IMPLEMENTATION OF THE CYA-RSAT PROGRAMS

A Process Evaluation of the California Youth Authority's Residential Substance Abuse Treatment (RSAT) Programs (Year 1)

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Chapter 1

INTRODUCTION

This report summarizes findings of a process evaluation of the Residential Substance Treatment (RSAT) Program of the California Department of the Youth Authority (CYA). Funded by the Office of Criminal Justice Planning, the CYA-RSAT program is operated at three institutional sites: (1) the Karl Holton Drug and Alcohol Abuse Treatment Center in Stockton, (2) the Heman G. Stark Youth Correctional Facility in Chino, and (3) the Ventura School in Camarillo. As a result of the RSAT funds, each of these institutions has been able to enhance the treatment components of its existing Formalized Drug Programs (FPDs).

The goal of CYA-RSAT as articulated in the original proposal is to provide a safe and chemical-free environment in which participants can:

- Discover the thinking errors and faulty belief systems they use to justify their chemical-dependent behavior.
- Acquire the skills necessary to modify these beliefs and behaviors which will enable them to adopt a sober lifestyle.

HISTORICAL BACKGROUND

In 1943, CYA began to provide training and parole supervision to youthful offenders. In an effort to reform these offenders, CYA moved quickly to establish camps and institutions which would house and provide education and training to youths formerly detained in state reformatories, county jails, detention homes, and army camps. Camps were established throughout the state as were institutions, including those that would accommodate older youths. In 1960, the Youth Training School opened in Chino, California. Known today as the

Heman G. Stark Youth Correctional Facility (YCF), this institution was named after the CYA's longest acting director who served from 1952 to 1968. Shortly thereafter, in 1968, the Karl Holton School for Boys was opened in Stockton, California. This school was part of a general population facility which housed male offenders ages 17 to 24, but, in 1994, was converted to the Drug and Alcohol Abuse Treatment Center. Today this institution is known as the Karl Holton Drug Abuse Treatment Youth Correctional Facility, a facility devoted exclusively to the provision of substance abuse treatment. In 1970, due to declines in the number of female commitments, the Ventura School for Girls (founded in 1913 and acquired by CYA in 1942) became a co-educational facility. Thus it is now referred to as the Ventura School. Earlier, in 1964, this facility became the site of the reception clinic for all girls entering CYA, and it remains so today.

THE RSAT EVALUATION

The process evaluation of CYA-RSAT sought to determine the extent to which program activities and services have achieved this goal and to assess the effectiveness of each program with respect to implementation. The evaluation was conducted by the UCLA Drug Abuse Research Center (DARC) located in Los Angeles.

THE INSTITUTION

The UCLA DARC is a multidisciplinary group of health and social science experts who conduct research on the epidemiology and natural history of drug abuse, treatment of drug abuse, drug use and HIV/AIDS and drug policy. DARC has earned a national reputation for quality work in a field where research-based expertise is essential to developing policy options for addressing one of the country's leading social problems. The Center is organizationally located within the UCLA Neuropsychiatric Institute.

Under the direction of M. Douglas Anglin, Ph.D., DARC has completed, or is conducting, significant studies for the National Institute on Drug Abuse, The National Institute of Justice, the Robert

Wood Johnson, Jr. Foundation, the California Department of Alcohol and Drug Programs, and the Center for Substance Abuse Treatment. The results and implications of this research have been disseminated widely through publication and presentations to researchers, policy makers and practitioners.

THE EVALUATORS

The evaluation study was coordinated by David Farabee, Genevieve Monahan, Angela Hegamin, Sylvia Sanchez, Virginia Gil-Rivas, and Ari Kaleschstein.

Dr. David Farabee is the Principal Investigator of the RSAT evaluation. He served as lead analyst for the Texas Commission on Alcohol and Drug Abuse (1992-1995) and was Assistant Professor of Psychiatry and Research Scientist at the University of Kentucky Center on Drug and Alcohol Research (1995-1997). He is presently study director of a five-year evaluation of the California Substance Abuse Treatment Facility (funded by the California Department of Corrections). He has published in the areas of substance misuse, crime and offender treatment.

Dr. Genevieve Monahan is a Co-Principal Investigator on the RSAT evaluation. She has been affiliated with DARC for the last four years and played a major role in the California Drug Use Forecasting (CAL-DUF) study of drug use among juvenile and adult arrestees throughout California. She is a consultant to the California Department of Corrections, Community Prisoner Mother's Program. Genevieve is a public health nurse with 20 years of clinical experience working with underserved, multicultural populations in Southern California.

Dr. Angela Hegamin is the Project Director of the RSAT Evaluation. She recently became affiliated with DARC. She has worked as a health educator in the areas of tobacco use and HIV/AIDS prevention and has been involved in numerous health research studies. Her most recent accomplishment has been her studies in the area of public policy development and analysis. Her current research interests include disability and substance abuse, perinatal substance abuse and barriers to treatment utilization among multicultural populations.

Sylvia Sanchez is a Research Associate at DARC. She has a bachelor's degree in Criminal Justice with an emphasis in corrections. She has

worked with juvenile offenders on probation and was part of the security team at the 1996 Summer Olympics in Atlanta, Georgia. In addition to being a research associate on the RSAT Evaluation, Sylvia works part-time as an interviewer for the Adult Drug Abuse Monitoring Project at DARC.

Virginia Gil-Rivas is a consultant on the RSAT Evaluation. She is currently a doctoral student in health psychology at the University of California, Irvine and has worked as a clinician and researcher in the area of substance use and abuse for 8 years and has published several journal articles on the topic of substance abuse. Her current research interests include exposure to negative life events, PTSD, risk and protective factors associated with substance abuse and delinquency among adolescents and young adults, and prevention and treatment interventions for high risk adolescents.

Dr. Ari Kaleschstein served as a consultant on the assessment portion of this evaluation. He holds a Ph.D. in clinical psychology and is currently a post-doctoral scholar at the UCLA Drug Abuse Research Center. Dr. Kaleschstein also completed a post-doctoral appointment in neuropsychology at the UCLA School of Medicine. He has published a number of articles in the areas of psychological assessment and neuropsychological testing.

ACKNOWLEDGMENTS

The timely completion of the CYA-RSAT evaluation would not have been possible without the cooperation and support of the CYA. We are especially grateful for Elaine Duxbury and Stephen Bright's guidance in research design and implementation, and for Rudy Haapanen's assistance with the Offender-Based Information Tracking System.

We would also like to express our gratitude to all of the staff at the Karl Holton, Ventura, and Heman G. Stark programs for facilitating our on-site data collection and for sharing their valuable program knowledge with us. In particular, we would like to thank Pete Zajac, Gordon Heitman, Dan Villareal, and Gary Maurer at Karl Holton; Mike Naluai, Peggy Grover-Courtney, Carlton Baines, and Richard Matamoros at Heman G. Stark; and Ruby Gaston, Michael Rowan, and Mary Herrera at Ventura.

Finally, we wish to thank DARC staff Janice Pride, Carolyn Potter, and Lori Souza for their invaluable assistance in conducting this study and preparing this report.

Chapter 2

THE PROPOSED PROGRAM

The California Department of Youth Authority (CYA), Residential Substance Abuse Treatment (RSAT) Program was funded in October 1997 by the Office of Criminal Justice Planning (OCJP). The CYA-RSAT program completed its first year of implementation on October 31, 1998. The program provides treatment to substance-abusing wards during their last 7-12 months of incarceration. Once paroled, wards receive aftercare treatment for a period of 6 months. The in-custody phase of the program is conducted at three separate institutional sites: (1) Karl Holton Drug and Alcohol Abuse Treatment Center located in Stockton, a 534-bed institution in Stockton. This facility provides substance abuse treatment to male offenders ages 16-22. (2) Heman G. Stark Youth Correctional Facility located in Chino. This 300-bed program provides treatment to young adult males ages 18-25, and is part of a larger general population facility. (3) The Ventura School in Camarillo provides treatment for wards in a 65-bed female unit and a 65-bed male unit, both part of a larger general population facility; wards in these programs are ages 15-25.

The proposed CYA-RSAT Program sought to improve existing Formalized Drug Program (FDP) treatment components at each of these sites. The FDP at each site is comprised of a three-phase in-custody treatment modality: Orientation, Treatment Core and Pre-Release. In addition, an aftercare modality is delivered in which 6 months of aftercare is provided to wards once they have been released to parole. This modality consists of two phases: Intensive Re-entry and Case Management. Wards undergo screening at the CYA Reception Center Clinics to determine eligibility for RSAT program participation.

IN-CUSTODY COMPONENT

Orientation Phase

The first 30 days of the FDP were to constitute the orientation phase during which wards undergo screening and assessment conducted by the staff psychologist to determine "suitability for intensive substance [*sic*] treatment." Drug testing was to be done within 72 hours of admission. Wards were to be familiarized with the expectations of the program with respect to establishing a drug-free, safe and supportive environment conducive to recovery. Finally, wards were to have participated in a case conference with the staff psychologist and the treatment team supervisor to assess "readiness for treatment" and to develop a treatment plan based on the ward's particular needs.

Treatment Core Phase

The second phase of the program is referred to as the treatment core phase. This phase was to last approximately 6 months in duration. Its chief purposes are:

- To present wards with a variety of opportunities, through classroom-based instruction and group counseling sessions, to discover and confront thinking errors and faulty belief systems used to justify their drug and alcohol abuse and criminal behavior.

- To coach, encourage, and support wards in modifying their beliefs and behaviors which will enable them to adopt a chemical-free, crime-free lifestyle.

- To teach the skills necessary to prepare wards for responsible and productive citizenship, literacy and employability.

- To develop progressively a realistic "Life Plan" for sobriety and productive citizenship.

- To encourage a chemical-free lifestyle by conducting drug tests on a randomly selected sample of wards on a weekly basis.

The primary curriculum used during the treatment phase was to be Hazelden's *Design for Living* (DFL). The DFL contains 45 lesson plans that correspond to steps 1 through 9 of Alcoholics Anonymous' 12 Steps in Recovery. For wards with learning difficulties, Gordon Graham's *Framework for Recovery* was to be used in lieu of the DFL. During this phase random drug testing was to be done on approximately 10% of the wards per week and when "reasonable suspicion" of drug use was evident.

Pre-Release Phase

Upon completion of the in-custody treatment phase of the program, wards were to enter the pre-release phase. This 2-month phase was designed to prepare wards for transition to parole. Relapse prevention was to be emphasized in an effort to prepare wards to deal with internal and external cues to return to drug use. During the final 30 days of this phase all wards were to be drug tested.

AFTERCARE COMPONENT

The aftercare component of the CYA-RSAT programs is *not* funded by the RSAT grant. However, since aftercare is a part of the FDPs at Holton, Ventura and Stark, a brief summary of this component is presented in this section.

Intensive Re-Entry Phase

The first 90 days following release to parole constitute the intensive re-entry phase. During this phase, parolees receive the following services subject to availability of parole services in the geographical area to which the ward is paroled:

Level One (Urban or Suburban Residential Areas with High Population Density and an Array of Readily Available Parole Services):

- Face-to-face contact with field parole agent no fewer than eight times and at least once a week for the first 30 days following release. Twenty-five percent of the contacts can be done by resource providers.
- Face-to-face contact with a field parole agent four times per month and at least once every two weeks for the remaining 60 days.
- Mandatory weekly urine testing for the entire intensive re-entry period.
- A minimum of one counseling session (group or individual) per week, preferably with a certified abuse counselor. Each parolee receives a minimum of twelve hours of counseling during the intensive re-entry period.

- A case staffing at 30 and 90 days attended by a parole agent, parole supervisor, the parolee (if possible), and a written progress report from the drug counselor. The purpose of this review is to evaluate progress on the parolee's life plan and readiness to transfer to "case management" status.

Level Two (Rural or Outlying Residential Area with Moderate Population Density and Only Basic Parole Services Available):

- Face-to-face contact with field parole agent no fewer than once a week for the first 30 days following release.
- Face-to-face contact with a field parole agent two times per month for the remaining 60 days.
- Mandatory urine testing two times per month for the entire intensive re-entry period.
- A minimum of four counseling sessions (group or individual) per month, preferably with a certified abuse counselor.
- A case review summary is provided and reviewed at the 30 and 90-day intervals. If feasible, a written report from a substance abuse counselor is reviewed.

Level Three (Remote Residential Area with Minimal Population Density and Few Parole Services Available):

- Face-to-face contact with field parole agent no fewer than two times per month for the first 90 days following release.
- Mandatory urine testing two times per month for the entire intensive re-entry period.
- A minimum of two counseling sessions (group or individual) per month, preferably with a certified abuse counselor.
- A case review summary is provided and reviewed at the 30 and 90-day intervals. If feasible, a written report from a substance abuse counselor is reviewed.

Case Management Phase

The case management phase begins at 90 days post-release to parole and lasts for a period of 90 days. During this phase, parolees receive the following services subject to availability of parole services in the geographical area to which the ward is paroled:

Level One (Urban or Suburban Residential Areas with High Population Density and an Array of Readily Available Parole Services):

- Face-to-face contact with field parole agent twice per month.
- Certified substance abuse counseling sessions twice per month, preferably with a certified counselor. Each parolee receives a minimum of six hours of counseling during this phase. Twenty-five percent of the contacts can be dome by resource providers.
- Two mandatory urine tests per month.
- Staff case after seven months on parole to establish individualized supervision and services plans.

Level Two (Rural or Outlying Residential Area with Moderate Population Density and Only Basic Parole Services Available):

- Face-to-face contact with field parole agent twice per month.
- Two group counseling sessions per month.
- Two mandatory urine tests per month.
- Staff case after seven months on parole to establish individualized supervision and services plans.

Level Three (Remote Residential Area with Minimal Population Density and Few Parole Services Available):

- Face-to-face contact with field parole agent one time per month.
- One mandatory urine test per month.
- Staff case after seven months on parole to establish individualized supervision and services plans.

SPECIFIC RSAT ENHANCEMENTS TO THE FDP

As a result of the RSAT funds, CYA was to enhance its FDPs at Holton, Stark and Ventura as follows:

- Improve the programs' screening and assessment process by designing and implementing a standardized, sequential assessment system to determine wards' eligibility for the programs, the presence of co-occurring disorders, and likelihood of completing the program. This data is to be incorporated into the individualized treatment programs for each ward. To this end,

  - Two staff psychologists (one at Stark, one at Ventura) were to be hired to "administer, analyze and interpret selected screening and assessment instruments," to "conduct therapeutic treatment, to provide "consultation and training" to FDP staff and to "collect, compile, and analyze data for the evaluation of the RSAT enhancement FDP."

  - A psychology graduate student assistant program was to be established at Holton and Stark to assist the psychologists at these sites.

- Increase the frequency and regularity of drug testing by purchasing testing supplies and equipment, paying salaries of staff responsible for collecting urine specimens,

performing laboratory testing and maintaining test results data. Specific testing requirements include: conducting mandatory drug testing of all wards within 72 hours of arrival to program, weekly random drug testing of 10% of all wards in the FDP, mandatory testing of all program participants within 30 days of release to parole, and testing of those suspected of drug use.

- Increase the knowledge level of counseling staff by developing a competency-based, in-service training curriculum. To this end,

  - Pre-/Post-tests were to be administered in conjunction with the provision of such training.

  - Grants funds were to be used to provide backup relief for YCCs to facilitate their participation in in-service training.

- Enhance the capability of staff to deliver treatment core components within targeted timeframes. To this end,

  - One-hour of backup-relief per YCC per week was to be provided to relieve staff of custody duties when conducting counseling sessions with wards.

  - Two youth counselors were to be hired at Stark to provide release time for existing youth counselors to conduct counseling sessions with wards.

  - A "bidding process" was to be opened to recruit certified alcohol and drug abuse counselors (CADAC) to provide specialized substance abuse counseling services at Stark.

- Increase the number and improve the quality of treatment services provided during the pre-release phase. To achieve this enhancement,

  - A pre-release counselor was to be hired who would spend 2/3 time at Stark and 1/3 time at Ventura. This individual would be responsible for "bridging the communication gap" between institutional and field

parole staff to ensure that wards receive planned and coordinated services.

- Develop and implement an outcome-based evaluation plan to measure effectiveness of the RSAT enhanced FDPs. To this end,

  - DARC was contracted to conduct a process and outcomes evaluation study of CYA-RSAT.

Each of the proposed enhancements was to be implemented across the three program sites (unless otherwise indicated above). Hence, the existing FDPs at Holton, Ventura and Stark were to undergo modifications in order to achieve the goals outlined in the CYA-RSAT proposal. It should be noted that each of the original FDPs at Holton, Ventura and Stark has been developed to address the unique needs of its ward populations. As a result, the three programs have also evolved differently with respect to the use of the RSAT funds. Thus, certain enhancements may have been more advantageous to some sites than to others. Moreover, some enhancements may have been more difficult to implement for a given program site.

Chapter 3

METHODOLOGY AND TECHNICAL DESCRIPTION

To conduct this multi-site process evaluation, a number of standardized measures were developed or adapted. Since many of these address more than one domain of the process evaluation, each is described in the present section so as to avoid redundant explanations as they are cited throughout the report.

OFFENDER-BASED INFORMATION TRACKING SYSTEM (OBITS)

Aside from focus group data, all individual-level information regarding the wards was obtained from the OBITS database. OBITS was brought on-line in 1977. The system was created primarily to assist Central Office staff in making decisions about ward management, control and rehabilitation. The system concentrates on providing information to administrators, managers, analysts, and others about ward jurisdiction and confinement time, daily movements, characteristics, behavior and other activities while in the institution and on parole. The Information Systems Unit is responsible for maintaining the integrity of the information as well as overall management of the system.

OBITS is operated by computers at the Teale Data Center and is accessed by terminals in each of 11 institutions, 4 camps, 17 parole offices, 2 regional parole offices and Central Office. Ward movements (e.g., admissions, transfers, and releases) are entered into the system each working day by institution, camp, parole regions and Information Systems staff. The time losses/restorations for M-cases are entered by institution staff. M-case revocations and revoke time adjustments are entered by the southern regional parole office. The commitment information (referrals), all orders of the Youthful Offender Parole Board, as well as parole movement data (e.g., transfers, local confinement, and AWOL) are processed by the Information Systems Unit.

On-line records are kept on 13,000+ active wards and parolees. On-line records are also maintained on wards for seven years after date of discharge (currently 25,000+). The Population Management System and the Gang Services System also operate off OBITS. Additions of an educational sub-system to contain ward educational data and a risk classification sub-system are in the planning stages.

For the present study, a list of identification numbers was submitted to the CYA for all wards entering the Holton, Ventura, or Stark RSAT programs from the individual program start-dates (provided by local administrators) through September 15, 1998. Because programs operated under different timelines with regard to implementing the RSAT enhancements, start dates were as follows: Holton—January 1, 1998, Ventura—October 1, 1997, and Stark—March 1, 1998. This resulted in a total sample of 641 wards.

The following 21 variables were requested from the OBITS database and comprise the descriptive statistics section for present and future reports:

- Sex
- Date of Birth
- Ethnicity
- Ethnic Subgroup
- Offense Code for Jurisdiction Offense
- Jurisdiction Offense Statute
- County of Commitment in Jurisdiction
- Weapons Associated with Commitment Offense
- Marital Status of Ward's Parents
- Ward's Marital Status
- Number of Ward's Children
- Number of Prior Local Commitments
- Physical Handicap(s)
- Number of Ward's Siblings
- TABE Language Level
- TABE Math Level
- TABE Reading Level
- TABE Total Battery Score
- TABE Language Score
- TABE Total Mathematics Score
- TABE Total Reading Score

Additional data will be abstracted from wards' hall files and local databases (e.g., 4D) in the second year of this project. Of particular interest will be the violence risk scores in the 4D database and the social history narratives located in the hall files.

RELAPSE PREVENTION TRAINING QUESTIONNAIRE

The CYA Institutions and Camps Branch, in conjunction with the Parole Services and Community Corrections Branch, hosted four, day-long relapse prevention training sessions for CYA staff; two in Northern California at the Youth Authority Training Center in Stockton and two in Southern California at the Parole Offices in Covina. One-hundred and seventy staff members attended the sessions. The DARC evaluation team constructed pre- and post-test instruments for the training which included the following questions (See Appendix E for a copy of the questionnaire):

- Demographic information.
- Job title and assignment.
- Previous training they had in relapse prevention and sponsors of that training.
- How often they used relapse prevention in the past month .
- Definition of the terms relapse, lapse, prolapse, and abstinence violation effect.
- Identification of six steps in relapse prevention to cope with lapses or slips.
- Identification of six techniques in relapse prevention to deal with cravings.

The pre-test questions regarding specific relapse prevention terms, techniques, and skills were based on the Hazelden relapse prevention training module on preventing high-risk situations. The CYA training team identified this module as the core curriculum for the four sessions and they previewed the pre-test to ensure that the questions matched the content they planned to present. The pre-test was described and administered to participants by the same member of the DARC evaluation team at the beginning of each of the four relapse prevention training sessions. Assurances of confidentiality of the data were reviewed at this time. Participants completed the questionnaires within 10-15 minutes and the questionnaires were immediately collected by the DARC evaluation team member.

The post-test instrument was constructed from the same items as the pre-test with the addition of two items; one asked participants to rate the effectiveness of the training and the other invited them to comment on the training. Approximately 1 month following the relapse prevention training sessions, a single member of the DARC evaluation team contacted the participants by telephone to conduct the post-test. The post-test items and their parallel pre-test items were compared. The open-ended question regarding participants' comments regarding the training were analyzed, coded and summarized by a single member of the research team.

WARD FOCUS GROUPS

Focus groups were conducted with wards at each of the three program sites. The purpose of these groups was to solicit wards' opinions regarding the treatment program. Specifically, wards were asked to respond to the following 10 questions:

1. What part of the drug treatment program do you find most useful?
2. How would you describe your relationship with the treatment team supervisors? Counselors? Parole agents?
3. How often do you meet with the same counselor on a regular basis?
4. Have you had the same counselor throughout your entire stay in the program? If not, please explain.
5. If applicable, in what way(s) do "lock-downs" affect your relationship with treatment team supervisors? Counselors? Parole agents?
6. Can you relate to the experiences of the people shown in the videos or other materials (e.g., workbooks and other handouts) used in the program?
7. How could the videos and or written materials be improved?
8. Do you have suggestions for improving or changing the program?
9. What successes or achievements have you had as result of being in the program?
10. What other concerns do you have regarding this program?

Wards were selected using a stratified random sample from current population rosters at each institution. Wards were first stratified by living unit, then randomly selected from each unit to ensure that all units were represented. In keeping with the requirements set forth by the UCLA Human Subject Protection Committee (HSPC), only wards 18 years of age and older were allowed to participate in these groups. Recruiting minors for the study would have required court approval from each ward's county of commitment. Although court approval will be sought for the second year of this evaluation, it is unlikely that the exclusion of minors from the first-year focus groups poses a significant threat to the generalizability of findings. In fact, among the three RSAT programs evaluated, minors constituted only 15% of the total ward population.

To ensure that wards did not feel coerced into participating in the focus group, initial groups of 10 wards at each site were convened so that the DARC group facilitators could describe the purpose of the study and invite the wards to participate. Wards were given an information sheet with the following description:

"The UCLA Research Center will be conducting a discussion among selected wards about their views of the program in what we call focus groups. The group will have 6-8 people in it and will last about one hour. If you are picked and agree to participate, the topics for the group discussion will concern your participation in the Residential Substance Abuse Treatment Program, including how and why you entered the program, what you have been doing in the program, what your opinion of the program is, and what your plans are upon release to parole. In order to help preserve confidentiality, you will select a nickname and the leader will use that name during the focus group rather than your real name. You will also be asked to complete a questionnaire providing basic background information (e.g., age, ethnicity, education, conviction offense), but no personal identifying information appears on the completed questionnaire. All of the information you provide will be used for research purposes only; the information will be identified by code number only; and your name will not appear on any transcripts, questionnaires, or forms related to the focus group. The information will be treated and maintained as strictly private, and the researchers cannot be forced to release any information that identifies you with the data provided. Your participation in this study will have no effect on your possibility for parole.

Please indicate on the next page whether you would like to participate

in the focus group and write in your name and CYA number. Place the form in the box provided. We will randomly select the group members from the names of those of you who have agreed to participate. Feel free to ask any questions before you turn in the form."

Candy bars were offered as reimbursements for their time to wards at the Ventura and Holton programs. The participation rates were quite high. One-hundred percent of the initially selected wards agreed to participate at the Holton and Ventura (boys) programs. One out of 10 potential participants declined at the Stark and Ventura (girls) programs, resulting in 90% response rates for these programs, and an overall participation rate of 95%. One hundred percent of the wards invited to participate in the Spanish-language focus group at Holton agreed to do so. A description of focus group participants is provided in Table 3.1 in Appendix F.

YOUTH CORRECTIONAL COUNSELOR (YCC) QUESTIONNAIRE

The purpose of the YCC Questionnaire was to profile the background and training of the treatment staff and to assess their perceptions of their respective programs. Because focus groups were determined to be impractical, given the YCCs' schedules and workload, this questionnaire was developed to gather the necessary information while minimizing the disruption to program functioning.

The YCC Questionnaire consists of 92 questions and can be completed in approximately 15-20 minutes (see Appendix A). The majority of the questions are yes/no or Likert-type scales. The conceptual domains include: demographics, education, related job histories, job performance, and perceived quality/effectiveness of existing services.

A total of 42 questionnaires (Holton N=24, Ventura N=9, and Stark N=9) had been completed and returned to DARC at the time of this report. These samples represent low response rates from the Holton (response rate=49%) and Stark (response rate=23%) programs. The Ventura sample, on the other hand, represents 90% of the total number of YCCs at that program.

CORRECTION INSTITUTIONS ENVIRONMENT SCALE (CIES)

The CIES was developed to assess the social climate of prison and jail settings (Moos, 1974). It consists of 36 true/false items and is completed by institutional staff. These items assess dimensions such as staff/counselor relationships, staff/offender relationships, and the presence of a rehabilitative or strictly custodial philosophy (see Appendix D).

Because this form was administered concurrently with the YCC Questionnaire, the total number of responses was also 42, with the same response rates as described above.

PROGRAM ADMINISTRATOR AND SUPERINTENDENT INTERVIEWS

Much of the information presented in this report was derived from interviews conducted and recorded at the CYA RSAT programs at Holton, Ventura, and Stark. All participants were selected from available personnel using staff organizational charts and included counselors, parole agents, supervisors, and superintendents (N=20). The participation rate for these interviews was 100%, that is, all who were asked to provide interviews agreed to do so.

Items comprising these semi-structured interviews covered a range of program implementation issues, including successes of the RSAT enhanced program, barriers to implementation, and recommendations for improvement.

Participants were told that their answers would remain confidential and that their input in this process would be included in a report that DARC would prepare and submit to the CYA. Every participant gave his or her permission. Copies of the administrator and superintendent interviews can be found in Appendices B and C.

Chapter 4

WARD CHARACTERISTICS

The following ward descriptions are based on data collected from the Offender-Based Information Tracking System (OBITS), maintained by the CYA. Although additional wards will be included in the baseline cohort for this evaluation, the present sample consists of all wards entering an RSAT-enhanced program from the individual program start-dates (provided by local administrators) through September 15, 1998. Because programs operated under different timelines with regard to implementing the RSAT enhancements, start dates were as follows:

- Holton—January 1, 1998
- Stark—March 1, 1998
- Ventura—October 1, 1997

DEMOGRAPHICS

Table 4.1 presents demographic and background characteristics of wards admitted into RSAT-enhanced programs through September 15, 1998 (N=641). The typical ward in these programs was approximately 19 years old, Hispanic, unmarried, with parents who are separated or divorced. The female wards (at Ventura) were more likely to be white, and less likely to be Hispanic, than the male wards. Likewise, the female wards were more likely than the male wards, overall, to have children of their own. Almost all of the wards have at least one brother or sister, with an average of more than three.

Table 4.1: Ward Demographic and Background Characteristics by RSAT Program (N=641)

	Program Site				
	Holton	**Stark**	**Ventura (Boys)**	**Ventura (Girls)**	**Total**
N	318	145	88	90	641
Mean Age (SD)	18.7[a] (1.6)	20.0[b] (1.7)	20.2[b] (1.7)	19.2[c] (2.1)	19.3 (1.8)
Race (%)					
White	18.9	11.8	13.6	28.9	18.0*
Hispanic	54.3	60.4	58.0	43.3	54.6
African American	20.1	25.0	22.7	20.0	21.8
Asian	4.1	1.4	2.3	1.1	2.8
Other	2.2	1.4	3.4	6.7	2.8
Married (%)	0.0	0.0	0.0	0.7	0.2
Any Children (%)	11.8	20.8	18.2	22.5	16.2*
Mean no. children (SD)	1.8[a] (2.3)	1.3[a] (1.5)	1.1[a] (0.3)	1.7[a] (1.8)	1.5 (1.8)
Marital Status of Parents (%)					
Unknown	2.2	4.9	1.1	5.6	3.2
Never married	31.9	21.5	27.3	39.3	29.9
Married	22.0	23.6	19.3	15.7	21.1
Divorced/separated	44.0	50.0	52.3	39.3	45.8
Any Siblings (%)	96.5	95.8	88.6	89.9	94.3**
Mean no. siblings (SD)	3.4[a] (2.0)	3.5[a] (2.0)	3.6[a] (1.8)	3.4[a] (2.1)	3.4 (2.0)

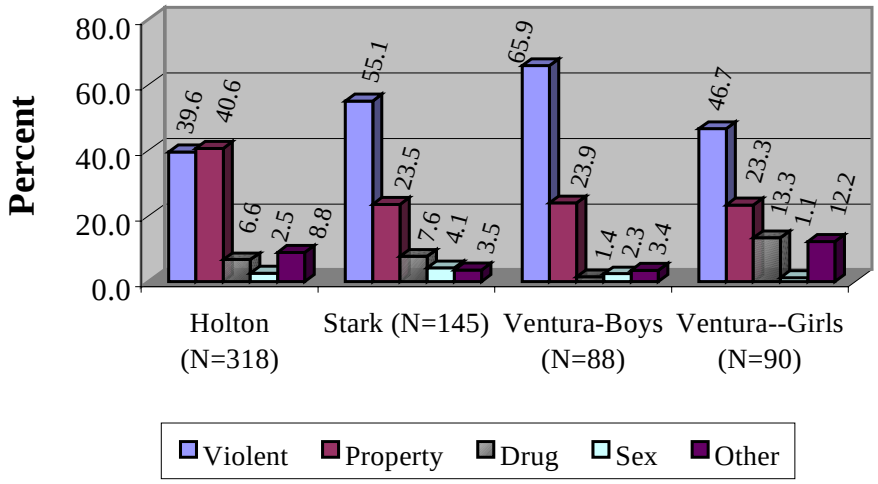
Note: Mean values with different superscripts are significantly different from one another at the .05 level; For overall chi-square comparisons, * p<.05, **p<.01.

CRIMINAL HISTORIES

There are nearly 100 offense codes in the OBITS database, ranging from disorderly conduct to homicide. For the purposes of this report, these offenses were re-categorized as **Violent** (homicide, robbery, assault), **Property** (burglary, theft), **Drug** (possession, sales, under the influence), **Sex** (rape, sexual delinquency), or **Other** (miscellaneous felony or misdemeanor) offenses. Violent crimes accounted for nearly half (48%) of the commitment offenses; property crimes accounted for slightly under a third (32%). The remaining commitment offenses fell evenly between drug (7%) and other (7%) categories, with sex-related crimes accounting for less than 3%.

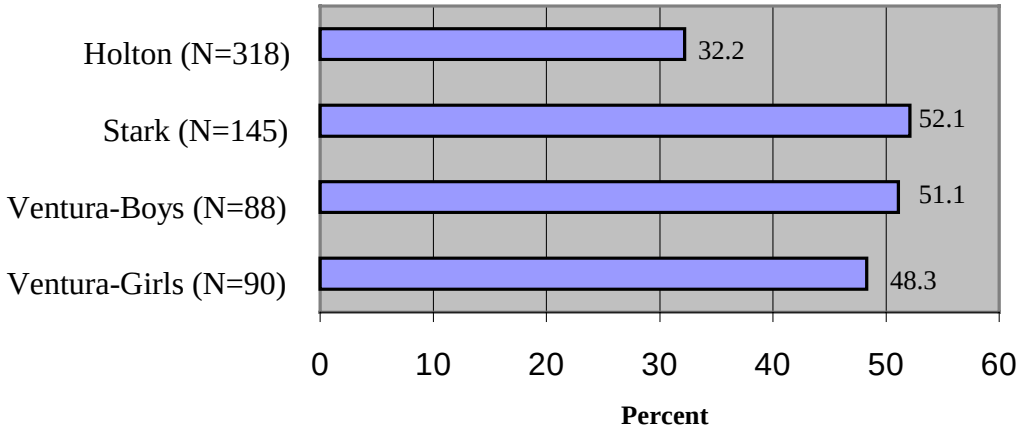
The prevalence of these commitment offense categories, however, differed substantially by program site. As shown in Figure 4.1, wards at Holton were equally likely to be committed for property or violent offenses. For the other programs, violent offenses were the most common. In addition, female wards were more likely than males to have been committed on either drug or "other" charges.

Figure 4.1: Commitment Offense Categories by RSAT Program



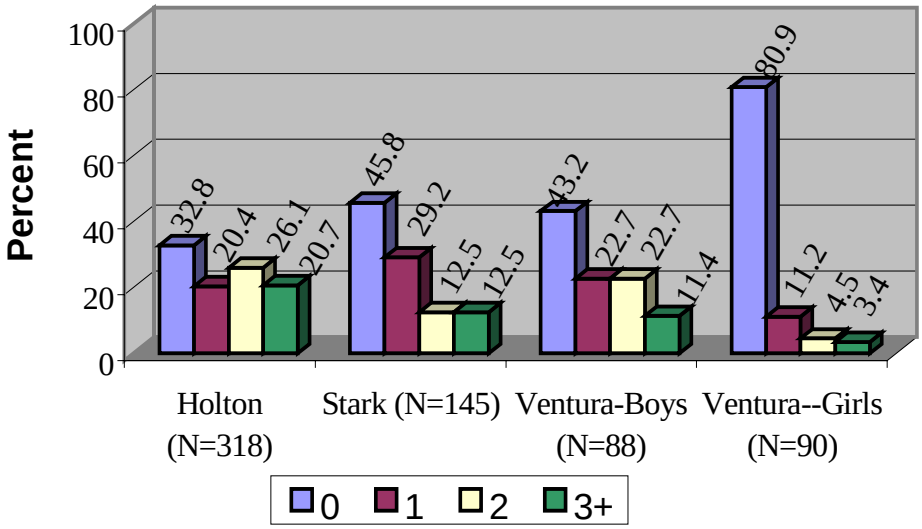
The crime categories depicted in Figure 4.1 are consistent with percentages of wards for whom weapons were associated with their current commitment offense. Overall, weapons were involved in 42% of the commitment offenses of these wards. As shown in Figure 4.2, however, weapons were least likely to be involved for wards entering the Holton program.

Figure 4.2: Percentage of Wards with Weapons Associated with Commitment Offense



With regard to the number of prior local commitments, the male wards in this sample appear to have had more regular criminal justice involvement than the female wards (see Figure 4.3). Not only are the female wards less likely to have had three or more prior commitments, but they are far more likely than the males to have never had a prior local commitment.

Figure 4.3: Prior Local Commitments by Program Site



According to a nationwide study of recidivism rates among state and federal prison parolees, sex, race, and extent of prior criminal involvement were among the most effective predictors of re-arrest (Bureau of Justice Statistics, 1989). Therefore, because of the substantial demographic and criminal history differences between wards at each of the RSAT program sites, direct comparisons between programs are not possible. Subsequent sections of this report discuss findings separately for each RSAT program site. This is not to facilitate cross-program comparisons, but is necessary because collapsing across these program populations would obscure important differences related to treatment needs and outcomes.

Chapter 5

HOLTON FORMALIZED DRUG PROGRAM

The FDP at the Karl Holton Drug Abuse Treatment Youth Correctional Center was activated in 1994. Hazelden's *Design for Living* (DFL) was initially chosen to be implemented at the Holton FDP for three key reasons: the curriculum 1) was identified to have been developed specifically for the correctional setting, 2) had been used by the CYA, Southern California Drug Treatment Center with success for some years, and 3) contained both counselor and student materials. The DFL is administered both on the living units and in the classroom at Karl Holton. However, a companion curriculum entitled *Social Thinking and Decision Making*, a program developed by Kathy Larson (1988), is used at Holton to familiarize wards with methods of problem solving and evaluating the consequences of their behavior--including acts of violence and substance abuse. It is also designed to help orient wards to the FDP during the first three months of their stay. More recently, the FDP has adopted the *Framework for Recovery (FFR)* curriculum by Gordon Graham and Company, Inc. This curriculum is an alternative to the DFL that is used with wards who have learning disabilities.

The FDP at Karl Holton is a 34-week intervention. During the program's *orientation phase*, wards are housed at the Donner Orientation unit, where they receive units A, B, and C of the DFL curriculum. Wards also receive Lessons 1 through 14 of the Social Thinking and Decision Making companion curriculum, including the Nine Steps of Problem Solving. Each ward also undergoes educational assessment in order to determine classroom assignment. A baseline urinalysis is also taken during the orientation phase. During the *treatment core phase* of the program, wards attend DFL classes as part of their educational requirements and take part in group counseling on the living units. Wards also meet with their institutional parole agent for progress checks -- once at the end of the first month of treatment and again approximately 60 days prior to their scheduled parole date. Counseling and small group sessions serve to reinforce that which is taught in the DFL classes (i.e., units D through N of the DFL curriculum). In addition, as part of this phase, wards receive Karl

Holton School (KHS)-Lessons 1 through 10 of the Social Thinking and Decision Making companion curriculum.

A select group of wards are eligible to participate in the Mountain Public Service (MPS) Program, a volunteer search and rescue program. Wards who have severed their gang ties in favor of positive alternatives to gang membership are eligible to participate in Project IMPACT, a gang prevention and awareness program.

A typical day for wards during the *treatment core phase* begins with physical exercise at 5:30 a.m. and continues with educational and vocational classes that take place from 8:10 a.m. to 3:00 p.m. Lunch is served on the living unit from 12:30 to 1:30 p.m. Group and individual counseling and special workshops take place during the evening. Examples of ongoing groups include the Victim's Awareness and the Young Men as Fathers (YMAF) groups. Individual and group counseling is provided by youth correctional counselors (YCC) whose typical load is 10-12 wards. YCCs must meet two times per week in a face-to-face counseling session with each of the wards on their caseloads in addition to meetings in group sessions.

During the *pre-release phase*, wards receive units O through U of the DFL which helps to prepare them for dealing with issues that will likely arise during the aftercare phase. Field parole and Employment Development Department (EDD) representatives discuss the following issues with wards: parole expectations, relapse prevention, recovery dynamics, family support, and employability. EDD representatives visit Holton on a monthly basis. This information is provided to wards to prepare them for release to parole.

Upon completion of the in-custody phase of the program, a parole release hearing is scheduled for each ward in preparation for the *aftercare phase* of the program. The Youthful Offender Parole Board (YOPB) reviews the ward's progress in the program, parole release plan, and Personal Life Plan and makes a recommendation for parole release or non-release. Wards who are paroled are subject to conditions established by YOPB, including mandatory drug testing and participation in aftercare treatment coordinated by their field parole agent.

THE RSAT-ENHANCED PROGRAM AT HOLTON

As a result of the RSAT grant, Holton has expanded its existing FDP services. Table 5.1, Appendix I, presents each of the originally proposed enhancements to the RSAT program with respect to the FDP at Holton. Enhancements that were proposed in the RSAT application but that do not apply to Holton are designated "Not Applicable." Figure 5.2, Appendix I illustrates the timeline on which tasks related to specific RSAT enhancements occurred during Year 1.

The following implementation issues were identified in the course of the process evaluation of the Holton FDP:

Screening and Assessment

Although many of the treatment staff acknowledge the importance of both initial and ongoing assessment of wards on their caseloads, a formal mechanism for linking information obtained during clinical assessment with treatment strategies is lacking. Moreover, most treatment staff were unfamiliar with the concept of "sequential assessment" as presented in the original proposal. The psychological assessment component of the program at Holton has not been sufficiently elaborated in order to facilitate communication between psychology staff and treatment staff and to coordinate more effectively (i.e., link assessment information to actual treatment) the services provided to wards. Holton's general assessment protocol (as of October 15, 1998) appears in Appendix J.

Staff Training

There appears to be a consensus on the part of staff at Holton that more training should be provided to all treatment staff. A relapse prevention training was conducted but the target audience of this training was primarily field parole agents rather than YCCs. The train-the-trainer approach that was espoused by program administration at all three sites does not appear to have resulted in the "trickling down" of information to line staff. This problem is magnified by the general infrequency of staff training and limited funds for staff training.

Staff Recruitment

Limited resources for providing staff training posed an obstacle as did delays in hiring new treatment staff due to prolonged security clearance process. The latter issue often resulted in the loss of qualified candidates. Moreover, as a result of the prolonged hiring process, the program lost several outstanding candidates for its graduate intern program.

Budgetary Deficiencies/Ambiguities

There was a general lack of knowledge on the part of staff regarding availability of current or future RSAT funds. Some staff reported that they had purchased resources only to learn that funds were not available. As a result, program planning was impeded and staff time allotments could not be determined *a priori*.

Staff Turnover

Staff reported that there was a high degree of staff turnover experienced by Holton primarily associated with the departure of teachers in the program who refused to teach the 12 Steps of Recovery due to its religious foundation. Although a few of these individuals remain, the program now administers the DFL in the classroom.

Multiple Issue Wards

Staff report that it is not uncommon for Holton to receive wards who have been determined to have issues in addition to their substance abuse (e.g., victim restitution, gang involvement) which could have been addressed by other CYA programs prior to their arrival but were not. As a result, the treatment staff must deal with many issues it is not adequately trained to address.

Absence of Technical Support

A lack of technical support for computer hardware and software applications was reported by staff at Holton. This deficiency may have implications for the ability of Holton staff to access information on wards maintained in existing computerized databases and to coordinate services for wards on their caseloads with services provided by other members of the treatment team.

ADMINISTRATOR INTERVIEWS

This section is organized according to the questions the participants were asked; responses by participants from Holton FDP are presented in summary form. Nine face-to-face interviews were conducted between September and October of 1998.

The length of time for the interviews ranged from 30 minutes to two hours. One or more questions were asked on several topics that elicited interviewees' perspectives on the implementation of the RSAT programs. Those questions and participants' responses are presented below (copies of the questionnaires can be found in Appendices B & C).

How long have you worked for the drug treatment program?

The mean number of years staff had worked for the Formal Drug Program was 4 years, and the mean number of years staff had worked for the RSAT program was 9 months.

Do you enjoy your job?

- I enjoy having contact with the wards as a surrogate parent and coaching and providing fellow staff with a vision for the program.
- I love the program and the staff and providing specialized curricula.
- I like managing activities and seeing the results of the program.
- I like training and administering activities in the institution.
- I like talking to the wards about "where they are."

Have you ever done work like this before?

- I worked at two other CYA programs, and worked for an alcohol diversion program at a community counseling center with elementary-aged children.
- I was a counselor and parole agent at two programs.

Previously involved in developing a substance abuse program at another facility.

- My focus has been primarily on treatment in the community and CYA.

- I did sex offender counseling for mental health at Preston and Chad for 4 years.
- Never in corrections. Twenty years as a psychologist in hospital or university settings.

What are your educational credentials?

Overall, the educational credentials of the staff included: a B.S. in Organizational Behavior, B.A. in Social Work, B.A., in Psychology and an M.S. and an M.A. in Criminal Justice, an M.A. and M.S. in Social Work, and a Ph.D. in Counseling Psychology.

What enhancements has your program been able to add as a result of the RSAT grant?

- Standardization of the treatment and training, enhanced drug testing, extra personnel for casework training and small group sessions.
- Continuum of treatment expanded and intensified, staff freed up from custodial duties, more groups that are more effective and creative, videos, curriculum that supports all of the above, and enhanced service delivery.
- Better quality small group counseling due to improved training and back-up relief for treatment staff.
- Hiring of psychology interns was most important enhancement.
- Provided additional training and treatment team meetings, additional casework, educational materials for wards and counselors (e.g., books and pamphlets), and increased the visibility of the program in the community.
- Were able to add assessment instruments and computers, increased drug testing, increased treatment services hours (additional 10 hours per month), to hire additional staff (one person was added to allow counselors to do their case work), training for staff (training on small group counseling and different modalities), orientation to our program for our new staff, were able to start an intern training program, and more mental health services.
- Allowed the staff more freedom to do their case work, provided staff training (further development of treatment package), fine-tuned the program, team development- has provided us with the resources to make it possible -- gave us time to dedicate to team building and planning, to buy materials (books, curriculum materials, and guidelines).

What have been some of the successes so far in the RSAT enhanced program?

- Team meetings were successful as was standardization of group facilitation and information collection.
- Better relationships were established between staff and wards; wards are able to receive more attention. All staff, even custodial staff, began working toward the goal of preparing kids to return to the community and be drug free.
- The training. The connection between education department and treatment staff has resulted in enrichment of our program.
- The staff appreciates the increase in their counseling time. Wards seem to appreciate that the staff are somewhat more available. Team training has improved, drug testing is done more frequently, and the wards are aware of increased monitoring.

What have been some of the barriers to implementing the RSAT enhanced program so far?

- Not knowing the actual availability of resources (e.g., how much money there is and how much has been spent).
- Resources were given and then they were taken back.
- Our second-year budget was reduced by 50% and we had high staff turnover. Many teachers are not willing to teach 12-step philosophy, since it has religious underpinnings.
- Money for training has been limited.
- Once they find a potential new employee, it takes four months to get them cleared by security.
- We don't have enough technical support for computer hardware and software problems.
- It is an increased workload for everyone – youth counselors and parole agents have an increased load; we are doing a lot of work.
- Parole branch did not understand their role in the program; they felt they were not getting any money out of this and this led to delays. This resulted in the relapse prevention training committee having to develop parole guidelines for ward Life Plans and relapse prevention. The aftercare component is very weak here for a continuum of treatment; parole and institutions and camps are working together to improve this.
- When we opened, we were going to get wards who had already participated in other programs (e.g., victims, gangs) and the main focus here would be drug treatment – we had to expand admissions

to include wards that have not completed other components prior to coming here.

What are the main objectives of this project? What are the secondary objectives?

Primary objectives:

- Educating the wards on substance abuse, having them recognize their patterns of substance abuse, and identifying paths to becoming substance free.
- Enhance the services delivery in the program and be a support mechanism to staff so that services are more effective.
- Establish a database of what works with this population, offer a strong connection to field parole, and validate Holton's treatment program.
- Reduce recidivism as it relates to substance abuse.
- Provide additional resources to enrich our treatment program.
- Find out what treatment strategies work best with this population.
- Provide wards with tools and resources they can use when they go out into the community, and help them change their perspectives on how to deal with life, drugs, and abstinence.

Secondary objectives:

- Demonstrate a healthy way of establishing coping skills that are transferable.
- Deliver the continuum of services throughout parole period equipping staff to provide services.
- Provide more services to the wards.

How is the communication between treatment staff and CYA administration?

- Communication is difficult at times. Too many buffers in- between. Site administration did not know that RSAT existed until about a week before it started. Parole did not know that RSAT was a priority, and that they were involved to this extent.
- Weekly Executive Officer meetings take place between the superintendent, assistant superintendent, and program administrator; communication and input is 2-way.
- Spotty at best. There is little face-to-face communication and little support from Sacramento CYA.
- There is sense of alienation. There is a belief that CYA has little understanding of what's happening in the field.

- Sacramento CYA seems understaffed. Programs are often "raided" for data by Sacramento office but we are never given feedback.
- When we receive information we quickly disseminate the information and implement changes. We hold audits to examine if goals are implemented. The communication from bottom to top is good.
- We meet weekly to talk about the program, information is disseminated to treatment staff. Communication is going well at all staff levels and flows "two-ways."

In your opinion, what have been some of the start-up plans or activities that have been successful?

- Standardization of curriculum treatment modality and small group training.
- The ability for staff (youth counselors and psychologists) to do more treatment. Being able to pay psychology interns to increase services and relieve youth counselors to sit down and talk to the wards.
- Training on small group techniques and having one Design for Living class per day.
- Stronger linkages to field parole.
- Hiring of interns has allowed them to provide actual psychological services.
- I think most plans were successful. We have to do more documentation. We are not sure what to store (i.e., data and records needed for the evaluation).
- Augmentation of casework services, increased psychological testing (materials), and additional drug testing and computer software.

In your opinion, what have been some of the start-up plans or activities that have not been successful?

- I am concerned about parole; they do not have the staff to monitor the program.
- "On Solid Ground" took a long time to gain acceptance.
- We had difficulties providing and gathering information and trying to standardize services provided at all dorms.
- We have not been able to measure anything since we just started the grant in November.
- The oversight and coordination could be better.

- I think we could do better with giving out equal pieces of the pie (among the programs) in terms of what we have to implement the program with.

If you had to plan a program like this, what would you do differently?

- Certain program elements might become more uniform between the three institutions.
- I would bring evaluation on-line sooner.
- Work with smaller populations and be stricter in ensuring frequency and quality of treatment groups.
- Treatment should be provided by a better-trained, para-professional group. Provide regular training and certification. Curricula and treatment modules must have strong research supporting them before they are considered for use in the program. Since this is a "tail-end" institution, all other programming requirements (e.g., victim awareness) should be completed by the time wards arrive. This way, they could focus more intensely on substance abuse treatment.
- CYA should consider using contract treatment staff, rather than custody staff.
- Create a different curriculum for those individuals who are returning to the program (parole violators). I would lengthen the program to 12 months.
- Wards entering would have completed their court-ordered (gangs, parenting) courses.
- More training – enhance the resources and training that are available to counselors and identify successful strategies. Increase individual counseling. Our population has lots of needs and counselors cannot adequately deal with them.
- I like the direction we are taking. I would like to have a better-defined source of funding to allow us to make plans for treatment.
- Take more time to plan and implement our goals and objectives.
- We need to eliminate staff that are negative about the program and are not committed.
- We should remove staff who don't want to be here; including teachers.

Have you received enough training? If not, what areas need attention?

Two individuals said they had received enough training. Those who said they needed more training identified the following as areas that needed attention:

- I need to understand medication issues and subsequent treatment directions. How to provide core treatment. We need Design For Living training on a continual basis. Some staff may be providing treatment, but also want to address other issues (e.g., sex offenders, suicide).
- The direct treatment staff need more training (counselors and parole agents).
- We never have received enough training. It is important to receive refresher training.
- I need to become more comfortable with the treatment materials.

Is the physical environment appropriate for this program? Why or why not?

Most of those interviewed said that the physical environment was appropriate; samples of their responses included:

- It operates a lot like a school. It's a learning environment.
- We have dorms and small group rooms. The teachers have classrooms. Having teachers on the dorms would be helpful.
- It lends itself to treatment. Our dorms are open door programs and we can watch ward interaction. Each unit has a room if we need to isolate someone, we can watch the dynamic of the groups and manage the groups better.

Comments about what could be done to improve:

- I would like to have more space to conduct treatment groups. I would like to give more privacy to wards.
- We would like to have individual rooms. It would be good for the therapeutic environment.

How will you know the program is successful? Do you have your own measure of success. If so, what does your measure include?

- Employment of wards.

- If wards are able to recognize that being in the program planted a seed and that the seed can grow and that they can succeed.
- By the wholehearted delivery of services this program becomes meaningful and relationships form; that's how we'll know the program is working.
- Parole performance as measured by the evaluation. Reduced relapse -- but lapses shouldn't count as a failure.
- Recidivism rate – our recidivism compared to that of wards coming out of treatment programs in the other institutions; also drug use and criminal behavior.
- Reasons for parole violations.
- Interviews with parolees; find out what they found helpful about the program.
- When we could definitely say that over the years that the wards involved did better by good research. If you have murderers, robbers, rapists and they get arrested for car theft or burglary but are not hurting people – or if a person goes longer before relapse – that's also a measure of success. "Costs" are avoided by the state or county or agencies.
- If there are high staff morale levels in the institution.

YOUTH CORRECTIONAL COUNSELOR SURVEY

The following results are based on responses to the YCC Questionnaire administered to correctional staff at Holton (N=24).

In my current job setting--
I am able to meet with wards on my caseload regularly.

Strongly Disagree	4.4%
Disagree	17.4%
Neutral	34.8%
Agree	26.1%
Strongly Agree	17.4%

I am able to differentiate between wards needing support and wards needing discipline.

Strongly Disagree	0.0%
Disagree	4.2%
Neutral	16.7%
Agree	37.5%
Strongly Agree	41.7%

I am able to obtain backup relief to perform my counseling duties regularly.

Strongly Disagree	25.0%
Disagree	29.2%
Neutral	16.7%
Agree	29.2%
Strongly Agree	0.0%

I use psychological assessment and testing information to create a treatment plan for each ward on my caseload.

Strongly Disagree	29.2%
Disagree	25.0%
Neutral	25.0%
Agree	16.7%
Strongly Agree	4.2%

I have effective strategies for working with people whose race/ethnicity is different than mine.

Strongly Disagree	0.0%
Disagree	4.2%
Neutral	20.1%
Agree	50.0%
Strongly Agree	25.0%

I have received sufficient substance abuse training to perform my job effectively.

Strongly Disagree	12.5%
Disagree	37.5%
Neutral	41.7%
Agree	8.3%
Strongly Agree	0.0%

My primary responsibility is to provide security.

Strongly Disagree	0.0%
Disagree	4.2%
Neutral	8.3%
Agree	37.5%
Strongly Agree	50.0%

My primary responsibility is to provide counseling.

Strongly Disagree	25.0%
Disagree	8.3%
Neutral	16.7%
Agree	45.8%
Strongly Agree	4.2%

***How would you rate the relative effectiveness of your program in the following areas?* (Scale:1=Poor, 2=Below average, 3=Average, 4=Above average, 5=Excellent)**

The overall program	3.4 (SD=.72)
Services for limited English-speaking wards	2.8 (SD=.92)
Individual counseling sessions	3.0 (SD=.9)
Group counseling sessions	3.1 (SD=.9)

WARD FOCUS GROUPS

This section summarizes themes that emerged during ward focus groups conducted at Holton (N=8, English language, N=10, Spanish language) in October 1998. Questions and corresponding responses are presented, and, where applicable, cross-program trends are identified.

What part of the drug treatment program do you find most useful?

Wards felt that the Design for Living (DFL) was valuable, particularly, monolingual Spanish-speaking wards. Social thinking skills were also useful to wards and perceived as being directly applicable to their lives. Other useful elements included the education component, the 12 steps, the moral inventory, trade and employment skills, the victim awareness class, the teachers, and simply "being away" from their negative social environments. One ward considered the whole program to be useful.

How would you describe your relationship with the treatment team supervisors? Counselors? Parole agents?

Responses to this question varied tremendously with some believing that most staff want to do their jobs well and others asserting that staff avoid talking to wards about their problems. One ward felt that many staff took power to the extreme. According to other wards some staff discriminate on the basis of wards' ethnicity, with wards of like ethnicity receiving preferential treatment.

How often do you meet with the same counselor on a regular basis?

Few wards reported meeting individually with the same counselor on a regular basis. Most reported meeting with their counselors during regular groups. Lack of Spanish-speaking staff means that some wards have counselors with whom they cannot communicate. Although bilingual wards translate for these wards, this may impede the provision of private individual counseling.

Have you had the same counselor throughout your entire stay in the program? If not, please explain.

All participants reported having had the same counselor from the beginning of their program involvement.

Can you relate to the experience of the people shown in the videos or other materials (e.g., workbooks and other handouts) used in the program?

Responses to this question varied widely with some wards believing that documentaries would be a more appropriate type of educational tool, since films of this type feature real people who have actually experienced the circumstances being documented. In general, some felt that videos and materials were boring or unimportant; others seemed to value their inclusion. A noteworthy finding was that none of the videos shown to monolingual Spanish speaking wards was in Spanish.

How could the videos and or written materials be improved?

Responses to this question were mixed, but most wards felt that some combination of videos, written materials and discussion of the information introduced in these media among the wards would work best. Videos or materials alone could not make the program work. In

fact, one ward was opposed to having excessive amounts of written materials since he felt that verbal information was better.

Chapter 6

VENTURA FORMALIZED DRUG PROGRAM

The Formalized Drug Program (FDP) at the Ventura School was activated in 1986. The FDP at Ventura consists of 230 hours of formal counseling and drug education. During the program's *orientation phase*, female wards (housed in the Mira Loma unit) and male wards (housed in the Casa del Colegio unit) receive 7 hours of formal orientation to the program. The order in which small group sessions are conducted varies from female to male units. Ward assignments to particular groups are made at the discretion of institutional parole agents. Each ward must first participate in an orientation session. Hazelden's DFL is administered in the classroom at the Mary B. Perry High School at Ventura. Companion materials are used by both the female and male program units to conduct the following core groups of the program.

- *Stress Management* (3 hours) – Teaches specific stress reduction techniques for wards to use while confined, including identification and management of stress triggers.

- *Victims* (8 hours) – Introduces wards to the concepts of empathy, remorse and restitution and to the Youth Authority's guidelines for restitution; teaches wards about the costs of crime to society, both economically and emotionally. Introduces the concept of victims' rights.

- *Cage Your Rage* (10 hours) – Uses videos and materials developed by Michael Cullan to teach wards about techniques for managing their anger.

- *Freedom from Gangs* (10 hours) -- Teaches wards to identify the unwarranted loyalties they have to gangs and to denounce gang values and to replace them with their own individual values. Videos and testimonials enhance the delivery of this information.

- *The Twelve Steps* (10 hours) – Teaches wards the 12 Steps of sobriety and provides an opportunity for wards to practice applying these steps in their own personal lives.

- *Relapse Prevention* (10 hours) – Uses the Hazelden Relapse Prevention Series to teach wards the concepts of lapse, prolapse and relapse. This series consists of videos and educational pamphlets. Encourages wards to identify the AA/NA group they will attend while on parole.

- *Pre-Parole* (10 hours) – Teaches survival skills while on parole including those related to employment, education, conditions of parole and Department of Motor Vehicles requirements.

- *Framework for Recovery* (10 hours)– Explains the recovery process as a step-by-step, lifetime process.

- *On Solid Ground* (10 hours) – Uses the On Solid Ground series (including videos and workbooks) developed by Gordon Graham to teach wards to examine the motives and stressors in their daily decision making. Teaching wards to opt for clarity over procrastination, to adopt coping skills to deal with problems and to broaden their thinking to preclude prejudging others.

- *Inner Child* (Bradshaw) (15 hours) – Uses the Bradshaw Dysfunctional Family series to introduce the concepts of the alcoholic and the addictive personality. Encourages wards to self disclose and be a "champion" rather than continue to be a survivor.

- *Parenting* (10 hours) – Uses written assignments and videos to teach parenting skills to wards in order to provide wards an opportunity to learn and practice positive communication and parenting skills.

- *NA, AA Alanon* – Exposes wards to the NA, AA Alanon principles. Volunteers visit the living units on a monthly basis.

- *The Life Plan* – Completed by all wards at different intervals of confinement. Constitutes his or her plan for sobriety once paroled. Used by the field parole agent to plan post-treatment phase for parolees.

During the *treatment core phase* of the program, wards attend DFL classes as part of their educational requirements and take part in group counseling on the living units. Wards also meet with their institutional parole agent for progress checks, once at the end of the first month of treatment and again toward their scheduled parole date (approximately 60 days prior to schedule parole date). Counseling and small group sessions comprise the core of the Ventura FDP's services.

The typical day for wards during this program phase begins with breakfast at 7:00 a.m. and continues with educational and vocational classes which take place from 8:00 a.m. to 3:15 p.m. Lunch is served on the living unit from 11:09 a.m. to 12:06 p.m. Group and individual counseling and special workshops take place from 3:00 – 9:45 p.m. Individual and group counseling is provided by YCCs whose typical caseload is 8-10 wards. YCCs must meet two times per week in a face-to-face counseling session with each of the wards on their caseloads in addition to meetings in group sessions.

During the *pre-release phase*, wards are prepared to deal with issues that will likely arise during the aftercare phase. Field parole agents help wards finalize their Personal Life Plans.

Upon completion of the in-custody, treatment phase of the program, a parole release hearing is scheduled for each ward in preparation for the *aftercare phase* of the program. The YOPB reviews the ward's progress in the program, Parole Release Plan and Personal Life Plan and makes a recommendation for parole release or non-release. Wards who are paroled are subject to conditions established by the YOPB including mandatory drug testing and participation in aftercare treatment coordinated by their field parole agent.

THE RSAT-ENHANCED PROGRAM AT VENTURA

As a result of the RSAT grant, Ventura has expanded its existing FDP services. Table 6.1, Appendix I presents each of the originally proposed enhancements to the RSAT program with respect to the FDP at Ventura. Those enhancements which do not apply to Ventura are designated "Not Applicable." Figure 6.1, Appendix I illustrates the timeline on which tasks related to specific RSAT enhancements occurred during Year 1.

The following implementation issues were identified in the course of the process evaluation of the Ventura FDP:

Screening and Assessment

While screening and assessment instruments were identified in the RSAT proposal, staff report that these instruments have not been useful in the clinical assessment of wards over time. Hence, the psychological assessment component of the Ventura program has been limited to the provision of individual counseling and to the search for alternative, longitudinal assessment tools (Refer to Table 11.1).

Staff Training

Treatment staff at Ventura have proceeded with the provision of drug treatment services. However, many express concerns surrounding their lack of sufficient training to be qualified to facilitate group discussions among wards. Staff contend that the inability to hire people in recovery

has been a major barrier to implementation of groups that are engaging to wards.

Staff Turnover

Staff turnover appears to have affected this program's ability to conduct its services. Youth Correctional Counselors, who are in labor union positions, often depart for positions with more attractive schedules in other programs. This has the potential of disrupting the continuity of services provided to wards. The program is currently attempting to fill three counseling vacancies, so many of the small group services have been temporarily suspended.

Institutional Policy

Because institutional policy requires that camp beds remain near full capacity, wards are often removed from the program and transferred to camps. This has been disruptive to the provision of program services and to wards, both remaining and transferred. Another institutional barrier results from the transfer and enrollment of wards with very late parole dates. Staff noted that these wards occupy beds that would otherwise be filled by wards with earlier parole dates who would be less disruptive to the program and who would perhaps be more motivated to participate in the program.

ADMINISTRATOR INTERVIEWS

This section is organized according to the structured interview schedule. Responses below are summarized based on a total of eight program administrator interviews conducted from August to October 1998.

How long have you worked for the drug treatment program?

The mean number of years staff had worked in the FDP was 2 years, and the mean number of years in the RSAT program was 8 months.

Do you enjoy your job?

The majority stated that they loved their jobs. They identified working with other staff members and the wards as the most important reasons for enjoying their work.

Those who felt some "frustration" in their jobs reported the lack of resources and constraints by the inherent "politics" as negative aspects of their work.

Have you ever done work like this before?

- I worked for a drug treatment and detoxification clinic as a counselor for 1 year, and I worked in drug abuse prevention in the schools.
- I worked with a state mental health institution.
- I was a youth counselor in one of the institutions.
- I was a youth counselor in another CYA program.
- I worked for as a counselor at two community drug abuse treatment programs.
- I worked in a youth diversion program, a school program, and as a community worker and liaison with a school psychologist.
- I have not had drug treatment program experience prior to this.

What are your educational credentials?

Overall, the educational credentials of the staff included: An A.A. Degree, B.A. in Sociology, B.A. in Behavioral Science, B.A. in Education, B.S. in Psychology, M.A. in Counseling and a Ph.D. in Clinical Psychology.

What "enhancements" has your program been able to add as a result of the RSAT?

- We were able to hire a psychologist, a relief person, more substance abuse training materials (e.g., workbooks, videos), a computer, more testing materials, and two new curricula for the teachers (i.e., Hazelden & Design for Living (DFL).
- More coverage time for youth correctional counselors to run groups, substance abuse curriculum is more standardized and is improved.
- We were able to get the relapse prevention materials.
- Funds paid for more testing for drugs, one television and VCR, and we added a physical exercise component to program.

What have been some of the successes so far in the RSAT enhanced program?

- We can conduct a lot more substance abuse program groups and can conduct smaller specialty groups.
- Now it's possible to deal with mini-crises, rather than just focus on acute ones.
- Groups are being held more consistently.
- We hired additional staff to deal with the workload.
- The unit has become more credible as a treatment program. We can address some issues regarding chemical dependency better now.
- Staff feel good about their work. Adding a psychologist has been an asset and the girls relate well to her.
- They have been able to buy some new training materials for YCC staff – many of whom had no prior formal training in substance abuse.
- The kids are much more educated with the Formal Drug Program's terms and information. They're speaking the terms, jargon, and language. The staff are also speaking the same language.
- The reduction in the size of drug groups, from 20 to 25 per group to 12 to15 per group.
- Wards are now practicing their 12 steps; concepts of having control over their life, personalizing their Life Plans.
- Relapse modules have been the most effective.
- Our approach is more 'hands on."
- I have seen an increase in self-esteem in the wards since we implemented these modules, and they are opening up more and dealing with larger issues.
- The pointing out of patterns of behavior that send them to failure.
- Case conferencing has become more proactive and structured.
- There's an increased sense of community among the wards; they have created their own group which they handle.
- We now have the ability to hire psychology interns.

What have been some of the barriers to implementing the RSAT enhanced program so far?

- Trying to find an assessment sensitive to pre- and post- treatment changes in drug use knowledge and attitudes.
- It's hard to narrow your focus when there is so much work to be done and you have to split time between the male and female units. It would be preferable to have a psychologist for each unit.
- Having to share parole agents with other units.
- There's no evidence of sequential assessment.

- The relapse prevention curriculum has been identified, but training was so long in coming that they had to do it ourselves.
- The staff don't quite understand how the program should be run. It would be nice to have standardization with the exception of keeping the flexibility necessary to adapt.
- It was very difficult to initiate a physical fitness component.
- Having additional staff to allow counselors to do their counseling and conduct groups – we need more staff to do the supervision and monitoring of wards, so we can do our work as counselors.
- Lack of clear definition from a central person in Sacramento. It seems more important to fill (the beds) for the fire fighting camps than the drug programs.
- Lack of staff training – most staff have no background in the field and we are not allowed to hire people in recovery.
- They are getting some kids with very late parole dates while those with earlier parole dates are not being enrolled.
- There is an information-sharing barrier (between PAIII, administrative staff and treatment staff). The staff needs to be better educated on the program so this doesn't happen.
- Time is a barrier. We don't have enough time for groups. The groups are too short for treatment interventions; we need at least 1.5 hours.
- The groups have been too large (we had 18 wards per group); we are trying to decrease to 8 to 10.
- Staffing problems. Some of the staff are not committed to the place and there is too much staff movement to other facilities (i.e., turnover).
- We need to meet certain institutional quotas. Sometimes I need to send wards that need treatment to camps.
- Institutional policy constraints and requirements; when camp beds are low, they pull girls from FDP. They have to keep camp beds full. This can be disruptive to the program.
- The kids need to be exposed to the curriculum more than once in order to really make changes in their behavior.
- My caseload is too big. I do less counseling now and my paperwork has increased; I have more tasks here than in a regular facility. I can only see wards for 25 minutes every 60 days.
- Politics within the institution
- We need one parole agent for each program. Have to use the same staffing formula as those in the general population.
- The YOPB has poor understanding of addiction and makes poor recommendations for parole.
- The physical layouts need more counseling space.

What are the main objectives of this project? What are the secondary objectives?

Primary objectives:

- To provide drug education and hope that they will realize their problems to be able to be productive once on parole.
- To get wards to understand drug use and to prevent relapse, help develop empathy for victims, and help wards realize what led to drug use and crime so they can change.
- Supply wards with social skills and decision-making skills. Point out their dependency to drugs and how to live their lives without drugs and understand relapse and relapse prevention.
- Build the self-esteem of the wards, teach values, build a sense of community and increase personal responsibility.
- To have kids leave here drug free and confident in their ability to withstand the onslaught of triggers.
- Give the addict options and knowledge about their addictive patterns so they can use the resources available to them to avoid incarceration, death and physical damage.
- For wards to understand their role in victimizing others as relates to their crimes.
- To brake the chain of family addictive patterns.
- Staff turnover. People never settle down. It's hard to establish cadres of workers or treatment team.

Secondary objectives:

- To provide education, training and treatment to youthful offenders who have committed crime so they parole.
- Safety and security of the facility.
- Parole planning and life planning once they're out.
- Wards can demonstrate the ability to work and remain productive, to demonstrate the capacity to change by using 12-steps, and recognize their responsibility to help other addicts.
- Pay restitution for the damage they have caused.

How is the communication between treatment staff and CYA administration?

Many felt communication was good or improving:

- Communication is getting better. Now that they are getting confident about what the program is supposed to be accomplishing, and communication has improved.

Others cited the following areas that needed to be improved:

- We need a central coordinator.
- Information is filtered down from the supervisor. I don't understand all the politics of the grant. I'm aware of what the grant outlines and recommendations are. The administration has been very helpful; they identified and use the strengths of each staff member.
- Sometimes we get requests for activities and changes immediately and sometimes there is a 2 week delay on information. Sometimes we don't have resources to implement changes imposed by administration.
- Up until the Transfer of Knowledge conference communication was somewhat limited.

In your opinion, what have been some of the start-up plans or activities that have been successful?

- Involvement of Sacramento, good communication between the three programs, field parole follow-up services, and hiring UCLA to do the evaluation.
- Greater participation of groups, the ability to offer therapy, decreasing the previous 6-month waiting list, adding AA/NA groups and freeing up youth counselors' time for treatment.
- Use of the relapse prevention, dysfunctional family and Framework for Recovery programs and beginning a physical activities program.
- Hiring a staff psychologist and having more consistency of casework coverage and drug testing.
- The ability to start life planning immediately which will be done at the beginning of relapse prevention.

In your opinion, what have been some of the start-up plans or activities that have not been successful?

- Youth Counselors could use more training and we still need more staff.
- We need more money to obtain adequate training and education because we won't get any more money next year. Many of the staff members do not have adequate information.
- Hiring of staff, development and implementation of relapse prevention.
- Sequential assessment, in-service training curricula for RSAT staff, and appropriate use of pre-release coordinator position.

If you had to plan a program like this, what would you do differently?

- I would anticipate things such as population decrease and I would have one parole agent per unit (rather that ½ per unit) and I would have hired a YCC post position (versus relief).
- I would double the staff, hire a person to just do groups, have one psychologist per unit, have one parole agent assigned to each unit; make treatment groups smaller, and have more staff training for groups, crisis management, and substance abuse.
- I would make sure that all my staff were trained and certified, have a plan for the program and allow my staff to participate in its development, and obtain more information about treatment strategies that have been successful.
- Place more priority on training and curriculum; hire a person to cover behind training and casework.
- I would isolate it from the rest of the population and have staff commit to 3 years in program.
- Identify resources in the community (other than AA and NA) to come in, give 120 days to wards in program (without school) -- as they come in.
- More emphasis to orientation to the program for wards, train staff prior to starting program.
- Need better groups settings (rooms that are more appropriate).
- Use more time for one on one meetings, individual counseling. Counselors have too many administrative tasks and security activities.
- We need to examine other models of drug rehabilitation.
- Increase physical activities starting from beginning of program.
- Have an academic advisor available in the unit.
- Some kids should not go to school until they resolve some of the behavioral problems such as kids who have problems in school end up in lock down and cannot participate in program.

Have you received enough training? If not, what areas need attention?

Most people interviewed felt they had not received enough training. Their suggestions for areas that needed more attention included:

- More cross-training.
- The physical effects of drugs on the brain.
- I would like to become a certified substance abuse counselor.
- More training specific to drug use.
- More training in working with females and how to treat them.

Is the physical environment appropriate for this program? Why or why not?

Those who thought the environment was not appropriate for the program gave the following reasons and suggestions for improvement:

- We are trying to make it a community program, but so many of our programs are away from the unit. This has implications for the wards' language, jargon, etc. and for efforts to increase knowledge.
- We need space for therapy on units, we need classrooms and offices to conduct the treatment services. Right now we are using any room that is available (e.g., the laundry area, day room or dining area).

How will you know the program is successful? Do you have your own measure of success. If so, what does your measure include?

- We are working on how to measure who is successful and we are working with field parole who will help to determine who's successful.
- By reducing recidivism; lowering relapse rates.
- Right now we don't have a measure of success, we don't have a tool. Here it is if the ward has completed the program. In a measure of success, I would include: how long they were clean, changes in drug and alcohol use, and involvement of the family in recovery and relapse.
- Wards become more willing to take control of their lives and speak to each other.
- Watching the violation series to see if they violate parole and get returned to custody.
- Number of honorable discharges from CYA.
- I look for change; wards taking responsibility over their lives and actions.
- We're counting on UCLA to answer that. I'm not sure what the CYA research shows. They give lots of information in but never get feedback.

YOUTH CORRECTIONAL COUNSELOR SURVEY

A number of the YCC Questionnaire items directly addressed program implementation issues targeted by the RSAT services enhancement grant. These items are discussed below with regard to the implementation issue they address.

The following results are based on responses to the YCC Questionnaire administered to correctional staff at both male and female treatment units at Ventura (N=9).

In my current job setting--

I am able to meet with wards on my caseload regularly.

Strongly Disagree	0.0%
Disagree	33.3%
Neutral	55.6%
Agree	11.1%
Strongly Agree	0.0%

I am able to differentiate between wards needing support and wards needing discipline.

Strongly Disagree	0.0%
Disagree	0.0%
Neutral	0.0%
Agree	55.6%
Strongly Agree	44.4%

I am able to obtain backup relief to perform my counseling duties regularly.

Strongly Disagree	11.1%
Disagree	44.4%
Neutral	44.4%
Agree	0.0%
Strongly Agree	0.0%

I use psychological assessment and testing information to create a treatment plan for each ward on my caseload.

Strongly Disagree	0.0%
Disagree	11.1%
Neutral	44.4%
Agree	33.3%
Strongly Agree	11.1%

***I have effective strategies for working with people whose race/ethnicity is different than mine*.**

Strongly Disagree	0.0%
Disagree	0.0%
Neutral	11.1%
Agree	55.6%
Strongly Agree	33.3%

***I have received sufficient substance abuse training to perform my job effectively*.**

Strongly Disagree	22.2%
Disagree	66.7%
Neutral	11.1%
Agree	0.0%
Strongly Agree	0.0%

My primary responsibility is to provide security.

Strongly Disagree	11.1%
Disagree	0.0%
Neutral	0.0%
Agree	44.4%
Strongly Agree	44.4%

My primary responsibility is to provide counseling.

Strongly Disagree	22.2%
Disagree	11.1%
Neutral	44.4%
Agree	22.2%
Strongly Agree	0.0%

***How would you rate the relative effectiveness of your program in the following areas?* (Scale:1=Poor, 2=Below average, 3=Average, 4=Above average, 5=Excellent)**

The overall program	3.3 (SD=.71)
Services for limited English-speaking wards	2.8 (SD=.44)
Individual counseling sessions	2.6 (SD=.73)
Group counseling sessions	3.1 (SD=1.1)

WARD FOCUS GROUPS

This section summarizes themes that emerged during ward focus groups conducted at Ventura (N=8, males, N=8, females) in October 1998. Questions and corresponding responses are presented, and, where applicable, cross-program trends are identified.

What part of the drug treatment program do you find most useful*?*

Males

Most wards felt that groups, especially support groups, were the most useful part of the program. Other useful aspects included relapse prevention, the DFL class and visits from NA speakers.

Females

While wards found relapse prevention materials to be useful, they felt that teachers were not knowledgeable about relapse. One ward stated that the pharmacology class was great because it teaches wards how to keep clean, avoid getting disease and about overdose and withdrawal.

How would you describe your relationship with the treatment team supervisors? Counselors? Parole agents?

Males

Respondents noted that, for the most part, wards get along with staff. However, staff can make things difficult for wards who challenge the information presented in groups. There appears, however, to be a two-way exchange in operation, with wards sometimes provoking unfavorable responses from staff, and staff provoking behavioral problems among wards.

Females

Wards felt that staff lack firsthand knowledge and can only provide book knowledge. Oftentimes, staff stereotype wards on the basis of their addictions. What individual counseling that does occur does not deal with serious issues; rather, counseling sessions focus on behavior problems. Moreover, the emphasis on sanctioning ward behaviors

often precluded the implementation of essential program elements (e.g., regularly scheduled groups).

How often do you meet with the same counselor on a regular basis?

Males

Wards are discouraged that individual counseling is a rare occurrence and that staff do not make additional time for wards' in-depth personal issues that may contribute to substance abuse. Staff avoid discussion of these issues by informing wards that if they were there to provide individual counseling to everyone who wanted it, they would not be able to conduct other essential program elements (e.g., provision of meals, conducting groups). Most wards reported that they were not given the opportunity to meet with their counselor individually, even after several requests.

Females

Wards felt that what little individual counseling that does occur does not address serious problems; rather it deals with behavior problems.

Have you had the same counselor throughout your entire stay in the program? If not, please explain.

Males

Many wards reported having had more than one counselor since the beginning of their stay.

Females

Many wards reported having had more than one counselor since the beginning of their stay.

Can you relate to the experience of the people shown in the videos or other materials (e.g., workbooks and other handouts) used in the program?

Males

Most wards believed the videos to be outdated, "dumb," rehearsed, exaggerated or even comical.

Females

One ward noted that videos often presented characters with lifestyles so drastically different than hers (e.g., a crack addict living on the streets) that she could not relate to them.

How could the videos and or written materials be improved?

Males

Most wards wanted more updated videos, even movies dealing with the issue of substance abuse. These videos should have real people not actors with whom wards can relate.

Females

All of the participants felt that the videos should be updated and should use people who have experienced the same problems as wards.

Chapter 7

STARK FORMALIZED DRUG PROGRAM

The FDP at the Heman F. Stark Youth Correctional Facility was activated in 1976. Each ward participates in a 12-week orientation that seeks to "break down the 'criminal culture'" and anti-social values that may impede behavior change. During the *orientation phase*, each ward participates in a case conference with his counselor to establish treatment objectives. Wards are then assigned to a drug treatment group in which they participate in small group discussions based upon *Bradshaw's Dysfunctional Family* curriculum. Wards who demonstrate a commitment to the principles of the program are permitted to begin the *treatment core phase* of the program.

During the *treatment core phase* of the FDP at Stark, *Hazelden Design for Living* (DFL) is administered in a small group setting. Wards with limited English language skills are assisted by bilingual wards. Wards are required to develop a life plan for dealing with their substance abuse and to undergo mandatory random drug testing during this phase. YCCs at Stark must provide 1 hour of small group counseling per week. This one-hour session is devoted to the discussion of objectives established during the ward's initial case conference. Each ward must participate in 5 hours of small group counseling per week during this 20-week phase. Wards also meet with their institutional parole agent for progress checks once at the end of the first month of treatment and again toward their scheduled parole date (approximately 60 days prior to schedule parole date). Small group counseling sessions comprise the core of the Stark FDP's services since, unlike the FDPs at Holton or Ventura, Stark's program does not offer the DFL in the classroom setting. Instead, wards receive all FDP services on the living units exclusively.

The typical day for wards during this program phase begins at 7:15 a.m. and continues with educational and vocational classes which take place from 8:00 a.m. to 3:00 p.m. Lunch is served on the living unit from 11:30 a.m. to 12:30 p.m. Group and individual counseling and special workshops take place throughout the day. Examples of ongoing groups include Anger Management, Gang Awareness and Victim's Awareness.

Upon completion of the in-custody, treatment phase of the program, a parole release hearing is scheduled for each ward in preparation for the *aftercare phase* of the program which lasts 8 weeks. The YOPB reviews the ward's progress in the program, parole release plan, and personal life plan and makes a recommendation for parole release or non-release. Wards who are paroled are subject to conditions established by YOPB including mandatory drug testing and participation in aftercare treatment coordinated by their field parole agent. During the program's *aftercare phase*, relapse prevention, parole expectations, recovery dynamics, family support, employment and the life plan are emphasized by the field parole agent. Participation in AA and NA groups is mandatory for all parolees.

THE RSAT-ENHANCED PROGRAM AT STARK

As a result of the RSAT grant, Stark has expanded its existing FDP services. Table 7.1, Appendix I presents each of the originally proposed enhancements to the RSAT program with respect to the FDP at Stark. Figure 7.1, Appendix I depicts the timeline on which tasks related to specific RSAT enhancements occurred during Year 1.

The following implementation issues were identified in the course of the process evaluation of the Stark FDP:

Staff Recruitment

Staff report that it is difficult to hire staff right away. For example, it took 6 months to hire a psychologist and 8 months to hire a parole agent. The program was unable to fill its graduate student intern position for 1 year. According to staff, the Certified Drug and Alcohol Counselor (CADAC) vacancy was not filled due to a lack of communication about the availability of funds for the position and the manner in which Personnel advertised the position vacancy (i.e., over the internet).

Safety

The issue of safety is paramount to the implementation of this program. "Lock downs" are a frequent occurrence. When a "lock down" occurs,

all program activities cease. Hence, YCCs are not allowed to perform their counseling duties.

Staff Turnover

The rebidding process had an initial impact upon the composition of the counseling staff. Several YCC vacancies were created in 1997 due to this process. However, these positions have been filled, and the treatment staff who remain appear to be the most committed to their jobs.

Institutional Policy

The educational services provided by the institution for general population wards do not take wards' drug treatment program participation into consideration. Thus classes are scheduled during RSAT small group meeting times. As a result, wards do not receive the benefits of both the educational and the drug programs. In addition, the transfer and enrollment of wards with very late parole dates poses another barrier. The program is forced to enroll wards who have too much time, who do not want to participate, and who tend to be disruptive to the program.

ADMINISTRATOR INTERVIEWS

This section is organized according to the questions asked of the participants; responses are presented in summary form. A total of 5 interviews were conducted with Stark administrators between August and October 1998.

How long have you worked for the drug treatment program?

The mean number of years staff had worked for the FDP was 11 years, and the mean number of years staff had worked in the RSAT program was 5 months.

Do you enjoy your job?

All of those interviewed said they enjoyed their jobs and specific reasons included:

- There is more control over the kids here.

- I enjoy the people I work with because they are conscientious.

Have you ever done work like this before? If so, where? For how long?

- No, I have not had drug treatment program experience prior to this.
- I worked for the FDP at another CYA program.
- I worked for an outpatient facility and did alcohol and drug counseling of high-risk kids.

What are your educational credentials?

The educational credentials of the staff included: 3 years of college, a B.A. in Psychology with one year of postgraduate studies, B.A. in Behavioral Sciences, and a Ph.D. in Clinical Psychology.

What enhancements has your program been able to add as a result of the RSAT grant?

- We hired a staff psychologist, a YCC, we bought two VCR's per unit, and more groups are being conducted (from 17 to now more than 25 per week).
- We reduced the size of treatment groups, and identified dual diagnosis wards through the clinical psychologist. We are able to include diagnostic information in treatment and develop specialized programs to address individualized needs, and can offer a continuum of services from institutions to parole due to parole liaison position.
- The reduction in the size of drug groups, from 20-25 per group to 12-15 per group.
- We were able to purchase more materials for assessment (e.g., a software package for scoring the MMPI-2, Psychopathology Checklist, Beck Dependency Inventory, Adult Neurological Screening, Carlson Personality Survey).

What have been some of the successes so far in the RSAT enhanced program?

- The staff enjoy having more resources, it's stressful to have to beg for equipment; now equipment is available when you need it. The new YCCs are available for advice and conduct 10 groups per week each.
- It has been a more treatment oriented program; we are able to

have a more treatment oriented relationship with wards. We are reviewing cases every 60 days – there is more disclosure of need, feelings and concerns from wards. Wards are working more on psychological issues.

- In case conferences wards are able to talk about Bradshaw and 12 Steps and put it into their own words.
- Tension among team members has decreased because people have more time to conduct their activities and the level of job satisfaction has increased. Training has enhanced the program and people are happy doing all of these activities.

What have been some of the barriers to implementing the RSAT enhanced program so far?

- It's almost impossible to merge educational and safety needs and to run the program. Education thinks they have priority! General treatment folks don't make drug treatment a priority; there's not enough staff. A second period (in the school) was added and now guys in the RSAT program can't make their (education) class because they have groups. A kid missed a class due to an RSAT program victims class.
- The inability to hire staff right away; we were not able to hire a psychologist for 6 months, and it took 8 months to hire a parole agent. Were unable to fill an internship program position for 1 year.
- Keeping our beds full; we were forced to take people that did not meet the criteria for RSAT (i.e., time left in CYA). We lost about half the staff and had to get the new people trained. We need more than one clinician – we have a backlog for assessment and treatment of wards with one psychologist for 300 beds.
- Lack of input into staffing of the program – so could have had another staff psychologist. We could be doing more with more help. We do not have much say about who can get into the program and who cannot. They get guys that have too much time and don't want to be here and are disruptive.

What are the main objectives of this project? What are the secondary objectives?

Primary objectives:

- To break the vicious drug cycle by exploring their family histories and examining dysfunction and addressing the denials.
- We need to measure the success of our program. We need to know if the treatment modalities used are adequate.

- To give wards an opportunity to achieve and maintain sobriety, to prepare them for sobriety when they leave, and to track them in some way so we can see what we need to do to the program.
- To assist people coming out in completing a successful parole and to live substance free.

Secondary objectives:

- To teach them to realize that they're dysfunctional; it's not their fault but their environment. They are not bad people.
- Provide wards with education and work skills, assist them in developing social skills and better interpersonal relationships, and to guidance on how to develop of a Life Plane that is realistic.
- To pay attention to other needs that guys have and address them (e.g., dual diagnosis).

How is the communication between treatment staff and CYA administration?

- Communication is good. Information is coming down.
- Our programs work independently – we dictate what happens in the programs. There is not much direction coming from the top on how the program is implemented. We believe that our program should have more involvement in the grant writing and decision-making regarding the distribution of funds. We need to be able to provide input on program needs.
- There was some lack of communication around funds for certified drug and alcohol counselors. They lost money because personnel advertised the position on the Internet. It was an ineffective way of recruiting and there was a lack of communication about the funds.

In your opinion, what have been some of the start-up plans or activities that have been successful?

- The staff meetings were held when everyone was first brought on board. The expectations of the YCC's were spelled out up front.
- The Bradshaw training was another success.
- Breaking down of group sizes and having a clinical psychologist to help us work with dual diagnosed wards.
- Relapse prevention. We trained the counselors in this from scratch, and then we discovered Hazelden. Sacramento got word and they liked it so they implemented it.

In your opinion, what have been some of the start-up plans or

activities that have not been successful?

- We would have liked the institution to give us latitude to choose our own staff. Most of the staff signed on due to "best hours" or to be off-days/weekends. Their hearts were not in it. Wards are being short-changed due to bidding.
- There was confusion regarding testing and assessment. It would have been nice if program could have been planned better. People devising the plan may not be the ones implementing it.

If you had to plan a program like this, what would you do differently?

- I would like to have an exemption from institutional bidding. I would give extra perks to the YCCs. I would like the option of hiring staff. I want people who want to be here. I would also like to see funding for more drug tests, so they can re-test those suspected of tampering samples; ideally we would like to test everyone.
- I would include smoking cessation clinics. I would dedicate YCCs to drug groups and treatment only (not have them supervise wards and conduct security duties). I would have a total of three clinical psychologists (1 for every 100 wards). I would have two full-time coaches to assist in the structure of physical exercises.
- Include people in the planning who will have to implement it.

Have you received enough training? If not what areas need attention?

Half of those interviewed said they had not received enough training and their recommendations for improving staff training included:

- I would like to be trained in Reality Therapy by William Glassner. This is confrontational therapy which emphasizes personal responsibility and aims to do away with the "poor me syndrome."
- We need more training in small group dynamics, other treatment modalities (e.g., understanding the problems or issues in wards' thinking), ways to identify skill needs, and a refresher training in Hazelden.

Is the physical environment appropriate for this program? Why or why not?

- No, I would like to be able to do away with the sliding doors on the unit. Kids yell names out of their rooms at other kids and when staff come down the halls to address them, wards can see down the hallway through the gap in the door and therefore stop before they are caught. We need doors that swing open. Individual rooms would be great.
- It could be improved by having rooms assigned for treatment or by creating partitions for day rooms to create a more private atmosphere for treatment.
- It works out pretty well. I can supervise kids who are outside of my office. We could have more open space outlets for groups.
- Here the groups are not isolated enough from the living unit. Groups are now being conducted in a living room where everyone can walk through.

How will you know the program is successful? Do you have your own measure of success? If so, what does your measure include?

- We will know by recidivism rates. That is, do they come back? We will also know by the ratios of guys eligible for versus denied parole, by identifying those who achieve 6 months of successful parole, by documenting those who receive marketable job skills before parole (or proof of a job is even better), by college applications, proof of registration, financial aid, and by attendance at AA/NA meetings and interaction with sponsor.
- By learning more about the manner in which wards internalize the treatment curriculum. Do they understand it? Can they talk about it? The ultimate success would be for wards to remaining drug free.
- If guys are actually tracked and if they have access to all programming that they can get and if they are paroled and get access to resources they need there (e.g., AA groups and counseling).
- We could do testing after each module gives them wards' scores on each scale, 60-day case conference looks at progress or lack thereof, whether kids are paroled, once parole, whether they stay out there.

YOUTH CORRECTIONAL COUNSELOR SURVEY

The following results are based on responses to the YCC Questionnaire administered to correctional staff at Stark (N=9).

In my current job setting--
I am able to meet with wards on my caseload regularly.

Strongly Disagree	22.2%
Disagree	0.0%
Neutral	0.0%
Agree	55.6%
Strongly Agree	22.2%

I am able to differentiate between wards needing support and wards needing discipline.

Strongly Disagree	0.0%
Disagree	0.0%
Neutral	0.0%
Agree	66.7%
Strongly Agree	33.3%

I am able to obtain backup relief to perform my counseling duties regularly.

Strongly Disagree	33.3%
Disagree	11.1%
Neutral	22.2%
Agree	11.1%
Strongly Agree	22.2%

I use psychological assessment and testing information to create a treatment plan for each ward on my caseload.

Strongly Disagree	44.4%
Disagree	44.4%
Neutral	0.0%
Agree	0.0%
Strongly Agree	11.1%

I have effective strategies for working with people whose race/ethnicity is different than mine.

Strongly Disagree	11.1%
Disagree	0.0%
Neutral	33.3%
Agree	22.2%
Strongly Agree	33.3%

I have received sufficient substance abuse training to perform my job effectively.

Strongly Disagree	11.1%
Disagree	55.6%
Neutral	0.0%
Agree	22.2%
Strongly Agree	11.1%

My primary responsibility is to provide security.

Strongly Disagree	0.0%
Disagree	0.0%
Neutral	11.1%
Agree	44.4%
Strongly Agree	44.4%

My primary responsibility is to provide counseling.

Strongly Disagree	33.3%
Disagree	44.4%
Neutral	22.2%
Agree	0.0%
Strongly Agree	0.0%

***How would you rate the relative effectiveness of your program in the following areas ?* (Scale:1=Poor, 2=Below average, 3=Average, 4=Above average, 5=Excellent)**

The overall program	2.9 (SD=.78)
Services for limited English-speaking wards	3.0 (SD=.71)
Individual counseling sessions	2.7 (SD=.71)
Group counseling sessions	2.7 (SD=.50)

WARD FOCUS GROUPS

This section summarizes themes that emerged during the ward focus group conducted at Stark (N=7) in October 1998. Questions and corresponding responses are presented, and, where applicable, cross-program trends are identified.

What part of the drug treatment program do you find most useful*?*

Wards at this program site were the most discouraged of all about the impact of groups and drug treatment program elements on their drug abuse once paroled. They were very skeptical about their potential for becoming drug free, noting that actions (i.e., what they experience in recovery) are what really matter, not words (i.e., what staff tell them they will experience).

How would you describe your relationship with the treatment team supervisors? Counselors? Parole agents?

There is a high level of concern among wards at this site about disclosure of information in group sessions to YCCs who, once the group is over, become custody staff now holding sensitive information about their wards. The issue of trust is paramount, and wards in the group saw their counselors more as custody staff than treatment staff.

How often do you meet with the same counselor on a regular basis?

According to wards, no individual counseling takes place at this program.

Have you had the same counselor throughout your entire stay in the program? If not, please explain.

All participants reported having had the same counselor from the beginning of their program involvement.

Can you relate to the experience of the people shown in the videos or other materials (e.g., workbooks and other handouts) used in the program?

According to some group participants, there is an over-reliance upon videos such that videos have become a substitute for actual treatment provided by counselors. Many wards in this group also stated that the terms used in Bradshaw's curriculum are confusing and too technical. According to one ward, many of the elements of the Bradshaw curriculum contradict the messages given in the Hazelden Relapse Prevention curriculum.

How could the videos and or written materials be improved?

Most wards wanted more videos featuring characters that have experienced addiction themselves, even movies dealing with the issue of substance abuse. In addition, wards felt that materials should remove religious references. Bradshaw should not be used because its terminology is too confusing.

WARD FOCUS GROUP CROSS-PROGRAM TRENDS

The following trends were noted across the three program sites from data collected during ward focus groups:

General Trends

Wards in all focus groups agreed that small group sessions are beneficial when they occur. Wards emphasized the importance of peer-led support groups rather than groups led by staff.

Wards at Holton and Ventura noted that some treatment staff take their problems out on wards and simply do not appear to want to be there.

However, other treatment staff are perceived to be supportive. Wards at these two program sites also felt that favoritism took place. "Certain staff pick their favorites," according to one ward.

Responses to this question indicate that limited or no individual counseling occurs between YCCs and wards at any of the three program sites. Wards are discouraged by this and express a clear desire for more one-on-one counseling.

At Holton and Stark, most wards reported having had the same counselor throughout their entire stay. Wards at Ventura experienced frequent counselor changes, with the majority having had more than one counselor during their stay.

Wards across all three program sites believed that the videos used in the programs were difficult to relate to and lacked credibility. They were disappointed to see that actors as opposed to actual recovering addicts were featured in these videos (e.g., the relapse prevention video of the Hazelden Relapse Prevention Series). Wards noted that people in videos were usually white, middle class and clearly not of the same background as wards. Most would prefer that AA/NA volunteers (or other recovering addicts) be invited to talk to wards. This appears to have happened in the past across all three sites, but, according to wards, it is now an infrequent occurrence.

According to wards at all three program sites, videos and materials should feature real people who are recovering addicts. These individuals should be young – "our age"-- and the videos should be more current (i.e., created in the 1990s). Wards stated that they would like less paperwork and more verbal exchange of experiences related to drug abuse recovery.

Many wards are concerned about staying drug-free once they are paroled and returned to the communities from which they originated. Some believe that their greatest challenge will be resisting return to drug abuse as a result of substance abuse by others in the community (e.g., parents, siblings, or friends). Others worry that their lack of education and employment options will hasten their return to selling drugs.

Most believed that field parole agents could be most helpful by providing a list of names and emergency telephone numbers of individuals who could assist wards on the verge of relapse. One ward suggested that parole agents enlist parolees to make presentations to kids about the harmful effects of drug use. Others felt that parole

agents could help by setting and maintaining high standards to which parolees would aspire (e.g., the expectation that wards will be successful in school), by making home visits, by initiating communication with wards on their caseloads before they are paroled, and by providing support to wards who experience lapses to substance abuse as opposed to issuing immediate sanctions (e.g., revocation of parole). Wards felt that they could talk more openly with their parole agents about their problems, including drug abuse, if parole agents were more supportive.

Chapter 8

INSTITUTIONAL MANAGEMENT

One of the presumed effects of an intensive, corrections-based drug treatment program is improved daily functioning and offender management. The present study examined two indicators of institutional functioning for the three RSAT-enhanced drug programs: (1) the prevention of ward drug use, and (2) the promotion of a therapeutically oriented environment.

WARD DRUG TESTING

The use of illicit drugs and alcohol continues to be a problem within most correctional facilities (Camp & Camp, 1997). As mentioned above, RSAT programs are required to conduct regular, random drug tests on 10% of the wards weekly. Not only is this intended to discourage drug use among RSAT wards, but it also provides a relatively unbiased indicator of drug use within these programs.

For the present study, drug-testing data were requested from each site covering the time periods ranging from each of the individual RSAT program start-dates through September 15, 1998.[1] Thus, for Holton, data were collected from January 1, 1998, for Stark--April 1, 1998, and for Ventura--October 1, 1997.

Across all three programs, rates of positive drug tests were extremely low. At Karl Holton, out of a total of 2,305 urinalyses conducted, 25 (1.1%) were positive.[2] At the Heman G. Stark program, a total of 289 drug tests were conducted. Out of these, 3 (1%) were "undetermined," 3 (1%) had been altered in some way, and 4 were positive (1.3%). Finally, at the Ventura School, a total of 305 wards were tested during

[1] At the time of this report, data were only available through August at Karl Holton.

[2] It should be noted that the drug test data from Karl Holton were reported as total number of positive *tests*, rather than number of wards testing positive. Since each urine specimen was tested for an average of 4 to 5 substances, it is feasible that a single urine specimen could account for more than one positive result.

the specified period. Of these, 4 (1.3%) tested positive. Not all program sites reported specific substances associated with positive urinalyses. However, where the substance was reported, THC, [3] the psychoactive ingredient in marijuana, accounted for all of the positive tests.

CORRECTIONAL INSTITUTION ENVIRONMENT SCALE (CIES)

To assess the perceptions of correctional officers at the RSAT programs versus other youth correctional institutions, the CIES was administered to correctional counselors at the Holton (N=23), Stark (N=9), and Ventura (N=9) programs and compared with national norms from custody staff at non-treatment correctional facilities for youth (N=858). The CIES was developed to assess the social climate of prison and jail settings (Moos, 1974). The short form consists of 36 true/false items and is completed by institutional staff. These items assess nine dimensions that measure the social climate of correctional programs: Involvement, Support, Expressiveness, Autonomy, Practical Orientation, Personal Problem Orientation, Order and Organization, Clarity, and Self Control (see Appendix D).

Figure 8.1 (see Appendix D) compares correctional officers' ratings of the Holton, Stark, and Ventura RSAT programs with a national sample of correctional officers' ratings of their own institutions. Higher scores on these subscales indicate more positive responses. Subscale definitions are also provided in Appendix D.

Although national norms are provided in Figure 8.1, they represent a broad array of juvenile facilities—including county juvenile halls and vocational programs. The findings below should be interpreted with caution, given the small number of respondents for each program.

Holton

Correctional staff at Holton gave their institution positive ratings, overall, relative to correctional staff at Chino and those comprising the national normative sample. Staff gave the highest ratings to Order and Organization (i.e., the importance of order and organization in the program) and to Staff Control (i.e., the degree to which staff use measures to keep residents under control). Holton staff gave lower

[3] Delta-9-tetrahydrocannabinol.

ratings on Expressiveness (i.e., the extent to which wards and staff are encouraged to openly express themselves) and Autonomy. Aside from these exceptions, Holton's rating tended to approximate those of the national normative sample.

Ventura

Responses from Ventura's correctional staff closely paralleled those of Holton and the national sample. Exceptions to this were Ventura staff's ratings on the Involvement, Order and Organization, and Staff Control dimensions—each of which exceeded the national norms.

Stark

Correctional staff at Stark, the most secure institution of the three evaluated, gave their institution lower overall ratings on Involvement (i.e., how active residents are in the day-to-day functioning of the program, Support (i.e., the extent to which staff and residents are encouraged to support each other, Expressiveness, Autonomy, Personal Problem Orientation (i.e., the extent to which residents are encouraged to understand their personal problems), and Clarity (i.e., the extent to which residents know what to expect of the day-to-day program routine and procedures). However, correctional officers at Stark gave their institution relatively high ratings (compared to the national sample) on Order and Organization and Staff Control dimensions.

Again, the reader should interpret these results carefully, given the extremely small sample sizes for each program. Higher response rates are anticipated in the second year of the evaluation, thus increasing the reliability and generalizability of the CIES subscales.

Chapter 9

RELAPSE PREVENTION TRAINING

The CYA Institutions and Camps Branch, in conjunction with the Parole Services and Community Corrections Branch, hosted four day-long relapse prevention training sessions; two in Northern California at the Youth Authority Training Center in Stockton and two in Southern California at the Parole Offices in Covina, CA. Approximately one hundred and seventy staff members (parole agents, youth correctional counselors, treatment supervisors, other administrators) attended the sessions: 86 attended in Northern California and 84 attended sessions the sessions in Southern California.

The sessions were observed by DARC evaluation team members. The Program Manager and two parole agents from CYA staff (one from Holton and the other from Stark) developed the relapse prevention curriculum based on the Hazelden relapse prevention materials[4]. The CYA facilities were more than adequate and the training team had access to audiovisual equipment and supplies. The Hazelden materials were selected by the RSAT workgroup in consultation with the training staff of the formal drug programs and complete kits of the relapse prevention series were purchased for distribution to Institutions and Camps and Parole Branches. Unfortunately, at the time of the training, the RSAT funds were being "held up" and were not expected to be available to the field until several weeks following the training.

The training schedule and content were fairly consistent. However, some modification to the schedule was made between session I in the North and session II in the South to include a small group discussion of options parole agents have in responding to lapses and relapses among parolees during parole and how to integrate relapse prevention techniques into parolees' Personal Life Plans (an aftercare treatment plan that follows wards from the institution to the community upon release). This modification in the training was made when it was discovered that there was more available time in the agenda than originally anticipated. The sessions were varied and included introductions to key RSAT workgroup members and administrators, an

[4] Previously, Hazelden had recommended a professional relapse prevention trainer to them and they found the training expensive ($1,000/day) and the content to be well within their skill level to present to other employees, so they decided to do the training themselves.

overview of the RSAT grant and related funding, goals and objectives of the training, small group discussions, and audiovisual and lecture presentations on managing high-risk situations. Participants were actively engaged in the small group discussions and question/answer periods of the training. At the end of the day they were informally asked what they liked about the training and recommendations for improving the training and the training was subsequently revised slightly to incorporate those suggestions (e.g., participants said they would have preferred to hear about details of the RSAT grant and funding allocations early in the program rather than late in the afternoon).

A sample agenda for the training included:

9AM	Introduction Overview of training
9:45AM	Group activity where participants worked in small groups to identify symptoms of major drugs of abuse and related relapse issues
10AM	Preview of videotape on high-risk situations (first of six videotapes in the Hazelden series on relapse prevention that will be used throughout CYA Institutions and Camps and Parole Branches)
10:45AM	Break
11AM	Didactic presentation on major concepts of relapse prevention Personal Life Plan – integrating relapse prevention techniques
12PM	Lunch
1PM	Parole Guidelines/Contracts – detailed discussion of options for managing lapses and relapses during parole and review of proposed contract for "vendors" who provide substance abuse related services (e.g., individual and group counseling) in parole offices
2PM	Implementation – how CYA intends to implement "continuum of care" system-wide, focusing on relapse prevention as the crucial link between the Institutions and Camps and Parole Branches
3PM	Questions and answers, evaluation

RELAPSE PREVENTION TRAINING PRE- AND POST-TEST RESULTS

The following data are from participants' results for the relapse prevention training pre-test.

Only 30 of the 170 participants previously had formal relapse prevention training. The mean training time for the 30 individuals who reported having received prior training was 14 hours (range=2-56 hours, SD=12 hours). Sponsors of previous training included: the CYA (n=23, 14%), a university (n=6), and the federal government (n=1, <1%). Regardless of whether or not they had received formal relapse prevention training, 76 reported that they used relapse prevention techniques with wards and parolees in their caseload (almost never n=3, 2%, sometimes n=10, 9%, half the time n=35, 20%, most of the time n=12, 7%, and almost always n=16, 9%). The number of participants who could correctly identify terms, strategies, and techniques of relapse prevention included: relapse (n=144, 94%), lapse (n=53, 27%), prolapse, (n=12, 7%), abstinence violation effect (n=9, 5%), six steps in relapse prevention (n=63, 37 %, mean=1, SD=.73), six techniques in relapse prevention (n=15, 9%, mean=1.2, SD= .41).

Post-tests were completed for 81 (48%) participants approximately 1 month after the pre-test, revealing modest, though not statistically significant, improvement in knowledge regarding the steps and techniques reviewed in the Hazelden curriculum on relapse prevention: knowledge of the six relapse prevention steps (pre-test mean=.28, post-test mean=.32; t-value = -.40, df=80, 2-tail Sig=.69 CI+=-.22, .15, SE of Mean=.09); six relapse prevention techniques (pre-test mean=.10, post-test mean=.19; t-value = -1.47, df=80, 2-tail Sig. = .15 CI=-.20, .03, SE of Mean=.06). At the time of the post-test, only 22 (27%) of the participants reported receiving the Hazelden relapse prevention packets.

On a scale of 1 to 10, with 1 being the most negative and 10 being the most positive rating, the mean rating of the "usefulness of the relapse prevention training you attended for the work you do with the wards/parolees you work with" was 6.1 (SD=2.5).

The following responses were obtained from the open-ended question "What recommendations would you make to improve the training?"

- Make sure those attending the training actually need this training.

- Was not really training – more of a presentation of materials and why they were using them.
- Break into training slowly (slower pace with more depth, didn't contain enough information) (n=2).
- Should have more detailed training with more information and time spent on relapse prevention material (not just what it is, but how it works, more training in Relapse Treatment Plan (e.g., Life Plan- how it will relate to other programs and institutions, more emphasis on program components – not just a short film) (n=3).
- More time for staff to brainstorm ways to implement it; the material reviewed in training didn't give a basis for how to use them (n=2).
- More take-home materials.
- Information needs to be clearer – no distinctions made between different available drugs.
- More focus on changing the social economic aspects (represented) in the films (youths can't relate them).
- More training locally (n=3).
- How to get a "buy in" from the wards.
- More realistic, actual people that this program has helped (testimonials).
- Bring parolees in to participate in training for direct contact (e.g., a panel) (n=4).
- Relevancy of videos to certain groups (e.g., younger teens, those with lower literacy).
- Written material is at a high level and needs to be deciphered.
- Would recommend repeating this training as a skills building session for all sites as was done previously only this time do more hands-on role playing.
- There needed to be everything in place before the training was done (money, materials etc.).
- Monitor the participants more closely.
- Be able to walk out of the training.
- Need follow-up training to ensure that the parole field agents are doing what they wanted them to do.
- It should've been a bit more honest, since funds are needed to get it started.
- More statistics regarding the impact of aftercare and how we can have a greater impact on recidivism rates (hard figures to show changes).
- Using the materials daily.

- Need resources available for parolees (e.g., community residential drug programs) (n=2).
- More realistic videos (maybe have parolees in them, what is really happening in the field – some of the training components don't fit, need to relate more to offenders) (n=3).
- Using role models (or identifying persons) that parolees could relate to.
- Discuss accountability for the parolee.
- How to do prevention treatment in the office.
- Everyone should attend the training.
- Needs to be geared towards CYA staff, teachers, and parole agents.
- Good form of unity for field and institution.
- Looks and sounded good yet you can't really say what good or bad points are until it is put into action.

SUMMARY OF THE RELAPSE PREVENTION TRAINING

The CYA Institutions and Camps Branch, in conjunction with the Parole Services and Community Corrections Branch, hosted the relapse prevention training sessions across the state. The training curriculum was based on the Hazelden module on managing high risk situations, the first of six relapse prevention lessons in a packet CYA has purchased for distribution system-wide. From the observations of the training by DARC evaluation team members, and from feed-back from program participants, the training appeared to be designed as an introductory session to terminology and concepts of relapse prevention, to introduce the RSAT grant to parole staff, and to communicate the desire to have CYA personnel within the institutions and the field use relapse prevention as "the common language" linking critical components of treatment and aftercare. Overall, the response to the training was positive from the majority of those responding to the post-test questions. Participants stated that they agreed that relapse prevention is an important new strategy for supporting recovery, and they were interested in having more training in this area.

Chapter 10

REVIEW OF EFFECTIVE SUBSTANCE ABUSE TREATMENT FOR JUVENILE OFFENDERS

In order to provide a context for the summary and recommendations in the following section, this section briefly reviews the literature regarding critical components of effective substance use treatment among juvenile offenders. The treatment needs of juvenile offenders are complex and are often compounded by the presence of co-occurring disorders (e.g., conduct disorder, attention deficit hyperactivity disorder, mood disorders), maturational issues (e.g., variations in physical and emotional development, differing ages of onset and levels of addiction), physical health needs, family problems, and involvement with negative peers (Bischof, et al., 1995; Brook, et al., 1998; Chavez, DeGraffenreid Riggs, 1998; Dembo, Williams, & Schmeidler,1993; Epstein, et al., 1995; Greene, et al., 1997; Thornberry, et al., 1996; Widom,1991). Substance abuse treatment has been demonstrated to effectively alleviate many of these physical, behavioral, and social problems, as well as reduce recidivism and relapse to drug use for juvenile and adult offenders (Dembo, et al., 1993; Peters, 1993; USDOJ, 1998; Wexler, et al., 1994).

Despite the proven success of treatment and the well documented high prevalence of substance use among juvenile offenders, few juvenile justice facilities offer comprehensive treatment services to their wards (Catalano & Hawkins, 1996; CSAT 1993; Epstein, et al., 1995; Loeber & Keenan, 1994; VanKamen and Leober, 1994). The few programs that do provide treatment offer access to 12-step or other self-help modalities with random drug testing. Only a minority of programs provide comprehensive assessment of individualized case management and treatment planning (CSAT, 1993, Mulvey, Arthur, & Repucci, 1993; ONDCP, 1996). The inability of the juvenile justice system to meet the community standard for appropriate substance abuse treatment for adolescents is largely due to chronic underfunding compared to the numbers of adolescents entering the system and to competing institutional needs (e.g., security measures to prevent escape from custody (Bazemore & Terry, 1997).

Comprehensive screening and assessment are critical components of effective substance abuse treatment. Comprehensive assessment is essential for the identification of crucial physical and mental health needs, social problems, as well as substance abuse treatment needs (CSAT, 1994). Ongoing assessment is also important for developing and revising individualized treatment plans, matching wards to

treatment modalities and adjunct services, and optimizing the effectiveness of interventions (Borduin, et al., 1995; CSAT, 1994; Dembo, Williams, & Schmeidler, 1993; Lipsey, 1992; McLellan, 1998; OJJDP, 1996; Tolan & Guerra, 1994).

Model programs are structured and they use a variety of methods designed to meet the individual needs of adolescents including: (1) cognitive-behavioral individual and group counseling (to enhance motivation for and engagement in the treatment process), (2) family therapy (to elicit family support for treatment and provide an opportunity to deal with underlying family problems), (3) case management (to link to other services and oversee treatment progress), (4) random drug testing (to monitor lapses and sanction negative behavior), (5) didactic instruction (to reinforce concepts from counseling and focus on other special issues such as anger management and conflict resolution, HIV prevention, pregnancy and parenting, healthy sexuality, gang issues, among others), (6) psychiatric treatment for co-occurring psychological disorders, and (7) linkage to community-based self-help and other services (Carroll, 1998; Catalano, et al., 1991; CSAT, 1993; Daley, 1998; ONDCP, 1996; McLellan, 1998; Mercer, 1998; Mulvey, Archer, and Repucci, 1993; Stitzer, 1998; Mulvey, Archer, and Repucci, 1993; Winters & Stinchfield, 1995)

These programs develop formal policies and procedures and clearly articulate the philosophy, mission, vision, roles, treatment and documentation requirements, and policies concerning all critical program elements (CSAT, 1993). Treatment plans are individualized and counselors hold regularly scheduled meetings to review treatment progress and revise treatment plans as needed; contracts are made with clients regarding their commitment to and participation in treatment (CSAT, 1994; ONDCP, 1998). The duration of treatment lasts at least 9 months and counseling sessions occur a minimum of twice a week (Borduin, et al., 1995; Fagan, 1990; Jainchill, 1997; Lipsey, 1992; Tolan & Gorman-Smith, 1997; ONDCP, 1998).

Effective programs demonstrate the ability to collaborate and communicate well with other units within the institution, community-based agencies and other community resources that are enlisted to provide additional services to adolescents in the program (USDOJ, 1998). The programs include “meaningful” vocational education and structured school environments where teachers are well oriented to the philosophy, goals and objectives of the treatment program (DeGraffenreid Riggs, 1998). Staff training is comprehensive and ongoing and is provided by content experts in the treatment field.

Training and quality improvement are ongoing and include strategies for working effectively as part of the treatment team, providing comprehensive case management, and serving in an advocacy function (Carroll, 1998). Staff caseloads are manageable and permit adequate contact with adolescents in the program (Bazemore & Terry, 1997). Non-correctional staff ideally provide the majority of treatment within the program (Inciardi, 1998). Staff are encouraged to become certified in substance abuse treatment within their own disciplines if possible (e.g., social work, psychology) or as substance abuse counselors (CSAT, 1993). Gender issues are appropriately addressed (e.g., pregnancy, parenting, post-traumatic stress from exposure to violence and other victimization as children and adults (Barthwell, 1998). The program hires individuals who reflect the populations they serve including the presence of bilingual staff and materials when appropriate (Brook, et al., 1997; Sanders-Phillips, 1998; Szapocznik, 1998). When people in recovery are hired as staff they have the same level of training as others in program and have at least 2 to 5 years of sobriety (CSAT, 1993).

While there are many barriers to incorporating families in substance abuse treatment programs within the juvenile justice system, family counseling has proven to be an effective way to improve family communication and behavior (Liddle & Dakof, 1995; Szapocznik, 1998). Juvenile offenders frequently return to their families upon release and family counseling can be an important adjunct to substance abuse treatment that supports recovery.

Comprehensive aftercare is another critical feature of program success (Dembo, et al, 1995; Inciardi, 1996). Program graduates should become affiliated with a recovery group and other supportive services within the community to support their continued abstinence, for without this support relapse and recidivism are likely (Altschuler & Armstrong, 1992; CSAT, 1993).

Finally, effective programs accept the responsibility for determining to what extent their program is succeeding by having outside evaluators conduct outcomes evaluation. Findings from evaluation studies are used to revise and refine the treatment program (CSAT, 1993).

In summary, effective programs are holistic, highly structured, and use a number of strategies to provide substance abuse treatment. Treatment is delivered by staff who are empathetic and committed, and they provide individual, group, and family counseling using cognitive-behavioral approaches. The intensity and duration of treatment in these programs is sufficient to bring about significant psychological and

behavioral change. The ecological context in which substance abuse treatment occurs within correctional institutions poses significant challenges to providing high-quality, comprehensive and effective treatment. The CYA institutional branches have been described as the "tail end" of the juvenile justice system in California, receiving the "worst of the worst" among juvenile offenders (Little Hoover Commission, 1994). However, the CYA staff are known for the very qualities ("hard work and high ideals and the determination to provide services to wards despite budgetary cutbacks") that are associated with successful treatment outcomes (Little Hoover Commission, 1994). Hopefully, with the recent infusion of new federal funding for residential substance abuse treatment CYA's formal drug programs will now be in a position to incorporate as many of these effective program components as possible. With the growing number of juveniles entering the criminal justice system in California it is imperative that we provide the highest quality of treatment possible to this subgroup of adolescent offenders whose substance use places them at ever greater risk for serious, long term, and even life-threatening problems (Little Hoover Commission, 1994).

Chapter 11

SUMMARY AND RECOMMENDATIONS

The primary goal of the first year of this research was to document the implementation of the RSAT service enhancements at the Holton, Ventura, and Stark FDPs. Overall, the evaluators found that the three programs demonstrated fidelity to their original plans for program implementation. From our formal and informal interviews with administrators, counselors, parole agents, and wards regarding the enhanced programs, it is clear that there is a great deal of enthusiasm and optimism about the potential contribution the grant could make to reducing recidivism and relapse among drug-using wards when they are released to parole.

While they have achieved many things with the RSAT enhancements, there are a number of important challenges that lie ahead as they enter the second year of the grant, including:

- Lack of uniformity of the screening and assessment process, both within and between institutions.
- Inadequacy of staff training.
- Frequent turnover among key program staff in all three programs due to promotions, voluntary separation, and retirement.
- Concern about maintaining current levels of RSAT grant funds at each program site.
- Heavy caseloads and competing custodial responsibilities for counseling staff.

Based on the findings of this study, we recommend the following:

- Initial and ongoing screening and assessment need to be standardized and adequately funded. Procedures should also be in place to ensure that assessment results are taken into consideration when developing individual treatment plans.

- Funding should be dedicated to providing high-quality, comprehensive, and ongoing training for all staff providing treatment to wards in FDPs (see Staff Development Checklist in Appendix H).

- The intensity of individual and counseling services should be increased to recommended standards.

- Greater emphasis should be placed on recruiting staff with prior experience and/or formal training in substance abuse or a related field in health or social services.

- Additional staff should be hired (counseling and/or custody) to reduce YCC caseloads.

The three FDPs currently receiving the enhanced funding under RSAT should be fully funded so that adequate program assessment can be completed and important questions about what works, for whom, and under what circumstances can be answered. As the only RSAT-funded program for juvenile offenders, these answers will be critical to developing drug abuse treatment programs for young, drug-involved offenders in California as well as the nation.

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APPENDICES[5]

A. Youth Correctional Counselor Questionnaire
B. Semi-Structured Administrator Interviews
C. Semi-Structured Superintendent Interviews
D. Correctional Institution Environment Scale (CIES)
E. Pre- and Post-Tests for Relapse Prevention Training
F. Description of focus group participants
G. "Adolescent Drug Abuse: Clinical Assessment and Therapeutic Intervention" (Rahdert & Czechowicz, 1995)
H. Staff Development Checklist
I. Proposed Program Enhancements and Implementation Timelines
J. Overview of General Assessments Used at Each Program

[5] Appendices A-J are available upon request. If you would like to receive a copy of the appendices, please contact the California Department of the Youth Authority, Research Division: 4241 Williamsbourgh Drive (Suite 216), Sacramento, CA 95828; telephone: (916) 262-1493; ATTN: Josephine Blue.

APPENDIX A:

Youth Correctional Counselor Questionnaire

APPENDIX B:

Semi-Structured Administrator Interviews

APPENDIX C:

Semi-Structured Superintendent Interviews

APPENDIX D:

Correctional Institution Environment Scale (CIES) and Figure

APPENDIX E:

Pre- and Post-Tests for Relapse Prevention Training

APPENDIX F:

Description of Focus Group Participants

APPENDIX G:

"Adolescent Drug Abuse: Clinical Assessment and Therapeutic Intervention"
(Rahdert & Czechowicz, 1995)

APPENDIX H:

Staff Development Checklist

APPENDIX I:

Proposed Program Enhancements and Implementation Timelines

APPENDIX J:

Overview of General Assessments Used at Each Program