____

_____

_____

CHEMICAL DEPENDENCE: A DISEASE

B. Stage Two: Social or Occasional Use.

In this stage you may use once a week or less. You may not get a real good high or buzz. What you are saying to yourself is "Look, I can take it or leave it."

C. Stage Three: Regular Use.

Now you are using at least once or twice weekly. You want to make sure you can get it. You want to get high or get a buzz or get drunk. You do not have any worries about using the drug. You may already have a drug of choice. A person may move from the experimental phase very rapidly to this phase.

D. Stage Four: Dependence.

In this stage drugs have become a major part of your life. Drinking and/or using have become important to you although you may not be aware of this. Using has become a regular part of your life similar to taking a shower, eating, or going out with friends. You may use before school, at lunch and/or right after school.

1. Write down the changes in your use as to:

- When you used:

_____

_____

_____

- How much you used:

_____

_____

_____

When you reach this dependence stage, you usually do not consider how much your alcohol or weed costs. You do not let the price stop you from using. You find ways of getting money to use: borrow, do odd jobs, use up our paycheck, steal, and/or sell drugs.

CHEMICAL DEPENDENCE: A DISEASE

- What did you do to get money to use?

_____

_____

- Give examples of your preoccupation.

_____

_____

In this stage you begin having more problems: problems at home, money problems, school difficulties (usually grades and attendance, often you drop out of school as your dependence gets worse), and trouble with the law. You may also change friends or drop friends that do not use.

- List changes in your life due to your using?

1._____

2._____

3._____

4._____

5._____

6._____

7._____

Not everyone will follow these stages. You may start using every weekend at parties. You may begin using daily after a few days or a few weeks. The important thing to keep in mind is that you have your own **relationship** with the drug. Whether it is marijuana, cigarettes, alcohol, or cocaine. In order for you to recover and learn to live without drugs you **must look honestly** at your relationship: what you use, when, how much, where, what happens when you use, what you like about using, and what happens when you try to stop using.

CHEMICAL DEPENDENCE: A DISEASE

D. Your definition for Chemical (drug) Dependence

As you can see, there are several pieces that make up being chemically dependent. Write out your definition for chemical dependence.

CHEMICAL DEPENDENCE: A DISEASE

Because of the strong role brain chemistry plays in chemical dependence, scientists consider chemical dependence a disease such as diabetes or heart disease. The term disease literally means "the lack of ease." When we have a disease, we are experiencing abnormal changes in our body. A part of our body is undergoing a change in its **structure** (what it looks like) and **function** (what it does). When our bodies undergo stress and change, the body is thrown off balance.

In cancer, there is an uncontrolled growth of cells which kills the normal tissues from which they grow. As a result a person can have a variety of symptoms depending upon the type of cancer, such as unusual bleeding, a lump in an area, a mole which gets larger and changes color, constant coughing, and hoarseness. Instead of cells helping us to lead healthy lives, these cells attack the body, causing changes which can result in our death.

Chemical dependence is considered a disease because of the changes in our brain due to the effect of the drug on our brain chemistry. A change takes place in what the brain does and what happens afterwards especially in regards to the release of dopamine. A disease has these three conditions or characteristics:

- First, a disease is **primary**. In other words, it is the main reason why the body is experiencing changes and problems. You can use because you are depressed, because you have difficulty dealing with your feelings, or because of a lot of reasons. These reasons do not cause the disease; they are not responsible for your dependence. You are dependent, or an alcoholic and/or addict because of the action between your brain and the drug.

- Second, A disease is **progressive.** It does not stay the same, it continues moving along, getting worse. It has a predictable course of movement. You can tell what is going to happen over time. In many cases, you have a pretty good idea of what the end will look like. Your tolerance will build up. You will need more of the drug. You will use more. Problems will continue to happen. With certain drugs, your body will experience various medical problems. In short, the amount you use and the problems you experience keep advancing and keep progressing.

- Third, a disease is **chronic. Chronic means the disease does not go away. It stays with you.** Once you have it, you will always have it. You can keep diabetes under control and not experience problems but you will still have it. Even when you stop using drugs and remain sober and clean for years, you still will be chemically dependent. Once you begin using again, you will find that the progression back to the levels of your heavy use will happen very quickly. The disease does not go away.

STEP FIVE

Working the Fifth Step means reading your Fourth Step to yourself, your Higher power, and another person. You read it so you do not forget anything. You come face to face with the words **you wrote down.**

1. Write out your fears about doing the Fifth Step.

2. Read about Step Five in the AA and NA books and other readings.

3. Ask someone who has done a Fifth Step about the experience.

4. When you do a Fifth Step, you talk about your life from the beginning. Let the person know about your childhood, about what when on in your life. You might have already done this if you went over your life history with this same person. If so, you can then begin with your Fourth Step.

APPENDIX H

H-1

Youth's Name _____

STATE OF MICHIGAN
FAMILY INDEPENDENCE AGENCY

"We Strengthen Individuals and Families Through Mutual Respect and Mutual Responsibility"

Maxey Training School

Substance Abuse Treatment Program
Initial Assessment

Name	DOB	Age
Date	Admission Date to Program	
Committing Offense		
Prior Placement 1		Dates
Prior Placement 2		Dates
Prior Placement 3		Dates
Prior Placement 4		Dates
Court Placements 1		Dates
(including detention) 2		Dates
3		Dates
Highest Grade Completed		
Current Grade/Educational Services		
Court	Judge	
Delinquency Service Worker		

Chief complaints:

History of Complaints:

Personal and Family History (if any change from Maxey Model Intake form):

Childhood Development

History of abuse and impact of treatment

Mother

Father

H-3

Youth's Name _____

Appetite/Nutrition

Sleep

Mental Health:

Alcohol/Drug Use

	Alcohol	Marijuana	Cocaine	Inhalants	Psychedelics	Other:
Chemical Abused						
Drug of Choice						
Age at 1st Use						
Age at onset of problem						
Ave. amt./use						
Use during C/O						
Parental abuse						

History of previous treatment

Pattern/Frequency of Use

History of Alcohol and/ Chemical Use

Triggers (people, places, and events)

Barriers to Treatment

Loss of Control

Withdrawal Symptoms (how often substance is taken to relieve or avoid withdrawal symptoms)

Family Substance Abuse History

Compulsion to Use (Energy/time spent in activities needed to acquire substance or take substance and time spent recovering from effects of use)

Describe how use causes social disruption (giving up recreational activities, social occasions,

Youth's Name _____

isolation)

Concurrent Issues

Mental Status:

Appearance Facial expression

Attitude/General Behavior

Psychomotor Activity
Stream of Mental
Activity
Thought Content
Orientation
Memory
Judgment
Coping Style

Strengths (include youth's perceptions)

Weaknesses (include youth's perceptions)

Identified Clinical Problems

Biopsychosocial Diagnostic Summary

Tentative Diagnosis: **Primary**
Secondary

Comments/Other Information

Psychiatric Input (recommendations/comments)

Treatment Recommendations:
Goal 1

H-5

Youth's Name _____

Objective A
Objective B
Objective C

Goal 2

Objective A
Objective B
Objective C

Goal 3

Objective A
Objective B
Objective C

Goal 4

Objective A
Objective B
Objective C

Therapist's Signature Date

Group Leader/Social Worker Signature Date

Program Manager's Signature Date

APPENDIX I

STATE OF MICHIGAN
FAMILY INDEPENDENCE AGENCY

"We Strengthen Individuals and Families Through Mutual Respect and Mutual Responsibility"

Maxey Training School

MASTER TREATMENT PLAN

Name **DOB** **Age**

Date **Admission to Program**

I. CURRENT SITUATION:

II. TREATMENT ISSUES:

A. Legal:
B. Chemical Use:
C. Intrapersonal:
D. Interpersonal:
E. Family:
F. School:

III. RESIDENT AND FAMILY/COMMUNITY STRENGTHS AND RESOURCES

A.
B.
C.

IV. TREATMENT PLAN:

A. Legal:

1. Goal:
   - Objectives 1
   - Objectives 2
   - Objectives 3
   - Objectives 4

A. Legal:

1. Goal:
   - Objectives 1
   - Objectives 2
   - Objectives 3
   - Objectives 4
2. Goal:
   - Objectives 1
   - Objectives 2
   - Objectives 3
   - Objectives 4
3. Goal:
   - Objectives 1

Objectives 3
Objectives 4

4. Goal:
Objectives 1
Objectives 2
Objectives 3
Objectives 4

D. Interpersonal:

1. Goal:
Objectives 1
Objectives 2
Objectives 3
Objectives 4

2. Goal:
Objectives 1
Objectives 2
Objectives 3
Objectives 4

3. Goal:
Objectives 1
Objectives 2
Objectives 3
Objectives 4

4. Goal:
Objectives 1
Objectives 2
Objectives 3
Objectives 4

E. Family:

1. Goal:
Objectives 1
Objectives 2
Objectives 3
Objectives 4

2. Goal:
Objectives 1
Objectives 2
Objectives 3
Objectives 4

3. Goal:
Objectives 1
Objectives 2
Objectives 3

Objectives 4

4. Goal:

Objectives 1
Objectives 2
Objectives 3
Objectives 4

F. School:

1. Goal:

Objectives 1
Objectives 2
Objectives 3
Objectives 4

2. Goal:

Objectives 1
Objectives 2
Objectives 3
Objectives 4

3. Goal:

Objectives 1
Objectives 2
Objectives 3
Objectives 4

4. Goal:

Objectives 1
Objectives 2
Objectives 3
Objectives 4

APPENDIX J

J-1

STATE OF MICHIGAN
FAMILY INDEPENDENCE AGENCY

"We Strengthen Individuals and Families Through Mutual Respect and Mutual Responsibility"

Maxey Training School

Session Note Forms

Youth Name			**Date**		
Type of Session:	**Group**			**Individual**	
FOCUS					
CONTENT					
INTERVENTION					
ASSESSMENT					
PLAN					
ADDITIONAL COMMENTS					
PROGRESS ON GOALS/WORK RELATED TO TREATMENT GOAL(S)					

APPENDIX K

K-1

STATE OF MICHIGAN
FAMILY INDEPENDENCE AGENCY

"We Strengthen Individuals and Families Through Mutual Respect and Mutual Responsibility"

Maxey Training School

Quarterly Progress Report on Substance Abuse Treatment

Progress on Goals
Goal 1:
Additional Objectives
Additional Objectives
Additional Objectives
Goal 2:
Additional Objectives
Additional Objectives
Additional Objectives
Goal 3:
Additional Objectives
Additional Objectives
Additional Objectives
Family work progress:
Recommendations for aftercare:
Additional comments:
Signature:
Date:

APPENDIX L

APPENDIX M

APPENDIX N

N-1

STATE OF MICHIGAN
FAMILY INDEPENDENCE AGENCY
Office of Juvenile Justice
Maxey Training School, PO Box 349, Whitmore Lake, MI 48189

INFORMATION RELEASE AUTHORIZATION

I hereby authorize Maxey Training School or designee to release/exchange information with:

Facility/Program Name:_____

Address:_____

_____

Regarding:_____ Date of Birth:_____
(Name of youth/client PLEASE PRINT)

1. **Specific information to be disclosed:**

Psychosocial History	Medical Records
Psychiatric Evaluation	Education Reports
Psychological Tests/Reports	Substance Abuse Information

Other_____

2. **Purpose and need for such disclosure:**

Evaluation/Assessment	Coordination of Services
Follow-up Treatment	Medication Evaluation

Other_____

This consent expires after one year. This consent may be removed at any time by verbal or written notice to Maxey Training School. Redisclosure of information is not permitted without written notice.

Client/Youth Signature:_____ Date:_____

Parent/Gdn Signature:_____ Date:_____

Release.Doc/pi/lc documents/091798

APPENDIX O

MAXEY TREATMENT ACTIVITY MONITORING FORM

Social workers and group leaders should complete this form each Friday, and submit it to their program manager for review and signature. Please indicate whether the treatment activity occured, even if you did not participate. For example, if the PM covered ART, or the LGL held meetings. There is space at end of form to describe special activities.

For the week of:_____ **Center/Hall/Group#:**_____

Group Meetings: (Include retreats, psychodrama, anger work and marathon sessions, and indicate length)

Date:_____ **Youth/Topic/Task:**_____
Date:_____ **Youth/Topic/Task:**_____
Date:_____ **Youth/Topic/Task:**_____
Date:_____ **Youth/Topic/Task:**_____
Date:_____ **Youth/Topic/Task:**_____

Family Sessions: (Please indicate if these were held anywhere other than Maxey)

Date:_____ **Family/Topic/Task:**_____
Date:_____ **Family/Topic/Task:**_____
Date:_____ **Family/Topic/Task:**_____
Date:_____ **Family/Topic/Task:**_____
Date:_____ **Family/Topic/Task:**_____

Individual Sessions:

Date:_____ **Youth/Topic/Task:**_____
Date:_____ **Youth/Topic/Task:**_____
Date:_____ **Youth/Topic/Task:**_____
Date:_____ **Youth/Topic/Task:**_____
Date:_____ **Youth/Topic/Task:**_____
Date:_____ **Youth/Topic/Task:**_____
Date:_____ **Youth/Topic/Task:**_____
Date:_____ **Youth/Topic/Task:**_____
Date:_____ **Youth/Topic/Task:**_____
Date:_____ **Youth/Topic/Task:**_____

Mental Health Consultations: (Include Clinical Meetings, and indicate as such)

Date:_____ **Youth/Topic:** _____
Date:_____ **Youth/Topic:** _____
Date:_____ **Youth/Topic:** _____
Date:_____ **Youth/Topic:** _____
Date:_____ **Youth/Topic:** _____

Initiatives: (A structured group cooperative or initiative with processing afterwards)

Date:_____ **Activity:**_____
Date:_____ **Activity:**_____

Community Meetings: (A meeting of entire wing for discussion, problem solving)

Date:_____ **Topic:**_____
Date:_____ **Topic:**_____

Psychoeducational Classes: (A structured didactic presentation and discussion; do not include ART)

Date:_____ **Topic:**_____
Date:_____ **Topic:**_____

Aggression Replacement Training:

Skillstreaming: **Date:**_____ **Topic:**_____ **Staff:**_____
Anger Control: **Date:**_____ **Topic:**_____ **Staff:**_____
Moral Reasoning: **Date:**_____ **Topic:**_____ **Staff:**_____

Off-Grounds:

Date:_____ **Activity:**_____
Date:_____ **Activity:**_____
Date:_____ **Activity:**_____

Placements, Releases and LOA's:

Date:_____ **Youth:**_____ **Where:**_____
Date:_____ **Youth:**_____ **Where:**_____

Court Appearances:

Date:_____ **Youth:**_____ **Court:**_____
Date:_____ **Youth:**_____ **Court:**_____
Date:_____ **Youth:**_____ **Court:**_____
Date:_____ **Youth:**_____ **Court:**_____

Training:

Date:_____ **Topic/Location:**_____
Date:_____ **Topic/Location:**_____
Date:_____ **Topic/Location:**_____

DSW Contacts:

Date:_____ **Youth/Topic:**_____
Date:_____ **Youth/Topic:**_____
Date:_____ **Youth/Topic:**_____
Date:_____ **Youth/Topic:**_____
Date:_____ **Youth/Topic:**_____
Date:_____ **Youth/Topic:**_____
Date:_____ **Youth/Topic:**_____
Date:_____ **Youth/Topic:**_____
Date:_____ **Youth/Topic:**_____
Date:_____ **Youth/Topic:**_____

Other:

Date:_____ **Description:**_____
Date:_____ **Description:**_____
Date:_____ **Description:**_____
Date:_____ **Description:**_____
Date:_____ **Description:**_____

_____ _____

Group Leader or Social Worker Date **Program Manager** **Date**

[formmon.sam 5/7/96]

MAXEY PROGRAM MANAGER MONITORING FORM

Program managers should complete this form each Friday to document their respective weekly monitoring checks of the following program activities and procedures. ***For program managers who supervise more than one hall or wing, a separate form should be completed for each hall or wing.*** **This form should be submitted to the Center Director.**

For the week of:_____ **Center/Hall:**_____

Monitored Activity	Please indicate number for each group	
Group Meetings/Sessions/Therapy	Group 1 ____	Group 2 ____
Family Sessions:	Group 1 ____	Group 2 ____
Individual Sessions:	Group 1 ____	Group 2 ____
Mental Health Consultations:	Group 1 ____	Group 2 ____
Initiatives & Cooperatives:	Group 1 ____	Group 2 ____
Community Meetings:	Group 1 ____	Group 2 ____
Psychoeducational Classes:	Group 1 ____	Group 2 ____
Aggression Replacement Training (ART):		
Anger Control:	Group 1 ____	Group 2 ____
Moral Reasoning:	Group 1 ____	Group 2 ____
Skillstreaming:	Group 1 ____	Group 2 ____
Off-Grounds:	Group 1____	Group 2 ____
Placements, Releases & LOA's:	Group 1 ____	Group 2 ____
Court Appearances:	Group 1 ____	Group 2 ____

Please indicate the date you reviewed the following for your wing or hall:

Hall Logs (Log entries are complete; group meetings and group sessions logged) **Date:** _____
Medication Logs (Logs completed and initialed by staff) **Date:** _____
U.I.R.'s (UIR's accurately completed; PM initialed and wrote follow-up if indicated) **Date:** _____
Employee Time & Attendance Records **Date:** _____
Room Restriction Forms (Hourly approvals & 24 hour reviews done by supervisor) **Date:** _____

Please indicate the date(s) the following occurred:

Team Meetings **Date(s):**_____
Team Building/Team Training **Date(s):** _____

Comments/Issues/SpecialActivities:_____

_____

_____

_____

_____

_____ _____

Program Manager Date Center Director Date

[formpm4.sam] 5/22/96

APPENDIX P

P-1

GROUP SESSION EVALUATION

Date: _____ Site: GOC Seq Type: SA TG
Facilitator:_____ Group
Topic:_____
Ending time: _____ # of people on wing:_____
Begin. time: _____ # of people in group:_____
Total time: _____

1. The group facilitator's clear identification of a goal for the day's group was:
   Excellent Good Okay Not Good Terrible
   comments:

2. Thee group facilitator's use of understandable language:
   Excellent Good Okay Not Good Terrible
   comments:

3. The group facilitator's gatekeeping:
   Excellent Good Okay Not Good Terrible
   comments:

4. The group facilitator avoided monopolizing the group discussion:
   Excellent Good Okay Not Good Terrible
   comments:

5. The group facilitator's provided a summary and closing for the meeting:
   Excellent Good Okay Not Good Terrible
   comments:

6. The listening skills of the group participants:
Excellent Good Okay Not Good Terrible
comments:

7. The group's involvement in the discussion through their verbal responses:
Excellent Good Okay Not Good Terrible
comments:

8. The group participants appeared to be expressing honest feelings:
Excellent Good Okay Not Good Terrible
comments:

9. The group participants displayed understanding of issues:
Excellent Good Okay Not Good Terrible
comments:

10. The group participants showed respect for others present:
Excellent Good Okay Not Good Terrible
comments:

11. The groups participants expressed empathy for each other:
Excellent Good Okay Not Good Terrible
comments:

APPENDIX Q

Q-1

Substance Abuse Program Survey

The University of Michigan is evaluating the Maxey Substance Abuse program. As part of that evaluation, we would like to ask you some questions about your experience at Maxey and before coming to Maxey. Your answers will help us understand why some succeed and some fail in the program. You are free to answer these questions or not. Your answers will not be shared with Maxey staff or anyone else. We will only report the results of our analysis of everyone's amswers taken together. If you decide **not** to answer, no one at Maxey will know, so your decision will have no effect on how you are treated at Maxey. You can leave any question blank if you wish; you can also stop answering at any point. If you do not want to answer or you stop answering, it is probably best to just draw or write on the pages until we are all finished. If you have any questions, fell free to ask one of us in the room or Maxey staff.

William C. Birdsall, Ph.D.

1. What is your full name _____

2. . What is your birth date? _____/___/_____
Month/Day/Year

3. When did you first start in your current group at Maxey?

_____/___/_____
Month/Day/Year

4. What level are you on in the Maxey Model?

_____

5. Please check [✓] the box which fits how you feel about these part(s) of Maxey:

	Excellent	Good	Okay	Not Good	Terrible
School					
Food					
Group Sessions					
Hall Staff					
Family Sessions					
Family Visits					
Maxey Overall					

Q-3

14. How much more education do you think you will complete when you leave Maxey? Check [✓] the sentence that best fits how you feel.

____I will not go back to school.
____I will finish high school and receive a diploma
____I will complete my GED
____I will go to a vocational/technical school
____I will earn a two-year college degree.
____I will earn a four-year college degree.
____Other: please list another answer if none of these is correct.

15. Check [✓] the box that describes how often the following things happen **in your family.**

	never	a few times	a lot	almost everyday
People get drunk.				
People use drugs.				
People sell drugs.				
People are violent.				
People listen to me.				
People help me be good.				

15. Check [✓] the box that describes how often the following things happen **in your neighborhood.**

	never	a few times	a lot	almost everyday
People get drunk.				
People use drugs.				
People sell drugs.				
People are violent.				

16. Please circle *yes* or *no* to tell us more about your neighborhood:

We have good schools	yes	no
Good jobs are available	yes	no

17. Please add on the back page any other comments that might help us evaluate the program.