Evaluation of the Young Offender Model

Final Report

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EXECUTIVE SUMMARY

The Connecticut Department of Mental Health and Addiction Services (DMHAS) identified young offenders (ages 16-20) involved in substance use as a group in need of specialized substance abuse treatment. DMHAS was particularly concerned that young African American and Latino offenders receive treatment that was culturally appropriate and age specific. Therefore, the Young Offender Model (YOM) was designed to deliver culturally competent and age-specific treatment with added emphasis on motivational enhancements and methods to increase retention.

The Young Offender Model project included an outpatient treatment program built upon the cognitive self-change approach with additional psycho-educational and case management components. The 4-to-6 month program included individual, group, and family therapy; referrals for psychiatric services, drug screenings, and crisis intervention. Treatment services were provided by two community agencies, Community Solutions, Inc. (CSI) and the Alcohol and Drug Recovery Center (ADRC). Community Solutions, Inc. was located in Hartford's North End and served primarily African American clients. A satellite office of the Alcohol and Drug Recovery Center was established at the Hispanic Health Council located in Hartford's South End.

The goals of the Young Offender Model program were to provide rapid substance abuse assessment, referral, and treatment to young adults immediately upon entry into the criminal justice system, and to provide these services in a manner that was responsive to the cultural and developmental needs of this specific target population. This project aimed to provide substance abuse treatment and other supportive services to young offenders, to provide additional capacity and to promote coordination across the system of care. It was hoped that this project would have a lasting effect on the integration of services across state agencies by facilitating the identification of an appropriate service strategy that could be replicated throughout the State of Connecticut.

Evaluation Summary

The Department of Criminology and Criminal Justice at Central Connecticut State University conducted the evaluation of the Young Offender Model project. The evaluation had three areas of focus. First, the evaluators observed the referral and assessment process of CSSD and DMHAS to determine if the appropriate young offenders were being referred to treatment in a timely manner. Second, it looked at the effectiveness of the substance abuse treatment programs. Third, the evaluation attempted to assess the efficacy of the cognitive self-change model as a viable substance abuse treatment program.

Evaluation Findings

A total of 220 clients were referred to the YOM project over the four year period. Of these 220, 180 attended one of the two substance abuse treatment programs and 35

youth completed these programs. YOM participants appeared to suffer from a wide range of emotional and behavioral problems and self-defeating traits. In terms of emotional functioning, clients reported experiencing significant levels of anxiety, depression, and anger. In addition, a large proportion (30-50%) reported symptoms most associated with psychotic spectrum disorders. Substance use patterns appeared to be chronic with cannabis and alcohol being the drugs of choice. Clients did not view substance use as a significant problem worthy of treatment. Predominant traits appeared to be lack of empathy and lack of social responsibility.

The analysis of program completion for the two substance abuse treatment programs found that there was a low completion rate for both programs (21%). This completion rate became even lower when program no shows were taken into consideration (16%). The exploration of predictors of program completion found three items. These were obtaining employment while in treatment, high level of reality testing, and a high level of optimism increased clients' probability of completing the four to six month substance abuse treatment program.

Two major conclusions were drawn from this research. First, the low program completion rate for ADRC and CSI clients was discouraging. Even though this population could be considered challenging, it was reasonable to have expected a higher completion rate given the low client-to-treatment staff ratio (neither program had more than 10 clients in the program at one time and often only had five to seven), the case management services, and the myriad of resources available from the Byrne Grant funding. Second, we were unable to make conclusions regarding the efficacy of Bush's cognitive self-change substance abuse treatment model.

The low program completion may have been due to several factors. These were: (1) limited project oversight by the Department of Mental Health and Addiction Services caused by four project monitors over the four year project period; (2) lack of interagency communication between DMHAS, the Judicial Branch's Court Support Services Division (CSSD), and the Department of Children and Families (DCF); (3) high staff turnover at each of the substance abuse treatment programs and a lack of fully dedicated ADRC and CSI staff to the YOM project; and (4) there was no defined or develop curriculum for culturally competent or age appropriate treatment.

The evaluation was unable to assess the efficacy of the cognitive self-change substance abuse treatment model. This was a result of: (1) the YOM project mission was not aligned with the mission of the treatment staff; (2) treatment staff did not possess the high level of skill to properly implement this cognitive behavioral intervention; (3) the cognitive self-change program was offered to clients with little consideration given to their level of motivation to change.

The problems associated with the lack of success of the YOM project were organizational in nature, and did not reflect upon the treatment staff for either ADRC or CSI. These staff were dedicated, energetic, and caring individuals who tried to serve the best interests of their clients.

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INTRODUCTION

The Connecticut Department of Mental Health and Addiction Services (DMHAS) received a four year grant from the Federal Byrne Grant Program to pilot the Young Offender Model project (YOM), a substance abuse treatment project targeting African-American and Latino youth. The YOM project was developed from prior DMHAS research findings that young offenders with substance abuse problems were at an extremely high risk of long-term involvement with the adult criminal justice system. These young offenders, particularly African-American and Latino youth, had limited access to publicly funded substance abuse treatment programs.

The lack of adequate substance abuse treatment for Connecticut youth was further highlighted in a 1999 report published by the Connecticut Alcohol and Drug Policy Council. This report called for more detailed and accurate assessment, more timely referrals, and increased availability of treatment resources for offenders. The recommendations also consisted of the placement of substance abuse counselors in each court to provide immediate clinical assessment and referral to an appropriate treatment service. The Byrne Grant Program funding would allow DMHAS to follow the Connecticut Alcohol and Drug Policy Council's recommendations by changing Connecticut's substance abuse treatment system while increasing treatment capacity.

In addition, DMHAS was particularly concerned that young African American and Latino offenders receive treatment that was culturally appropriate and age specific. These concerns were incorporated into the Young Offender Model, which was designed

to deliver culturally competent and age-specific treatment with added emphasis on motivational enhancements and methods to increase treatment retention.

The following document is the final report of the YOM project evaluation. This report will first describe the structure of the project, as outlined by the Connecticut Department of Mental Health and Addiction Services followed by a detailed review of the substance abuse literature. The next section provides a description of the two treatment programs participating in the YOM project. The data analysis and results section will present quantitative analyses of selected psycho-social measures and program completion. The final section contains the overall evaluation conclusions, highlights several critical issues in substance abuse treatment and program implementation, and provides recommendations for future programming.

YOM Target Population

DMHAS defined the YOM target population as African-American and Latino youth between the ages of 16 and 20 years old referred from the Hartford Geographical Area Court. Hartford was chosen due to its lack of specialized treatment programs and high rates of poverty, unemployment, school dropout, and crime.

YOM Project Goals

The overall goals of the Young Offender Model project were to provide rapid substance abuse assessment, referral, and treatment to young adults immediately upon entry into the criminal justice system, and to provide these services in a manner that is responsive to the cultural and developmental needs of this specific target population. This project aimed to provide substance abuse treatment and other supportive services to young offenders, to provide additional capacity, and to promote coordination across the

system of treatment. It was also meant to have lasting positive effects on the integration of services across state agencies by facilitating the identification of an appropriate service strategy that could be replicated throughout Connecticut.

Specifically, the stated treatment goals were:

1. To expand the substance abuse treatment capacity for Latino and African-American young offenders in Hartford.
2. To reduce substance use disorders among young adults, ages 16-20, by assessing service needs immediately upon their entrance into the criminal justice system.
3. To improve the engagement of young adults in the criminal justice system by ensuring the cultural and age appropriateness of substance abuse treatment services.
4. To improve treatment outcomes by increasing retention of young offenders in outpatient treatment.
5. To help young offenders maintain treatment gains by strengthening the necessary community and family supports.
6. To end the fragmentation of the existing substance abuse treatment system for young adults.

YOM Project Activities

Intake and Assessment. A key to the success of the YOM project was the referral of appropriate clientele. In order to refer only those that are appropriate to the model, a thorough assessment and evaluation of each individuals needs was determined to be

paramount. In order to accomplish this a new DMHAS position was created under the title of "Clinical Evaluator and System Coordinator" (CESC).

The CESC was to be housed in the Hartford Superior Court and serve as a liaison between the criminal justice system and drug treatment programs. The primary focus of the CESC was to decrease or eliminate the fragmentation between select court-community sanctions and treatment/rehabilitation programs

The CESC's referral process was to consist of two parts. First, the Judicial Branch's Court Support Services Division staff would conduct a brief intake assessment of all young offenders that appear in the Hartford Superior Court and refer those young offenders needing further alcohol and other drug use screening to the CESC. Second, the CESC would conduct a thorough assessment of the clients' substance use, as well as several psychological and sociological variables, to determine the proper level of needed care. Youths' desire and motivation to seek treatment was also to be evaluated, as this was believed to influence the court's decision on the referral to treatment programs. In addition to the court, and if deemed appropriate for clients under the age of 16 years, the Department of Children and Families would be notified about other types of services the clients may be need.

DMHAS also felt that the court should receive ongoing feedback regarding the success of clients participating in YOM. Therefore, the CESC was to provide the court with a post-assessment report for each YOM participant. This report was to include information pertaining to severity of alcohol and/or drug use, family relationships, families' commitment to helping the young offender, other influences on the young

offenders decisions on substance abuse, and a plan for addressing the young offender's long-term substance abuse along with psychological and sociological treatment needs.

Substance Abuse Treatment Model. The substance abuse treatment component for the YOM project was an outpatient treatment program built upon the cognitive self-change approach (Bush, 1995, 2003) with additional psycho-educational and case management components. These programs were to last four-to-six months and were to include individual, group, and family therapy; referrals for psychiatric services, drug screenings, and crisis intervention. Treatment services were to be provided by two community agencies, Community Solutions, Inc. (CSI) and the Alcohol and Drug Recovery Center (ADRC). Community Solutions, Inc. was located in Hartford's North End and served primarily African-American clients. The Alcohol and Drug Recovery Center served Latino youth and operated out of a satellite office at the Hispanic Health Council located in Hartford's South End.

Case Management. Case management services was one of the centerpieces of the YOM project and was viewed as necessary to guarantee long term success of young offenders. The case management component was designed to coordinate services among YOM intensive case managers, court personnel, treatment staff, clinical evaluator/systems coordinator and treatment providers.

In particular, Young Offender Case Managers were funded at both treatment programs and were responsible for assessing the young offenders' needs on a continual basis, assisting in the development of a service plan in conjunction with court and community staff, linking the young offender to appropriate services, monitoring progress as part of a review team, and advocating for the needs of the Young Offender.

Interagency Cooperation. The YOM project was to be a collaborative effort between three state agencies: the Department of Mental Health and Addiction Services (DMHAS), the Judicial Branch's Court Support Services Division (CSSD), and the Department of Children and Families (DCF). In addition, a Young Offender Model Community Coordinating Committee was to be created with members from the criminal justice community (Hartford Superior Court, CSSD, and Community Partners in Action), treatment providers (ADRC and CSI), community and public health agencies (Hartford Department of Public Health, Latinos Contra SIDA), and Hispanic/Latino and African American community organizations (Hispanic Health Council, Inc., Upper Albany Neighborhood Collaborative, Inc.), and consumers (Connecticut community for Addiction Recovery). This committee would provide oversight of the program, make ongoing programmatic recommendations, and be represented on the Connecticut Alcohol and Drug Council Policy's Criminal Justice Subcommittee.

LITERATURE REVIEW

The following section provides a discussion of the theory and research underpinnings of cognitive treatment. Three of the most common and original models of cognitive restructuring are described as well as the *cognitive self-change* program that is being utilized in the YOM project. *Cognitive self-change* is compared and contrasted to these original models of cognitive intervention. In addition, characteristics of culturally sensitive treatment are reviewed followed by a discussion of the issues associated with managing contingencies or coercion to influence participation in treatment.

Cognitive Restructuring

Basic Principles of Cognitive Interventions

Cognitive restructuring is based on the hypothesis that a person's thoughts, interpretations, and self-statements about external events exert a strong influence on emotional and behavioral functioning. The goal in cognitive treatments is to help clients identify and challenge irrational and distorted thinking patterns, and assist them in constructing more adaptive belief systems. At present, there are three dominant models of cognitive restructuring: *self-instructional training* (SIT; Meichenbaum & Goodman, 1971), *Beck's Cognitive Therapy* (CT; Beck, 1964), and *Rational-Emotive Behavior Therapy* (REBT; Ellis, 1962).

Various forms of cognitive restructuring have grown out of the pioneering work of Beck (1964) and Ellis (1962) and have become increasingly popular among practitioners who work in a variety of treatment settings. All cognitive restructuring programs share several basic characteristics. As a group, proponents of cognitive

interventions propose a basic theory of psychopathology and disturbance, provide practitioners with a clear and consistent set of tools to use with clients, and support research attempts to validate the effectiveness of the interventions. In terms of basic principles and practices, all forms of cognitive intervention share the following premises (Kassinove & Tafrate, 2002):

- Humans constantly sense, perceive, interpret, and think about their experiences (past, present, and future). They are not mere reactors to the environment; rather, they actively interpret the environment. Thus, humans are also capable of thinking about their thinking.
- The nature of thinking, or the specific manner of thinking about events or experiences, has a powerful influence over feelings and behavior.
- Over time, and with repetition, thinking first becomes automatic and then inflexible. Like so many human functions, typical thinking responses become ingrained and less noticeable to us as we exhibit them. Thus, clients remain unaware of their own thinking when common triggering events appear.
- Changes in thinking are likely to be helpful in terms of reducing maladaptive emotional experiences and dysfunctional behaviors. In addition, although it is recognized that emotional and behavioral change can be accomplished by other means, it is only through changes in thinking that lasting improvement in functioning will occur.
- With increased awareness, thoughtfulness, and practice, thinking patterns can be modified. Such modifications are likely to lead to changes in emotional experiences and outward behaviors, and patterns of interactions with others.

However, rigid and ingrained thoughts are more difficult to change than are surface thoughts.

Although differences do exist in how various forms of cognitive intervention are applied to client problems, all share a belief in these basic principles. Thus, there are similarities in practice. One important similarity in terms of practice, is to help clients identify and describe specific ongoing problems or external situations also know as *activating events* or triggers. Thus, cognitive treatments as a group tend to be problem focused. Once a difficult activating (or triggering) event has been identified, the first step in using a cognitive intervention is to *conduct an assessment of what the client is thinking*. Although clients have many idiosyncratic thoughts related to adverse life events, those that are *most immediately connected to the emotional experience* are the ones that practitioners seek to identify and make explicit (Greenberger & Padesky, 1995). Some of these thoughts are conscious and persistent, and may be part of the client's report to the practitioner. Other thoughts are fleeting and may be below the level of conscious awareness. Simple strategies such as practitioner questioning, client self-monitoring, and role-playing are common strategies used to make relevant thoughts explicit.

Other basic characteristics of cognitive interventions such as collaborative empiricism, an active-directive therapeutic style, Socratic questioning, and between session homework assignments grew out of early work with primarily anxious and depressed clients (Beck, 1976; Ellis, 1962). In general these clients came to practitioners with characteristics such as a desire for help, and insight that anxiety or depression was contributing to distress and impairment. The practice styles developed were useful for

such adults. During the past 40-years, however, both Beck's and Ellis' models of treatment have been applied to a wider and ever growing range of problems. Modifications, in terms of emphasis, have been required to adequately address the unique characteristics of clients with less awareness and motivation for treatment such as those involved with the criminal justice system. Several recent reviews have found cognitive restructuring procedures to be a common element associated with successful substance abuse treatment for offenders (Leukefeld, Tims, & Farabee, 2002; McBride, Vander-Wall, Terry, & VanBuren, 1999; Wexler & Williams, 1986). Variations from the original models proposed by Beck and Ellis have been developed, and the broader term *cognitive restructuring* has been used to describe these interventions.

Three Basic Models of Cognitive Treatment

In Meichenbaum's *Self-instructional training model*, clients are taught to identify and change self-statements that lead to maladaptive behaviors, and to practice new self-statements to use when confronted with similar triggers. In Beck's *Cognitive Therapy* model clients are provided with skills to assess their typical thoughts related to negative feelings and self-defeating behaviors in order to help them perceive situations more accurately and realistically. In the work of Ellis and colleagues (*Rational Emotive Behavior Therapy*; REBT) the emphasis has been on fostering a more flexible and accepting philosophy in response to life's adversities. By helping clients become less demanding and more able to tolerate difficulties they become less likely to react with extreme emotions and behaviors. Basic characteristics of each of these cognitive approaches are outlined below.

Self-Instructional Training (SIT)

The premise of self-instructional training (SIT) is that people's verbal self-statements or instructions influence their behavior. New self-instructions can be developed; these can interrupt old thinking and behavior patterns, and also direct new responses to problematic situations (Rehm & Rokke, 1988).

In applying SIT to client problems, the practitioner would first identify situations where the client engages in problematic behaviors such as substance use. For example, the specific self-talk that the client engages in just prior to obtaining or using substances, and the relationship between the self-talk and substance use, would be discussed and evaluated. A client might reveal that prior to getting high, that he says to himself, "I just can't take feeling this way anymore! I will use just this one time so that I feel better. Besides it is not hurting anyone." Once identified, this statement would be replaced with a self-instruction likely to reduce the likelihood of use and help the client stay in control. New self-instructions are preferably developed in a collaborative fashion with the client. In this example, a new self-instruction might be, "My negative feelings always pass. Giving myself permission to use this one time makes me more likely to use again. My drug problem affects my ability to succeed." The client would practice rehearsing this new statement out loud and silently, both in and out of the sessions. Self-instructional strategies have been used for a number of clinical problems, to treat both children and adults. Additional information can be found in Meichenbaum and Cameron (1973) and Rehm and Rokke (1988).

Beck's Cognitive Therapy

As originally formulated in the 1960's, the emphasis in Beck's version of cognitive therapy was to help clients identify *distortions in thinking about the reality of life events*, and to replace those distortions with more *accurate and realistic perceptions and appraisals*. While this is still a major focus, the Beckian model has evolved to include three levels of cognitions: automatic thoughts, assumptions, and core beliefs.

Automatic thoughts. Human beings are constantly thinking and making evaluations about the world around them. Automatic thoughts are part of this ongoing inner dialogue that naturally occurs with everyone. Automatic thoughts are spontaneous and fleeting, and viewed to exist just below the level of conscious awareness. They may also take the form of images or memories. With minimal effort, most people are able to tune into this inner dialogue and identify specific thoughts as they occur moment to moment. Once brought to light, clients are taught to see how fleeting verbal messages impact on mood and behavior.

In treatment practitioners identify those automatic thoughts that are negative, distorted, and associated with strong negative emotions (e.g., anger) and self-defeating behaviors such as substance use. Similar to SIT, the initial focus is on helping clients notice the thinking that takes place when they have strong reactions and maladaptive behaviors.

Once specific thoughts are identified each is subjected to a *logical analysis* to determine whether or not interpretations about the situation are supported by available evidence. Through practitioner questioning, additional evidence for the veracity of each thought is considered, as is any alternative evidence that might contradict each thought.

The goal, thus, is to help clients think clearly and objectively about the external situation. In the final step, clients are taught to respond to their automatic thoughts with new thoughts that are more realistic and based on an analysis of available evidence.

In evaluating the client thoughts introduced in the example above, ("I just can't take feeling this way anymore! I will use just this one time so that I feel better. Besides it is not hurting anyone."), the practitioner would debate the accuracy of the thoughts with the client by asking a series of questions:

- Has telling yourself that you are going to use drugs only one time usually turn out to be true?
- Do your negative feelings last forever or do they move up and down?
- Have you ever been able to manage negative feeling without drugs?
- Does your drug use truly not harm anyone?

Through such questioning clients beliefs are weakened and ultimately replaced with more realistic and accurate appraisals. Initially, it may seem as though clients report a wide variety of automatic thoughts related to specific problematic experiences. However, in a short time practitioners are likely to notice reoccurring patterns. In addition, once the other underlying cognitions (assumptions and core beliefs) are identified, the content of automatic thoughts becomes more understandable and easier to predict (Beck, 1995).

Assumptions. Assumptions can be conceptualized as rules or attitudes that guide daily actions and also set expectations (Greenberger & Padesky, 1995). These assumptions are often not directly expressed verbally by clients, as they may themselves be unaware of them, and therefore they are not easily accessible to practitioners. Since

assumptions give rise to the automatic thoughts, one way to identify them is to make inferences from recurring themes found in automatic thoughts. Assumptions, when stated, typically take the form of "if-then" statements or "should" or "must" statements. For example, "If I let others get close then they will hurt me," or "Even if I try hard, (then) I probably won't succeed anyhow," or "I must not appear weak in front of others." Assumptions can be problematic to the extent that they are exaggerated, distorted, and maladaptive when applied rigidly across situations. Assumptions are believed to develop in response to early childhood experiences and interactions with others. Persistently negative or even traumatic experiences can lead to negative assumptions about oneself and result in negative expectations or attitudes regarding others.

Core beliefs. Core beliefs are proposed as the "deepest" or most abstract level of cognition. Core beliefs contain the most centrally held ideas related to self, other people, and the world. Negative core beliefs underlie maladaptive assumptions and distorted automatic thoughts. Thus, core beliefs may determine the way an individual automatically interprets reality, especially in ambiguous or stressful situations.

The advantage for practitioners in conceptualizing maladaptive assumptions and core beliefs lies in the larger roadmap that it provides to help direct interventions to help clients modify existing patterns. So, in addition to challenging overly negative automatic thoughts, practitioners might work behaviorally as well to "chip" away at existing patterns by providing experiences that challenge the basic ideas that drive emotional reactions and behaviors. Combining the emphasis on both thinking and behavior change has resulted in the term *cognitive-behavioral therapy*.

Ellis' Rational Emotive Behavior Therapy (REBT)

In contrast to the Beckian approach, which helps clients to more accurately perceive negative external events, the REBT approach helps clients *adjust* to events-*whether or not they have been accurately perceived*. Since clients often come into treatment with philosophies that are highly negative and rigid, they are prone to catastrophize when things go wrong, and typically think they do not have the ability to tolerate aversive situations. Thus, it is important to help place individual struggles and challenges in perspective. In that sense, the goal in REBT is to develop a lowered level of emotional reactivity through a philosophical shift about the world.

Although this approach may appear similar to Beck's Cognitive therapy, there are important differences. In the REBT model the clients' initial perceptions about the trigger and the automatic thoughts are neither debated nor challenged. Client *perceptions and thoughts about the trigger are assumed to be true* (e.g., "my teacher is out to get me."). Rather than debate the veracity of a specific thought, the practitioner explores the evaluations and meanings the client holds about the triggering event. In the REBT model, triggers are called *Activating Events*. Appraisals are called *Beliefs*, which can be rational or irrational. That is, they can be appropriate descriptors of the trigger or they can be beliefs which magnify the trigger out of proportion to reality. Finally, angry experiences and expressions are called *Consequences* in the REBT model.

The REBT intervention is aimed not at finding the truth, but at developing reasonable and moderate interpretations of the aversive situations. This is not to say that the REBT practitioner totally ignores accurate appraisals of reality. Rather, it is assumed

that reasonable interpretations about the adversities of life will lead to reduced emotional upset and an increased possibility of solving problems.

In the REBT model the four *core irrational beliefs* are labeled as *awfulizing*, *low frustration tolerance*, *demandingness*, and *global ratings (*Walen, DiGiuseppe, & Dryden, 1992). Each one has a rational alternative that assists clients in interpreting activating events in a more flexible and moderate manner.

Awfulizing is associated with the tendency to *exaggerate the consequences* or level of hardship associated with aversive events. Clients conceptualize events as *awful, horrible* or *terrible*, rather than bad, inconvenient, challenging, etc. Such exaggerations place undue focus on the negative and reduce the opportunity to generate solutions and see into the future, to a time when the event will be less meaningful in the client's life. *Awful*, *terrible* and *horrible* are very strong words that if examined carefully, really mean that everything has been lost. The goal at this stage of REBT is to show clients that such evaluations are too strong for what they usually are talking about, such as a job loss, a dating failure, infidelity, loss of money, difficulties at school, etc.

Clients also typically underestimate their ability to deal with discomfort or adversity and suffer with *low frustration tolerance*. For example, when faced with unfairness, can it be tolerated, or is it really "intolerable?" Whining about an inability to tolerate unpleasant and aversive events is rarely helpful. In fact, a better evaluation would be that while certain situations are disliked, they are nonetheless manageable. Increasing a clients tolerance for frustration fosters a problem solving orientation and increases optimism. Clients who learn to describe aversive triggers as difficult and

frustrating will do better than if they whine and moan about how they can't stand or cope with them.

Elevating personal *desires* to absolute *dictates* or unbendable rules that are imposed on the self, others, and the world is known as *demandingness.* Demandingness is reflected in client words such as *must* or *should* or *has to.* These words suggest no alternative. The goal in REBT is to teach a more flexible philosophy to clients (e.g., "That driver should signal before changing lanes" versus "It would be more considerate if that driver had signaled before changing lanes.") To simply sit back and demand that things *must* or *must not* happen just leads to emotional upset - without a solution.

The tendency to overgeneralize about people is known as *Global Self or Other Rating.* Clients *blame* or *condemn* themselves or other people "in total" for specific behavioral acts. As part of this blame, they tend to use inflammatory language (e.g., dope, asshole, idiot moron, etc.). In actuality, people do many good things and some bad things. Some people do more negative things than others. But even they do some good deeds once in a while. In REBT and many other philosophies and religions, clients are taught to look at *specific behaviors* of people and evaluate those specific behaviors accordingly.

Compared to the Beckian approach, REBT presents more philosophical positions to be addressed with the client. In addition, the practitioner is more accepting of the client's perceptions, which increases the therapeutic bond. At the same time, the goal is to encourage client acceptance of the reality that the world is unfair and that it is quite possible to tolerate most unfair events for long periods of time. These events, clients are taught, may be truly and strongly unlikable - but they are tolerable. Thus, REBT attempts

to introduce a less demanding and more tolerant philosophical view to help clients experience less distressing emotional arousal.

Similar to the Beck approach, in REBT, *irrational beliefs are disputed with the goal of teaching alternative semantically precise and rational ways of evaluating problematic triggers.* A number of methods can be used to achieve this end. The primary method of dealing with philosophical issues is through *logic (*e.g.,"Even though you don't like the negative feelings, why can't you tolerate them?"*).* Another method is to question the *functionality* of holding on to a specific position (e.g., "How does believing that you can't stand the negative feelings help you to stay in control?").

In contrast to SIT, REBT and Beck's approach hypothesize specific types of cognitions that lead to negative emotions and dysfunctional behaviors. These include misinterpretations of the external events (i.e., a tendency to interpret neutral or ambiguous situations as negative and/or malicious), demanding that unfair or unpleasant situations not exist, believing that triggers are not tolerable, exaggerating the potential hardship associated with aversive life events, and describing oneself or others in harsh, judgmental and overly critical terms. These beliefs are the targets of treatment in the latter two models.

Cognitive Self-Change (CSC)

The cognitive self-change program is a group administered cognitive restructuring intervention aimed at reducing thinking errors (or criminal thinking) among offenders in order to promote more productive behaviors. The cognitive self-change program consist of four steps: (1) *observing thinking,* (2) *recognizing particular thinking patterns that*

lead to criminal behavior, (3) *constructing alternative ways of thinking that do not lead to identified problem behaviors*, and (4) *rehearsal and practice of the new thinking skills*.

Groups are structured to include a number of components or exercises designed to accomplish the four steps noted above (Bush, 1995, 2003). Several of these exercises are described. Typically groups begin with *thinking reports*. Clients focus on identifying a specific situation that was problematic and are asked to describe it briefly and objectively. Then they are asked to list all the thoughts they recalled experiencing in the situation. In addition, clients are asked to label their emotional experiences that occurred at the time. This typically takes about 5-minutes per client. *Journal assignments* are also used to help clients learn new thinking skills in between group meetings. Journal assignments may include self-monitoring (noting anger experiences that occur weekly), additional practice with thinking reports outside of sessions, or to record efforts to use new ways of thinking. *The fearless criminal inventory* is another type of journal assignment. In this exercise clients are asked to list every time in their lives that they engaged in the problematic target behavior, reasons that they did it, and the consequences. Practitioners may also use *role-play* exercises to help clients identify problematic thinking patterns and to practice new ones.

Once clients are socialized into the model, they are asked to engage in *check-ins*. These include a description of situations where a client perceived a risk of engaging in a self-defeating or hurtful behavior. Check-ins include:

- a brief description of the event
- a report on associated thoughts and feelings
- an explanation on how these thoughts and feelings put the person at risk

- and a description of the thinking that was used or could have been used to reduce the risk.

Finally, a *relapse prevention plan* is discussed with each client prior to completing the basic cognitive self-change program. The relapse prevention plan involves three parts: identification of risk situations, descriptions of thoughts and feelings associated with risky behavior, and new thinking to reduce risk and redirect behavior.

In comparing the *cognitive self-change* model to the other models of cognitive treatment outlined earlier, *cognitive self-change* seems most similar to the *self-instructional training model* (SIT). Thoughts most associated with problematic behaviors are identified and replaced with thoughts that are likely to lead to different outcomes. Unlike REBT and Beck's cognitive therapy there are no specific types of thinking that are viewed as targets for change in CSC. In addition, there is no disputation component in the *cognitive self-change* program as is typical in both REBT and Beck's cognitive therapy. Thus, clients' current thinking is not debated or challenged. Eliminating the disputation component may help with the development of the therapeutic alliance. Challenging the beliefs of potentially unmotivated clients is likely to result in resistance. See Miller and Rollnick (1991) for a more detailed discussion of dealing with resistance with substance abusing clients. Allowing clients to see that there are two ways of thinking about a situation and having them take responsibility for exercising a simple choice as to whether or not they want to use the new thinking may help by-pass resistance associated with direct challenges.

Few studies have appeared in the treatment outcome literature on the effects of the *cognitive self-change* program specifically. Although this model has not been well validated, several early studies suggest optimism in using CSC with offender-clients. In one investigation, male offenders (n=196) released into the community participated in the cognitive self-change program and were compared to offenders from the same facility that did not receive a cognitive intervention. A significant difference in recidivism was observed between the two groups. Those receiving the CSC program had a 50% recidivism rate compared to a 71% recidivism rate for non-participants (Henning & Frueh, 1996). A second investigation examined the number of offenders who completed successful probation. Young males convicted of non-violent crimes received 10-hours of CSC during their residence at a halfway house. Offenders who received CSC had a 75% successful completion rate compared to a rate of 46% for the comparison group (O'Hara, 1997). While these studies show promise, other investigators have documented resistance in the process of self-examination and self-change in using CSC with offender-clients (Fox, 1999).

Culturally Sensitive Treatment

The Young Offender Model program was designed to deliver culturally sensitive treatment in order to maximize successful treatment outcomes. Racial and ethnic minorities tend to be less likely to seek treatment for substance abuse (Longshore, Hsieh, & Anglin, 1993; Sue, 1987), less likely to believe the treatment will be effective and less likely to complete treatment (Sue, 1987). There is increasing emphasis on providing culturally relevant treatment when dealing with racial and ethnic minority clients with mental health and/or substance abuse issues (Belgrave, Townsend, Cherry, &

Cunningham, 1997; Finn, 1994; Lee, 1997; Longshore, Grills, Annon, & Grady, 1998; Moore, 1992; Santiago-Rivera, 1995; Sue & Sue, 1990; Rowe & Grills, 1993; Terrell, 1993).

The American Counseling Association (ACA) and the Association of Multicultural Counseling and Development (AMCD) have adopted cross-cultural competencies and objectives as first presented by Sue, Arrendondo, & McDavis (1992) and later operationalized by Arredondo et al. (1996). These competencies include: the counselor's awareness of his/her own cultural values and biases; knowledge about his/her own racial and cultural heritage and how it might impact their views of normality/abnormality during the counseling process; the acquisition of skills to improve their understanding and effectiveness in working with culturally different populations; self awareness regarding their attitudes and beliefs about the racial and ethnic background of the client; knowledge about the particular group with whom they are working; and possess a working knowledge of the research and latest findings regarding the mental health and mental disorders affecting various racial and ethnic groups (Arredondo et al., 1996). Whereas there appears to be agreement in the literature regarding the importance of the broad concept of cultural sensitivity during the counseling process, there is less agreement regarding what actually constitutes effective treatment based on multicultural competencies. Several articles attempted to present ways in which counselors can be trained for multicultural competence (Arredondo et al, 1996; Arredondo & Arciniega, 2001; Arthur & Achenbach, 2002; and Stuart, 2004). Other investigators (Barrett, 2002; Thomas & Weinrach, 2004; Weinrach & Thomas, 2002, 2004) have argued that the Multicultural Counseling Competencies may actually contribute to racial discrimination

by counselors. Treatment decisions based on the race/ethnicity of the client rather than the diagnosed problem has the potential for racist treatment. Another study found that "…preference for some of the competencies varies as a function of ethnicity (Fraga, Atkinson & Wampold, 2004, p.62)". In a study using focus groups (Thompson, Bazile, & Akbar, 2004) African American participants reported that the race of the therapist was not as important as his/her understanding of the "historical issues and experiences of the African American community (p. 24)." The participants were also concerned about the therapist's socio-economic class and felt class might have a greater impact on the therapist's ability to understand their situation more than race.

Other investigators have recommended that culturally competent treatment address social stressors such as poverty and violence, prejudice and discrimination (both personal and systemic) (Harvey, Coleman, Wilson & Finney, 1999), sociocultural and sociopolitical factors such as migration and acculturation, area of residence, homelessness, language, inaccessibility of healthcare, (Canino & Spurlock, 2000; McLoyd, Ceballo, & Mangesldorf, 1997: Wyche, 2001) and their relationship to mental health and substance abuse issues. An Africentric approach would include an emphasis on rites of passage, strengthening cultural and racial identity, spirituality, and African history (Belgrave et al., 1997). Treatment involving Latino adolescents should incorporate the concepts of familism, and extended family relationships (i.e., compadrazgo, padrinos, & ahijados), respeto, and machismo into the treatment process (Thurman, Plested, Edwards, Chen, & Swaim, 2000).

In some cases the research has shown no difference between programs that emphasize a culturally relevant component and those that do not (Wooldredge, Hartman,

Latessa, & Holmes, 1994). However, others have shown positive effects related to the incorporation of a culturally sensitive treatment component. In one study (Forgey, Schinke, & Cole, 1997), there was no difference in the effectiveness of drug prevention programs immediately following the intervention, however, two years following the treatment, those students in the culturally competent program were less likely to drink and expressed an intention to drink less than comparison group students.

Puerto Rican (Brook, Whiteman, Balka, Win, & Gursen, 1998) and African American (Brook, Balka, Brook, Win, & Gursen, 1998) youth aged 16-24 with strong ethnic identity were less likely to succumb to the risks associated with substance use.

Brook, Whiteman, Balka, et al. (1998) found that Puerto Rican youth who reported strong identification with Puerto Rican culture, i.e., "Hispanic awareness, language preference, ethnic identity achievement" and "belonging to one's cultural group" offset such risk factors as peer acceptance of drug use, father's drug use, and drug availability.

Contingency Management / Coercion

Managing the contingencies (reinforcements and punishments) related to participation in treatment is often a crucial consideration when working with criminal justice clients. Such contingencies often take the form of client choice (e.g., complete a treatment program or return to prisons; participate in treatment or pay a fine; enroll in a treatment program and receive a better living situation). In maximizing the effects of contingencies, practitioners first create choices that reinforce and reward change and ignore or punish the continuation of criminal behavior. Also, to be effective it is useful for practitioners to clearly present the contingencies to clients, allow the responsibility for

the decision to rest with the client, and to remind clients frequently of the outcomes of their choices.

Perceived legal pressure was a strong predictor of retention for offenders who chose drug treatment over other legal sanctions. Moreover, the stronger the perceived legal sanction, the more likely the offender would remain in treatment (Young, 2002). Since retention is such an important predictor of successful treatment outcomes, the longer a client stays in treatment the greater chance for success (Prendergast, Farabee, Cartier, & Henkin, 2002). Farabee, Prendergast, & Anglin (1998) reviewed eleven studies of coerced treatment for criminal offenders in a variety of settings. These researchers concluded that with few exceptions, clients did as well as or better than clients with little or no legal pressure to participate in substance abuse treatment. In a recent study, Prendergast et al. (2002) compared inmates who voluntarily participated in a prison based substance abuse treatment program with inmates who involuntarily committed to a prison based treatment program. These researchers found no difference on measures of psychosocial functioning, rates of parole from the program, and intention to participate in community treatment following release from prison. However, as Prendergast et al. (2002, pp. 22-23) points out, "Involuntary clients change not because they are coerced into treatment but because as a result of coercion they remain in treatment long enough to become engaged in various treatment activities that help facilitate change."

Summary of Major Points from the Literature

The Young Offender Model program is an outpatient culturally sensitive substance abuse treatment program for youthful offenders based on the cognitive self-

change approach (Bush, 1995, 2003) with additional psycho-educational and case management components. The cognitive self-change approach is rooted in cognitive restructuring and involves helping clients change irrational and distorted thinking patterns. Clients work to develop new thinking patterns that are less likely to lead to risky behavior.

It was believed that culturally competent treatment would decrease client drop out rates and increase successful treatment outcomes. The Young Offender Model program was committed to the delivery of treatment in a manner that respects the cultural background of its clients. Finally, contingency management/coercion can be an effective tool to increase client retention particularly when dealing with an offender population.

YOM PROJECT COMPONENTS

There were two primary components of the YOM project. The first component consisted of creating a DMHAS staff position (the Clinical Evaluator and Systems Coordinator) and the second component was comprised of two substance abuse treatment programs (Community Solutions Inc., and Alcohol and Drug Recovery Center). The following section provides an overview of these project components along with a summary of clients who participated in the YOM project and the services provided by each program component.

Description of the Referral Process

The Clinical Evaluator and Systems Coordinator (CESC)

The DMHAS staff in this position was required to possess a Masters' Degree in either psychology or counseling, have a multicultural background, and be bilingual. The main functions of the CESC were to identify, assess, and recommend potential clients to the two YOM substance abuse treatment programs. In making these referral recommendations, the CESC focused on specific populations, age groups, races, and drug treatment related challenges. Another function of the CESC was to act as a liaison between the criminal justice system and drug treatment programs.

The daily activities of the CESC included:

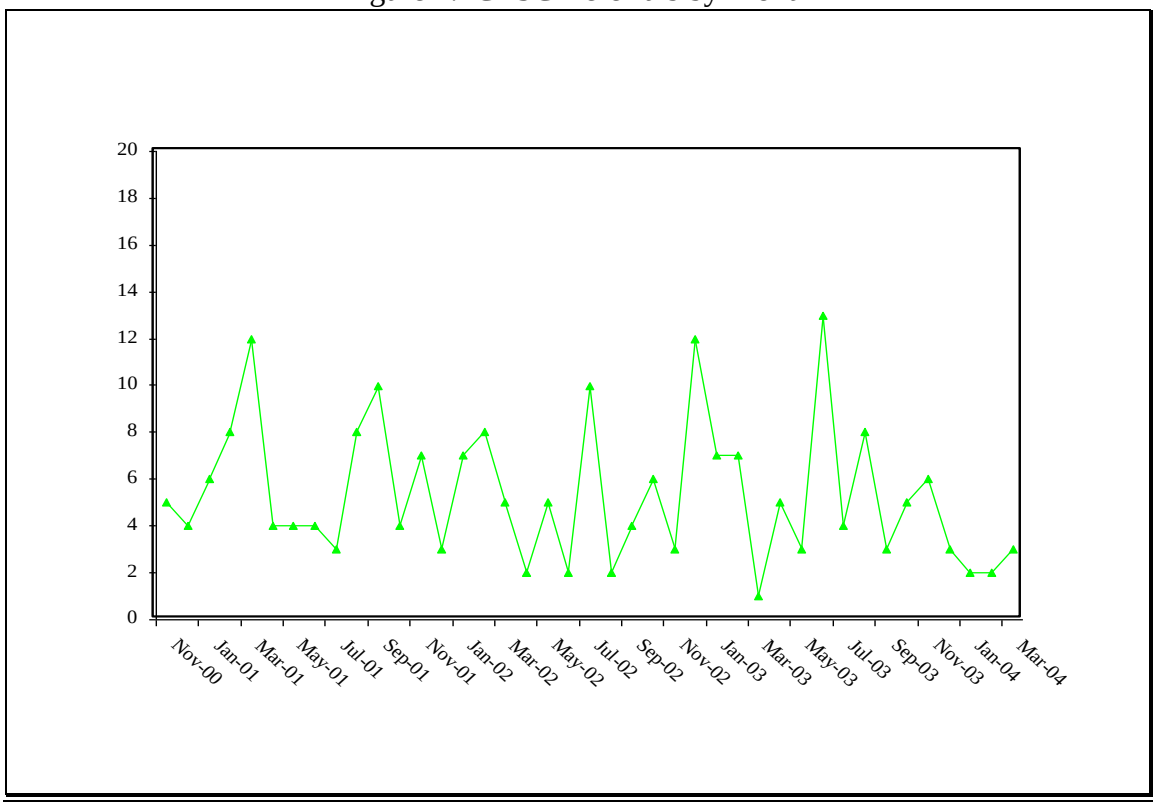
- Identification of potential clients from court documents and contacts within the court system.
- Contacting and informing clients, probation officers, or other court officers about the YOM project.

- Initial client intake and assessment at court.
- Referring clients to the appropriate YOM substance abuse treatment program.
- Collecting ongoing program information from the two YOM substance abuse treatment programs.

Program Referrals

A total of 220 clients were referred by the CESC to the two YOM substance abuse treatment programs over the four year project funding period (Figure 1). The CESC averaged 5 referrals per month with a high of 13 (June 2003) and a low of 1 (March 2003). The mode number of CESC referrals was 4 per month.

Figure 1. CESC Referrals by Month



The majority of program referrals were from probation officers (57%) followed by court referrals (23%). Several clients (19%) were referred from other sources such as

community-based programs, the Department of Children and Families, and CSSD sponsored programs. The percentage of referrals from probation, court, and other sources was equally distributed for ADRC and CSI.

Table 1. Sources of Program Referrals

	ADRC	CSI	Total
Court	28 (23%)	22 (22%)	50 (23%)
Probation	70 (57%)	56 (57%)	126 (57%)
Other	23 (19%)	19 (19%)	42 (19%)
Unreported	1 (1%)	1 (1%)	2 (1%)
Total	122	98	220

Of the 220 program referrals made by the CESC, 39 clients (18%) failed to show up to the substance abuse treatment programs for intake (Table 2). These program "no shows" were fairly equally distributed across the different referral sources. The highest percentage of no shows were referred from probation (38%) followed by court referrals (31%), and referrals from other sources (28%). ADRC had a slightly higher percentage of no shows than CSI (19% and 16% respectively).

Table 2. Program No Shows by Referral Source

	ADRC	CSI	Total
Court	7 (30%)	5 (31%)	12 (31%)
Probation	10 (43%)	5 (31%)	15 (38%)
Other	5 (22%)	6 (38%)	11 (28%)
Unreported	1 (4%)	0 (0)	1 (3%)
Total	23	16	39

Community Solutions Inc.

Social, State, Political, and Economic Context of the Program

Community Solutions Inc., was located in Hartford's predominantly African-American area of the North End. This area had a population of approximately 2,300 residents with the racial make-up being 69% African-American and 10% white (21% of the North End population were of other races or unknown). Additionally, 23% of the residents were of Hispanic ethnicity (U.S. Census, 2002).

Close to one-third (32%) of the population in the North End were at or below the poverty level and employment rates were 47% for males and 54% for females. The per capita income was $11,482 (U.S. Census, 2002).

Program Description

Staff. The program was funded to staff a substance abuse counselor and case manager positions. The DMHAS requirements for the substance abuse counselor were a Masters' Degree in psychology (or related social science field) and appropriate certification (Certified Drug and Alcohol Counselor). The case manager was required to possess a Bachelors' Degree in psychology (or related social science field) and be a Certified Drug and Alcohol Counselor. Both staff positions were expected to be culturally competent even though there were no established criteria for cultural competence.

Staff turnover was a significant problem at CSI. Since the inception of the program, two of the counselors vacated their positions. The first left CSI in July of 2002 and the second September 2003. This position remained vacant from September 2003

until the end of the YOM project. During this time the counselor responsibilities were performed by the case manager.

Staff training in cognitive self-change treatment. Throughout the project the counselors received *cognitive self-change* training and follow-up training with Dr. Bush. On several occasions Dr. Bush observed and modeled procedures onsite and provided feedback. Counselors and case managers found the training to be adequate but felt it was unnecessarily redundant. They believed the trainings needed to be more advanced to deal with the obstacles that are prevalent with this population. The staff members stated that they had a thorough understanding of the model but not how to apply it and make it relevant to the types of issues mentioned in the client groups.

Facility and participants. CSI was located in a predominately residential African-American neighborhood. The treatment groups took place in a small carriage house located behind a renovated Victorian residence housing the administrative offices for CSI. A total of 114 youth were referred to CSI over the four year project period with 98 showing up for treatment. Most the youth were African-American males, (89 male, 9 females). Their ages ranged from 16 to 22 years old with the average age being 18.5 years.

Treatment component. The clients would meet two evenings per week for two hours. The first hour was devoted to the cognitive self-change group sessions. Participants would check-in and review a situation or activating event that is related to getting into trouble. The second hour employed a psycho-educational approach based on solving relevant problems of group members. The second hour was also used for recreation (e.g., watching movies, playing basketball, etc.). The goal was to help clients

deal with practical problems they commonly face and to allow them to have fun when sober.

Case management activities. In addition to the CSC group therapy, clients were provided with assistance in several areas. Case managers and counselors assisted clients in obtaining and maintaining employment, enrolling and maintaining enrollment in educational classes (in both high school and technical classes), locating and securing enrollment in mental health services when deemed necessary, and other support services including transportation to and from YOM group sessions, necessary appointments, and home visitations.

Tables 3 and 4 summarize the amount of treatment and case management services provided to CSI participants. Clients averaged 134 days in the program with the average CSI client participating in 15 cognitive self-change and psycho-educational sessions.

Table 3. Services Provided to CSI Program Participants

	CSI (n = 98*)
Average Days in the Program	134
Average Number of Journal Reviews	0
Average Number of Cognitive Self-Change Sessions	15
Average Psycho-Educational Sessions	15
Average Individual Sessions	3
Average Other Sessions	0

*Does not include the 16 CSI no shows who received no services

The primary case management services provided to clients at CSI were 'other services'. These include such things as providing transportation for clients, assistance in resume writing, development of employment interviewing skills, and general life skills advice. Further, the case manager focused on re-enrolling clients back into school or assisted them in staying in school.

Table 4. CSI Case Management Services Provided

	CSI (n = 98*)
Family Services	7
Obtained Employment	8
Maintained Employment	10
Enrolled in School	19
Maintained School Enrollment	20
Mental Health Services	2
Other Services	53

*Does not include the 16 CSI no shows who received no services

Alcohol and Drug Recovery Center

Social, State, Political, and Economic Context of the Program

The Alcohol and Drug Recovery Center was selected for this project due to its location and prior work within Hartford's Latino community. This program was set in Hartford's South End, which had a population of approximately 5,800 people, of which 53% were Hispanic/Latino ethnicity (U.S. Census, 2002). Similar to Hartford's North End, this area had a high poverty rate (28%) and a low employment rate (23% of males and 45% of females were employed). The per capita income for this area was $12,448 U.S. Census, 2002).

Program Description

Staff. Similar to CSI, ADRC was provided funding to staff a substance abuse counselor and a case manager position. The DMHAS requirements for the substance abuse counselor was a Masters' Degree in psychology (or related social science field) and appropriate certification (Certified Drug and Alcohol Counselor). The case manager was required to possess a Bachelor's Degree in psychology (or related social science field) and be a Certified Drug and Alcohol Counselor). Both staff positions were expected to

be culturally competent even though there were no established criteria for cultural competence.

ADRC also had problems with staff turnover. The case manager left the position on medical leave midway through 2003 and did not return for four months. There was no temporary case manager assigned to assist the counselor, so that person functioned as counselor and case manager. Once the case manager returned, she was only there for one month before permanently leaving the position. The position remained vacant for the remainder of the program.

The counselor earned a Bachelor of Arts degree in Human Services. Although this was her first counseling position, she was a case manager for dually diagnosed substance abusers prior to obtaining this position. The case manager was working toward his undergraduate degree in criminal justice while employed at ADRC. He did have previous work experience with adolescents in a residential setting.

Staff training in cognitive self-change treatment. The counselor received cognitive self-change training with CSI staff as well as follow-up training with Dr. Bush. The case manager also had training with Dr. Bush. The counselor and the case manager found the training adequate and were happy to receive it. Dr. Bush also observed and modeled procedures onsite during the group sessions. ADRC staff members received feedback from Dr. Bush.

Facility and participants. ADRC's treatment center was located near the South End of Hartford. It was previously situated in a small office located in the basement level of an office and apartment building but relocated to a much larger first floor location. There were 122 referrals to ADRC with 99 showing up for treatment. All of the youth

were Latino and most were males (107 males and 15 females). Their ages ranged from 16 to 22 years old with the average age being 18.5.

Treatment component. Two groups met for two hours twice per week, one in the morning and the other in the evening. The evening group was more popular and usually had an average of five participants. Clients were supposed to commit to one group and not alternate between the two.

The first hour of the sessions focused on the *cognitive self-change* model. Participants would check-in and review a situation or activating event that was related to getting into trouble. The second hour was devoted to the psycho-educational component of the treatment and was focused on solving relevant problems of group members and also could be recreational (e.g., drug education, STDs, watching movies, going out to lunch, etc.). However, treatment staff attempted to bridge the psycho-educational issues to the cognitive self-change model.

Case management activities. Similar to CSI, ADRC case management activities consisted of providing a variety of assistance in addition to the weekly group sessions. These generally consisted of obtaining and maintaining employment, enrolling and maintaining their enrollment in school, locating and securing mental health services, and providing transportation to YOM group sessions and to other appointments.

ADRC program participants averaged 120 days in the program before completing or leaving the program (Table 5). During this time the average client received 16 cognitive self-change and psycho-educational sessions.

Table 5. Services Provided to ADRC Program Participants

	ADRC (n = 99*)
Average Days in the Program	120
Average Number of Journal Reviews	0
Average Number of Cognitive Self-Change Sessions	16
Average Psycho-Educational Sessions	16
Average Individual Sessions	6
Average Other Sessions	0

Table 6 presents the amount of case management services provided to program participants at ADRC. The primary case management services provided to clients at ADRC are 'other services' (e.g., providing transportation for clients, assistance in resume writing, development of employment interviewing skills, and general life skills advice).

Table 6. ADRC Case Management Services Provided

	ADRC (n = 99*)
Family Services	27
Obtained Employment	14
Maintained Employment	21
Enrolled in School	29
Maintained School Enrollment	26
Mental Health Services	25
Other Services	86

`*Does not include the 23 ADRC no shows who received no services

EVALUATION METHODOLOGY

The purpose of the evaluation was to assess the efficacy of the Young Offender Model project. The evaluation was centered on two major research questions. These were: (1) were the appropriate youth referred to the ADRC and CSI in a timely manner; and, (2) did the treatment model produce short term and long term effects on substance use of young offenders. The following section presents an overview of the evaluation methodology, including a summary of the evaluation design, recruitment of study participants, data, and instruments.

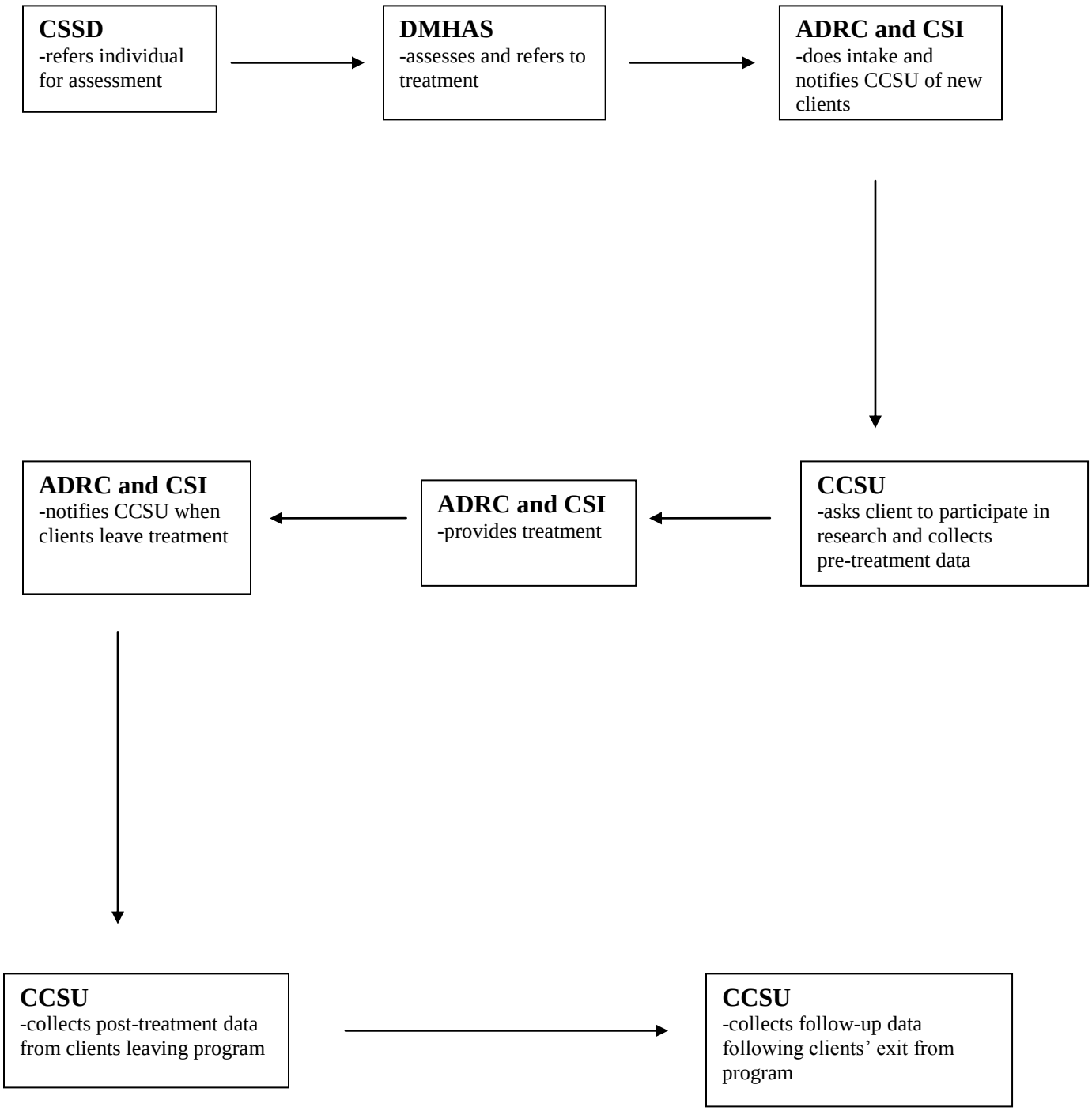
The evaluation was developed with a quasi-experimental research design. That is, data were to be collected from youth as they entered the programs, as they left the programs, and three to six months after they left the programs. A comparison group was constructed of youth being adjudicated who had not been referred to the either program (this assesses the referral process by comparing youth referred to treatment to youth not referred).

Study Participants

Recruitment of Treatment Group Study Participants

Figure 1 provides a flowchart of contacts with YOM participants by court staff, DMHAS staff, treatment staff, and evaluation staff. The DMHAS Clinical Evaluator and Systems Coordinator (CESC) was the gatekeeper into the YOM project. This individual reviewed court dockets and spoke with court officials to determine the appropriate youth to refer to the two treatment programs (ADRC and CSI).

Figure 2. Young Offender Model Case Flowchart



Once the individual was referred to a treatment program, ADRC and CSI conducted standard program intake procedures and were to notify CCSU evaluation staff of new clients. Evaluation staff would meet with new clients at the program site and ask them to participate in the research study. (The client was under no obligation to participate in the research and was still be allowed to go to treatment if he/she refused to be in the CCSU research.) If the client agreed to be in the study, evaluation staff collected pre-treatment data from them.

Once admitted, clients would then attend the treatment program. When clients left the programs, either through completion or by dropping out, ADRC/CSI staff were to notify evaluation staff. Evaluation staff would collect additional information.

Recruitment of Comparison Group Study Sample

A comparison group was created to assess the efficacy of the client referral process. That is, do the youth referred to the YOM project reflect the general population of youth in Hartford Superior Court. Court Support Services Division staff assisted in the recruitment of this group. The comparison group was developed by matching the treatment group in several areas including age, gender, and ethnicity. Evaluation staff, in conjunction with CSSD staff, asked probation officers to refer clients meeting the defined characteristics. The clients were told that CCSU was conducting research concerning the development of programs to meet the needs of young offenders. The clients were given a flyer describing the research project and an appointment was scheduled for clients and evaluation staff to meet in the offices of CSSD. These clients were asked to complete the same paper and pencil tests as the treatment group.

Description of Treatment and Comparison Group Study Sample

A total of 220 clients were referred to the substance abuse treatment programs. Thirty nine (39) failed to report to the programs. There were 181 clients who completed the program intake process and 110 were referred to evaluation staff and 71 were not referred to evaluation staff. There were a number of reasons clients were not referred to evaluation staff. They may have attended one or two sessions and then dropped out or they may have refused to meet with evaluation staff. Of the 110 who were asked if they wanted to participate in the research, 56 agreed and completed pre-treatment paper and pencil tests and 54 declined to be in the evaluation.

Of the 181 clients who completed the intake process, 35 completed the program. Of the 56 clients who agreed to complete pre-treatment paper and pencil tests, 23 completed the program, but only 15 completed post-treatment paper and pencil tests. Of the 15 clients who completed post-treatment paper and pencil tests, evaluation staff were only able to locate 2 clients who completed the follow-up paper and pencil tests.

The Addiction Severity Index was administered to 37 ADRC clients and 19 CSI clients along with 30 comparison group participants. The average education level across the three groups was 10 years, with CSI clients having a lower percentage (5%) of clients enrolled in school than ADRC (14%) and the comparison group (14%). Employment and unemployment rate percentages among the ADRC and CSI treatment groups were relatively similar, while the comparison group had a much higher part-time employment percentage (62%) and a much lower unemployed percentage (17%) than ADRC (35%) or CSI (37%). The majority of participants in all three groups reported living with their parents or family, with CSI as the highest (95%), followed by the comparison group

(79%), and then ADRC (68%). ADRC had the highest percentage living with a significant other (14%) when compared to CSI (5%) and the comparison group (3%).

Table 7. Social Conditions within Addiction Severity Index

	ADRC (n=37)	CSI (n=19)	Comparison (n=29)
Average Years of Education	9.54	10.53	10.3
Currently in School	5 (14%)	1 (5%)	4 (14%)
Employment Pattern			
Full-time	9 (24%)	4 (21%)	6 (21%)
Part-time	12 (32%)	5 (26%)	18 (62%)
Not employed	13 (35%)	7 (37%)	5 (17%)
Unknown	3 (8%)	3 (16%)	0 (0)
Living Arrangement			
Significant other	5 (14%)	1 (5%)	1 (3%)
Parents or family	25 (68%)	18 (95%)	23 (79%)
Friends	1 (3%)	0 (0)	3 (10%)
Alone	2 (5%)	0 (0)	1 (3%)
Unknown	4 (11%)	0 (0)	1 (3%)

Table 8 shows self-reported arrest data for all three groups both for 'ever arrested' and 'average number of times arrested' portion of the Addiction Severity Index. ADRC participants had a significantly lower number of arrests for shoplifting and vandalism (8%) than participants from both CSI (21%) and the comparison group (24%), but a higher number of probation and parole violations arrests (22%) than CSI (16%) and the comparison group (14%). Arrests for drug charges, weapons offenses, burglary or larceny, and disorderly conduct were all higher percentages in the treatment groups (ADRC and CSI) than in the comparison group. CSI had the highest rate of robbery (21%), and the comparison group had the highest rate of assault (55%) of all three groups.

Table 8. Criminal History within Addiction Severity Index

	ADRC (n=37)		CSI (n=19)		Comparison (n=29)	
	Ever	Number	Ever	Number	Ever	Number
Shoplifting/vandalism	3 (8%)	2	4 (21%)	2	7 (24%)	3
Probation/parole violations	8 (22%)	1	3 (16%)	1	4 (14%)	1
Drug charges	25 (68%)	2	15 (79%)	2	14 (48%)	1
Weapons offenses	9 (24%)	1	5 (26%)	1	1 (3%)	1
Burglary/larceny	12 (32%)	1	8 (42%)	1	8 (10%)	1
Robbery	3 (8%)	1	4 (21%)	1	1 (3%)	1
Assault	9 (24%)	3	5 (26%)	1	16 (55%)	1
Rape	0 (0)	0	0 (0)	0	0 (0)	0
Disorderly conduct	6 (16%)	1	3 (16%)	2	2 (7%)	5

When comparing the number of months incarcerated between the three groups, CSI had a higher average rate per participant (8.5 months) than ADRC (5 months) or the comparison group (1.9 months)(Table 9). ADRC and CSI were relatively similar in percentage awaiting trial for a current charge (ADRC 27%, CSI 26%).

Table 9. Incarceration and Current Charges within Addiction Severity Index

	ADRC (n=37)	CSI (n=19)	Comparison (n=29)
Months incarcerated in life	5	8.5	1.9
Awaiting trial for current charges	10 (27%)	5 (26%)	0 (0)

Data and Instruments

Two primary types of data were collected for this evaluation. First, evaluation staff administered several paper and pencil tests to clients as they entered the substance treatment programs, as they completed these programs, and six months after program completion. The second data source was program tracking records maintained by the Clinical Evaluator and Systems Coordinator.

Evaluation Assessments

The paper and pencil tests consisted of a modified version of the Addiction Severity Index, Brief Symptom Inventory, the BarOn Emotional Quotient Inventory, and the Trait Anger Scale.

Addiction Severity Index (ASI). Administered in a structured interview format, this instrument included information on medical, psychiatric, social, legal, and occupational problems experienced by each participant.

BarOn Emotional Quotient Inventory (E-QI). The BarOn Inventory was a 133-item test containing the subscales: emotional awareness, assertiveness, self-regard, self-actualization, independence, empathy, interpersonal relationships, problem solving, social responsibility, reality testing, flexibility, impulse control, stress tolerance, happiness, and optimism.

Trait Anger Scale (TAS). The Trait Anger Scale was a 10-item scale measuring individuals' propensity to experience and express anger.

Brief Symptom Inventory (BSI). The BSI was a 53-item self-report symptom inventory that reflects psychological symptom patterns of common emotional and behavioral problems. In addition to providing a global index of reported symptoms, the BSI measures symptoms in the following discrete areas: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism.

Program Records

CSI and ADRC staff submitted monthly progress reports to the Department of Mental Health and Addiction Services that summarized the services provided to clients

during the previous month. This information includes the date of program referral, date of program intake, date the client left the program, the number and types of services provided, and whether the clients were discharged and reasons for any discharges.

Problems Hindering Data Collection

Several problems occurred over the project period that limited the amount of data collected for the evaluation. Of the 220 young offenders referred to the YOM project, pre-treatment data was collected on 56 clients (25%), we were able to collect post-treatment data on 15 of these 56 clients (27%), and we were able to collect six month follow-up data on two of these clients. The lack of collected data can be attributed to unmotivated clients, poor communication between substance abuse treatment staff and evaluation staff, and a transient clientele. The common and reoccurring data collection problems are stated below.

Clients:

- Clients failed to show up for initial or subsequent intake dates.
- Clients appeared at the initial group or group sessions, but left the program without returning (substance abuse program staff did not notify evaluation staff of new clients in a timely manner).
- Clients had an appointment to meet with evaluation staff and did not show up for that appointment.
- Client stated that he/she would participate, but was too tired to participate at that time. When evaluation staff returned to conduct the interview at a time of their choosing, the client was again be too tired or refused to participate.

- Client was under the influence of alcohol or drugs so the interview could not be performed.

Substance Abuse Treatment Program Staff:

- Counselors did not inform evaluation staff of potential clients until the clients had been in the program for an extended period of time.
- Counselors informed evaluation staff that there were no clients to interview during a session, but evaluation staff found out later that there were clients to interview.
- Counselors held sessions for the clients where evaluation staff were unable to conduct interviews (bowling, movie days, other recreational outings, etc.).
- Clients were often not included on the official tracking forms, hindering evaluation staff from seeing if there may be potential clients to interview.
- Counseling sessions were cancelled unbeknownst to evaluation staff.
- Counselors were discouraging clients from participating in the evaluation.

Follow Up Interviews

- Clients moved away from known residence following the program without leaving new contact information with counselors or the court system.
- Clients changed phone numbers without informing treatment staff.
- Programs were initially reluctant to give information to evaluation staff concerning phone numbers and addresses.
- Clients were not informed about the follow-up interviews by treatment staff.
- Evaluation staff were not notified of clients' program completion until after they had left the program.

Data Analysis and Results

The following section presents the findings of the evaluation data analysis. This section contains three components. The first component summarizes the pre-treatment paper and pencil tests for the participants in the two substance abuse treatment programs to provide a profile of YOM participants. The second component involves a program completion analysis. This quantitative analysis utilizes program records and pre-treatment paper and pencil test results to determine what influences YOM clients' completion or noncompletion of CSI and ADRC. The third component provides a summary of the clinical consultant's reports of the cognitive self-change treatment groups.

Pre-Treatment Assessments

Brief Symptom Inventory (BSI). The co-occurrence of substance use with a variety of other emotional and behavioral disorders is a well-known phenomenon in juvenile justice drug treatment that can affect the retention and success of program participants (Dembo, Livingston, & Schmeidler, 2002; Dembo, Schmeidler, Nini-Gough, & Manning, 1998; Hiller, Knight, & Simpson, 1996; Tims, Hamilton, Dennis, Godley, & Funk, 2000 cited by Tims, Leukefeld, & Farabee, 2002). Comorbidity patterns for participants in the present program are presented in the table below. In examining the frequencies of individuals who met the cutoff score ($T > 63$) on the BSI for experiencing significant distress, the overall pattern indicated that participants suffered from a range of additional psychopathology. In addition to substance use problems, ADRC clients suffered from an average of 3.8 disorders, while CSI clients experienced an average of

2.9 disorders. It appeared that ADRC recruited participants who had higher levels of distress and comorbid psychological symptoms.

In terms of the specific types of problems experienced by clients, all the symptom dimensions measured by the BSI were represented (Table 10). At ADRC, over 40% of the clients reported significant anxiety symptoms (obsessive compulsive, anxiety, & phobic anxiety) and 24% reported a significant mood problem. At CSI, anxiety related difficulties were also commonly reported with 38% of clients indicating obsessive and phobic symptoms and 13% reporting somatic symptoms of general anxiety. A higher percentage (38%) reported significant depressive symptoms. Of particular concern for participants at both sites, was that over one third of the sample scored in the clinical range on *psychoticism* and greater than one half of the participants scored in the clinical range on the dimension of *paranoid ideation*. This indicates that a significant portion of participants may suffer from interpersonal alienation, suspiciousness, and possibly delusions. Individuals who suffer from a psychotic spectrum disorder may not be appropriate for group outpatient treatment. Such clients are likely to have difficulty labeling emotional experiences and may suffer from disorganization in thinking. Individuals with psychotic symptomatology are likely to require a higher level of supervision and additional treatment components such as medication support.

Table 10. Number and Percentage of YOM Participants Meeting Criteria for BSI Disorders

Symptom Dimensions	ADRC (n=29)	CSI (n=13)
Somatization	8 (28%)	1 (8%)
Obsessive Compulsive	14 (48%)	5 (38%)
Interpersonal Sensitivity	13 (45%)	1 (8%)
Depression	12 (24%)	5 (38%)
Anxiety	10 (41%)	3 (13%)
Hostility	10 (41%)	4 (31%)
Phobic Anxiety	14 (48%)	5 (38%)
Paranoid Ideation	17 (59%)	9 (69%)
Psychoticism	13 (45%)	5 (38%)
Global Severity Index	15 (52%)	4 (31%)

Trait Anger Scale (TAS). For some of the participants, anger also emerged as a clinically relevant co-occurring problem. The mean Trait anger scores for ADRC clients was 21.47 (range 11 to 36) and for CSI clients was 22.15 (range 10 to 36). The level of anger reported indicates that clients at both sites were angrier than 76% of normal adults. However, when compared to an adolescent standardization sample, participants were angrier than approximately 40% of normal adolescents. Thus, depending on the participant's age, anger control may be viewed as a specific concern. More latitude may be given to younger clients, as emotional control is still being developed, whereas for older clients anger related difficulties may be viewed as being more problematic.

Emotional Quotient Inventory (EQ-I). Participant's EQ-I scores were compared to the standardization sample to describe average areas of weakness in interpersonal and emotional skills for clients at both sites (Table 11). Several areas of deficit emerged. Both ADRC and CSI clients reported poor development in the interpersonal areas of *empathy* and *social responsibility*. In terms of empathy clients reported a lack of awareness of others feelings and an inability to understand why others might feel the way they feel. In terms of social responsibility, clients have difficulty with cooperation,

responsibility, and contributing positively to members of their larger social group. As a group, ADRC clients reported additional deficits. More difficulties in interpersonal functioning would appear consistent with the higher rates of reported psychopathology of clients at this site. ADRC clients reported deficits in *self-actualization* (difficulty becoming involved n pursuits that lead to meaningful and rich lives), *interpersonal relationships* (low capacity for intimacy), *problem solving* (not adept at recognizing and defining problems and generating alternative effective solutions), and optimism (difficulty maintaining a positive attitude in the face of adversity).

Certainly, a larger sample of clients would be necessary to identify with more confidence specific areas of skill deficit. The above areas are presented as hypotheses related to clients' needs that may be considered targets of intervention programs. Such deficits can be directly addressed in the psycho-educational programming that is provided to clients. For example, treatment modules can be targeted at increasing empathy, making positive social contributions, and developing problem solving skills. In addition, areas of deficit can be addressed through cognitive restructuring in terms of examining clients' thinking patterns that contribute to poor performance in these areas. New thinking likely to lead to improvement can be highlighted.

Table 11. Mean EQ-I Subscale Scores.

	ADRC (n=31)	**CSI** (n=19)
Self-Regard	97.84	102.74
Emotional Self-Awareness	88.03	100.26
Assertiveness	92.94	104.00
Independence	95.06	103.84
Self-Actualization	**84.13**	91.47
Empathy	**77.39**	**72.16**
Social Responsibility	**78.35**	**76.58**
Interpersonal Relationship	**82.87**	89.95
Reality Testing	85.23	96.63
Flexibility	93.30	101.74
Problem Solving	**79.74**	89.47
Stress Tolerance	91.10	97.89
Impulse Control	91.97	96.63
Optimism	**83.87**	86.74
Happiness	92.81	90.74

* Provided in Standard scores (X = 100; SD = 15)
**Scores below 85 represent emotional skill deficits.
***Scores greater than 115 suggest significantly well developed emotional skills.

Addiction Severity Index (ASI). Table 12 displays the drugs used by clients at both program sites as well as the comparison group. Substance use patterns were wide-ranging with all drug categories represented. At both ADRC and CSI, marijuana use was the most common with over 75% of clients reporting cannabis use at some point in their lives. Approximately 70% of clients at both sites also reported alcohol usage. ADRC clients reported a higher incidence of heroin and cocaine use compared to their CSI counterparts. Comparison subjects reported similar use patterns with the exception that alcohol use was more common than cannabis.

Table 12. ASI Substance Use History

	ADRC (n=37)		CSI (n=19)		Comparison (n=29)	
	Ever	Age of Onset	Ever	Age of Onset	Ever	Age of Onset
Alcohol	26 (70%)	16	13 (68%)	14	27 (93%)	12
Heroin	4 (11%)	16	1 (5%)	*	6 (21%)	16
Methadone	1 (3%)	*	0 (0)	0	4 (14%)	15.5
Opiates	2 (5%)	15	2 (11%)	14	0 (0)	0
Barbiturates	0 (0)	*	1 (5%)	17	0 (0)	0
Cocaine	8 (22%)	16	1 (5%)	17	8 (28%)	16
Amphetamines	4 (11%)	16	1 (5%)	20	3 (10%)	17
Cannabis	28 (76%)	14	15 (79%)	12	24 (83%)	14
Hallucinogens	7 (19%)	15	2 (11%)	16.5	3 (10%)	16
Inhalants	1 (3%)	17	0 (0)	0	0 (0)	0

Additional information about client's substance use is provided in Table 13. Average periods of abstinence were relatively short in duration (3 to 5 months), indicating that drug use was a chronic pattern for most clients. Clients would spend on average between 70 and 115 dollars per month on substances. ADRC clients out-spent CSI clients by approximately 40%. Clients' ratings of the importance of treatment for changing substance use patterns were relatively low at both sites. Interviewers' ratings of treatment need were higher overall. This indicates that clients as group, lacked awareness of the negative costs associated with substance use and had low motivation for change.

Table 13. ASI Substance Use Problems and Perceived Treatment Need

	ADRC (n=37)	CSI (n=19)	Comparison (n=29)
Length of last voluntary abstinence (months)	3	4.89	2
Dollars spent on alcohol/drugs in past 30 days	116	69	38
Clients' perception of treatment importance (0-4 scale)	1.7	1.63	1.1
Interviewers' rating of clients' need for treatment (0-9 scale)	4.45	4	5.4

Summary of pre-treatment assessments. Based on the results of the psychological instruments, YOM participants appear to suffer from a wide range of emotional and behavioral problems and self-defeating traits. In terms of emotional functioning, clients reported experiencing significant levels of anxiety, depression, and anger. In addition, a large proportion (30-50%) reported symptoms most associated with psychotic spectrum disorders. Substance use patterns appeared to be chronic with cannabis and alcohol being the drugs of choice. Clients do not view substance use as a significant problem worthy of treatment. Predominant traits appear to be lack of empathy and lack of social responsibility.

ADRC clients in comparison to CSI clients report greater levels of overall psychopathology, more emotional and social skills deficits, and greater overall substance use. Given the serious levels of psychopathology, chronic patterns of substance use, and self-defeating traits, YOM participants can be considered a challenging population in need of extensive treatment in a number of problem areas.

Program Completion Analysis

The program completion analysis consisted of conducting a series of logistical regression analyses on program records' data and the pre-treatment paper and pencil tests to determine if any factors were predictive of clients' completion of ADRC or CSI.

Summary of program completers and noncompleters. CSI and ADRC had a total of 35 clients complete the four to six month treatment program (Table 14) for an overall completion rate of 21% (the completion rate was calculated by dividing the number of program completers by number of clients admitted to each program subtracted by the

number of clients currently in each program)(35/165). For ADRC, 122 clients were referred, 99 were admitted, and 23 did not show up for intake. Nineteen (19) clients have successfully completed the program (a completion rate of 22%). At CSI, 98 youth were referred, 82 were admitted, and 16 did not show up for intake. Sixteen (16) clients have completed the program (a completion rate of 21%).

Table 14. Program Completion

	ADRC	CSI
Clients Referred	122	98
Admitted	99	82
No Shows	23	16
Clients currently enrolled	11*	5*
Noncompleters	69	61
Completers	19	16
	(22%)**	(21%)**

*At the time of data analysis both programs had remaining clients
** Completion percentage is based on admitted clients who were not currently enrolled in the program

Services provided for completers and noncompleters. Tables 15 and 16 present the services provided program completers and noncompleters. Program completers at ADRC were enrolled in the program for a longer period than clients at CSI (243 days compared to 194 days). However, CSI provided a higher number of treatment sessions in a shorter span of time.

Table 15. Services Provided to Program Completers

	ADRC (n=19)	CSI (n=16)
Average Days in the Program	243	194
Average Number of Journal Reviews	0	0
Average Number of Cognitive Self-Change Sessions	38	30
Average Psycho-Educational Sessions	37	31
Average Individual Sessions	12	4
Average Other Sessions	0	0

Noncompleters stayed in the program an average of three months (90 days at ADRC and 119 days at CSI). CSI noncompleters participated in an average of twelve cognitive self-change and psycho-education sessions, while ADRC noncompleters participated in an average of thirteen cognitive self-change and psycho-education sessions.

Table 16. Services Provided to Program Noncompleters

	ADRC (n = 69)	CSI (n = 61)
Average Days in the Program	90	119
Average Number of Journal Reviews	0	0
Average Number of Cognitive Self-Change Sessions	13	12
Average Psycho-Educational Sessions	13	12
Average Individual Sessions	4	2
Average Other Sessions	0	0

Case management services provided for program completers and noncompleters. Table 17 presents the amount of case management services provided to program completers and noncompleters for ADRC and CSI. The primary case management services provided to clients at both ADRC and CSI are 'other services'. These include such things as providing transportation for clients, assistance in resume writing, development of employment interviewing skills, and general life skills advice. Overall, a lower percentage of program noncompleters received case management services.

Table 17. Case Management Services Provided

	ADRC		CSI	
	Completers (n=19)	NonCompleters (n=69)	Completers (n=16)	NonCompleters (n=61)
Family Services	6	21	0	0
Obtained Employment	6	8	6	2
Maintained Employment	8	13	8	2
Enrolled in School	12	17	8	11
Maintained School Enroll.	11	15	5	15
Mental Health Services	7	18	0	2
Other Services	18	68	15	38

Summary of Drug Tests. Table 18 provides a summary of the drug tests conducted at ADRC and CSI. Both programs appeared to be properly testing clients. More program noncompleters have tested positive than completers, however, the average number of positive drug tests was higher for ADRC completers than noncompleters.

Table 18. Summary of Drug Tests

	ADRC		CSI	
	Completers (n=19)	NonCompleters (n=69)	Completers (n=16)	NonCompleters (n=61)
Number of Clients Tested	19	58	16	53
Number of Clients Testing Positive	12	52	7	31
Average Number of Drug Tests	10	6	8	4
Average Number of Positive Tests	6	4	2	2

Reasons for noncompletion. Clients did not complete the substance abuse treatment programs for a variety of reasons (Table 19). The most common reason was for nondrug use noncompliance. Clients were discharged for not attending the treatment sessions, not actively participating in the treatment sessions, and showing disrespect toward treatment staff or other clients. A small number of clients in both programs were discharged for drug noncompliance (10) or were rearrested (10).

Table 19. Reasons for Program Noncompletion

	ADRC (n=69)	CSI (n=61)
Discharged drug noncompliance	3	4
Discharged other noncompliance	45	28
Incarcerated	7	3
Left against clinical advice	5	18
Left with advice and formal referral	9	8

Prediction of Program Completion

A series of logistic regression analyses were conducted to identify predictors of program completion. The logisitic regression analyses utilized program record data and the pre-treatment paper and pencil tests (Addiction Severity Index, the BarOn Emotional Quotient Inventory, and the Brief Symptom Inventory).

Program records data. A comparison of program completers to program noncompleters found one major statistical finding: clients who obtained employment during their YOM participation were more likely to complete the program than clients who did not (Table 20). The other two statistically significant variables (positive urine tests and number of cognitive self-change group sessions) are evident of time in the program rather than program performance.

Table 20. Logistic Regression Predicting Program Completion with Program Data

	B	Standard Error	Sign.
Cognitive Self-Change group sessions	0132	.032	.000
Obtained employment while in program	1.654	.827	.046
Maintained employment while in program	.618	.767	.420
Enrolled in school while in program	.915	.644	.155
Maintained school enrollment while in program	.988	.638	.121
Obtained mental health services while in program	-.978	.897	.276
Positive urine analysis while in program	-.338	.091	.000
Age at program entry	.353	.219	.107
Constant	-10.504	4.319	.015

-2 Log Likelihood 80.287
Cox & Snell R square .367
Model Chi-square 55.246 (p.=.001), df=8

Addiction Severity Index. Separate logistical regression analyses were conducted on program completion using the ASI for clients' arrest history (had the client ever been arrested of named offenses)(Table 21), drug use history (Table 22), and substance use problems and perceived treatment need (Table 23). These analyses did not produce any statistically significant findings. Given that the ASI is comprised of self-report questions pertaining to sensitive issues (namely, criminal history and substance abuse), the lack of findings may be due to a lack of clients honestly answering the questions.

Table 21. Logistic Regression Predicting Program Completion with ASI Self-Report Arrest

	B	Standard Error	Sign.
Shoplifting and Vandalism	-1.412	1.406	.315
Parole and Probation Violations	.282	.917	.758
Drug Charges	1.097	.811	.176
Weapons Offenses	-2.165	1.323	.102
Burglary, Larceny, and Breaking and Entering	-.472	.749	.528
Robbery	.823	1.194	.491
Assault	-.098	1.159	.933
Arson	3.431	2.265	.130
DWI or Motor Vehicle Violations	.158	.829	.849
Other Criminal Offenses	-.191	.915	.835
Constant	-.978	.813	.229

-2 Log Likelihood 62.410
Cox & Snell R square .172
Model Chi-square 10.587 (p.=.391), df=10

Table 22. Logistic Regression Predicting Program Completion with ASI Self-Report Drug Use

	B	Standard Error	Sign.
Alcohol	-.338	.740	.648
Cocaine	-1.406	1.181	.234
Marijuana	.395	.829	.634
Hallucinogens	-.727	1.254	.562
Multiple Drugs	.368	.771	.633
Constant	-.755	.649	.244

-2 Log Likelihood 53.182
Cox & Snell R square .070
Model Chi-square 3.352 (p.=.646), df=5

Table 23. Logistic Regression Predicting Program Completion with ASI Self-Report Substance Use Problems and Perceived Treatment Need

	B	Standard Error	Sign.
Months of Last Voluntary Abstinence	.055	.054	.310
Money spent on Alcohol/Drugs in Past 30 Days	-.004	.003	.191
Self-Perceived Treatment Need	-.263	.235	.263
Interviewer Perceived Treatment Need	.213	.146	.146
Constant	-1.176	.677	.082

-2 Log Likelihood 57.168
Cox & Snell R square .130
Model Chi-square 6.936 (p.=.139), df=4

BarOn Emotional Quotient Inventory. Two logistical analyses were conducted on the EQ-I constructs (Tables 24 and 25). We ran two separate analyses rather than one due to the low variable to sample size ratio. *Reality Testing* and *Optimism* were statistically significant predictors of program completion (Table 25). That is, clients who had the ability to accurately examine and assess their environments and those who could maintain a positive outlook even in the face of adversity were more likely to successfully complete the program than those having low scores on these two constructs.

Table 24. Logistic Regression Predicting Program Completion with the EQ-I Constructs

	B	Standard Error	Sign.
Self-Regard	-.005	.027	.860
Emotional Self-Awareness	.029	.031	.353
Assertiveness	-.016	.029	.579
Independence	.011	.025	.654
Self-Actualization	.030	.032	.341
Empathy	.028	.022	.209
Social Responsibility	.008	.024	.748
Interpersonal Relationship	-.041	.036	.254
Constant	-4.096	3.047	.179

-2 Log Likelihood 60.858
Cox & Snell R square .121
Model Chi-square 6.443 (p.=.598), df=8

Table 25. Logistic Regression Predicting Program Completion with the EQ-I Constructs

	B	Standard Error	Sign.
Reality Testing	**.091**	**.044**	**.038**
Flexibility	-.016	.030	.583
Problem Solving	-.031	.031	.313
Stress Tolerance	-.036	.034	.281
Impulse Control	-.018	.030	.552
Optimism	**.072**	**.036**	**.046**
Happiness	-.063	.033	.058
Constant	.293	3.753	.938

-2 Log Likelihood 51.354
Cox & Snell R square .250
Model Chi-square 14.084 (p.=.050), df=7

Brief Symptom Inventory. Correlational analysis was used to assess the BSI constructs on program completion rather than logistical regression analysis due to the high intercorrelation between the BSI constructs (Table 26). While correlational analysis does not allow one to test causal relationships between a series of constructs on program completion, it does individually test the relationships between program completion and each BSI construct. While the BSI constructs were highly correlated with each other, none were statistically related to program completion.

Table 26. Correlational Analysis of Program Completion with BSI Constructs

	Prog Comp	Soma	Obse Comp	Int. Sen	Depr	Anx	Host	Pho Anx	Para Idea	Paych	Glob Sev
Program Completion											
Somatization	-.13										
Obsessive Compulsive	.11	.58*									
Interpersonal Sensitivity	.09	.70*	.82*								
Depression	.15	.70*	.78*	.78*							
Anxiety	-.08	.76*	.77*	.82*	.82*						
Hostility	-.05	.59*	.77*	.82*	.68*	.68*					
Phobic Anxiety	.02	.50*	.58*	.62*	.58*	.59*	.56*				
Paranoid Ideation	.15	.61*	.83*	.83*	.79*	.72*	.79*	.62*			
Psychoticism	.19	.46*	.73*	.68*	.74*	.65*	.54*	.52*	.69*		
Global Severity Index	.08	.73*	.89*	.90*	.88*	.82	.85	.70*	.93*	.77*	

Summary of Program Completion Analysis

The analysis of program completion for the two substance abuse treatment programs found that there was a low completion rate for both programs (21%). This completion rate becomes even lower when program no shows are taken into consideration (16%). A more detailed discussion of the low completion rate will be presented in the final section of this report. The exploration of predictors of program completion found three items. These were obtaining employment while in treatment,

high level of reality testing, and a high level of optimism increased clients' probability of completing the four to six month substance abuse treatment program.

Summary of Clinical Consultant Notes

Over the course of the first to years of the YOM project, it was determined by the DMHAS and the substance abuse treatment program counselors that further acute training on the cognitive self-change model was necessary. As trainings were conducted, a clinical consultant was hired through DMHAS to evaluate the development of staff's practice of and implementation of the CSC model, to determine if the trainings were having a positive effect on CSC group development, and to make a decision on whether further CSC model training was needed. Further, the clinical consultant gave DMHAS feedback in the group treatment sessions. That feedback was given to treatment staff, who would have a concrete record of the work performed in order to review, analyze, and improve their CSC related group session skills.

There was progress made toward the proper implementation of the model since the additional training occurred. Counselors made improvements in the areas of 'thinking reports', 'cognitive check-ins', and 'focus' on the CSC model. An area of concern that remained was the 'homework assignments', and the follow through of those assignments.

Community Solutions Inc. CSI clients maintained an excellent therapeutic relationship with the primary counselor. The counselor's clients were responsive to her interventions and that individual matured as a therapist. CSI seemed to be executing the cognitive change strategy adequately. The group did not always maintain its focus given that there was only one group leader on a number of occasions. When a second counselor

was present, the focus was more easily maintained, therapy proceeded with more vigor, and the work more consistently followed the standards of the CSC model. The CSI counselors maintained sufficient professional distance, focused on the model, identified the core beliefs of the clients, and were better able to encourage new and healthy ways of thinking without being judgmental and without giving advice (which they previously had the tendency to do).

Overall, the counselors were moving in the direction of practicing the models appropriately, efficiently and effectively. The main counselor was able to keep a good rapport with clients, as well as being confrontive when necessary. This counselor was skilled at identifying risky thoughts, and was able to take the client all the way through to understanding how a situation could have an effect on his well-being. The whole group worked together collaboratively and stayed on task. Positive or negative thoughts were recognized as helpful or not helpful.

Alcohol and Drug Recovery Center. The ADRC counselors focused upon the core beliefs with consistency as they became accustomed to using the model. Counselors were able to identify clients' most central troublesome beliefs. In the past, the counselors tended to drift during the sessions and offer too much advice and support, but this seemed to make improvement. Both therapists were able to address negative confrontation over the past year and seemed to be much more capable of challenging their patients' thinking. One counselor was given the task of running the group alone (one was out on medical leave), and evolved into a taskmaster that kept the members clinically engaged. Most recently that therapist has kept on task relentlessly, kept order with an unruly groups of patients, was appropriately confrontational, and maintained excellent rapport with a no-

nonsense style. This counselor was easily able to identify core beliefs, feelings, and attitudes, and kept clients looking at the situation and self. The counselor was also able to assign responsibility but not blame to the client.

Issues of Concern. Although the counselors did make gains and practiced the CSC model efficiently, there were a number of issues of concern that may have diminished the quality of treatment. Despite the planning and decision to run the evaluation and supervision in this way, the goals seemed to be only partially accomplished. It was reported that although the counselors were able to learn to use the model, there were several environmental circumstances that prevented full execution of the models.

One issue of concern was with counselor attrition. As stated in last years report, the change of counselors, an unpredictable, uncontrollable event, made it more difficult for each group to have a well-trained counselor all of the time since continuity could not be maintained. Both CSI and ADRC groups experienced changes of counselors. For multiple groups, there were no co-counselors and a single counselor conducted the clinical work as well as the case management duties. The team approach was further weakened by the fact that the same four counselors did not remain for the duration of the treatment. Change of counselor might have been more easily tolerated and the group process less impeded if the counselors were extremely experienced in the model and did not need time to learn and mature in their practice.

Another issue of concern was that supervision did not occur on a routine and regular basis as was intended, recommended and planned. The counselors were becoming competent in delivering the CSC model, but a greater depth of approach was

needed. While basically adhering to parts of the model, all counselors could benefit from continued and ongoing supervision in order to deepen their level of expertise.

Lastly, an area of concern was with staff attendance. On several occasions the group therapy sessions were canceled due to lack of staff. With only one counselor, the group therapy sessions are dependent upon one therapist who may not be able to be at work.

CONCLUSIONS AND RECOMMENDATIONS

This final report concludes the four year Byrne Grant funded Young Offender Model project. The overarching goals of the YOM project were to provide (1) rapid substance abuse assessment, (2) expedited referrals to outpatient substance abuse treatment programs, and (3) enhanced cultural and age appropriate cognitive self-change treatment availability to African-American and Latino youth living in Hartford. To accomplish these goals, this project funded a DMHAS staff position (Clinical Evaluator and Systems Coordinator) housed in the Hartford Superior Court and four substance abuse treatment staff (a counselor and case manager at the Alcohol and Drug Recovery Center and Community Solutions Inc.) The evaluation sought to determine the effectiveness of the substance abuse treatment programs while testing the efficacy of the cognitive self-change substance abuse treatment approach. The following section summarizes the evaluation findings and provides recommendations for future programming.

Two major conclusions were drawn from this research. First, the 21% program completion rate for ADRC and CSI clients was discouraging. Even though this population could be considered challenging, it was reasonable to have expected a higher completion rate given the low client-to-treatment staff ratio (neither program had more than 10 clients in the program at one time and often only had five to seven), the case management services, and the myriad of resources available from the Byrne Grant funding. Second, we were unable to make conclusions regarding the efficacy of Bush's cognitive self-change substance abuse treatment model.

Low Completion Rate

There appeared to be several possible causes for the low program completion rate. First, there was limited project oversight by the Department of Mental Health and Addiction Services. There were four different DMHAS project monitors over the course of the four year project period. This resulted in a high level of fragmentation between program planning and implementation. Also, DMHAS project monitors did not have an in-depth knowledge of the project components or the daily program activities.

Second, there was a clear lack of interagency cooperation between DMHAS, the Judicial Branch's Court Support Services Division (CSSD), and the Department of Children and Families (DCF). Representatives from CSSD and DCF attended planning meetings early in the project period but stopped attending once the project was being implemented. The absence of interagency cooperation decreased the effectiveness of the Clinical Evaluator and Systems Coordinator in making rapid assessments and referrals. There was also no direct communication between substance abuse treatment staff and court personnel. When clients did not show up for treatment or stopped attending the program, treatment staff would notify the Clinical Evaluator and Systems Coordinator. We were unable to determine what the CESC did with this information or what actions the courts took on these youth.

Third, a number of problems within both substance abuse treatment programs also contributed to the low completion rates. These problems centered on staffing issues and limited adherence to the prescribed treatment model. Both programs had high staff turnover throughout the project period, often leaving one treatment staff to assume the role of both counselor and case manager. Even though this project provided funding for

four full-time treatment staff dedicated solely to the YOM project, ADRC and CSI staff were required to perform nonrelated duties and we were unable to determine exactly how much of their time was dedicated to this project.

Fourth, treatment staff received little or no structured formal weekly supervision from ADRC and CSI administrators resulting in a lack of consistent treatment program implementation. In addition, there was no defined or developed curriculum for cultural and age appropriate treatment. Although treatment was delivered in a community setting by treatment staff who were of similar race and ethnicity, these factors were not enough to constitute culturally competent treatment. The American Counseling Association (ACA) and the Association of Multicultural Counseling and Development (AMCD) have adopted cross-cultural competencies and objectives that include: the counselor's awareness of his/her own cultural values and biases; knowledge about his/her own racial and cultural heritage and how it might impact their views of normality/abnormality during the counseling process; the acquisition of skills to improve their understanding and effectiveness in working with culturally different populations; self awareness regarding their attitudes and beliefs about the racial and ethnic background of the client; and knowledge about the particular group with whom they are working (Sue et al., 1992; Arrendondo et al., 1996). None of these strategies were included in either substance abuse treatment programs' curriculum.

Unable to Assess the Efficacy of the CSC Treatment Model

A major goal of the evaluation was to determine the efficacy of the cognitive self-change model. This goal was not accomplished for several reasons. First and foremost, the YOM project mission was not aligned with the mission of the treatment staff. As

noted earlier, YOM clients as a group, not only suffered from chronic substance use problems, but also had a high level of co-morbid psychopathology, self-defeating attitudes, and practical life problems. To their credit, treatment staff demonstrated a caring attitude in the face of a difficult client profile. However, treatment staff seemed to view their mission as helping clients in a general sense, rather than a specific test of an intervention model. In fact, it seemed at times as if practitioners were being forced to engage in the cognitive self-change intervention when they would rather have been responding to clients concerns in a case management or practical problem solving orientation. From the practitioners' standpoint, the CSC intervention, which was intended to be the main focus of programming, appeared to become less of a priority, and at times was seen as an academic exercise that interfered with actually helping the clients. In short, there existed a basic lack of scientific understanding among the treatment staff. A well-constructed test of an intervention, is in the long-term, a way to help many more potential clients. Unfortunately, a valid test of the CSC model was not obtained in this trial program.

Second, cognitive behavioral interventions require a high level of skill to implement properly. Practitioners need to have skills in five areas (Beal & DiGiuseppe, 1998). (1) A basic *understanding of general psychopathology* is necessary in order to determine if clients are appropriate for a cognitive intervention. As noted earlier, a large percentage of clients reported schizophrenic-like symptoms. It may be that some of the clients were not appropriate for this intervention or not appropriate for a group treatment. It did not appear the there was any type of DSM- based screening process that would have restricted clients who would be less likely to benefit from the program from gaining

admission. The educational levels of the staff may not have been sufficient for such diagnostic impressions to be used in decision-making.

(2) Practitioners are more effective with an *understanding of the cultural influences* related to the clients that they serve. That the treatment staff was familiar with the environments of the clients was clearly an asset.

(3) Practitioners' need sufficient *skill related to intervention techniques.* Skills in delivering Cognitive restructuring programs requires a proper foundation of both cognitive and behavioral theory and principles of change, as well as several years of supervised experience with cognitive interventions. Although, practitioners in the YOM program received trainings on the model, they did not have significant experience with such interventions.

(4) Being able to conceptualize complex cases and understand how thinking styles contribute to a wide range of client problems is part of the *overall strategy* used in cognitive interventions. As noted earlier, practitioners had difficulty conceptualizing client thinking patterns into the types of problems that were routinely presented. This lack of being able to see how the cognition mediates clients' emotional functioning and behavioral reactions limited the usefulness of the CSC from the perspective of the practitioners.

(5) The manner in which cognitive interventions are delivered can be an issue related to practitioner *style*. For example, alternative cognitions can be provided to the client in a didactic style or elicited from clients in more Socratic style. Some practitioners adopt a very direct approach while others are more patient. Style often needs to be adjusted to the client population. The emphasis on training was on proper

technique and not much attention was paid to the more subtle style issues of how the intervention was delivered.

It seems that to successfully execute a cognitive intervention with such a difficult client population would require practitioners with a high level of familiarity and skill in cognitive restructuring programs. In the absence of the proper skill level, intensive supervision and oversight would be required to ensure that practitioners were delivering the model properly.

Third, the CSC program was offered with little consideration to clients' level of motivation for change. Lack of motivation is likely to have been an issue that affected both practitioner adherence to the model and also client retention. When motivational issues were considered they were dealt with by providing clients with positive rewards such as gift certificates. Best practices derived from the extensive literature on the process of increasing client commitment to change behaviors such as substance use were not incorporated (Miller & Rollnick, 2002). Providing a motivational component prior to the CSC program could possibly strengthen the outcome. Group treatment curriculums for fostering client awareness of the costs associated with current behavior patterns, resolving ambivalence, and increasing commitment for change currently exist (Ingersoll, Wagner, & Gharib, S., 2000) and should be considered.

A Note Regarding Treatment Staff

The problems associated with the lack of success of the YOM project are organizational in nature, and do not reflect upon the treatment staff for either ADRC or CSI. These staff were dedicated, energetic, and caring individuals who tried to serve the

best interests of their clients. In return, it appeared that the clients had a high level of trust and respect for the counselors and case managers.

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