Mohican Youth Center

RSAT Process Evaluation

Final Report

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by

Betsy Fulton, M.S.
Edward Latessa, Ph.D.
Jennifer Pealer, M.A.

University of Cincinnati
Division of Criminal Justice
P.O. Box 210389
Cincinnati, OH 45221-0389

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EXECUTIVE SUMMARY

The Mohican Youth Center (MYC) is a 160-bed secure facility operated by the Ohio Department of Youth Services (DYS). MYC is located in Loudenville, Ohio and has been in operation for approximately 64 years. In 1998, MYC was designated as a substance abuse treatment facility for drug-involved youth who are placed in DYS as the result of a felony adjudication. Youth assessed as needing long-term residential treatment are sent to MYC for the last six months of their sentence. This report presents the results of a process evaluation that was conducted by the University of Cincinnati from January 1998 to August 30, 1999.

A one-group post-test design was used to conduct the process evaluation. The specific research questions that were addressed include: 1) What is the profile of offenders being served? 2) What is the nature of the services being delivered? 3) What are the intermediate outcomes of the program? 4) How are offenders performing under post-release supervision? 5) What factors are associated with post-release success? The sample consists of 343 cases. The primary study period extended from the date of the first admission to the RSAT program (March 30, 1998) through March 31, 1999. Additionally, follow-up data was collected on a sample of terminated cases from their date of release until August 30, 1999.

Site personnel were responsible for collecting intake, treatment, and termination data on their respective program clients using standardized forms developed by the University of Cincinnati. Offenders' readiness for change was measured at intake and 90 days and their level of social and psychological functioning was measured at intake. The site also provided risk assessment and substance abuse assessment information on each

offender. In addition to quantitative data for measuring program process, the Correctional Program Assessment Inventory (CPAI, Gendreau and Bonta, 1994) was used as a measure of program integrity.

Descriptive statistics were used to describe the profile of program participants, program activities, termination, and follow-up data. Paired sample t-tests were used to examine the differences between offender motivation and psychological functioning scales at intake and 90 days. Chi-square analyses were conducted to identify factors associated with post-release success.

Some of the primary findings include the following:

- The participants possessed many risk factors including school problems, antisocial companions, poor use of leisure time, significant criminal histories, and serious substance abuse problems.
- The MYC program scored in the satisfactory range of the CPAI (62.3 percent). This indicates that the program has incorporated many of the principles of effective correctional intervention. Areas identified for improvement were consistency of services, treatment matching, consistency in the application of the behavioral management system, and quality assurance.
- The average length of stay was 171 days.
- MYC is a highly structured program which uses cognitive-behavioral and social learning approaches to treatment. Sixty-six hours of services per week are provided to RSAT participants. These services include school, 12-step recovery groups, criminality groups, substance abuse education groups, and relapse prevention skills training.

- According to program design, all residence receive the same type and dosage of services.
- Administration of the Personal Drug Use Questionnaire at intake and 90 days revealed an increase in the youth's determination to make positive changes in his drug/alcohol use.
- Of the 343 cases, 76 (22.2 percent) were still active in the program, and 267 (77.8 percent) had been successfully discharged.
- Of the 84 cases for which follow-up information on post-release performance was available, 55 (65.5 percent) participated in follow-up drug/alcohol treatment.
- Of these 84 cases, 12 (14.3 percent) of the offenders either reported or were detected using alcohol, and 15 (17.9 percent) either reported or were detected using drugs.
- Of these 84 cases, 28 (33.3 percent) were arrested for a new offense.
- Of these 84 cases, 12 (14.3 percent) were still on active probation, 35 (40.5 percent) had been successfully terminated, 4 (4.8 percent) had been revoked for a new arrest, 3 (3.6 percent) had been revoked for a technical violation, 11 (3.2 percent) had absconded from supervision, and 11 (3.2 percent) had been bound over to adult court.
- Females had lower rates of reported or detected drug/alcohol use, supervision failures, and new arrests as compared to males and that when compared to whites, blacks had similar rates of drug/alcohol use, higher rates of supervision failures, and lower rates of new arrests.
- Offenders who received follow-up drug/alcohol treatment were less likely to fail probation supervision, less likely to get arrested for a new offense, and more likely to have reported or have been detected using drugs/alcohol.

- Youth with longer lengths of stay did better on all indicators of post-release performance.

The findings of the process evaluation are limited by the extent of missing data on some variables, the lack of a comparison group, and small number of cases for which termination and follow-up data are available. The conclusions that can be drawn are primarily descriptive in nature and are not intended to speak to the effectiveness of the program.

MOHICAN YOUTH CENTER

RSAT PROCESS EVALUATION

The Mohican Youth Center (MYC) is operated by the Ohio Department of Youth Services, a statewide agency responsible for the operation of 13 secure facilities and parole services, and the care and supervision of approximately 4300 youth (2330 in facilities and 1979 on parole). MYC is a 160-bed secure facility located in Loudenville, Ohio and has been in operation for approximately 64 years. In 1998, MYC was designated as a substance abuse treatment facility for drug-involved youth who are placed in DYS as the result of a felony adjudication. Youth assessed as needing long-term residential treatment are sent to MYC for the last six months of their sentence. MYC is funded by a federal grant and matching funds from DYS. The grant is renewable for four years after which time DYS will fund the program in its entirety.

The Mohican RSAT program participated in a process evaluation that was funded by the National Institute of Justice and conducted by the University of Cincinnati. This report represents the culmination of this process evaluation that took place from March 30, 1998 to March 31, 1999.

STATEMENT OF THE PROBLEM

The intricate link between substance abuse and delinquent behavior is well documented. Drug testing conducted in twelve cities during 1997 revealed that 42 to 66 percent of male youths tested positive for at least one drug at the time of arrest (National Institute of Justice, 1998). Additionally, juvenile arrests for drug abuse violations increased 86 percent over the past decade (Snyder, 1999). The prevalence of drug and

alcohol use among juvenile offenders creates many challenges for an already overburdened juvenile justice system.

State and local agencies are searching for the most effective way of treating this challenging population. The three most common treatment approaches for substance abusing adolescents include 12-step based treatment, therapeutic communities, and family therapy (Winters, 1999). The Mohican Youth Center (MYC), the subject of this report, uses a combined 12-step and cognitive model of treatment. Thus, a brief review of the literature on these two models is appropriate.

12-step Model

For decades, the 12-step model has been the most prevalent model of substance abuse treatment for adolescents (Bukstein, 1994; Winters, 1999). The 12-step model was originated by the founders of Alcoholics Anonymous (AA) and is used by AA and other self-help groups that view alcoholism and other addictions as physical, mental, and spiritual diseases (Van Voorhis and Hurst, 2000). The 12 steps include:

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. We came to believe that a Power greater than ourselves could restore us to sanity.
3. We made a decision to turn our will and our lives over the the care of God as we understood Him.
4. We made a searching and fearless moral inventory of ourselves.
5. We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. We were entirely ready to have God remove all these defects of character.

7. We humbly asked Him to remove our shortcomings.
8. We made a list of all persons we had harmed and became willing to make amends to them all.
9. We made direct amends to such people wherever possible, except when to do so would injure them or others.
10. We continued to take a personal inventory and when we were wrong promptly admitted it.
11. We sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs (AA, 1976).

Although AA does not view itself as a professional model of therapy (Laundergan, 1982; McCrady and Irving, 1989), their 12-steps are considered a staple in many professionally-run substance abuse treatment programs (Winters, 1999). The Minnesota model, a renowned model of substance abuse treatment, rests heavily on the 12-steps and the AA orientation. Over the years, the 12-step model has been modified for use with adolescents (Winters and Schiks, 1989). Most of these modifications involve the simplification of some of the more abstract concepts.

Due to the importance of preserving the anonymity of AA and other self-help group members there is a dearth of research on 12-step programs; the research that is available suffers from serious methodological weaknesses (Winters, 1999). Studies of the Minnesota model report abstinence rates of 42-60 percent one year after treatment

(Keskinen, 1986; Alford, Hoehler, and Leonard, 1991; Reichter, 1991). A study that compared the outcomes of AA participants with the outcomes of a "no treatment" comparison group revealed more improvement in drinking and legal problems among the AA participants (Brandsma, Maultsby, and Welsh, 1980). According to Winters (1999), until more controlled studies are conducted, all that can be said about the effectiveness of the 12-step model is that it yields outcomes that appear to be better than no treatment at all.

Cognitive-Behavioral Approaches

Cognitive-behavioral models of substance abuse treatment are quickly becoming the preferred model of treatment for drug-involved offenders (Van Voorhis and Hurst, 2000). These programs seek to reduce alcohol and drug abuse in two ways: 1) by altering thinking that supports substance abuse; and 2) by manipulating the stimuli and consequences that prompt and maintain behavior.

Cognitive interventions are popular intervention strategies for both juvenile and adult offenders. They are based on research indicating that offenders are characterized by cognitve skills deficits (e.g., problem-solving, critical reasoning) and internalized antisocial values (Ross and Fabiano, 1985). According to Lester and Van Voorhis (2000), there are two basic types of cognitive interventions. Cognitive restructuring interventions are designed to challenge and modify the content of the offender's thinking. That is, they focus on changing the attitudes, values, and beliefs of offenders that excuse, support, and reinforce criminal behavior (Lester and Van Voorhis, 2000). Cognitive skills training is designed to enhance cognitive deficiencies by changing the form and process of thinking (Lester and Van Voorhis, 2000). These programs were developed to

address several cognitive deficiencies common to offenders including impulsivity, poor reasoning skills, conceptual rigidity, and egocentricity (Ross and Fabiano, 1985). Most cognitive interventions blend these two models.

There is a significant amount of empirical support for cognitive-based programming. Using an experimental design, a study of a cognitive intervention program in Colorado found that drug offenders participating in an ISP that incorporated a cognitive component had significantly lower rates of recidivism and drug use than participants in an ISP without the cognitive component (Johnson and Hunter (1992). Similarly, a quasi-experimental evaluation of the cognitive-based EQUIP program revealed significantly lower rates of recidivism for participants as compared to a matched comparison group that received no specialized treatment (Gibbs, Potter, and Goldstein, 1995).

Behavioral therapies attempt to increase or decrease target behaviors by manipulating the events that surround the behavior. Most common behavioral techniques in programs for offenders are operant conditioning techniques that attempt to modify behavior through the use of rewards and punishments (Lester, Braswell, and Van Voorhis, 2000). Many residential treatment programs use token economies to encourage the development of prosocial skills and behaviors (Agee, 1995; Phillips, Phillips, Fixen, and Wolf, 1973). In token economies, offenders are rewarded for exhibiting desired target behaviors by earning tokens or points that can later be exchanged for more tangible rewards. Token economies are often imbedded in phase or level systems. In these systems, programs are comprised of distinct phases that are associated with a different set of responsibilities and privileges. Depending on his/her performance, an offender can move up or down a phase, earning or loosing the associated privileges. Behavioral

contracting is another example of an operant conditioning technique that is designed to accelerate a specific target behavior (Spiegler and Guevremont (1993). A written contract states the specific behavior to be performed and specifies the reinforcers that will be administered for performing the behavior. Several meta-analyses have identified behavioral programming as characteristic of effective programs capable of reducing antisocial behavior (Andrews, Zinger, Hoge, Bonta, Gendereau, and Cullen, 1990; Lipsey and Wilson, 1997). Given the positive results of cognitive and behavioral therapies, programs that combine these two approaches offer a promising avenue for reducing substance abusing behavior. However, more controlled studies on the effectiveness of substance abuse interventions for adolescents are desperately needed.

The Residential Substance Abuse Treatment programs funded by Subtitle U of the Violent Crime Control and Law Enforcement Act of 1994 offer a promising avenue for exploring the issues associated with the effective treatment of drug-involved youth. The process evaluation described herein was funded under this federal initiative. It represents a first step in examining the effectiveness of long-term residential treatment for drug-involved male adolescents at Ohio's Mohican Youth Center. The evaluation uses both qualitative and quantitative measures to describe the target population, the nature and quality of the services provided, and preliminary outcomes of the Mohican RSAT program.

METHODOLOGY

Research design

A one-group post-test design was used to conduct the process evaluation. The specific research questions that were addressed include:

- What is the profile of offenders being served by MYC?
- What is the nature of the services being delivered?
- What are the intermediate outcomes of MYC?
- How are offenders performing under post-release supervision in terms of relapse and recidivism?
- What factors are associated with post-release success?

Sample

The sample consists of 343 male youth placed in MYC between March 30, 1998 and March 31, 1999.

Study Period

The primary study period extended from the date of the first admission to the RSAT program (March 30, 1998) through March 31, 1999. Additionally, follow-up data was collected on a sample of terminated cases from their date of release until August 30, 1999.

Data Collection[1]

Site personnel were responsible for collecting intake, service, and termination data on their respective program clients using standardized forms developed by the University of Cincinnati (see Appendix A). The site also provided agency-specific assessment information on each offender (e.g., Youthful Level of Services Inventory).

[1] It should be noted that a service tracking form was developed by the University of Cincinnati to track: 1) quantitative measures of the nature and amount of service provided, 2) movement through program phases, 3) program violations, and 4) the number and results of drug tests conducted. Due to problems with the implementation of this instrument, these data were not collected.

Data forms were checked periodically to ensure the quality and completeness of the data. Follow-up data were collected by UC staff through written surveys of parole officers. An automated database was developed to maintain the data using Visual FoxPro.

In addition to quantitative data for measuring program processes, the Correctional Program Assessment Inventory (CPAI) was used as a measure of program integrity. The CPAI provides a standardized, objective way for assessing the quality of correctional programs against empirically based standards. The CPAI is designed to ascertain the extent to which correctional programs have incorporated certain principles of effective intervention. There are six primary sections of the CPAI:

1) Program implementation - this section focuses on the qualifications and involvement of the program director, the extent to which the treatment literature was considered in the program design, and whether or not the program is consistent with existing values in the community, meets a local need, and is perceived to be cost-effective.

2) Client pre-service assessment - this section examines the program's offender selection and assessment processes to ascertain the extent to which clients are appropriate for the services provided. It also addresses the methods for assessing risk, need, and responsivity factors.

3) Characteristics of the program - this section examines whether or not the program is targeting criminogenic attitudes and behaviors, the specific treatment modalities employed, the use of rewards and punishments, and the methods used to prepare to the offender for release from the program.

4) Characteristics and practices of the staff - this section concerns the qualifications, experience, stability, training, and involvement of the program staff.

5) Evaluation - this section centers on the types of feedback, assessment, and evaluations used to monitor how well the program is functioning.

6) Miscellaneous - this final section of the CPAI includes miscellaneous items pertaining to the program such as ethical guidelines and levels of funding and community support.

Each section of the CPAI consists of 6 to 26 items for a total of 77 items that are designed to operationalize the principles of effective intervention. The number of items in each section represents the weight given to that particular section relative to the other sections of the instrument. Each of these items is scored as "1" or "0." To receive a "1" programs must demonstrate that they meet the specified criteria (e.g., the director is involved in some aspect of direct service delivery to clients; client risk of recidivism is assessed through a standardized, quantifiable measure). Based on the number of points earned, each section is scored as either "very satisfactory" (70% to 100%); "satisfactory" (60% to 69%); "satisfactory, but needs improvement" (50% to 59%); or "unsatisfactory" (less than 50%). The scores from all six areas are totaled and the same scale is used for the overall assessment score. Some items may be considered "not applicable," in which case they are not included in the scoring. Data for the CPAI are gathered through structured interviews with program staff at each of the sites. Other sources of information include the examination of program documentation, the review of representative case files, and some observation of program activities. Upon conclusion of the assessment, a report is issued that outlines the programs' strengths and areas needing improvement for each of the six sections of the CPAI.

Process Variables Examined

There were three main categories of process variables examined including offender characteristics, termination data, and post-release treatment and supervision.

Offender characteristics. The standardized intake form (see Appendix A) was used to collect basic demographic information on each offender including age, sex, race, years education, and employment/school status at arrest. Additional background

information was also collected including type and frequency of substance use, prior treatment experiences, and criminal history.

Supplemental information that was collected on offender characteristics includes: the offenders' readiness for change as measured by the Personal Drug Use Questionnaire (PDUQ; see Appendix A); their level of psychological and social functioning as measured by the Client Self-Rating Form (see Appendix A); their risk of recidivism as measured by the Youthful Level of Services Inventory-Revised; and their severity of substance abuse problem as measured by the Juvenile Automated Substance Abuse Evaluation (JASAE).

Nature of services provided. Although quantitative measures of treatment dosage are not available, the results of the CPAI and the schedule of activities were used as indicators of the services provided.

Termination data. The information collected regarding the offenders' termination from their respective programs included type of termination (successful or unsuccessful) and criminal justice placement and residency upon termination (see Appendix A).

Post release treatment and supervision. A data collection instrument was developed (see Appendix A) to gather general information from parole officers regarding each offenders' treatment and supervision activities during the period of supervision after release from the program.

Outcome Variables Examined

Intermediate outcomes that were examined included changes in offender motivation for treatment as measured by the re-administration of the Personal Drug Use

Questionnaire and completion of treatment.[2] Longer-term outcomes that were examined included several measures of substance abuse relapse and recidivism. Relapse was measured as any new substance use (yes or no), and as the type and frequency of use throughout the follow-up period. Recidivism was defined as any new arrest (yes or no); any new conviction (yes or no); the number of new arrests and convictions; the type of new offense (property, personal, drug, other); revocation (yes or no); and time to first new arrest. Information regarding the case status at the end of the follow-up period and status in employment/school was also collected.

Analysis

Descriptive statistics were used to describe the profile of program participants and termination and follow-up data. Paired sample t-tests were used to examine the differences between offender motivation at intake and 90 days. Chi-square analyses and t-tests were conducted to identify factors associated with post-release success.

Five specific research questions will be answered below. Complete descriptive statistics on Mohican's RSAT program can be found in Appendix B. Summary statistics will be provided below in text and graphic formats.

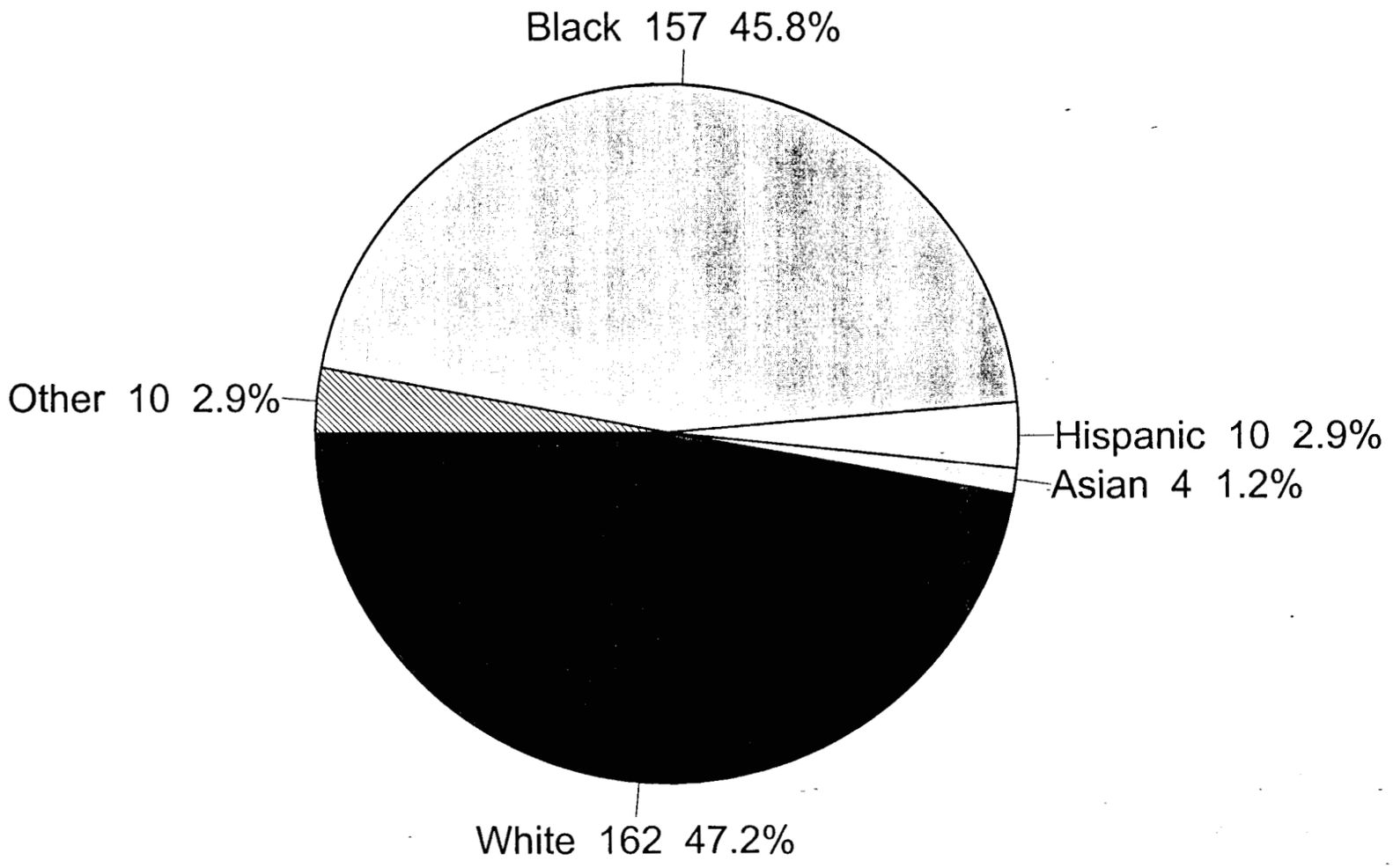
RESULTS

What is the profile of offenders being served by the Mohican RSAT program?

Demographics. The RSAT population included 162 (47.2%) white and 157 (45.8%) black males (Figure 1). The ages of participants ranged from 13.47 to 19.49

[2] The Personal Drug Use Questionnaire (PDUQ) and the Client Self-Rating Form were to be administered at 90 days and termination. Due to problems with the implementation of the instruments, only the PDUQ was readministered , and this was done only with 89 youth.

Figure 1 Race

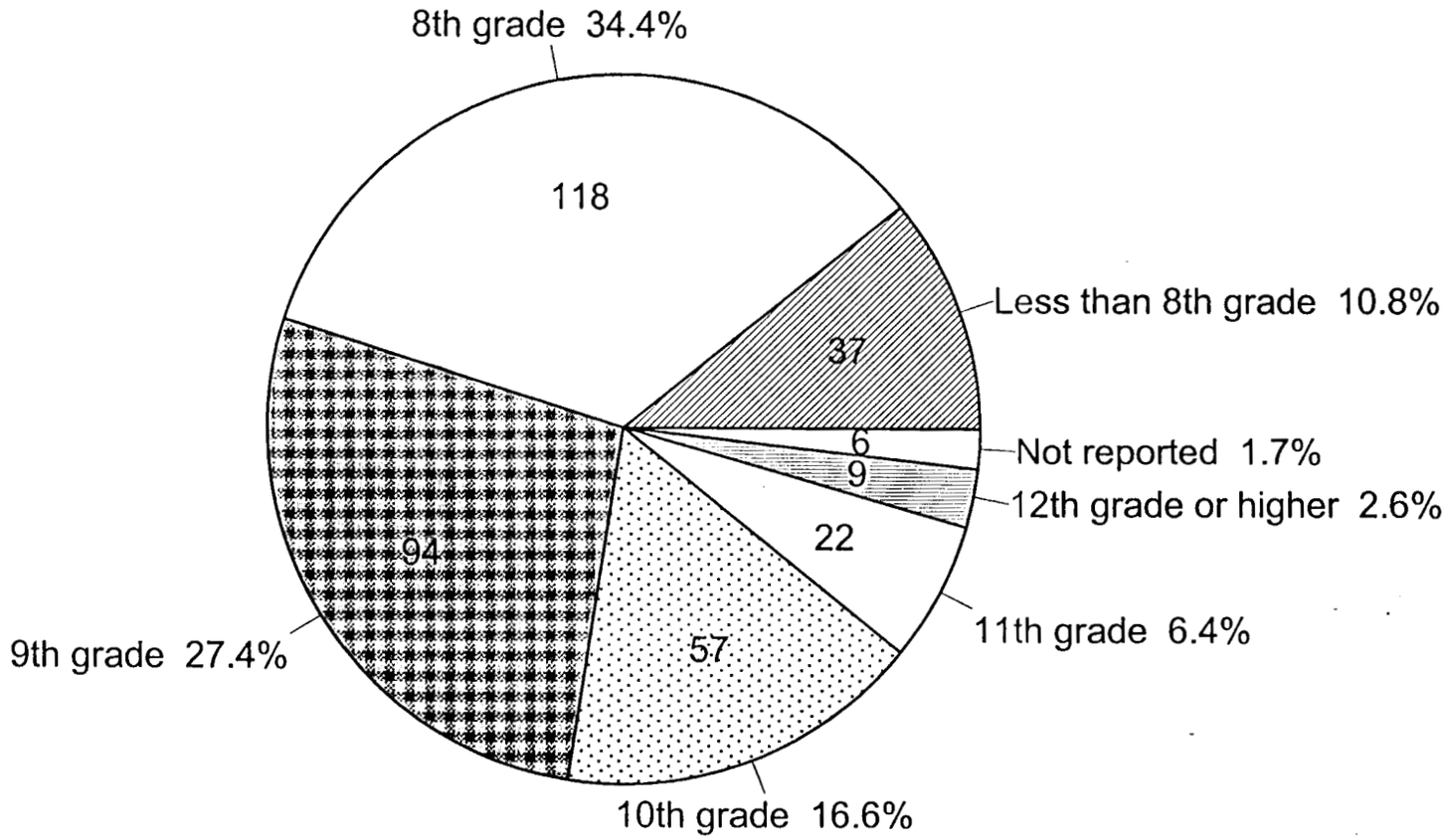


years with a mean of 16.89. The majority of program participants (71.7%) were unemployed prior to arrest. Only two (.6%) of the participants were married and 55 (16.1%) had one or more dependents. The majority (86%) lived with their parents/guardians prior to arrest.

School performance. Two hundred fifty-four (74.1%) of the participants were enrolled in school prior to their arrest. The mean number of years' education completed at intake was 8.76 (Figure 2). There was a high prevalence of school problems among RSAT participants with 71.4% reporting a history of truancy, 61.8% reporting low achievement, 62.1% reporting a history of disruptive behavior in school, and 77.8 % reporting a history of suspensions/expulsions.

Criminal History. The reliability of the information provided on the criminal history of RSAT participants is questionable due to unclear definitions. Some staff provided information based on the number of charges and others provided information based on the number of arrest incidences. Additionally, there is a lot of missing data. The information provided, however, suggests that the majority of RSAT participants had a significant criminal history. Based on 255 cases, the age at first arrest ranged from 4 to 18 with a mean of 13.47. Fifty-three percent of the cases reported having at least one prior felony conviction; information pertaining to prior felony convictions was not available on the remaining 46.4% of the cases. The mean number of prior felony convictions was 3.21. Forty-seven percent of the cases reported having at least one prior misdemeanor conviction; information pertaining to prior misdemeanor convictions was not available on the remaining 52.25 of the cases. The mean number of prior misdemeanor convictions was 4.97. Forty-three percent of all participants had been arrested on a prior drug charge. Fifty-two percent of RSAT participants had one or more

Figure 2 Highest Grade Completed



prior sentences to a secure facility, 74 percent had one or more prior sentences to community supervision, and 44 percent had been unsuccessfully terminated from community supervision on one or more occasions. Most RSAT participants were sentenced to DYS as the result of a conviction for property (44%) or person (34%) offenses (Figure 3). The majority of cases were either felonies of the second (33%) or fourth (24%) degrees (Figure 4).

Substance Abuse History. Participants reported having used multiple types of substances prior to their arrest at high rates of frequency. The most prevalent type of prior drug use among RSAT participants was for alcohol (93.6%) and marijuana (99.1%), followed by hallucinogens (33.2%) and depressants (23.6%). Daily use of substances was common among this population with 75.8 percent reporting daily use of at least one substance. The predominate drugs of choice were marijuana (76.4%) and alcohol (14.3%) (Figure 5). Sixty-one percent of RSAT participants reported a family history of substance abuse. The mean age of first alcohol use was 11.56 and the mean age of first drug use was 12.17. A majority of RSAT participants (52.8%) have a history of prior treatment, with 20 percent having participated in long-term residential treatment, 13 percent having participated in short-term inpatient treatment, and 31 percent having participated in outpatient treatment (Figure 6).

Results of the JASAE (ADE Incorporated, 1997) administered to participants upon intake to DYS confirm the severity of substance abuse among this population. The JASAE provides a summary score indicating the level of care required. As the summary score increases, the need for more intensive intervention increases. A score of 21 or above indicates the need for intensive treatment and possibly residential care. MYC's target population is youth with a JASAE score of 21 or above. JASAE scores were

Figure 3 Crime Type

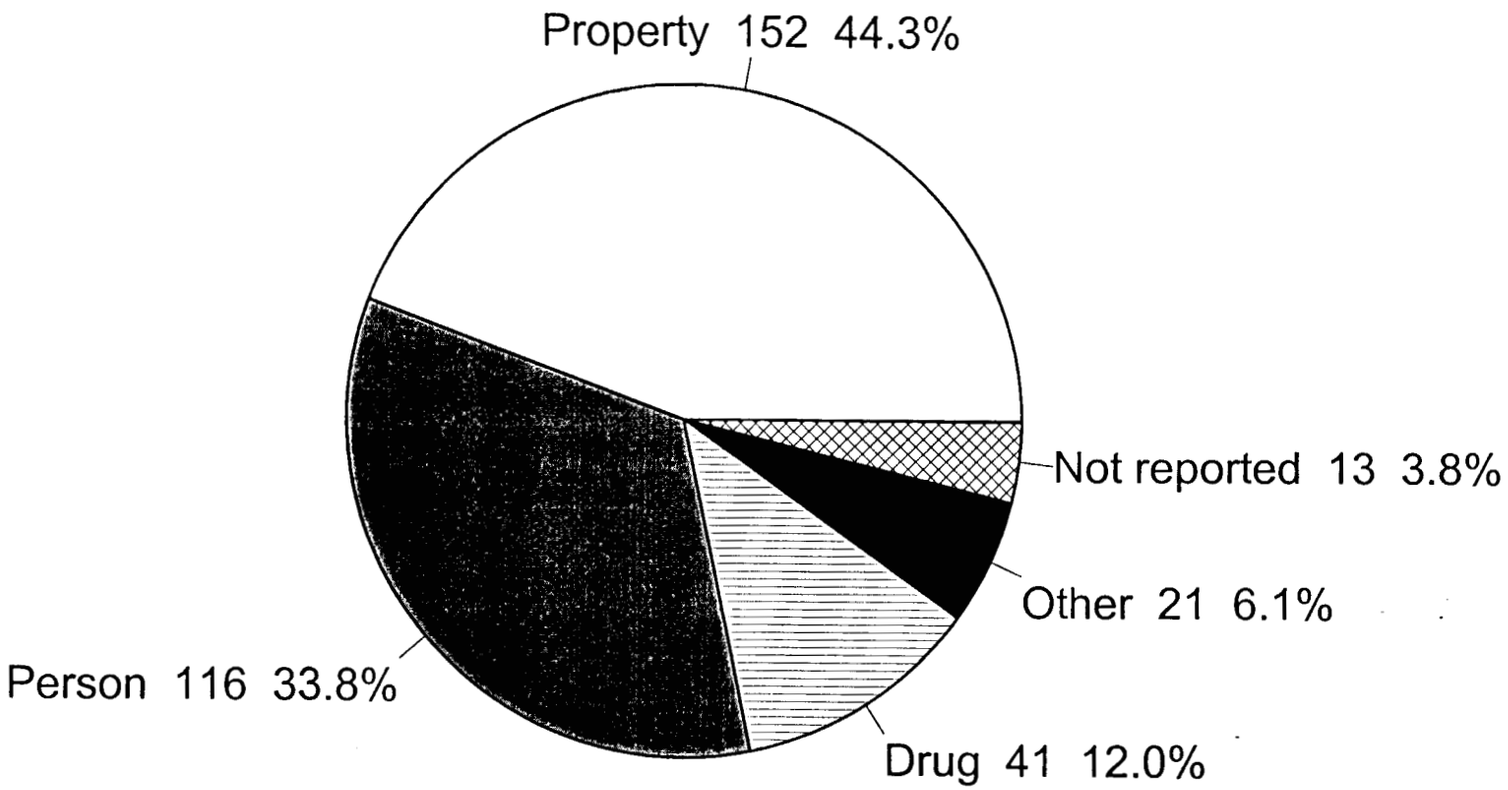


Figure 4 Felony Level

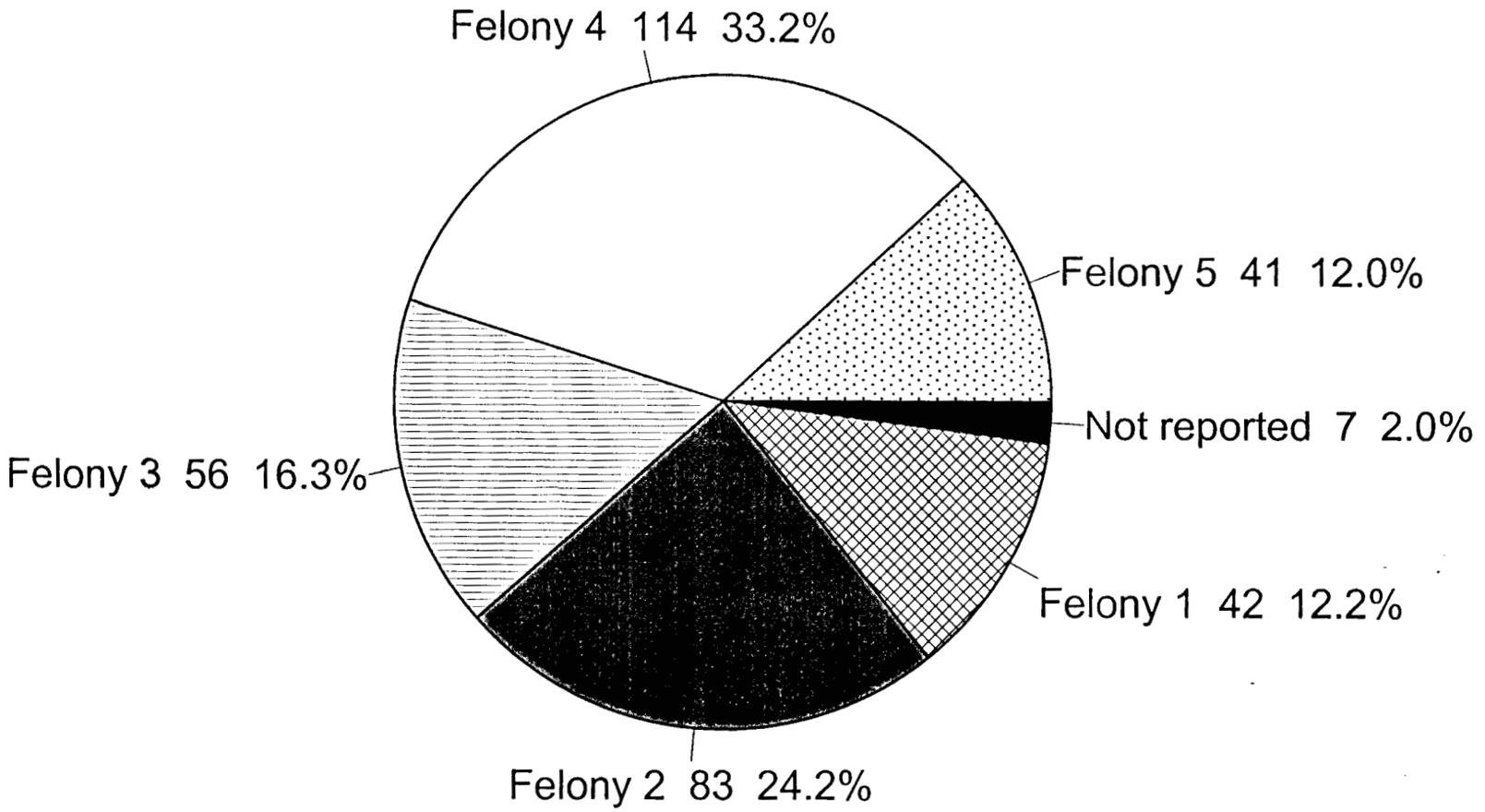


Figure 5 Drug of Choice

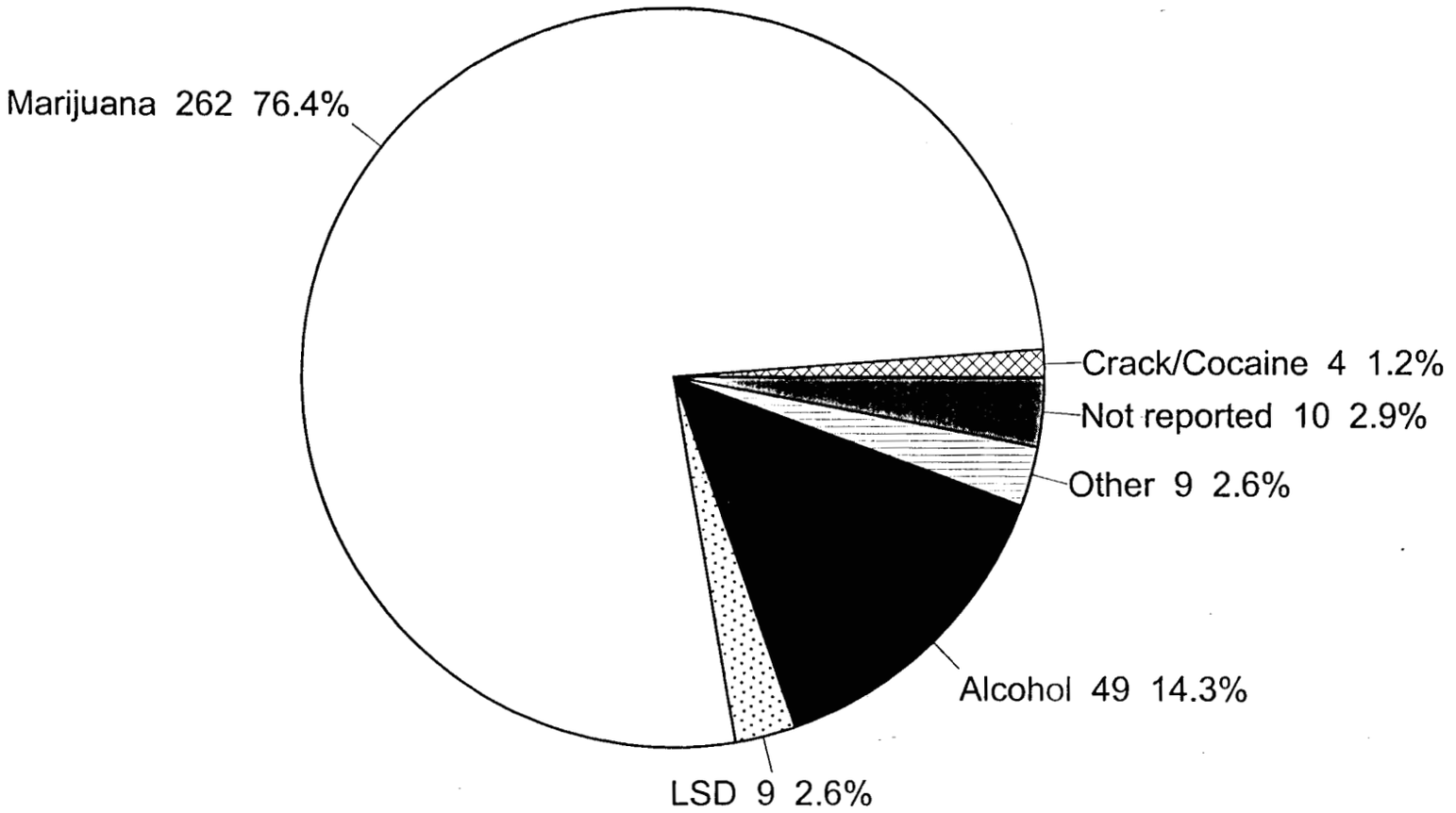
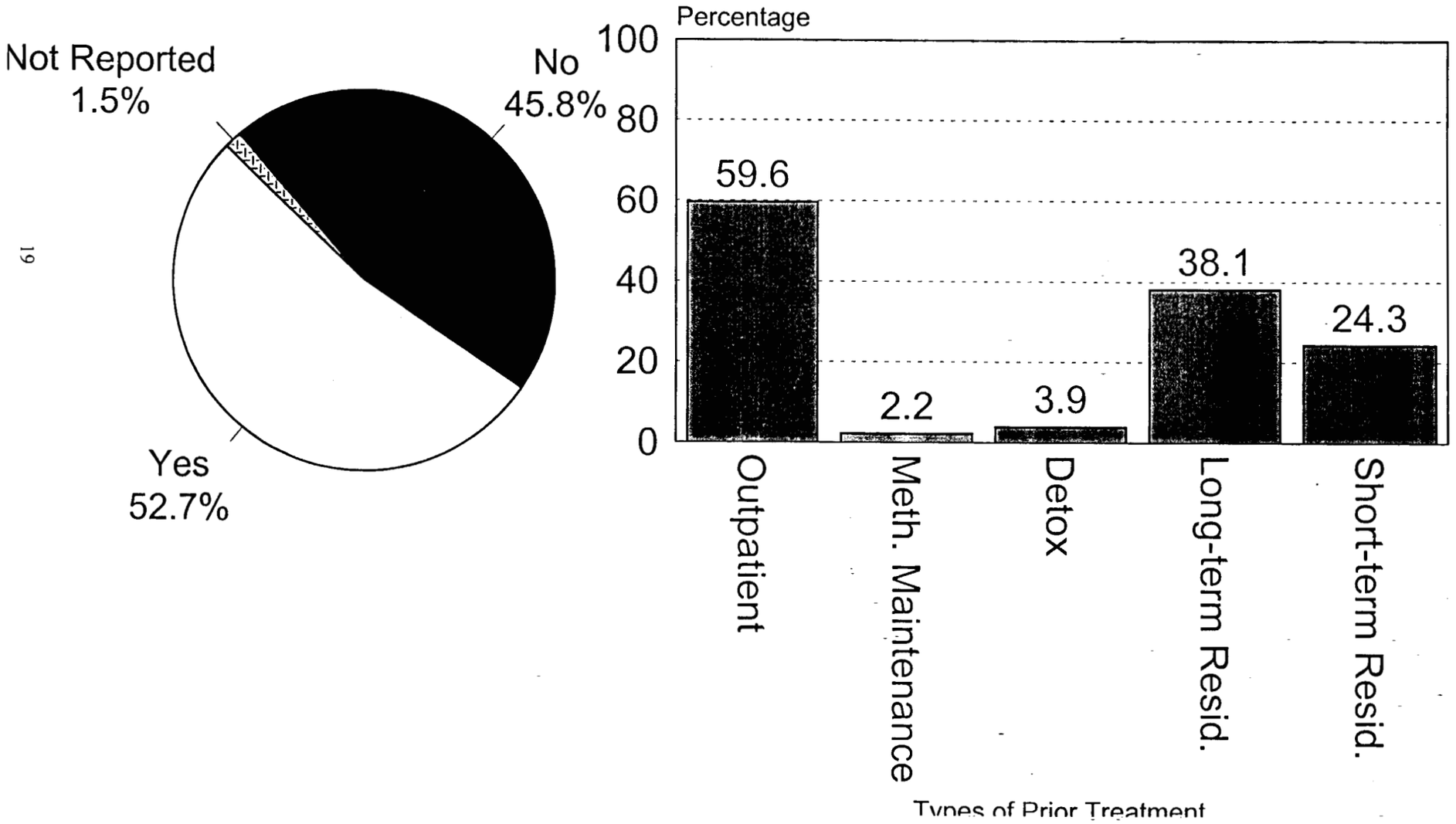


Figure 6
History of Prior Treatment



available for 197 RSAT participants. The scores ranged from 17 to 74 with a mean of 48.02. The distribution of JASAE scores (Figure 7) suggests that MYC's population is comprised of youth with "severe substance abuse problems along with ingrained patterns and attitudes supporting this problem." (ADE Incorporated, 1997, p. 6).

Risk Level. In July 1998, DYS instituted the Youthful Level of Services Inventory (YO-LSI). The YO-LSI is an objective and quantifiable assessment instrument that examines both static and dynamic risk factors including criminal history, family circumstances, employment/educational achievements, peer relationships, substance abuse, leisure/recreation, personality characteristics, and antisocial attitudes.

Due to its recent implementation, YO-LSI scores were only available on 72 cases. The YO-LSI includes eight subcomponents. Depending on their scores, youths are classified as low, moderate, or high risk for each of the subcomponents. A total score is also provided that indicates their overall risk of recidivism. Table 1 reports the percentage of youth that fell into each risk category for each subcomponent. The data reveal that in addition to the criminal history and substance abuse components, a high percentage of youth score high risk on the education (62.5%), peer (54.2%), and leisure time (75%) components. Total scores of 35-42 are considered very high risk for recidivism; scores of 23-34 are considered high risk of recidivism; scores of 9-22 are considered moderate risk of recidivism; and scores of 0-8 are considered low risk of recidivism. The mean YO-LSI score was 24.06. The majority of RSAT participants scored in the high risk category (Figure 8).

Psychological and Social Functioning: Psychological and social factors such as depression, anxiety, risk-taking, antisocial values, and hostility have been found to be positively related to substance abusing behaviors and longevity and success in treatment,

Figure 7 JASAE Scores

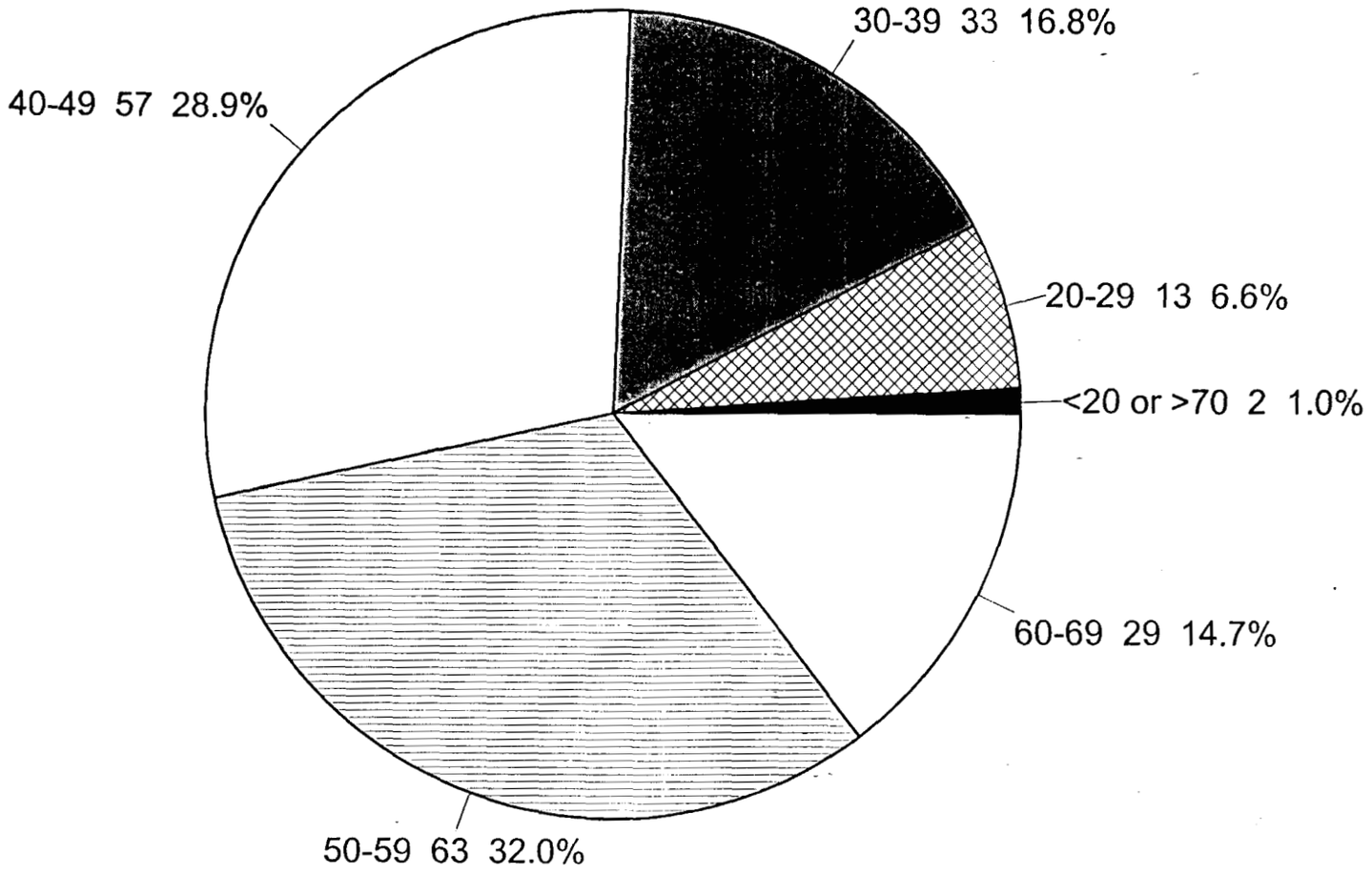
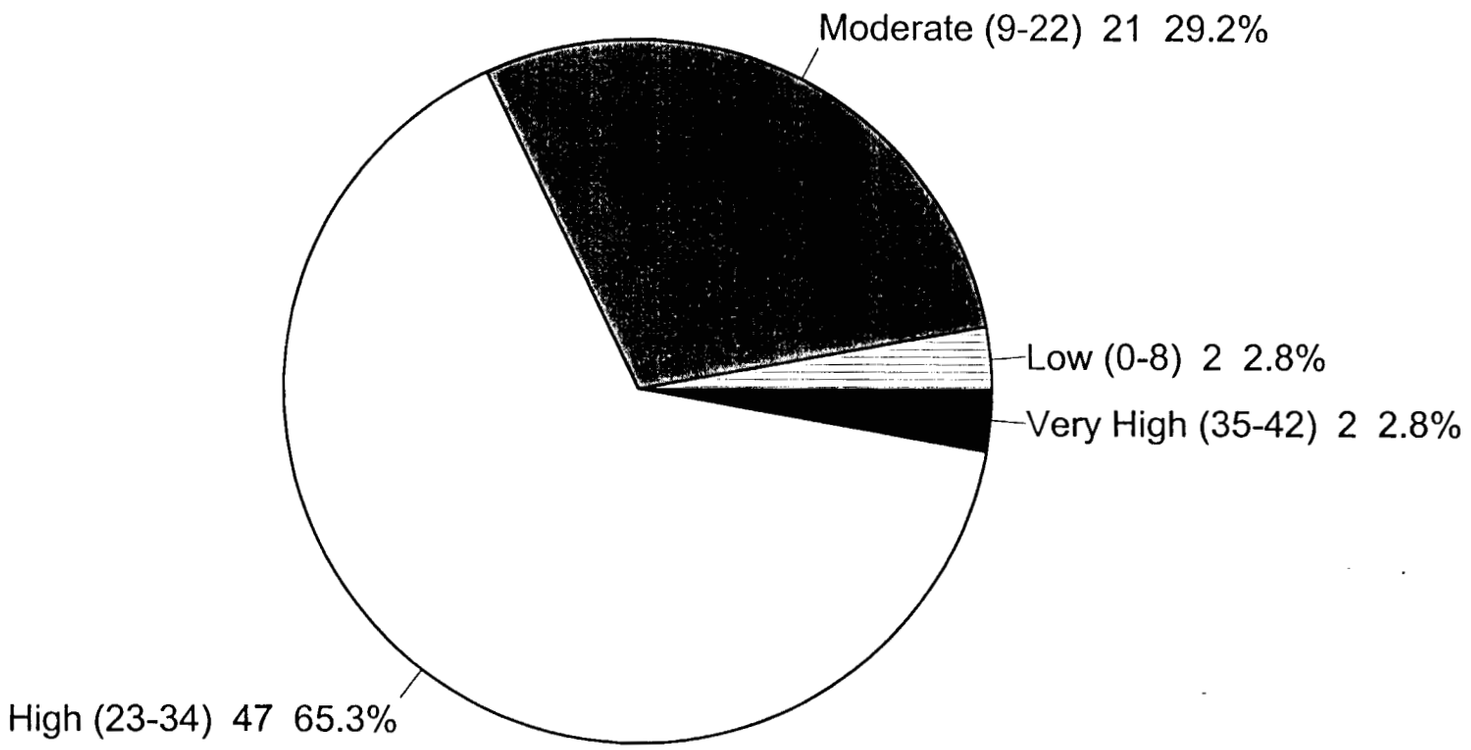


Table 1: Youthful Level of Service Inventory (YO-LSI) Risk Categories (N=72)

Subcomponent	N	Percentage
Prior and Current Offenses, Adjudications		
(possible range of 0-5)		
Low (0)	2	2.8
Moderate (1-2)	14	19.4
High (3-5)	56	77.8
Family Circumstances and Parenting		
(possible range of 0-6)		
Low (0-2)	28	38.9
Moderate (3-4)	31	43.1
High (5-6)	13	18.1
Education/Employment		
(possible range of 0-7)		
Low (0)	3	4.2
Moderate (1-3)	24	33.3
High (4-7)	45	62.5
Peer Relations		
(possible range of 0-4)		
Low (0-1)	2	2.8
Moderate (2-3)	31	43.1
High (4)	39	54.2
Substance Abuse		
(possible range of 0-5)		
Low (0)	2	2.8
Moderate (1-2)	7	9.7
High (3-5)	63	87.5
Leisure/Recreation		
(possible range of 0-3)		
Low (0)	3	4.2
Moderate (1)	15	20.8
High (2-3)	54	75.0
Personality and Behavior		
(possible range of 0-7)		
Low (0)	4	5.6
Moderate (1-4)	43	59.7
High (5-7)	25	34.7
Attitudes/Orientations		
(possible range of 0-5)		
Low (0)	16	22.2
Moderate (1-3)	48	66.7
High (4-5)	8	11.1

Figure 8 Risk Categories



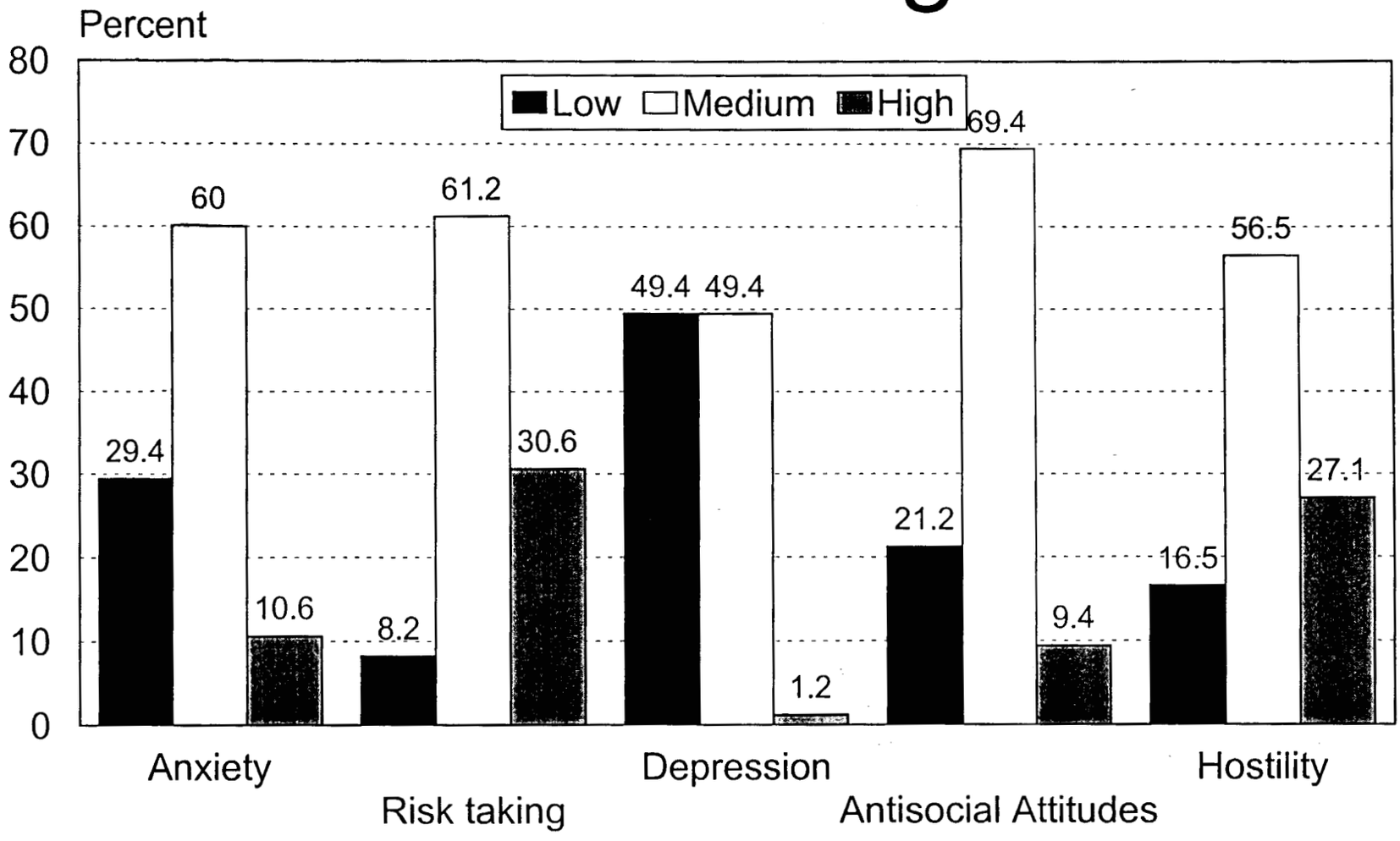
while factors such as self-esteem, self-efficacy, and decision-making confidence have been found to be negatively associated with substance abusing behaviors and with longevity and success in treatment (Simpson and Knight, 1998). These areas, therefore, are all potential targets for treatment. Theoretically, therapy should reduce individuals' levels of anxiety, depression, risk-taking, hostility, and antisocial values, and increase their self-esteem, decision-making, and self-efficacy.

As indicated, the client self-rating form (Simpson and Knight, 1998) was used as a measure of youth's level of psychological and social functioning. It was not implemented as designed (i.e., at intake, 90 days, and discharge), and thus, information regarding changes in the social and psychological scales measured by the client self-rating form are not available. What is available, however, is information regarding the level of psychological and social functioning of 85 youths at intake. As Figures 9 and 10 reveal, the majority of youth scored within the middle ranges of the scales. The most prominent problem areas are in risk-taking and hostility. A low percentage of youth had scores that would indicate serious problems with anxiety, depression, self-efficacy, decision-making, self-esteem, or antisocial attitudes.

What is the nature of the services being delivered?

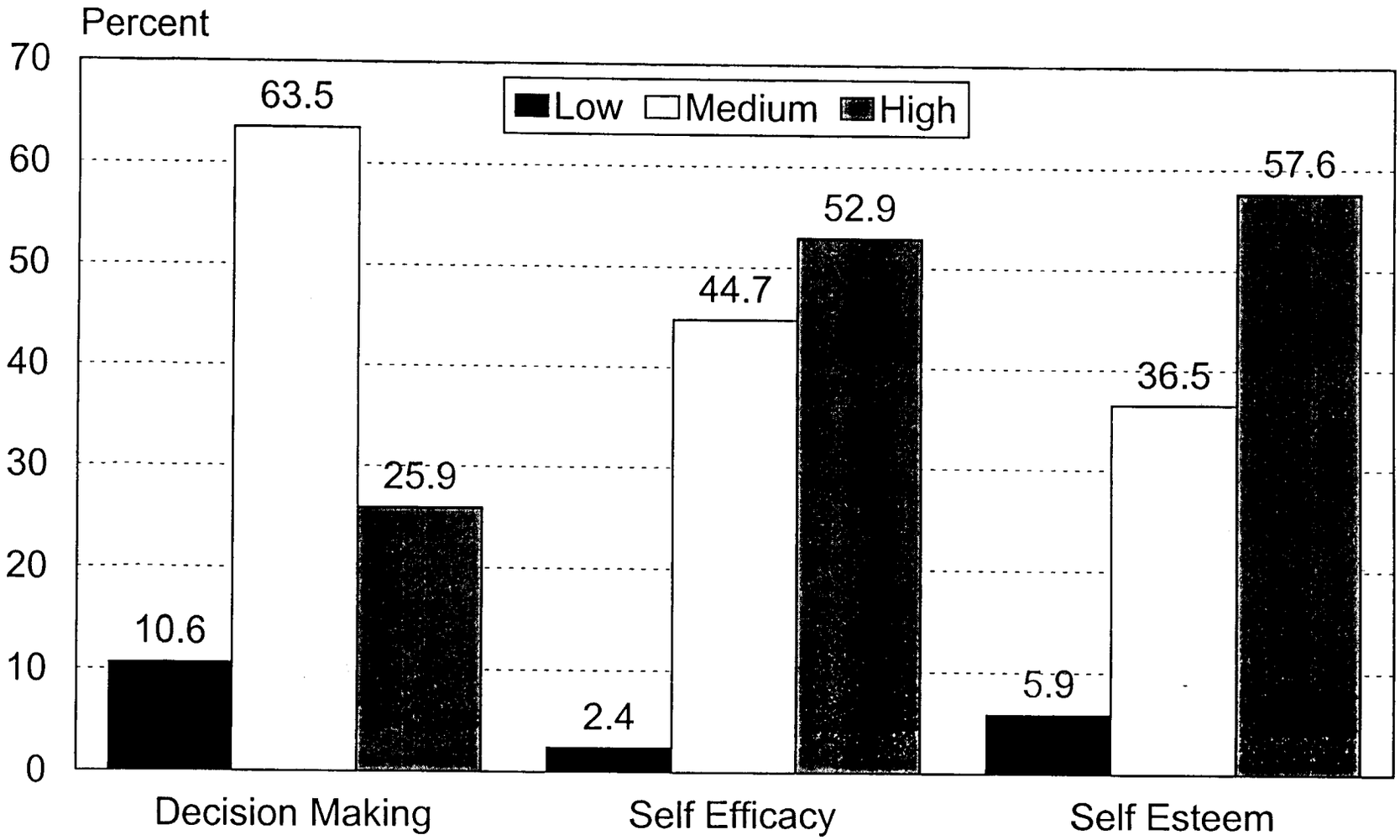
During the study period for the process evaluation, the treatment model at MYC was a combination of the 12-step model, a cognitive-behavioral approach, and a positive peer culture. MYC was, however, shifting to a therapeutic community model of treatment and had instituted some of the terminology and procedures common to therapeutic communities. The therapeutic community was fully instituted in August

Figure 9 Psychological and Social Functioning Scales



Youth were placed in the low, medium, or high category based on which third of the scale their score fell within. Higher scores indicate a problem in the social or psychologial function measured.

Figure 10 Psychological and Social Functioning Scales



Youth were placed in the low, medium, or high category based on which third of the scale their score fell within. Lower scores indicate a problem in the social or psychologial function measured.

1999. This section of the report reflects the amount and nature of services provided prior to the implementation of the therapeutic community.

General Services Provided. Although the initial evaluation design included quantitative measures of service delivery (i.e., frequency and dosage of specific types of treatment provided) this information was not collected on individual offenders since all residents at MYC received the same level and type of services.

MYC's RSAT program is a six month residential program consisting of a six week orientation phase, a 12 week core treatment phase, and a six week relapse prevention phase. Table 2 summarizes the amount and type of services that was to be provided to youth during each of these programmatic phases.

Following are brief descriptions of the educational groups provided:

- Normative culture groups – these groups were designed to help the youth identify and resolve problem behaviors and thinking errors, develop competencies, and encourage and support each other.
- Criminality groups – these groups were designed to challenge criminal thinking patterns.
- Substance abuse education groups - these groups provide youth with basic education on drug and alcohol use, its consequences, and relapse prevention skills.
- Pathways – these groups focus on the disease model of drug addiction and introduce youth to the 12-step process of recovery.
- Young Men's Work – these groups are designed to assist youth in developing problem-solving and conflict resolution skills.

- Relapse Prevention Skills – these groups teach youth how to identify and cope with their emotional, physical, and social risk factors. Youth develop a relapse prevention plan.

Table 2. Number of Hours of Services Provided

	Phase		
Type of Treatment	Orientation	Core Treatment	Relapse Prevention
Normative Culture Group	6 hrs/week	6 hrs/week	6 hrs/week
Pathways	1.5 hrs/week	1.5 hrs/week	1.5 hrs/week
Meditation	7 hrs/week	7 hrs/week	7 hrs/week
Recreation	14 hrs/week	14 hrs/week	14 hrs/week
Criminality Group	3 hrs/week		
Substance Abuse Education	3 hrs/week	4.5 hrs/week	
Relapse Prevention			12 hrs/week
Young Men's Work		1.5 hrs/week	
Self-directed (Homework)	1.5 hrs/week	1.5 hrs/week	1.5 hrs/week
School	30 hrs/week	30 hrs/week	30 hrs/week
Total	66 hrs/week	66 hrs/week	72 hrs/week

In addition to the above listed groups and activities, youth receive individual counseling and participate in house meetings.

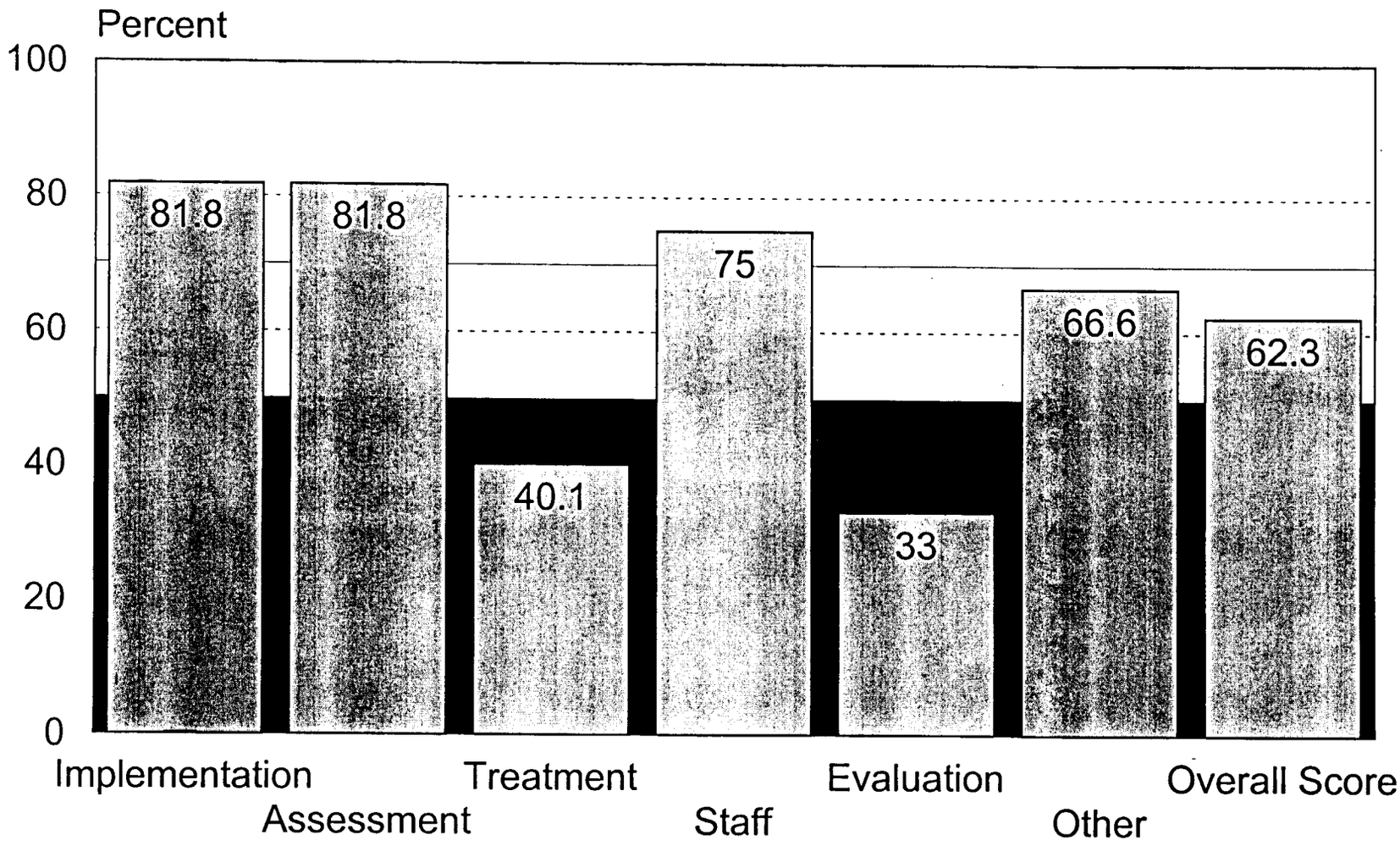
CPAI Results. As indicated in the methodology section of this report, the CPAI was used to examine the quality of services being delivered at MYC. This section of the report will provide a summary of the CPAI results which reflect the strengths and weaknesses of the program

As indicated in the first section of this report, the CPAI is a tool designed to ascertain how well a program is meeting certain principles of effective intervention. Programs receive an overall score and a score for each of the six sections of the CPAI with less than 50 percent considered "unsatisfactory," 50 to 59 percent considered "satisfactory but needs improvement," 60 to 69 percent considered "satisfactory," and 70 to 100 percent considered "very satisfactory." The average overall CPAI score for 150 programs across the United States is 54.4; MYC's RSAT program scored 62.3 percent (Figure 11). Following is a summary of MYC's program strengths and areas needing improvement. For a complete copy of the report, please see Appendix C.

The following areas were identified as program strengths:

- Strong leadership - The superintendent and the clinical director of the facility each have a long tenure with DYS. The clinical director, who is responsible for overseeing the daily operations of the program, has an educational background in drug and alcohol abuse ministry and is a certified chemical dependency counselor III. She has been intricately involved with the development of all aspects of the RSAT program.
- The developmental process – the RSAT program was developed to address the prevalence of youth who demonstrated serious drug and alcohol problems. A transition committee, responsible for overseeing MYC's transition from a generalized medium security facility to a substance abuse treatment facility, ensured that the program was designed to be consistent with the treatment literature on effective programs, that the goals of MYC were consistent with the overall mission of DYS, and that the program was cost-effective and sustainable.
- Client pre-service assessment – all youth undergo a battery of assessments upon intake to the DYS reception center including a social history, medical examination,

Figure 11 CPAI Results



Very Saftisfactory=70-100%; Satisfactory=60-69%; Needs Improvement=50-59%; Unsatisfactory=less than 50%.

educational history, gang assessment, substance abuse assessment, risk assessment, psychological assessment, and a suicide risk assessment. Two of the assessment instruments (YO-LSI and JASAE) are quantifiable, objective measures of risk and need that provide a summary score that can be used in treatment classification. DYS also measures several responsivity factors, or personal characteristics, that may interfere with treatment including intellectual abilities and psychological patterns of interpersonal sensitivity, anxiety, depression, and hostility.

- Theoretical basis – the treatment services provided by MYC combine a social learning approach that provides opportunities for modeling and behavioral rehearsal techniques, and a cognitive behavioral approach that aims to challenge antisocial attitudes, increase victim empathy, and develop self-control procedures. Both approaches have proven effective in reducing recidivism.
- Program structure – youth are involved in therapeutic activities for approximately 13 hours a day. Youths' whereabouts and peer associations are closely monitored.
- Transitional services – youth are taught relapse prevention skills. An aftercare specialist or parole officer meets with the youth prior to his release to arrange follow-up drug and alcohol services in the community.
- Program staff – staff are well qualified and committed to the program philosophy. Additionally, there is low staff turnover.

The following areas were identified as areas needing improvement:

- Outdated assessment information - although DYS conducts a comprehensive assessment upon a youth's intake, a follow-up assessment is not conducted upon intake to MYC. Thus, some of the more dynamic assessment information may be outdated.

- Lack of consistency in services provided – although various treatment manuals and curricula were available to social workers for conducting the aforementioned educational and therapy groups, there was little consistency across treatment staff in the content or nature of the services provided. This made it difficult to determine if youth were receiving the intended continuum of services (i.e., basic education, skill building, and relapse prevention). Furthermore, there appeared to be some overlap and duplication of services.
- No treatment matching – effective programs vary the intensity of treatment according to the client's level of risk, and match clients to services based on their specific criminogenic needs and responsivity factors. Essentially, all MYC participants received the same level of supervision and treatment and group assignments are determined by space available rather than important personal characteristics of clients and staff.
- Behavioral management system – a transition in behavioral management systems led to the inconsistent application of rewards and punishments and to negative behaviors going unattended during the period of the process evaluation.
- Release criteria – at the time of this program assessment, youth were being automatically released from MYC when their sentences expired regardless of progress in treatment or the extent to which they demonstrated prosocial attitudes and behaviors. The implementation of a DYS Release Authority in July 1998 was designed to rectify the situation by ensuring that a youth's release was based on progress in treatment.
- Quality assurance – at the time of the assessment there were minimal quality assurance mechanisms in place. Staff were not receiving individualized clinical

supervision and there was little oversight being provided for educational and therapy groups.

- Program stability – constant change in programming and DYS policies jeopardized the smooth functioning of the program. MYC staff struggled to incorporate these changes and keep up with day-to-day service delivery. The constant change led to inconsistencies in program practices and staff shortages due to turnover and participation in training. At one point, several social workers were carrying an extra workload without the benefit of active supervision.

In sum, MYC is a research-based program with the capacity for becoming a high quality program that reflects the principles of effective correctional intervention. Many of the areas identified for improvement were being addressed at the time of the assessment. Major programmatic changes, however, were not instituted until August 1999. The CPAI results, therefore, reflect the general state of the program throughout the study period.

What are the intermediate outcomes of MYC?

Readiness for Change: The Personal Drug Use Questionnaire, designed to measure readiness for change, was to be administered at intake, 90 days, and discharge. Although the instrument was administered at least one time on 314 cases, time 2 measures were only available on 89 cases and no time 3 measures were available. Thus, information regarding changes in treatment readiness as measured by the Personal Drug Use Questionnaire are only available on 89 cases.

According to Miller (1994), higher scores on the precontemplation and contemplation scales suggest uncertainty and ambivalence about the need for change,

higher scores on the determination and action scales suggest a commitment to change, and higher scores on the maintenance scale suggest that an individual has accomplished initial change and is seeking to maintain it. It is hoped, then, that participation in therapy would, over time, result in lower scores on the precontemplation and contemplation scales and higher scores on the determination, action, and maintenance scales. A comparison of means between time 1 and time 2 scores on the Personal Drug Use Questionnaire reveals almost no changes in the precontemplation, action, and maintenance scales (Table 3). A slight change occurred between time 1 and time 2 scores on the contemplation scale but in the opposite direction anticipated. At face value, this could suggest that youths' uncertainty and ambivalence about the need for change increased during their stay in treatment. Since the difference in mean scores from time 1 to time 2 is not statistically significant, however, it is likely that this slight fluctuation in scores occurred by chance and that it does not reflect increased uncertainty and ambivalence about the need for change. The change in time 1 and time 2 scores on the determination scale is, however, statistically significant and suggests that on average youths' determination to make positive changes in their drug/alcohol use increased with participation in treatment.

Number and Type of Program Discharges: Of the 343 clients who participated in MYC between March 30, 1998 and March 31, 1999, 76 (22.2%) were still active in the program and 267 (77.8%) had been successfully discharged from the program. The average length of stay was 171 days.

Table 3: Paired Sample t-tests on Personal Drug Use Questionnaire, Time 1 - Time 2

Scale	No. of pairs	Time 1 Mean	Time 2 Mean	t-value	Sig
Precontemplation (range 4-20)	89	8.53	8.13	-.98	.328
Contemplation (range 4-20)	89	12.55	13.25	1.70	.093
Determination (range 4-20)	89	14.71	16.00	2.57	.012
Action (range 4-20)	89	16.91	16.89	-.05	.959
Maintenance (range 4-20)	89	16.53	16.37	-.39	.694

How are offenders performing under post-release supervision?

Of the 267 youths who were successfully discharged from MYC, only 124 termination forms were available. These termination forms were completed by the researcher based on the youth's case files maintained by DYS. The data reveal that all 124 youths were placed under parole supervision. Information gleaned from discharge plans revealed that specific drug/alcohol treatment had been arranged for 70 (56%) of these youth. Other youth were given a general directive to obtain follow-up drug/alcohol treatment as part of their parole supervision requirements. The majority of these youth (92%) were planning to reside with a family member or relative upon their release.

Follow-up questionnaires were sent to the supervising officers of these 124 offenders to inquire about the offender's supervision activities and performance on parole. Eighty-four (67.7%) responses were received.

Supervision Activities: Fifty-five (65.5%) of the offenders participated in drug/alcohol treatment while under parole supervision (Table 4). Types of treatment participation varied from residential treatment to support groups, with standard outpatient treatment being the most common type of treatment received. Only 9 (16.4%) of these offenders were still actively participating in drug/alcohol treatment. Twenty-three (41.8%) had been successfully terminated from treatment and 13 (23.6%) had been unsuccessfully terminated.

Table 4: Participation in Drug and Alcohol Services During Post-Release Supervision

Variable	N	Percentage
Drug/Alcohol Services Received (n=84)		
Yes	55	65.5
No	24	28.6
Not Reported	5	6.0
Type of Service Received (n=55)		
Residential	1	1.8
Intensive Outpatient	5	9.1
Standard Outpatient	32	58.2
Other	13	23.6
Not Reported	4	7.3
Treatment Status (N=55)		
Active	9	16.4
Inactive	39	70.9
Not Reported	7	12.7
Type of Termination from Treatment (n=55)		
Successful	23	41.8
Unsuccessful	13	23.6
Not Reported	19	34.5

Participation in other types of services was minimal (Table 5). Only 13 (15.5%) were participating in AA/NA on a regular basis, 43 (51.2%) had received educational/vocational services, 33 (39.3%) had received employment services, 17

(20.2%) had received mental health services, 6 (7.1%) had received cognitive therapy, and 10 (11.9%) had received family counseling.

Table 5: Number and Percent Participating in Other Types of Services (n=31)

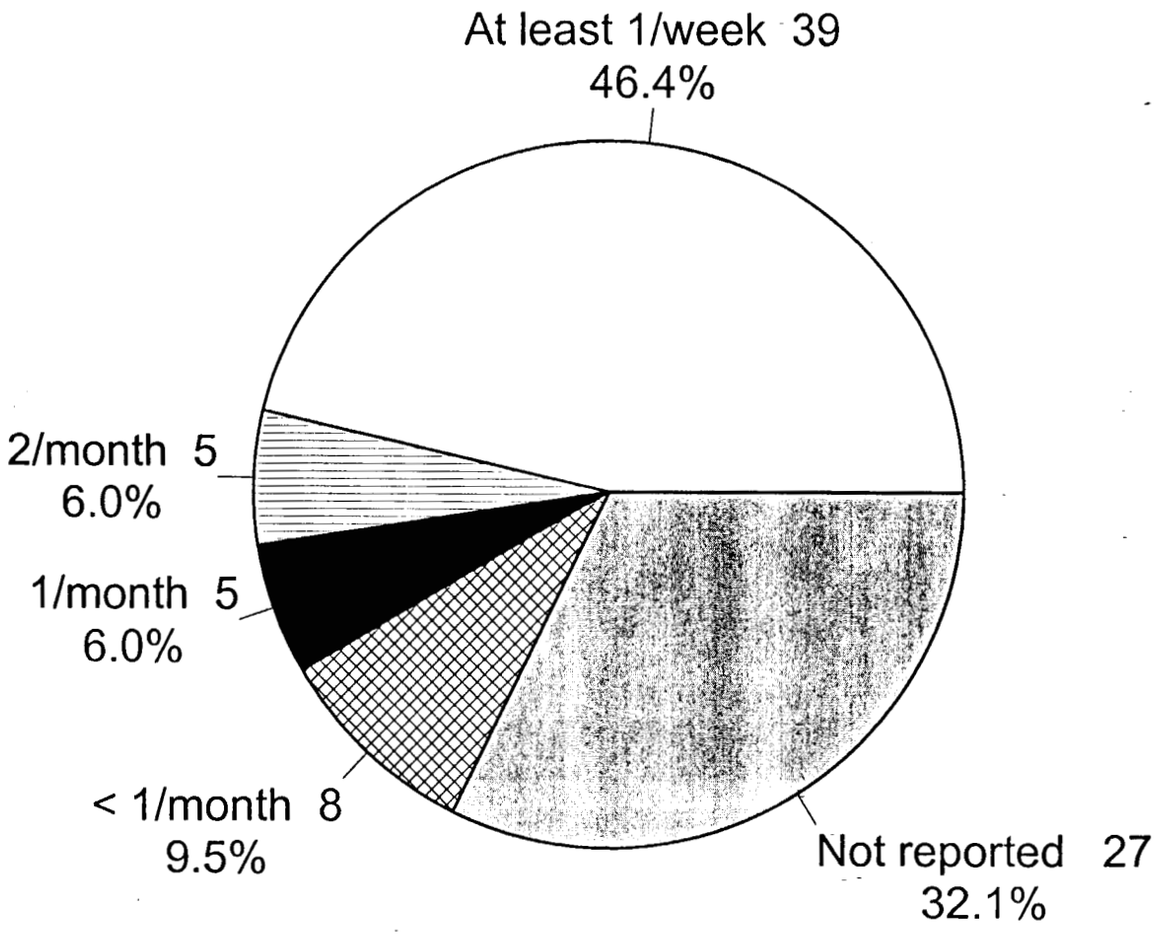
Service	N	Percentage
AA/NA	13	15.5
Education/Vocational	43	51.2
Employment	33	39.3
Mental Health	17	20.2
Cognitive Therapy	6	7.1
Domestic Violence	0	0
Family/ Counseling	10	11.9

Information on offenders' reporting status indicates that 39 (46.4%) were receiving intensive levels of supervision with requirements to report at least once a week. The remaining cases reported to their officer twice a month or less (Figure 12).

Performance on Probation: Thirty (35.7%) of the offenders for whom post-release data is available are employed. Eighteen (21.4%) were attending school.

Based on officers' reports of reported or detected alcohol or drug use, the majority of offenders were able to abstain from alcohol or drug use throughout their post-release supervision (Table 6). Twelve (14.3%) of the offenders either reported or were detected

Figure 12 Reporting Status



using alcohol. The number of days between release from MYC and the first reported or detected alcohol use ranged from 27 to 274 days with an average of 107.38 days.

Fifteen (17.9%) offenders either reported or were detected using drugs. The most frequently used drug was marijuana. The number of days between release from MYC and the first reported or detected drug use ranged from 44 to 165 days with an average of 86 days.

Table 6: Drug and Alcohol Use

Variable	N	Percentage
Reported of Detected Alcohol Use (n=84)		
Yes	12	14.3
No	62	73.8
Not reported	10	11.9
Number of Times Use Alcohol (n=12)		
1	3	25.0
2	2	16.7
3	1	8.3
5	1	8.3
Not Reported	5	41.7
Reported or Detected Drug Use (n=84)		
Yes	15	17.9
No	58	69.0
Not reported	11	13.1
Number of Times Use Drugs (n=15)		
1	3	20.0
2	5	33.3
3	1	6.7
Not Reported	6	40.0
Type of Drug Used (n=15)		
Marijuana	15	100.0
Cocaine	2	13.3
Opiates	0	0
Barbiturates	0	0
Hallucinogens	2	13.3

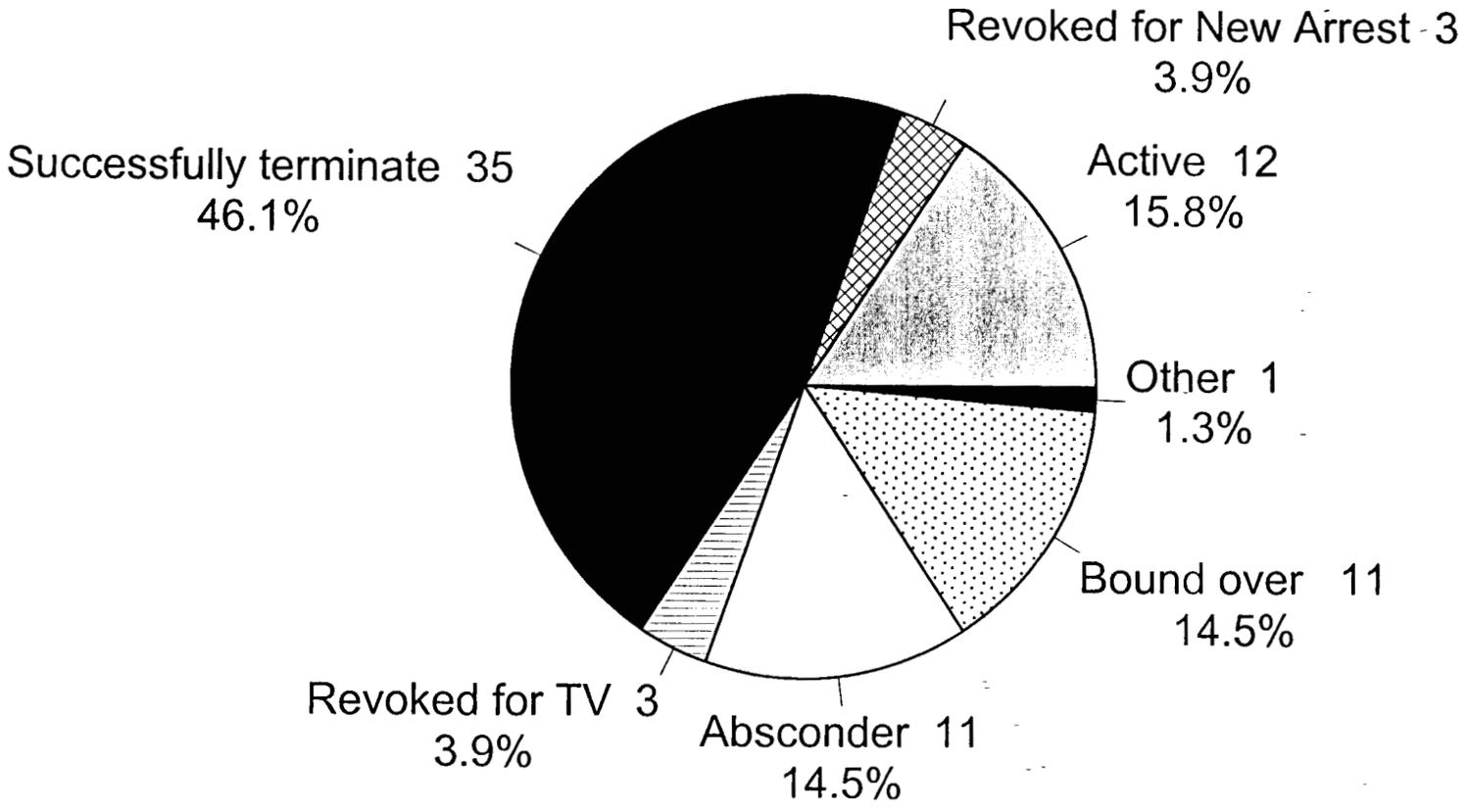
Twenty-eight (33.3%) of the youth were arrested for a new offense (Table 7). Thirteen of these arrests had resulted in convictions and 10 were still pending at the end of the study period. Charges included aggravated burglary (1), aggravated robbery (3), assault (3), breaking and entering (5), CCW (1), domestic violence (1), DUI (1), grand theft auto (1), possession (4) , receiving stolen property (2) , and underage drinking (1). The number of days between release from MYC and the first new arrest ranged from 42 to 386 days with an average of 148 days.

Table 7: Number and Percent with a New Arrest and Conviction

Variable	N	Percentage
Any New Arrest (n=84)		
Yes	28	33.3
No	44	52.4
Not Reported	12	14.3
Number of New Arrests (n=28)		
1	18	64.3
2	4	14.3
4	1	3.6
Not Reported	5	17.9
Any Convictions (n=84)		
Yes	13	15.5
No	56	66.6
Pending	10	11.9
Not Reported	5	5.9
Number of Convictions (n=13)		
1	10	76.9
2	2	15.4
4	1	7.7

Parole Status: As of August 31, 1999, 12 (14.3%) of the 84 offenders for whom follow-up data is available were still on active probation and 35 (40.5%) had been successfully terminated (Figure 13). Four (4.8%) offenders had been revoked for a new

Figure 13 Parole Status



arrest, 3 (3.6%) had been revoked for a technical violation, 3 (3.6%) had a revocation pending, and 11 (3.2%) had absconded from supervision. Eleven (3.2%) of the youth had been bound over to adult court.

What factors are associated with post-release performance?

Ordinarily, multivariate analysis would be conducted to identify factors that are associated with post-release performance. Multivariate analysis has the advantage of being able to control for the influence of other factors while examining the variables of interest. This type of analysis was not possible, however, because of the limited number of cases for which follow-up data is available (n=84). Instead, chi-square analyses and t-tests were conducted to examine associations between various factors and post-release performance. Because of the small sample size used for these analyses, the results should be reviewed with caution.

Youth Characteristics. Chi-square analysis was conducted to examine the relationships between the race of the offender and their post-release drug/alcohol use, arrest, and failure on supervision (i.e., revoked, absconded, bound over) (Table 8). These analyses revealed that non-whites had higher rates of reported or detected drug/alcohol use, supervision failures, and new arrests. None of these relationships were statistically significant.

Chi-square analysis also was conducted to examine if having had any type of previous treatment was related to the three indicators of post-release performance. The results are mixed: Offenders who had prior treatment experience were more likely to have reported or have been detected using drugs/alcohol and less likely to fail on

Table 8: Chi-Square Analyses – Offender Characteristics and Post-Release Performance

Characteristic	Percentages		
	D/A use	Supervision Failure	New arrest
Race			
White	21.9	33.3	32.4
Non-white	22.5	45.5	44.7
χ^2	.004	1.21	1.16
p	.95	.27	.28
Previous treatment			
Yes	24.4	37.8	38.1
No	20.0	44.1	41.4
χ^2	.19	.32	.08
p	.66	.57	.78

Note: Due to missing data, the number of cases varies according to which variable is being examined

supervision or be arrested for a new offense. The former result may reflect an increased severity of drug/alcohol abuse among the group of youth with prior treatment experiences. Again, however, none of these relationships were statistically significant

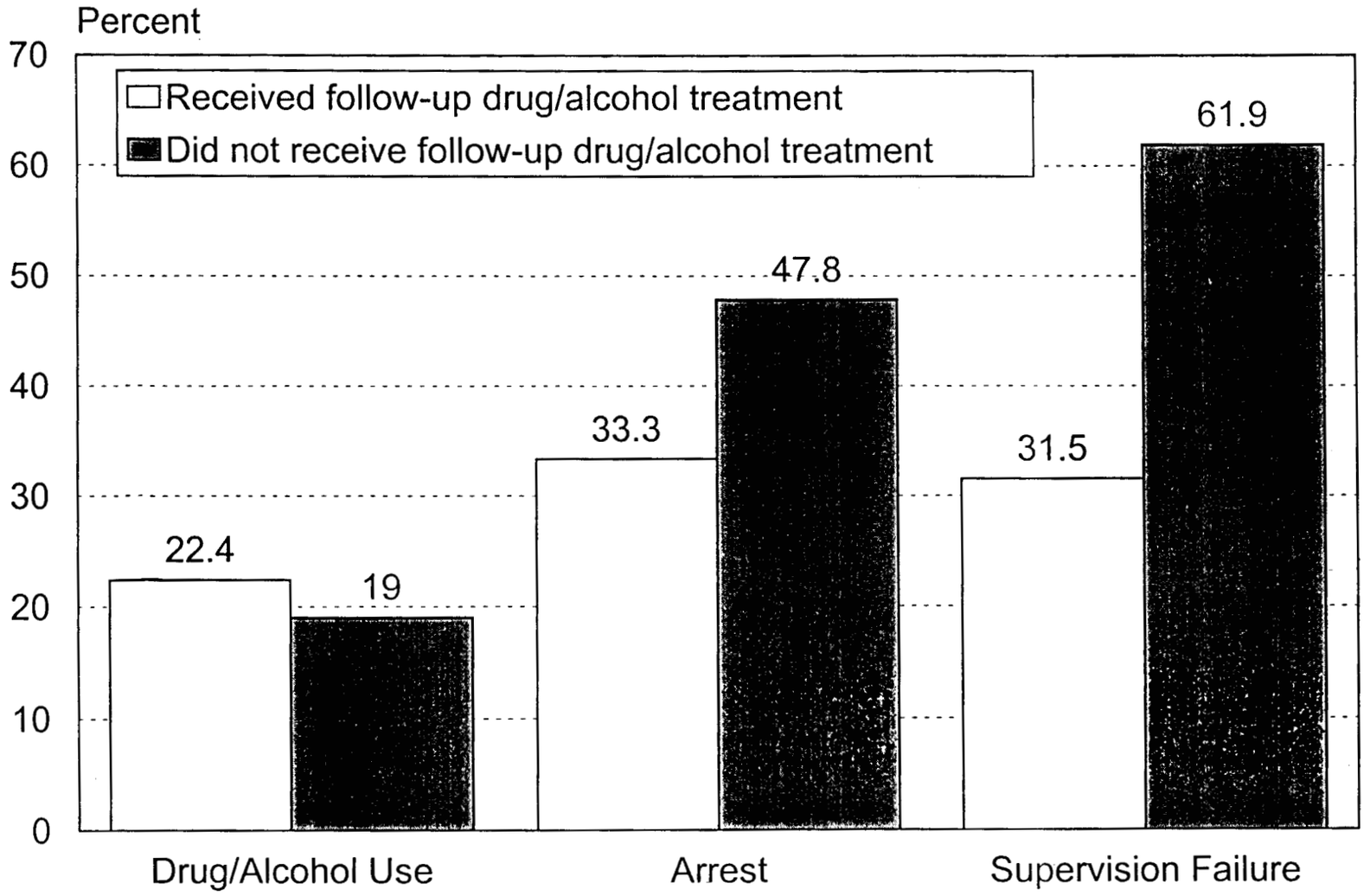
T-tests were conducted to examine the relationship between youths' age and JASAE scores and post-release performance (Table 9). The mean ages of youth were similar whether or not they had used drugs/alcohol, failed on supervision, or been arrested for a new offense. These results suggest that age was not associated with post-release performance. The JASAE scores for youth who did not use drugs/alcohol, were successful on supervision, and had no new arrests, were lower as compared to youth who reported or were detected using drug/alcohol, failed on supervision, and were arrested for a new offense. These differences, however, were not statistically significant.

Table 9. T-tests: Offender Characteristics and Post-Release Performance

Characteristic	Number of cases	Mean	SD	t value	p
Age					
No drug/alcohol use	53	16.90	1.12	.36	.718
Drug/alcohol use	15	17.02	1.11		
Successful on supervision	45	16.89	1.09	.56	.576
Supervision failure	31	17.04	1.16		
No new arrest	41	16.99	1.03	1.34	.184
New arrest	27	16.62	1.19		
JASAE					
No drug/alcohol use	34	44.71	12.23	.71	.480
Drug/alcohol use	13	46.62	6.02		
Successful on supervision	28	44.00	11.15	1.69	.098
Supervision failure	24	49.00	10.03		
No new arrest	27	44.15	10.54	1.56	.125
New arrest	19	49.12	10.69		

Program Characteristics. Chi-square analysis also was conducted to examine the relationship between whether or not the offender received follow-up drug/alcohol treatment and post-release drug/alcohol use, arrest, and failure on supervision. The results are mixed (see Figure 14). When compared with offenders who did not receive follow-up drug/alcohol treatment, offenders who did receive follow-up drug/alcohol treatment were less likely to fail probation supervision (31.5% versus 61.9%; χ^2=5.83, p=.015) less likely to get arrested for a new offense (33.3% versus 47.8%; χ^2=1.38, p=.239), and more likely to have reported or have been detected using drugs/alcohol (22.4% versus 19.0%, χ^2=.101, p=.75). The only statistically significant relationship was

Figure 14 Chi Square Analysis Follow-up Drug/Alcohol Tratment and Post-Release Performance



between follow-up drug/alcohol treatment and success on supervision. The first two comparisons suggest that follow-up drug/alcohol treatment had a positive impact on post-release performance. The increased likelihood of reported or detected drug/alcohol use among offenders receiving follow-up treatment could be the result of increased drug testing as part of the treatment being delivered to this group.

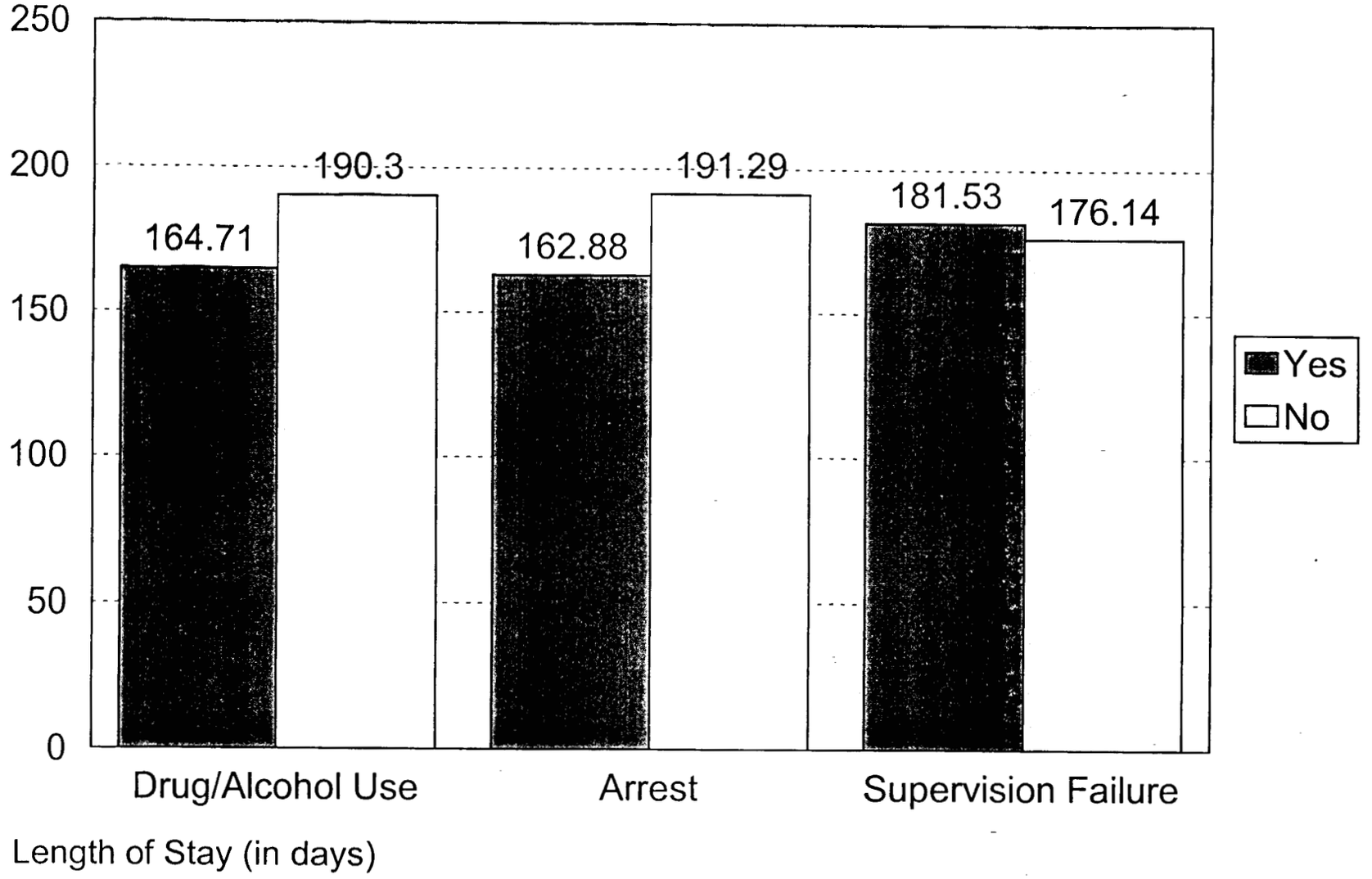
T-tests were conducted to examine the relationship between length of stay in treatment and post-release performance. Although youth with longer lengths of stay did better on all indicators of post-release performance, none of these relationships were statistically significant (Figure 15).

DISCUSSION

Limitations of Study

The conclusions of this process evaluation are limited by the extent of missing data on some variables. Furthermore, the lack of a comparison group and the small number of cases for which termination (n=124) and follow-up (n=84) data are available, suggest that any findings regarding intermediate (i.e., changes in readiness for change, changes in social and psychological factors, completion of treatment) and ultimate (i.e., relapse, recidivism) outcomes should be viewed with caution. The conclusions that can be drawn are primarily descriptive in nature and are not intended to speak to the effectiveness of the program. A quasi-experimental outcome study is needed to examine the program's effect on the subsequent substance abusing and criminal behavior of MYC's RSAT participants.

Figure 15 T-test Analysis Length of Stay and Post-Release Performance



General Conclusions

The available data on the characteristics of the RSAT population suggest that MYC is targeting an appropriate population for the type of intensive treatment provided by RSAT. The data reveal that the majority of RSAT participants have substantial criminal histories and are at moderate to high risk of recidivism. JASAE scores revealed that all but one participant scored 21 or above on the JASAE indicating a severe substance abuse problem and the need for residential treatment. JASAE scores ranging from 17 to 74, however, suggest a broad range in the severity of substance abuse problems among RSAT participants. An initial statistical test suggests that offenders who failed on supervision, were arrested for a new offense, and reported or were detected using drugs or alcohol had higher mean JASAE scores. Although this relationship was not statistically significant, it highlights the need to conduct further analysis to identify how characteristics of the youth are related to post-release performance. These types of relationships could not be fully explored because of limited termination and follow-up data.

The results of the CPAI suggest that MYC's RSAT program was of satisfactory integrity. During the study period, the treatment model at MYC reflected cognitive-behavioral and social learning approaches, both of which have been shown to be effective with offender populations. Other program strengths included strong leadership, high program structure, and qualified staff. Problems with program integrity appeared to stem from general instability; facility staff were still adjusting to the transition from a generalized medium security facility to a substance abuse treatment facility, to ongoing program development, and to several new DYS initiatives (e.g., the implementation of

the YO-LSI and the DYS Release Authority). These changes interfered with day-to-day service delivery and contributed to a lack of consistency in the services provided.

Despite the limited data on the intermediate outcomes of treatment, two interesting results were revealed. First, it should be noted that no youth were unsuccessfully discharged from the program. Any program infractions were handled within the program and did not necessitate transfer to another institution. Successful release from the program, however, should not be confused with progress in treatment. During the CPAI, it was revealed that a youth's movement through the program was more dependent on the completion of their sentence than it was on the acquisition of prosocial attitudes and behaviors.

Second, it was hypothesized that involvement in treatment would increase offenders' readiness for change as measured by the Personal Drug Use Questionnaire (Miller, 1994) and that this increased readiness for change would, in turn, lead to reductions in relapse and recidivism. No significant changes occurred on four of the five scales. A statistically significant increase on the determination scale, however, suggests that, on average, youths' determination to make positive changes in their drug/alcohol use increased with participation in treatment. The Personal Drug Use Questionnaire may not be a good measure of fluctuations in the readiness for change on an incarcerated population. Many of the RSAT participants come from other DYS institutions where they could have been incarcerated for an extensive period of time. By virtue of their incarceration, these youth have already made changes in their drug/alcohol use. These behavioral changes were reflected in high scores on the action and maintenance scales at intake. The determination scale is more sensitive to changes in attitudes about drug/alcohol use. Although many youth had changed their substance abusing *behavior*

prior to entering RSAT, they may still have had *attitudes* that support drug/alcohol abuse. Changing these attitudes is, therefore, a critical target for RSAT. The increase in the mean score on the determination scale from time 1 to time 2 is an indicator that MYC is achieving this goal and should be viewed as a favorable result.

A strong aftercare component has been identified as an essential ingredient for effective juvenile justice programs (Lipsey and Wilson, 1998). Although the majority of youth (65.6%) participated in some type of follow-up drug/alcohol treatment during their parole supervision, participation in other services was minimal. Chi-square analyses revealed that although offenders who received follow-up drug/alcohol treatment were more likely to have reported or have been detected using drugs or alcohol, they were less likely to have been arrested for a new offense or to fail probation supervision.

Fifteen (17.9%) offenders either reported or were detected using drugs and 12 (14.3%) offenders either reported or were detected using alcohol. These figures are quite low considering that studies have shown that 54 percent of all alcohol and drug abuse patients can be expected to relapse (Simpson, Joe, Lehman, and Sells, 1986). At the time of the follow-up report, 12 (14.3%) of the offenders were still on active parole and 35 (40.5%) had been successfully terminated. Thirty-two (38.1%) youth had been unsuccessfully terminated from parole due to a technical violation, new arrest, or absconsion. This recidivism rate is on par with other juvenile justice studies reporting an average recidivism rate of 45 percent (Clear and Cole, 1998).

T-tests revealed that, on average, youth with longer lengths of stay did better on all indicators of post-release performance. This finding concurs with a number of previous studies reporting a negative relationship between the length of stay in treatment and measures of relapse and recidivism.

Recommendations

The following recommendations are offered based on the findings of this process evaluation.

1) Develop an assessment process to be conducted on youth upon intake into MYC to obtain updated assessment information on those youth who have been incarcerated in DYS for six months or longer.
2) To avoid a one-size-fits-all approach, vary the intensity of services according to the youth's level of risk, match youth to treatment components that address their specific criminogenic needs, and match youth to staff based on important responsivity factors.
3) Improve the consistency of services provided by developing treatment curriculum and by implementing ongoing mechanisms of quality control (e.g., group observation, clinical supervision, client satisfaction forms).
4) Train staff on behavioral theory and the effective use of a behavioral model of treatment, including the distribution of rewards and punishments.
5) Retain youth in treatment of a minimum of six months.
6) Educate parole officers and other aftercare agencies on the nature of the TC.
7) Work with parole officers to develop appropriate aftercare services for graduates.

In addition to the above recommendations for program modifications/additions, it is recommended that future evaluation activities include:

1) data on the discrete services provided by the program to allow for a more complete assessment of how well the "needs principle" is being implemented and to facilitate the exploration of the "black box" of treatment;

2) data on intermediate outcomes such a changes in antisocial values, social and psychological functioning, and readiness for change to explore the short-term impact of the program;

3) multivariate analyses designed to identify offender characteristics and program components that are associated with post-release success; and

4) an experimental or quasi-experimental design to examine the effectiveness of the program in reducing substance abuse and criminal behavior.

As indicated, throughout the study period, MYC was shifting to a therapeutic community model of treatment. Although the effectiveness of TCs with adult populations has been well-documented (Field, 1989; Inciardi, Martin, Butzin, Hooper, and Harrison, 1992; Wexler, Falkin, and Lipton, 1988) the model has only recently been applied to adolescents. MYC offers a unique opportunity for testing this model on a juvenile population and for comparing the results with the cognitive-behavioral approach used during this first study period.

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APPENDIX A

DATA COLLECTION INSTRUMENTS

OHIO'S RESIDENTIAL SUBSTANCE ABUSE TREATMENT PROGRAMS
Standardized Intake Form

1) _____ Name of individual completing form

2) _____ Program code
1= Cuyahoga County Youth Development Center
2= Mohican Youth Center
3= MonDay
4 = Noble Correctional Institute

IDENTIFYING INFORMATION

3) _____ Case #

4) _____ Name
Last First Middle Initial

5) _____ SSN

6)_____/_____/_____ Date of birth

OFFENDER CHARACTERISTICS

7) _____ Race: 1=White 2=Black 3=Hispanic 4=Native American 5=Asian 6=Other

8) _____ Sex: 1=Male 2=Female

9) _____ Marital status: 1= Married 2=Not married

10)_____ Number of dependents (under 18 years of age)

11)_____ Highest grade completed: 1-12 =Grades 1-12; 13 =Some college; 14 =Bachelors or higher

12) _____ If completed less than 12 grades, did the offender earn a GED? 1=Yes; 2=No

13) _____ Employment status prior to arrest
1=Employed full-time (35 hours or more/week) 2=Employed part-time (less than 35 hours/week) 3=Unemployed

Youth only:

14) _____ Was the youth enrolled in school prior to arrest? 1=Yes 2=No

15) School problems experienced by youth: 1=Yes 2=No
_____ truancy
_____ low achievement
_____ disruptive behavior
_____ suspensions/expulsions

16) _____ Where was the youth living when arrested for this offense?
1=Parent(s)'/guardian(s)' home 2=Foster care 3=Group home 4=Secure placement

17) _____ Does the youth have a record of running away from home? 1=Yes 2=No

CURRENT OFFENSE

18) _____ Most serious charge

19) _____ Level of conviction offense:
1=F1 2=F2 3=F3 4=F4 5= F5 6=M1 7=M2 8=M3 9=M4 10=Status offense

20) _____ Length of sentence in months

21) _____/_____/_____ Date incarcerated/placed in facility (i.e., date sentenced to DYS or DRC or date placed in general population of MonDay or YDC)

22) _____/_____/_____ Date screened for RSAT

23) _____/_____/_____ Date placed in RSAT program

CRIMINAL HISTORY

24) _____/_____/_____ Date of first arrest
(if exact date is unknown, please indicate age of first arrest _____)

25)

Number of prior arrests (adult and juvenile)	Number of prior convictions (adult and juvenile)
_____ Felony	_____ Felony
_____ Misdemeanor	_____ Misdemeanor
_____ Status offense	_____ Status offense

26) _____ Has the offender ever been arrested on a drug charge? 1=Yes 2=No

27) _____ Number of prior sentences to a secure facility

28) _____ Number of prior sentences to community supervision

29) _____ Number of unsuccessful terminations from community supervision

SUBSTANCE USE HISTORY

30) _____ Offender's diagnosis upon intake (DSM-IV criteria)

31)	Substance used 1=Yes 2=No	Frequency of use 1=Daily 2=Once a week or more 3=Less than once a week	Drug(s) of choice (Rate the top 1 to 3 drugs of choice from favorite (1) to least favorite (3)
_____	Heroin	_____	_____
_____	Non-crack cocaine	_____	_____
_____	Crack	_____	_____
_____	Amphetamines	_____	_____
_____	Barbiturates/Tranquilizers	_____	_____
_____	Marijuana	_____	_____
_____	LSD	_____	_____
_____	PCP	_____	_____
_____	Inhalants	_____	_____
_____	Over the counter drugs	_____	_____
_____	Alcohol	_____	_____
_____	Other	_____	_____

32) _____ Age of first alcohol use

33) _____ Age of first drug use

34) _____ Do any immediate family members have a substance abuse problem? 1=Yes 2=No

35) _____ Has the offender received previous drug/alcohol treatment? 1=Yes 2=No

36) If yes, indicate the number of times the offender has experienced each of the following types of treatment:

_____ Detoxification
_____ Methadone maintenance
_____ Outpatient
_____ Short-term inpatient (30 days or less)
_____ Residential

37) _____ Is the offender dual diagnosed with mental illness and substance abuse? 1=Yes 2=No

MYC only:

38) _____ Record the JASAE summary score

YDC only:

39) _____ Record the ADAS summary score

Please attach the following completed instruments OR a summary of results/scores:
Noble - PII
Mohican - YO-LSI
MonDay - LSI and MAPP
Youth Development Center - SASSI

Personal Drug Use Questionnaire

Today's Date: _____/_____/_____

Name:_____

Birthdate: _____/_____/_____

This information will be kept confidential. Your answers will not affect your status in the program.

Directions: Each of the statements below describes a way that you might or might not feel about your drug use. There are no right or wrong answers, we just want to know your opinion. Please use the following scale to tell us whether you agree or disagree with each of the statements listed below. Just circle the one number closest to your opinion (to the right of each statement).

1	2	3	4	5
Strongly Disagree	Disagree	Undecided/ Unsure	Agree	Strongly Agree

		Circle One				
1.	I really want to make changes in my use of drugs.....	1	2	3	4	5
2.	Sometimes I wonder if I am an addict.....	1	2	3	4	5
3.	If I don't change my drug use soon, my problems are going to get worse.....	1	2	3	4	5
4.	I have already started making some changes in my use of drugs.....	1	2	3	4	5
5.	I was using drugs too much at one time, but I've managed to change that.....	1	2	3	4	5
6.	The only reason that I am here is that somebody made me come.....	1	2	3	4	5
7.	Sometime I wonder if my drug use is hurting other people.....	1	2	3	4	5
8.	I have a drug problem.....	1	2	3	4	5

1	2	3	4	5
Strongly Disagree	Disagree	Undecided/ Unsure	Agree	Strongly Agree

Circle

9. I'm not just thinking about changing my drug use, I'm already doing something about it	1	2	3	4	5
10. I have already changed my drug use, and I am looking for ways to keep from slipping back to my old pattern	1	2	3	4	5
11. I have serious problems with drugs	1	2	3	4	5
12. Sometimes I wonder if I am in control of my drug use	1	2	3	4	5
13. My drug use is causing a lot of harm	1	2	3	4	5
14. I am actively doing things now to cut down or stop my use of drugs	1	2	3	4	5
15. I want help to keep from going back to the drug problems that I had before	1	2	3	4	5
16. I know that I have a drug problem	1	2	3	4	5
17. There are times when I wonder if I use drugs too much	1	2	3	4	5
18. I am a drug addict	1	2	3	4	5
19. I am working hard to change my drug use	1	2	3	4	5
20. I have made some changes in my drug use, and I want some help to keep going	1	2	3	4	5

OHIO'S RESIDENTIAL SUBSTANCE ABUSE TREATMENT PROGRAMS
Client Self-rating Form
(Adapted from TCU DCJTC Client Evaluation of Self and Treatment)

Today's date: _____/_____/_____

Full name: _____

Birthdate: _____/_____/_____

Directions: Each of the statements below describes a way that you might or might not feel about yourself. There are no right or wrong answers, we just want to know what you think. Please use the following scale to tell us whether you agree or disagree with each of the statements listed below. Just circle the one number closest to your opinion (to the right of each statement).

1	2	3	4	5
Strongly Disagree	Disagree	Undecided/ Unsure	Agree	Strongly Agree

	Circle One				
1. You like to take chances	1	2	3	4	5
2. You feel sad or depressed	1	2	3	4	5
3. Sometimes you feel that you are being pushed around in your life	1	2	3	4	5
4. You consider how your actions will affect others	1	2	3	4	5
5. Sometimes a person has to break the law in order to get ahead	1	2	3	4	5
6. You have much to be proud of	1	2	3	4	5
7. In general, you are satisfied with yourself	1	2	3	4	5
8. You like the "fast" life	1	2	3	4	5
9. You feel mistreated by other people	1	2	3	4	5
10. You have thoughts of committing suicide	1	2	3	4	5
11. You have trouble sitting still for long	1	2	3	4	5
12. You don't have much in common with people who never break the law	1	2	3	4	5
13. You plan ahead	1	2	3	4	5
14. You like others to feel afraid of you	1	2	3	4	5

1	2	3	4	5
Strongly Disagree	Disagree	Undecided/ Unsure	Agree	Strongly Agree

Circle One

15. You have trouble following rules and laws	1	2	3	4	5
16. You feel lonely	1	2	3	4	5
17. You like friends who are wild	1	2	3	4	5
18. You like to do things that are strange or exciting	1	2	3	4	5
19. Most people would commit crime if they knew they wouldn't get caught	1	2	3	4	5
20. You feel like a failure	1	2	3	4	5
21. There is never a good reason for breaking the law	1	2	3	4	5
22. You have trouble sleeping	1	2	3	4	5
23. You feel interested in life	1	2	3	4	5
24. You sometimes want to fight or hurt others	1	2	3	4	5
25. You think about the possible results of your actions	1	2	3	4	5
26. You stay away from anything dangerous	1	2	3	4	5
27. You feel you are basically no good	1	2	3	4	5
28. You have a hot temper	1	2	3	4	5
29. You have trouble making decisions	1	2	3	4	5
30. You think of several different ways to solve a problem	1	2	3	4	5
31. You feel nervous	1	2	3	4	5
32. There is really no way you can solve some of the problems you have	1	2	3	4	5
33. You analyze problems by looking at all the choices	1	2	3	4	5

1	2	3	4	5
Strongly Disagree	Disagree	Undecided/ Unsure	Agree	Strongly Agree

	Circle One				
34. Your temper gets you into fights or other trouble.....	1	2	3	4	5
35. You make decisions without thinking about consequences.....	1	2	3	4	5
36. You have trouble concentrating or remembering things.....	1	2	3	4	5
37. There is little you can do to change many of the important things in your life.....	1	2	3	4	5
38. You feel extra tired or run down.....	1	2	3	4	5
39. You make good decisions.....	1	2	3	4	5
40. You feel afraid of certain things, like crowds or going out alone.	1	2	3	4	5
41. You only do things that feel safe.....	1	2	3	4	5
42. You get mad at other people easily.....	1	2	3	4	5
43. You wish you had more respect for yourself.....	1	2	3	4	5
44. You have little control over the things that happen to you.....	1	2	3	4	5
45. You worry or brood a lot.....	1	2	3	4	5
46. You often feel helpless in dealing with the problems of life.....	1	2	3	4	5
47. You have carried weapons, like knives or guns.....	1	2	3	4	5
48. You feel tense or keyed-up.....	1	2	3	4	5
49. You are always very careful.....	1	2	3	4	5
50. You think about what causes your current problems.....	1	2	3	4	5
51. You can do just about anything you really set your mind to do..	1	2	3	4	5
52. You feel a lot of anger inside you.....	1	2	3	4	5
53. You feel tightness or tension in your muscles.....	1	2	3	4	5
54. What happens to you in the future mostly depends on you.....	1	2	3	4	5

OHIO'S RESIDENTIAL SUBSTANCE ABUSE TREATMENT PROGRAMS

Service Tracking Form

Client Name: _____ _____ **Case No:** _____

Program code:_____ 1 = YDC; 2 = Mohican; 3 = MonDay; 4 = Noble

1. Specialized Services Provided

Using the codes provided below, please maintain a log of services provided to the offender including the type of service, date started, date ended, and progress in treatment.

Type of Service*	Date Started	Date Ended	Please check the box which describes the offender's progress in treatment		
			Achieved Objectives	Some progress	No progress

***Service Codes (if a code is not listed, please write name of service in column 1 of table)**

1 = Adult Basic Education/ GED/other schooling
2 = Anger management
3 = Art therapy
4 = Assertiveness training
5 = Cognitive therapy
6 = Employment
7 = Family therapy
8 = Individual counseling
9 = Life skills training
10 = Peer encounter groups
11 = Problem solving skills training
12 = Rational-emotive therapy
13 = Relapse prevention
14 = Relaxation training
15 = Self-instructional training
16 = Social skills training
17 = Substance abuse education
18 = Vocational skills training

2. Treatment Phases

If your program uses a phase or level system, please indicate the client's start and end dates for each phase. If a client regresses or repeats a phase, please indicate the reason for the regression in column four. Otherwise, leave column four blank.

Phase Name	Start date	End date	If moved back to earlier phase, please indicate reason

3. Drug Testing

Date of Test	Result (1=positive; 2=negative)	If positive, for what drug(s)?*

***Substance Codes**

1=Cocaine 2=Amphetamine 3=THC 4 = Benzodiazapime 5 = PCP 6= Opiate 7 = Alcohol

4. Program Violations

Please record violations committed by the client throughout his/her participation in the residential phase of the therapeutic community.

Date of Violations	Type of Violations (check all types that apply for the date specified. If the offender committed multiple violations of one type, record the number of violations committed instead of a checkmark)				
	Written pull-up	House	Cardinal	Major	Institutional Infractions

OHIO'S RESIDENTIAL SUBSTANCE ABUSE TREATMENT PROGRAMS

Standardized Termination Form

Please indicate the circumstances surrounding the client's discharge from the program including the date of discharge, type of discharge, and plan for aftercare.

1) Client Name: _____

2) Social Security No:_____

3) Program code:_____ 2 = Mohican; 3 = MonDay; 4 = Noble

4) Date of discharge ____/____/____

5) Type of discharge _____

1=Successful completion (achieved treatment goals)
2=Successful completion (completed required time but did not achieve treatment goals)
3=Unsuccessful termination (disciplinary, lack of participation/progress)
4=Voluntary withdrawal from program
5=Escape/Absconsion
6=Unable to participate due to reclassification, medical, out to court
7=Other (specify: _____)

6) Living arrangements upon discharge_____

1=With family/relatives
2=With friends
3=By him/her self in apartment/house
4=Group home
5=Halfway house
6=Foster care
7=Other (specify: _____)

7) Has continued drug/alcohol treatment been arranged for the client? _____ 1=Yes; 2=No

8) Criminal Justice Placement _____

1=Probation supervision
2=Parole supervision
3=Jail
4=Prison
5=DYS institution
6=Other (specify:_____)

9) To facilitate the collection of follow-up data, please provide the following information on the agency responsible for the offender's supervision/custody upon discharge from RSAT.

Agency (probation, parole, institution)_____

Probation/Parole Officer's name_____

Address_____

City, State, Zip_____

Phone Number _____

10) Please provide reassessment information by attaching the following items Or a summary of results/scores.

Monday - LSI reassessment
Noble - PII reassessment

RSAT FOLLOW-UP DATA

Please 1) Write legibly. 2) Use an "X" to mark the box(es) next to the appropriate answers. 3) Leave the question blank if the information is unknown or not available.

1. Offender's name: _____

2. Offender's SSN: _____

3. Has the offender received any follow-up drug/alcohol services since his/her release from Mohican?

☐ yes ☐ no - skip to question 4

A. If yes, which types of treatment? ("X" all that apply.)

☐ residential

☐ intensive outpatient treatment

☐ standard outpatient treatment

☐ other (please specify: _____)

B. Is the offender still active in drug/alcohol treatment?

☐ yes - skip to question 4 ☐ no

C. If no, was the offender successfully or unsuccessfully terminated from treatment?

☐ successfully ☐ unsuccessfully

4. Does the offender attend AA/NA meetings at least once per week?

☐ yes ☐ no

5. What other services has the offender received since his/her release from Mohican? ("X" all that apply.)

☐ educational/vocational

☐ employment services

☐ mental health counseling (group or individual)

☐ cognitive skills training

☐ domestic violence treatment

☐ family/marital counseling

6. Place an "X" in the box that best describes the offender's current employment status.

☐ unemployed

☐ retired

☐ student

☐ disabled

☐ employed part-time (< 35 hrs./week)

☐ employed full-time (35 + hrs./week)

7. Place an "X" in the box that best describes the offender's reporting status?

☐ once a week or more ☐ once a month

☐ twice a month ☐ less than once a month

8. Has the offender reported alcohol use or tested positive for alcohol use since released from Mohican?

☐ yes ☐ no - skip to question 9

A. If yes, number of times: _____

B. Date of first reported/detected alcohol use since released: _____/_____/_____

9. Has the offender reported drug use or tested positive for drug use since released from Mohican?

☐ yes ☐ no - skip to question 10

A. If yes, number of times: _____

B. For which drugs? ("X" all that apply.)

☐ marijuana ☐ barbiturates

☐ cocaine ☐ hallucinogens

☐ opiates

C. Date of first reported/detected drug use since released: _____/_____/_____

10. Has the offender had any new arrests since released from Mohican?

☐ yes ☐ no - skip to question 11

If yes, please indicate the date(s) of any new arrest(s), the offense(s) leading to the arrest(s), and whether or not the offender was convicted of the offense(s).

Date?	Offense?	Conviction?
_____/_____/_____	_____	☐ yes ☐ no ☐ pending
_____/_____/_____	_____	☐ yes ☐ no ☐ pending
_____/_____/_____	_____	☐ yes ☐ no ☐ pending
_____/_____/_____	_____	☐ yes ☐ no ☐ pending
_____/_____/_____	_____	☐ yes ☐ no ☐ pending

11. Please place an "X" in the box that best describes the offender's probation status and record the date where appropriate:

- ☐ active
- ☐ successfully terminated (date of termination: _____/_____/_____)
- ☐ revocation pending
- ☐ revoked for new arrest/conviction (date of revocation: _____/_____/_____)
- ☐ absconder (date of absconsion _____/_____/_____)
- ☐ other (please specify: _____)

THANK YOU FOR YOUR HELP!

APPENDIX B

DESCRIPTIVE STATISTICS

Table B1: Demographic Characteristics

Characteristic	Frequency (N=343)	Percent
Race		
White	162	47.2
Black	157	45.8
Hispanic	10	2.9
Native American	1	.3
Asian	4	1.2
Other	9	2.6
Age at Intake		
(x=16.89; range=13.47-19.49)		
13	6	1.8
14	18	5.0
15	50	15.0
16	90	25.9
17	112	33.5
18	55	15.5
19	3	.9
Not reported	9	2.6
Marital Status		
Married	2	.6
Not married	340	99.1
Not reported	1	.3
Number of Dependents		
(x=.21; range=0-4)		
0	283	82.5
1	40	11.7
2	14	4.1
3	0	0
4	1	.3
Not reported	5	1.4

Table B2: Social History

Characteristic	Frequency (N=343)	Percent
Highest grade completed (×=8.76)	1	.3
1st grade	1	.3
5th grade	11	3.2
6th grade	24	7.0
7th grade	118	34.4
8th grade	94	27.4
9th grade	57	16.6
10th grade	22	6.4
11th grade	7	2.0
12th grade	2	.6
Some college	6	1.7
Not reported		
School Performance	254	74.1
Number enrolled	245	71.4
Number truant	212	61.8
Number with low achievement	213	62.1
Number with disruptive behavior	267	77.8
Number with suspensions/expulsions		
Employment Status Prior to Arrest		
Employed full-time	20	5.8
Employed part-time	67	19.5
Unemployed	246	71.7
Not reported	10	2.9
Living Arrangements Prior to Arrest		
With parents/guardians	295	86.0
Foster care	5	1.5
Group home	5	1.5
Secure placement	33	9.6
Not reported	5	1.5
Number with History of Runaway	114	33.2

Table B3: Criminal History - Descriptive Statistics

Variable	Min.	Max.	Mean	Median	SD
Age at First Arrest (n=255)	4.00	18.00	13.47	13.59	2.09
No. of Prior Felony Arrests (n=206)	1.00	22.00	4.05	3.00	3.54
No. of Prior Felony Convictions (n=184)	1.00	16.00	3.21	2.00	2.66
No. of Prior Misdemeanor Arrests (n=204)	1.00	30.00	5.26	4.00	4.95
No. of Prior Misdemeanor Convictions (n=164)	1.00	30.00	4.97	4.00	4.91
No. of Prior Sentences to a Secure Facility (n=334)	.00	20.00	1.37	1.00	2.44
No. of Prior Sentences to Community Supervision (n=317)	.00	30.00	3.32	2.00	4.26
No. of Prior unsuccessful Terminations From Community Supervision (n=85)	.00	29.00	2.08	1.00	3.83

Table B4: Criminal History - Frequencies (n=343)

Variable	Frequencies	Percent
No. of Prior Felony Arrests		
One	46	13.4
Two	42	12.2
Three	36	10.5
Four or more	82	24.0
Not reported	137	39.9
No. of Prior Felony Convictions		
One	51	14.9
Two	47	13.7
Three	31	9.0
Four or more	55	16.0
Not reported	159	46.4
No. of Prior Misdemeanor Arrests		
One	36	10.5
Two	37	10.8
Three	21	6.1
Four or more	110	32.1
Not reported	139	40.5
No. of Prior Misdemeanor Convictions		
One	39	11.4
Two	24	7.0
Three	15	4.4
Four or more	86	25.0
Not reported	179	52.2
No. of Prior Sentences to a Secure Facility		
None	155	45.2
One	80	23.3
Two	48	14.0
Three	21	6.1
Four or more	30	9.0
Not reported	9	2.6
No. of Prior Sentences to Community Supervision		
None	62	18.1
One	72	21.0
Two	60	17.5
Three	28	8.2
Four or more	95	27.6
Not reported	26	7.6
No. of Prior Unsuccessful Terminations From Community Supervision		
None	131	38.2
One	54	15.7
Two	36	10.5
Three	15	4.4
Four or more	47	13.7
Not reported	60	17.5
Ever Arrested for a Prior Drug Charge?		
Yes	148	43.1
No	188	54.8
Not reported	7	2.0

Table B5: Current Offense (n=343)

Variable	Frequency	Percent
Level of Conviction Offense		
Felony 1	41	12.0
Felony 2	114	33.2
Felony 3	56	16.3
Felony 4	83	24.2
Felony 5	42	12.2
Not reported	7	2.0
Crime Type		
Person	116	33.8
Property	152	44.3
Drug	41	12.0
Other	21	6.1
Not reported	13	3.8

Table B6: Type of Prior Drug Use (n=343)

Drug	Frequency	Percent
Prior Use of Alcohol		
Yes	321	93.6
No	22	6.4
Prior Use of Marijuana		
Yes	340	99.1
No	3	.9
Prior Use of Cocaine		
Yes	48	14.0
No	295	86.0
Prior Use of Crack		
Yes	29	8.5
No	314	91.5
Prior Use of Narcotics		
Yes	42	12.2
No	301	87.8
Prior Use of Depressants		
Yes	81	23.6
No	262	76.4
Prior Use of Stimulants		
Yes	63	18.4
No	280	81.6
Prior Use of Hallucinogens		
Yes	114	33.2
No	229	66.8
Prior Use of Inhalants		
Yes	32	9.3
No	311	90.7
Prior Use of PCP		
Yes	10	2.9
No	333	97.1
Prior Use of Over the Counter		
Yes	17	5.0
No	326	95.0
Prior Use of Other Drugs		
Yes	58	16.9
No Drug	285	83.1

Table B7: Frequency of Prior Drug Use

Drug	Frequency	Percent
Alcohol (n=321)		
Daily	98	30.5
Once a week or more	112	34.9
Less than once a week	96	29.9
Not reported	15	4.7
Marijuana (n=340)		
Daily	240	70.6
Once a week or more	60	17.6
Less than once a week	35	10.3
Not reported	5	1.5
Cocaine (n=48)		
Daily	2	4.2
Once a week or more	8	16.7
Less than once a week	33	68.8
Not reported	5	10.4
Crack (n=29)		
Daily	4	13.8
Once a week or more	3	10.3
Less than once a week	21	72.4
Not reported	1	3.4
Narcotics (n=42)		
Daily	1	2.4
Once a week or more	7	16.7
Less than once a week	29	69.0
Not reported	5	11.9
Depressants (n=81)		
Daily	7	8.6
Once a week or more	18	2.2
Less than once a week	48	59.3
Not reported	8	9.9
Stimulants (n=63)		
Daily	5	7.9
Once a week or more	15	23.8
Less than once a week	35	55.6
Not reported	8	12.7
Hallucinogens (n=114)		
Daily	2	1.8
Once a week or more	25	21.9
Less than once a week	78	68.4
Not reported	9	7.9
Inhalants (n=32)		
Daily	3	9.4
Once a week or more	4	12.5
Less than once a week	23	71.9
Not reported	2	6.3
PCP (n=10)		
Daily	1	10.0
Once a week or more	2	20.0
Less than once a week	7	70.0
Not reported	0	0
Over the Counter Drugs (n=17)		
Daily	0	0
Once a week or more	7	41.2
Less than once a week	9	52.9
Not reported	1	5.9
Other Drugs (n=58)		
Daily	13	22.4
Once a week or more	10	17.2
Less than once a week	27	46.6
Not reported	8	13.8

Table B8 : Drug History

Variable	Frequency	Percent
Age at First Alcohol Use (x=11.56)		
9 and under	74	22.7
10 to 12	99	28.8
13 to 15	134	39.0
16 and over	17	5.0
Not reported	19	5.5
Age at First Drug Use (x=12.17)		
9 and under	46	13.5
10 to 12	126	36.7
13 to 15	152	44.3
16 and over	13	3.8
Not reported	6	1.7
First Drug of Choice		
Heroine	1	.3
Non-crack cocaine	2	.6
Crack	2	.6
Amphetamines	1	.3
Barbiturates/tranquilizers	3	.9
Marijuana	262	76.4
LSD	9	2.6
PCP	0	0
Inhalants	1	.3
Over the counter drugs	0	0
Alcohol	49	14.3
Other	3	.9
Not reported	10	2.9
Second Drug of Choice		
Heroine	1	.3
Non-crack cocaine	2	.6
Crack	5	1.5
Amphetamines	1	.3
Barbiturates/tranquilizers	4	1.2
Marijuana	30	8.7
LSD	17	5.0
PCP	2	.6
Inhalants	1	.3
Alcohol	112	32.7
Other	5	1.5
Not reported	163	47.5
Third Drug of Choice		
Heroine	1	.3
Non-crack cocaine	9	2.6
Amphetamines	3	.9
Barbiturates/tranquilizers	5	1.5
LSD	15	4.4
PCP	1	.3
Inhalants	2	.6
Over the counter drugs	1	.3
Alcohol	22	6.4
Other	7	2.0
Not reported	277	80.8

Table B9: Drug History

Variable	Frequency	Percent
Dual Diagnosis		
Yes	85	24.8
No	233	67.9
Not reported	25	7.3
History of Family Substance Abuse		
Yes	209	60.9
No	129	37.6
Not reported	5	1.5
History of Prior Treatment		
Yes	181	52.8
No	157	45.8
Not reported	5	1.5
No. Participating in Following Types of Treatment *(n =181)		
Detoxification	7	3.9
Methadone Maintenance	4	2.2
Outpatient	106	59.6
Short-term inpatient	44	24.3
Long-term residential	69	38.1

	Min	Max	Mean	Median	SD
JASAE Score	17.00	74.00	48.02	49.00	11.32

*Frequencies and percentages exceed 90 and 100, respectively, due to offenders participating in multiple types of treatment.

Table B10: Youthful Level of Services Inventory (n=72)

YO-LSI Scale	Minimum	Maximum	Mean	Median	SD
Prior and Current Offenses, Adjudications (range 0-5)	.00	5.00	3.32	4.00	1.16
Family Circumstances and Parenting (range 0-6)	.00	6.00	2.99	3.00	1.62
Employment/Education (range 0-7)	.00	7.00	3.76	4.00	1.72
Peer Relations (range 0 - 4)	.00	4.00	3.22	4.00	.99
Substance Abuse (range 0 - 5)	.00	5.00	3.92	4.00	1.21
Leisure/Recreation (range 0-3)	.00	3.00	1.89	2.00	.74
Personality and Behavior (range 0-7)	.00	7.00	3.49	4.00	1.80
Attitudes/Orientation (range 0-5)	.00	5.00	1.74	2.00	1.31
Total (range 0-42)	.00	35.00	24.06	24.50	6.51

Table B11: Descriptive Statistics for Client Self-Rating Form - Time 1

Scale	N	Minimum	Maximum	Mean	Median	SD
Anxiety (range 7-35)	85	8.00	31.00	19.32	20.00	5.05
Depression (range 6-30)	85	6.00	23.00	14.12	15.00	3.94
Self-esteem (range 5-25)	85	10.00	25.00	18.61	19.00	3.75
Decision-making (range 9-45)	85	15.00	45.00	30.18	30.00	6.34
Risk-taking (range 7-35)	85	9.00	35.00	23.48	23.00	5.32
Hostility (range 8-40)	85	9.00	40.00	25.52	26.00	6.68
Self-efficacy (range 7-35)	85	12.00	35.00	25.49	26.00	4.72
Antisocial attitudes (range 5-25)	85	5.00	23.00	14.06	14.00	3.49

Table B12: Termination Information

Variable	Min.	Max.	Mean	Median	SD
Average length of stay	5.00	550.00	176.63	171.00	85.01

	Frequency	Percent
Case status (n=343)		
Still active	76	22.2
Successfully discharged	267	77.8
Parole Region (n=124)*		
Akron	17	14.0
Athens	4	3.0
Cincinnati	13	10.0
Cleveland	20	16.0
Columbus	8	6.0
Dayton	9	7.0
Toledo	5	4.0
Not reported	76	61.0
Continued Drug Treatment Been Arranged (n=124)		
Yes	70	56.0
No	48	39.0
Not reported	6	2.0
Living Arrangements Upon Discharge (n=124)*		
With family/relative	114	92.0
Group home	3	2.0
Halfway house	1	1.0
Foster care	2	2.0
Other	4	3.0

*Termination information was only available on 124 cases.

APPENDIX C

CPAI RESULTS

Correctional Program Assessment Inventory©

Conducted on the Mohican Youth Center
Ohio Department of Youth Services
Loudenville, Ohio

By

Betsy Fulton, M.S.
Division of Criminal Justice
University of Cincinnati
Cincinnati, OH 45221-0389

October 1998

Summary of the Program

Mohican Youth Center (MYC) is a 160-bed secure facility operated by the Ohio Department of Youth Services (DYS). In 1998, MYC was designated as a substance abuse treatment facility for drug-involved youth sentenced to DYS as the result of a felony adjudication. Youth assessed as needing long-term residential treatment are sent to MYC for the last six months of their sentence. MYC is funded by a federal grant and matching funds from DYS. The grant is renewable for four years after which time DYS will fund the program in its entirety. MYC employs approximately 175 people including 13 clinical staff.

Procedures

The Correctional Program Assessment Inventory (CPAI, Gendreau and Andrews, 1992) is used to ascertain how closely a correctional treatment program meets known principles of effective correctional treatment. There are six primary sections of the CPAI: 1) program implementation and the qualifications of the program director; 2) client pre-service assessment; 3) characteristics of the program; 4) characteristics and practices of the staff; 5) quality assurance and evaluation; and 6) miscellaneous items such as ethical guidelines and levels of community support.

Each section is scored as either "very satisfactory" (70% to 100%); "satisfactory" (60% to 69%); "satisfactory, but needs improvement" (50% to 59%); or "unsatisfactory" (less than 50%). The scores from all six areas are totaled and the same scale is used for the overall assessment score. It should be noted that not all of the six areas are given equal weight, and some items may be considered "not applicable," in which case they are not included in the scoring.

Data were collected through structured interviews with selected program staff on October 20 and 21, 1998. Other sources of information included the observation of group sessions and the examination of several representative case files and other selected program materials.

Program Implementation

The first section examines how much influence the current program director had in designing and implementing the program, his/her qualifications and experience, his/her current involvement with the staff and the clients, and the overall implementation of the program.

Strengths:

The first area concerns the qualifications and involvement of the program director, or the person responsible for overseeing the daily operations of the program. The current clinical director has a master's degree in alcohol and drug abuse ministry and has earned her CCDCIII. With the exception of a three-year departure, she has been with DYS since

1989. During her tenure at Riverview, another DYS facility, she was appointed to the transition committee that was responsible for overseeing Mohican's transition from a generalized medium security facility to a substance abuse treatment facility. She has been intricately involved with all aspects of program development including the hiring, training, and direct supervision of the clinical staff.

The second area of focus is the creation of the program itself. Effective intervention programs have several dimensions: they are designed to be consistent with the treatment literature on effective programs; the values and goals of the program should be consistent with existing values in the community or the institution; the program meet a local need; and the program is perceived to be cost-effective.

The transition committee was responsible for reviewing pertinent treatment literature and for ensuring that the literature on effective programs was incorporated into the program design. The committee was aided by research conducted by the employees at the central office of DYS. A primary focus of the research has been on therapeutic communities.

The values and goals of Mohican are consistent with the overall mission of DYS. The central office has been supportive of the facility and its staff throughout the transition period. Although the transition to a substance abuse facility has been difficult for many of the custodial staff, the majority are supportive of the shift in focus. Furthermore, many of the custodial staff conduct group sessions as needed and participate on the treatment teams for youth assigned to their unit.

The program was developed to address the prevalence of youth who demonstrated serious drug and alcohol problems. The program is perceived as being cost-effective and sustainable.

Areas that Need Improvement:

Although some of the program materials were piloted at Circleville there was no formal pilot period at Mohican that allowed for the sorting out of program content and logistics.

The clinical director is not systematically involved in the delivery of direct services to youth.

Evaluation: Very Satisfactory

Recommendations:

- Before any changes are made to the program, a pilot phase should be undertaken to sort out program logistics and content. The pilot should last a minimum of one month.

- The clinical director should be systematically involved in direct service delivery (e.g., conducting groups, assessing youth, individual counseling) as a means of staying

abreast of the challenges faced by staff and youth and the skill level and resources required for the effective delivery of services.

Client Pre-Service Assessment

The extent to which clients are appropriate for the service provided, and the use of proven assessment methods is critical to effective treatment programs. Effective programs assess the risk, need and responsivity of offenders, and then provide services and treatment accordingly. The section on Client Pre-Service Assessment examines three areas regarding pre-service assessment: selection of clients, the assessment of risk, need, and personal characteristics of the client; and the manner in which these characteristics are assessed.

Strengths:

Youth referred to MYC have multiple areas of need in addition to substance abuse including educational, psychological, and social skill deficits. Rational exclusionary criteria have been established. These criteria include insufficient time to complete the program and offenders' whose primary treatment needs (e.g., mental health, sexual deviance) can be better served by placement in another DYS facility.

All youth undergo a battery of assessments upon intake to the DYS reception center in Circleville, Ohio including a social history, medical examination, educational history, gang assessment, substance abuse assessment, the Youthful Level of Service Inventory, the Brief Symptom Inventory, and a suicide risk assessment. These completed assessments are included in the youth's file upon transfer to MYC.

Two of the assessments used by DYS are quantifiable, objective measures of risk and need that provide a summary score that can be used in treatment classification. The Juvenile Automated Substance Abuse Evaluation (JASAE) is used to assess the severity of youths' substance abuse problem; it provides a summary score indicating the level of care required. Youth scoring 21 or above on the JASAE are referred to MYC. A JASAE is available on all youth participating in MYC. In July 1998, DYS instituted the Youthful Level of Services Inventory (YO-LSI). The YO-LSI uses multiple items to measure eight areas of risk and need that are associated with recidivism including criminal history, family circumstances and parenting, education/employment, peer relations, substance abuse, leisure/recreation, personality and behavior, and attitudes/orientation. YO-LSIs are only available on the youth most recently admitted to MYC.

DYS measures several responsivity factors, or personal characteristics, that may interfere with treatment. Youths' intellectual abilities are measured through the California Achievement Test (CAT) and psychological patterns including interpersonal sensitivity, anxiety, depression, and hostility are measured through the Brief Symptom Inventory (BSI). Both are quantifiable, objective instruments.

Areas that Need Improvement:

Although the majority of offenders referred to MYC appear to be appropriate for the services provided, many offenders have mental health needs or behavioral problems that are best served by another DYS institution. Additionally, many youth have been transferred to MYC too late in their sentence and, therefore, do not have a sufficient amount of time to complete the program.

The CAT and BSI instruments that are used to measure intellectual functioning and anxiety/depression do not provide overall summary scores for use in treatment classification.

Two major concerns regarding the assessment process should be noted. First, the assessment information for many of the youth referred to MYC appears to be outdated by the time they are transferred to MYC. Many of the youth receive some type of treatment at other DYS institutions prior to being transferred to MYC. Any changes in knowledge and attitudes as the result of this treatment or their incarceration is not captured in the current assessment information, nor are changes in youths' mental health status.

Rating: Very Satisfactory

Recommendations:

- It may be beneficial for MYC to consider the implementation of an abbreviated assessment process that captures current information regarding youths' knowledge and attitudes about substance abuse, their readiness for treatment, and their current mental health status.

- Quality assurance mechanisms should be instituted to insure that assessment findings are reflected in youths' treatment plans.

Program Characteristics

This section examines whether or not the program targets criminogenic behaviors and attitudes, the types of treatment used to target these behaviors and attitudes, specific treatment procedures, the use of positive reinforcement and punishment, and methods used to prepare clients for return to the community. Other important elements of effective intervention include the ratio of rewards to punishment; matching the client's risk, needs, and personal characteristics with the appropriate treatment programs, treatment intensity, and staff; and relapse prevention strategies designed to assist the client in anticipating and coping with problem situations.

Strengths:

The treatment and services offered by MYC are designed to target criminogenic needs and behaviors associated with recidivism including:

- changing attitudes, orientations, and values favorable to law violations and anti-criminal role models;
- promote more positive attitudes/increase performance regarding school work;
- relapse prevention;
- focusing on harm done to the victim; and
- alleviating the personal and circumstantial barriers to service (client motivation, denial).

MYC is in the process of establishing a therapeutic community in which the therapeutic milieu will serve as the primary agent of change. Some of the terminology and procedures common to therapeutic communities have recently been implemented (push-ups, pull-ups, learning experiences). Currently, the treatment services provided by MYC combine the 12-step model, a social learning approach that provides opportunities for modeling and behavioral rehearsal techniques that engender self-efficacy, and a cognitive behavioral approach that aims to challenge antisocial attitudes, increase victim empathy, and develop self-control procedures. Social learning and cognitive-behavioral approaches have proven effective in reducing recidivism. Specifically, MYC provides individual counseling and several educational and therapy groups including the following:

- Normative Culture Groups – these groups designed to help the youth identify and resolve problems behaviors and thinking errors, develop competencies, and encourage and support each other. They are conducted four times each week for 1.5 hours throughout the period of treatment.

- Criminality Groups – these 1.5 hour psycho-educational groups are conducted two times per week throughout the six-week orientation phase of the program. A curriculum by Hazelden is used to challenge criminal thinking patterns and assist offenders in identifying the link between their criminal behavior and substance abuse.

- Substance Abuse Education Groups – these groups are conducted throughout the youths' treatment with the intensity increasing as the youth progress through treatment (i.e., 3 hours per week during the orientation phase to 12 hours per week during the relapse prevention phase). The focus of these groups is on basic education about drug and alcohol use and its consequences and relapse prevention skills.

- Pathways – these groups focus on the disease model of drug addiction and introduce youth to the 12-step process of recovery.

- Young Men's Work – this ten session group is provided during the youths' core treatment phase for 1.5 hours each week. A Hazelden curriculum is used to assist the youth in developing problem-solving and conflict resolution skills that stop the need for violence.

MYC offers a very structured program. In addition to individual and group counseling, youth attend school and participate in therapeutic recreation and meditation. Thus,

program participants are involved in therapeutic activities for at least 40 percent of their time as recommended in the treatment literature. Additionally, their whereabouts and peer associations are closely monitored in the living units.

Youth have input in the rules and structure of the program through "house meetings" that are held on a weekly basis. The youth are responsible for setting the meeting agenda and are responsible for running the meeting. The purpose of the meetings is to raise and resolve concerns about the program.

Effective correctional intervention programs train clients to monitor problem situations and rehearse alternative, prosocial responses to these situations. A significant portion of group time is focused on helping offenders identify triggers and events leading to drug/alcohol abuse and other antisocial behavior. Offenders practice alternative prosocial behaviors through various exercises and role plays. Offenders also identify people whom they can call for support when faced with a difficult situation.

Effective intervention programs routinely refer clients to other services and agencies that help address their remaining needs. All youth are placed on parole upon their release from DYS and their remaining treatment goals are addressed. An aftercare specialist or parole officer meets with the youth prior to their release. Specific aftercare services are available in several regions. Youth in other regions are simply referred to the local substance abuse service for continued treatment.

Areas that Need Improvement:

The most effective correctional intervention programs have detailed treatment manuals that describe the instructional or therapeutic methods to be used when delivering a specific service. These manuals are then used by all treatment staff to insure the consistent and appropriate delivery of services. Although various treatment manuals (e.g., Hazelden curricula) are available to social workers for conducting the aforementioned educational and therapy groups, there was little consistency across treatment staff in the content or nature of the services provided. Each social worker prepares his/her own lesson plans based on materials available to them through MYC or personal resources. The observation of several groups and interviews with treatment staff suggest that the groups are targeting appropriate criminogenic needs, are highly structured and well-facilitated by staff, and that they encourage youth interaction and involvement. The problem lies, not so much in what is being done within each group, but with the lack of consistency across groups and social workers. It is very difficult to determine if youth are receiving the intended continuum of services (i.e., basic education, skill building, and relapse prevention). Furthermore, there appears to be some overlap and duplication between the substance abuse education and pathways groups. While some repetition is needed, too much can lead to boredom and frustration among the youth and hinder their motivation for positive change.

Effective correctional treatment programs vary the level of services according to the level of client risk. Because the risk level of participating offenders has only recently been

measured with the YO-LSI, it is difficult to determine if the intensity and duration of treatment is appropriately matched to the offender's level of risk. Essentially, all offenders receive the same level of supervision and treatment. Some offenders may receive more individual counseling than others but this is not systematically built into the treatment plan based on the youth's risk level.

Effective programs assign clients to treatment programs and treatment staff that match up best with their interests, style of learning, and personality characteristics. Currently, the primary determination for assigning youth to living units and, thus, to treatment staff is bed availability. A "dorm placement committee" has been established to examine factors to be considered in dorm assignment.

Effective programs also match treatment staff with programs or services that tap their expertise and interests. The treatment staff at MYC are involved in all programmatic aspects rather than specializing in areas that match their skills and interests.

MYC has a behavioral management system that includes six levels. As youth progress through levels, youth receive additional privileges. This behavioral management system is currently being modified. In the old system, youth earned "bad points" for rule violations. The juvenile correctional officer or treatment staff would write up youth for rule violations, awarding them 1 point for minor violations and 2-5 points for repeat or major violations. If a youth earned 36 or more points during a four week period the youth would lose a level and, hence, lose privileges. At that time the accumulation of points started over. Four primary problems existed with this system: 1) it focused, by design, on negative behaviors; 2) in many cases, youth would earn points but no other consequences; 3) there was often no interaction between the person who awarded the points and the youth; and 4) loss of levels and privileges was delayed by several weeks. Furthermore, if a youth earned too many points a hearing would be held and extra time could be added to his sentence. Because too much extra time was being given, this option was eliminated. This system violates the principles of effective intervention that suggest that the ratio of rewards to punishers should be at least 4:1 and that punishers be imposed immediately, at the earliest point in the deviant response, after every occurrence of deviant behavior, and that alternative prosocial behaviors are provided after punishment is administered.

The new system shifts the focus to rewarding positive behavior. Youth must meet certain criteria (e.g., consistent compliance with rules, progress in treatment, positive school performance) and petition the treatment team for a level change. Additionally, "learning experiences" are now given to youth as consequences for rule violation. Learning experiences are tools used in therapeutic communities to address antisocial behavior. They are consequences for behavior that are directly related to the infraction. For example, a youth might be required to write a letter of apology for swearing at someone, write an essay about the importance of good hygiene for an unkempt appearance, or perform extra cleaning duty for leaving a mess.

The system now in place is a hybrid of the old and new systems described above. The period of transition is leading to inconsistency among staff in the use of rewards and punishments and many negative behaviors are going unattended.

Because of the current lack of consistency in the delivery of treatment services, it is unlikely that youth are systematically exposed to increasingly difficult scenarios that encourage the practice of newly acquired skills and behaviors.

Release from the program is currently time-based. That is, when offenders complete their sentence, they are automatically released regardless of progress in treatment or the extent to which they demonstrate prosocial attitudes and behaviors. For youth sentenced after July 1, 1998 release decisions will be made on a case-by-case basis by the recently implemented DYS Release Authority. Program completion criteria are currently being developed by MYC. The decision regarding a youth's release from MYC or transfer to another institution will be up to the Release Authority based on information provided by the MYC treatment staff.

Community/family contact and support are essential to successful reintegration, and becomes even more important once a client is discharged from the treatment program. There is no evidence that the program routinely works with or trains family members on how to assist the offenders once they return home.

Evaluation: Unsatisfactory

Recommendations:

- A treatment manual that details the nature of the group treatment should be developed. This will facilitate staff training and the consistent delivery of services.

- Treatment intensity, or "dosage," should be clearly matched to the offender's level of risk as measured by a valid risk instrument. Higher risk offenders should receive more intense levels of treatment.

- Offenders should be matched to groups and treatment staff based on responsivity factors such as level of cognitive functioning, learning styles, level of anxiety, and communication styles. For example, low functioning offenders will have difficulty with a group facilitator highly verbal approach to treatment and high anxiety offenders will not respond well to a highly confrontational group or treatment staff.

- It may be beneficial for MYC to assign social workers to groups that best match their interest and expertise. This would give staff an opportunity to hone their skills in a particular area. It may also increase the consistency and the quality of the educational and therapy groups.

- Appropriate behavior and participation in treatment should be consistently rewarded. The ratio of rewards should be at least 4:1, and all staff should be well versed in the application of rewards and punishers.

- In order for punishers to be effective in extinguishing behavior the following conditions must be met: escape impossible, maximum intensity, earliest point in the deviant response, after every occurrence or deviant behavior, immediate, not spread out, and alternative prosocial behaviors provided after punishment is administered. Staff should also be trained to look for negative responses to punishers (e.g. emotional reactions, increase use of punishers, withdrawal, etc.).

- Opportunities should be developed (role plays, scenarios, additional privileges and responsibilities) to allow youth to practice newly acquired prosocial behaviors. This problem may be addressed with the full implementation of the therapeutic community where youth will encounter more responsibility and more difficult situations as they move through the hierarchy.

- Family members and significant others should be trained in how to provide help and support to the offenders during problem situations..

Staff Characteristics

This section concerns the qualifications, experience, stability, training, and involvement of the program staff. This scoring for this section was based on ten treatment staff.

Strengths:

The treatment staff at MYC are well qualified with 100 percent possessing a baccalaureate degree (80 percent in a helping profession) and 10 percent with a masters degree. Seventy percent of the treatment staff have been with MYC for at least two years, and 80 percent of the staff have prior experience with an offender treatment program. In addition to education and experience, staff appear to be hired based on personal qualities such as compassion for youth, optimism, integrity, and directness. Program staff are assessed yearly on skills related to service delivery and their input is encouraged through the weekly team meetings and participation on committees.

Areas that Need Improvement:

New staff training includes three weeks of pre-service training through DYS, a local orientation to MYC, and on-the-job training, none of which involves intensive training on cognitive or behavioral theories being used. During the transition to a substance abuse treatment program, all staff (including Correctional Officers) received 40 hours of substance abuse training. Since that time, however, new staff have not routinely received this training. Several staff have participated in Therapeutic Community Immersion Training provided by the Ohio Department of Alcohol and Drug Abuse Services although many more are in need of this training.

Although treatment teams meet once a week, no individual clinical supervision is currently being provided.

Evaluation: Very Satisfactory

Recommendations:

- New staff should receive three to six months of formal training in theory and practice of interventions employed by the program.

- The Social Workers should receive regular clinical supervision that is designed to review cases, address problematic issues, and enhance service delivery skills.

- As Juvenile Correctional Officers (JCOs) become more involved in treatment, their qualifications become more important. Effective treatment programs have well-qualified staff (i.e., 75% with a bachelors degree, 10% with a masters degree, and 75% with at least one year prior experience in an offender treatment program). MYC should evaluate the qualifications of the JCOs to ensure that the staff, as a whole, meets these criteria. It should be noted that in the case of staff shortages, JCOs are being asked to conduct groups. It is unlikely that they have the proper training to conduct these groups effectively, particularly without a detailed treatment manual.

Evaluation

This section centers on the types of feedback, assessments, and evaluations used to monitor how well the program is functioning.

Strengths:

Objective criteria regarding a youth's participation, performance, and attitudes are considered and rated as a means to monitor offender progress during weekly team meetings.

Areas that Need Improvement:

There are minimal quality assurance mechanisms in place. As stated previously, social workers are not receiving individualized clinical supervision. They are also given a lot of leeway in the content and nature of their groups. File reviews are not being conducted on a regular basis, nor are client satisfaction surveys being conducted. A survey has been developed and will be implemented in the near future.

Not scored:

There is an evaluation component to the federal grant that has been awarded to MYC. As part of this evaluation piece, offenders will be tracked with regard to recidivism.

Furthermore, plans are currently being made to conduct a formal outcome evaluation on the program that will involve the use of a comparison group.

Evaluation: Unsatisfactory

Recommendations:

- Client satisfaction surveys should be conducted annually.
- Other quality assurance mechanisms also should be implemented including individualized clinical supervision, random review of case files, and periodic observation of educational and therapy groups.
- In addition to the treatment team review as a means of monitoring progress in treatment, pre-post measures that capture changes in knowledge and attitudes related to specific treatment components may be beneficial. These should be developed once the treatment curricula has been developed and implemented.

Other

The final section in the CPAI includes miscellaneous items pertaining to the program such as disruptive changes in the program, funding, or community support, ethical guidelines and the comprehensiveness of the clients' files.

Strengths:

DYS has a written statement on the ethics of intervention. There have been no changes in program funding or in community support over the past two years that have jeopardized the program. There is a community advisory board that provides program oversight.

Areas that Need Improvement:

Although the client records are kept in confidential files, the information is not maintained in one comprehensive file that is accessible to JCOs and Social Workers for the purpose of monitoring and documenting progress.

Constant change in programming and DYS policies since MYC opened as a treatment facility is jeopardizing the smooth functioning of the program. Although the changes appear to consist of improvements, MYC staff are struggling to keep up with the policy changes and day-to-day service delivery. Additionally, the constant change is leading to inconsistencies among program staff. A Casework Supervisor position had been vacant for approximately one month at the time of the program assessment. This vacancy left several Social Workers without active supervision, and by required all Social Workers to conduct additional groups while also providing individual counseling and case management for 20 youth.

Evaluation: Satisfactory

Recommendations:

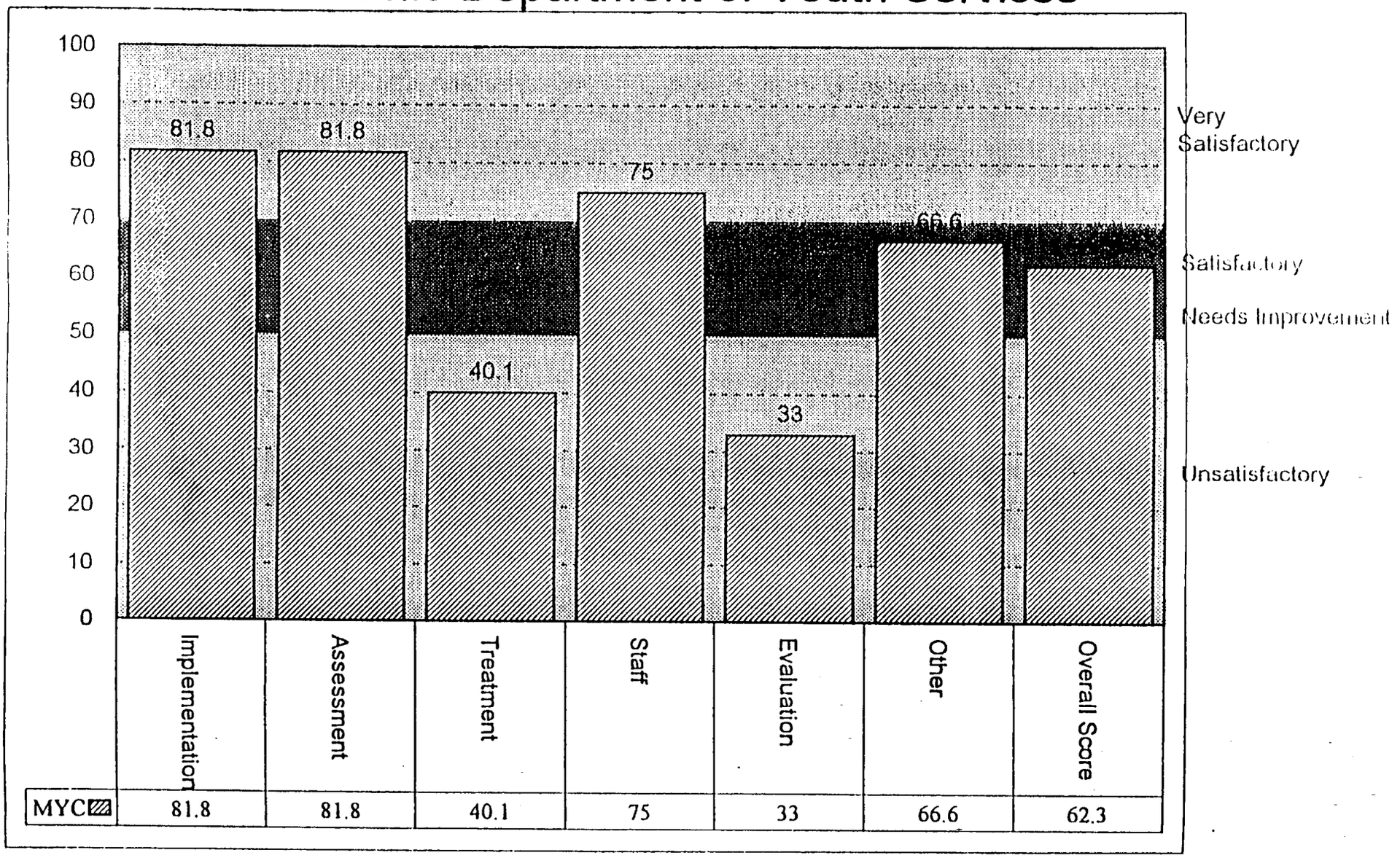
- Case files should be comprehensive and confidential. They should include social history, individual service plan, progress notes, and discharge plans.

- To maintain the integrity of services to youth, it may be beneficial for MYC to decelerate the change process by working with DYS to establish priorities. Stability is an essential ingredient for the provision of effective intervention.

OVERALL PROGRAM RATING:

The Mohican Youth Center received an overall score of 62.3 percent on the CPAI. This score is in the "satisfactory" range of the scale.

CPAI Scores for Mohican Youth Center
Ohio Department of Youth Services



Conducted October 1998. Very Satisfactory=70% or higher; Satisfactory=60-69%; Needs Improvement=50-59%; Unsatisfactory=less than 50%.