ACCESS: ASSERTIVE CONTINUING CARE ENSURING SOBRIETY AND SUCCESS FINAL EVALUATION REPORT

MARCH 2009

Rebecca Ward
Sandy Keaton
Kristen Rohanna
Cynthia Burke, Ph.D

401 B Street, Suite 800 • San Diego, CA 92101-4231 • (619) 699-1900

This publication was made possible by Grant Number 1 H79 TI16992-01 from the Division of Systems Improvement, Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA), United States Department of Health and Human Services. Its contents are solely the responsibility of the authors and do no necessarily represent the official views of CSAT, SAMHSA, or the U.S. Department of Health and Human Services.

BOARD OF DIRECTORS

SANDAG

The 18 cities and county government are SANDAG serving as the forum for regional decision-making. SANDAG builds consensus; plans, engineers, and builds public transit; makes strategic plans; obtains and allocates resources; and provides information on a broad range of topics pertinent to the region's quality of life.

CHAIR	FIRST VICE CHAIR	SECOND VICE CHAIR	EXECUTIVE DIRECTOR
Hon. Lori Holt Pfeiler	Hon. Jerome Stocks	Hon. Jack Dale	Gary L. Gallegos

CITY OF CARLSBAD
Hon. Matt Hall, Councilmember
(A) Hon. Bud Lewis, Mayor
(A) Hon. Ann Kulchin, Mayor Pro Tem

CITY OF CHULA VISTA
Hon. Cheryl Cox, Mayor
(A) Hon. John McCann, Deputy Mayor
(A) Hon. Steve Castaneda, Councilmember

CITY OF CORONADO
Hon. Carrie Downey, Councilmember
(A) Hon. Al Ovrom, Councilmember
(A) Hon. Michael Woiwode, Councilmember

CITY OF DEL MAR
Hon. Crystal Crawford, Mayor
(A) Hon. Carl Hilliard, Councilmember
(A) Hon. Richard Earnest, Deputy Mayor

CITY OF EL CAJON
Hon. Mark Lewis, Mayor
(A) Hon. Jillian Hanson-Cox, Councilmember

CITY OF ENCINITAS
Hon. Jerome Stocks, Councilmember
(A) Hon. Teresa Barth, Councilmember
(A) Hon. Dan Dalager, Deputy Mayor

CITY OF ESCONDIDO
Hon. Lori Holt Pfeiler, Mayor
(A) Hon. Sam Abed, Councilmember

CITY OF IMPERIAL BEACH
Hon. Jim Janney, Mayor
(A) Hon. Patricia McCoy, Mayor Pro Tem
(A) Hon. Jim King, Councilmember

CITY OF LA MESA
Hon. Art Madrid, Mayor
(A) Hon. Mark Arapostathis, Councilmember
(A) Hon. David Allan, Councilmember

CITY OF LEMON GROVE
Hon. Mary Teresa Sessom, Mayor
(A) Hon. Jerry Jones, Councilmember
(A) Hon. Jerry Selby, Councilmember

CITY OF NATIONAL CITY
Hon. Ron Morrison, Mayor
(A) Hon. Frank Parra, Vice Mayor
(A) Hon. Rosalie Zarate, Councilmember

CITY OF OCEANSIDE
Hon. Jim Wood, Mayor
(A) Hon. Jerry Kern, Councilmember
(A) Hon. Jack Feller, Councilmember

CITY OF POWAY
Hon. Mickey Cafagna, Mayor
(A) Hon. Don Higginson, Councilmember
(A) Hon. Betty Rexford, Councilmember

CITY OF SAN DIEGO
Hon. Jerry Sanders, Mayor
(A) Hon. Anthony Young, Councilmember
(A) Hon. Sherri Lightner, Councilmember

Hon. Ben Hueso, Council President
(A) Hon. Marti Emerald, Councilmember
(A) Hon. Todd Gloria, Councilmember

CITY OF SAN MARCOS
Hon. Jim Desmond, Mayor
(A) Hon. Hal Martin, Vice Mayor
(A) Hon. Rebecca Jones, Councilmember

CITY OF SANTEE
Hon. Jack Dale, Councilmember
(A) Hon. Hal Ryan, Councilmember
(A) Hon. John Minto, Councilmember

CITY OF SOLANA BEACH
Hon. Lesa Heebner, Councilmember
(A) Hon. Dave Roberts, Councilmember
(A) Hon. Mike Nichols, Mayor

CITY OF VISTA
Hon. Judy Ritter, Councilmember
(A) Hon. Bob Campbell, Mayor Pro Tem
(A) Hon. Steve Gronke, Councilmember

COUNTY OF SAN DIEGO
Hon. Dianne Jacob, Chairwoman
(A) Hon. Bill Horn, Chair Pro Tem
(A) Hon. Ron Roberts, Supervisor
Hon. Pam Slater-Price, Vice Chairwoman
(A) Hon. Greg Cox, Supervisor

IMPERIAL COUNTY
(Advisory Member)
Hon. Victor Carrillo, Supervisor
(A) Hon. David Ouzan, Councilmember

CALIFORNIA DEPARTMENT OF TRANSPORTATION
(Advisory Member)
Will Kempton, Director
(A) Pedro Orso-Delgado, District 11 Director

METROPOLITAN TRANSIT SYSTEM
(Advisory Member)
Harry Mathis, Chairman
(A) Hon. Ron Roberts
(A) Hon. Ernest Ewin

NORTH COUNTY TRANSIT DISTRICT
(Advisory Member)
Hon. Bob Campbell, Chair
(A) Hon. Jerome Stocks, Planning Committee Chair
(A) Hon. Dave Roberts, Monitoring Committee Chair

U.S. DEPARTMENT OF DEFENSE
(Advisory Member)
CAPT Steve Wirsching, USN, CEC,
Southwest Division Naval Facilities Engineering Command
(A) CAPT Robert Fahey, USN, CEC
Southwest Division Naval Facilities Engineering Command

SAN DIEGO UNIFIED PORT DISTRICT
(Advisory Member)
Laurie Black, Commissioner

SAN DIEGO COUNTY WATER AUTHORITY
(Advisory Member)
Mark Muir, Commissioner
(A) Howard Williams, Commissioner
(A) Gary Croucher, Commissioner

SOUTHERN CALIFORNIA TRIBAL CHAIRMEN'S ASSOCIATION
(Advisory Member)
Chairman Robert Smith (Pala), SCTCA Chair
(A) Chairman Allen Lawson (San Pasqual)

MEXICO
(Advisory Member)
Hon. Remedios Gómez-Arnau
Cónsul General of Mexico
Hon. Martha E. Rosas,
Deputy Cónsul General of Mexico

As of February 19, 2009

ABSTRACT

TITLE: ACCESS: Assertive Continuing Care Ensuring Sobriety and Success Final Evaluation Report

AUTHOR: San Diego Association of Governments

DATE: March 2009

SOURCE OF COPIES: San Diego Association of Governments
401 B Street, Suite 800
San Diego, CA 92101
(619) 699-1900

ABSTRACT: As formerly incarcerated youth return to the community, they are often faced with significant barriers to effective reintegration, including lack of educational and housing options, gang affiliation, an institutional identity, and substance abuse and mental health problems. During recent years, more attention has been paid to these reentry issues, which has resulted in the development of a number of evidence-based reentry models. One of these, Assertive Continuing Care (ACC), uses intensive case management, home visits, and parental/caregiver involvement to directly target the multiple barriers these youth face to successful reentry.

In 2004, using ACC as a model, Phoenix House of San Diego, Inc., created the ACCESS program to address the needs of young offenders reentering local communities from detention facilities in San Diego County. The following report provides a description of clients who entered the program and information on services provided, as well as outcomes measured by initial and six-month follow-up interviews, risk assessments, and criminal and placement history information. Results indicate that youth who successfully completed the program reported increased mental health, higher resiliency scores, and were less likely to recidivate.

ACKNOWLEDGEMENTS

Special thanks are shared with the staff members of the ACCESS program for their cooperation throughout this evaluation process, especially Program Director Elizabeth Urquhart, Program Coordinator Tiffany Crawshaw, and Case Managers Loretta Adame, Claudia Cortez, and Mariana Mesnik. The San Diego County Probation Department is gratefully acknowledged for allowing the interviewers access to its facilities. In addition, special appreciation is extended to the Phoenix House Foundation Institutional Review Board (IRB), particularly IRB Coordinator Jennifer Butler, and the Center for Substance Abuse Treatment, particularly Grant Project Officer George Samayoa, for their insights and oversight. Finally, this evaluation would not have been possible without the diligent work of Sara Andrews, Debbie Correia, Leigh Grossman, Jillian Heron, Betty Kuo, Grace Liwanag, Casey Mackereth, Cristina Magaña, Carmen Perez, and Pedro Ruiz, who assisted in various stages of the data collection process and compilation of information for this report.

TABLE OF CONTENTS

PAGE

EXECUTIVE SUMMARY 1

Introduction and Project Background 3

Description of the ACCESS Program 4
- Service Provision 4
- Program Challenges and Changes 5

Client Characteristics and Needs 6

Program Outcomes 7
- Criminal Behavior and Associations at Follow-up 7
- Substance Use at Follow-up 8
- Mental and Physical Health at Follow-up 9
- Satisfaction With the Program 9

Recommendations 10

CHAPTER 1 – INTRODUCTION AND PROJECT BACKGROUND 1-1

Introduction 1-3

Project Description 1-3

Report Overview 1-5

CHAPTER 2 – EVALUATION METHODOLOGY 2-1

Introduction 2-3

Research Design 2-3
- Process Evaluation 2-3
  - Research Questions 2-3
  - Data Collection Procedures 2-4
  - Analysis Plan 2-4
- Impact Evaluation 2-5
  - Research Questions 2-5
  - Data Collection Procedures 2-5
  - Analysis Plan 2-7
- Consent Procedures 2-7

Possible Study Limitations 2-8

Summary 2-9

PAGE

CHAPTER 3 – PROCESS EVALUATION 3-1

Introduction 3-3

Implementation of and Modifications to the Design Model 3-3
- Program Design 3-3
- Program Implementation and Modifications 3-4
  - Program Start-Up Delays and Challenges Enrolling Clients 3-5
  - Change in Length of Treatment 3-7
  - Staff Turnover and Maintaining Consistent Client Contact 3-8

Characteristics and Needs of Clients at Intake 3-9
- Demographics 3-9
- Substance Abuse 3-11
- Physical and Mental Health 3-13
- Crime and Delinquency 3-14
- School and Vocation 3-17

Level of Service Provided to Clients 3-18
- Length of Time in Program 3-18
- Intensity of Services to Client and Parent 3-18

Nature of Partnerships Among Stakeholders 3-20

Summary 3-20

CHAPTER 4 – PROJECT OUTCOMES 4-1

Introduction 4-3

Clients' Discharge Status 4-3

Clients' Housing, School, and Employment Status at Follow-up 4-4

Clients' Delinquent and Criminal Activity at Follow-up 4-5
- Risk and Protective Factors 4-5
- Delinquent Acts and Peer Relationships 4-7
- Official Probation Records 4-9

Clients' Substance Use at Follow-up 4-11

Clients' Physical and Mental Health Status at Follow-up 4-13

Clients' Satisfaction With Services Received 4-14

Summary 4-16

CHAPTER 5 – OVERVIEW AND RECOMMENDATIONS 5-1

Introduction 5-3

Summary 5-3
- Process Evaluation 5-3
- Impact Evaluation 5-4

Recommendations 5-4

REFERENCES R-1

LIST OF TABLES

PAGE

EXECUTIVE SUMMARY

Table 1 Clients' Reported Substance Use 9

CHAPTER 2

Table 2.1 Number of Assessments Completed at Each Time Point 2-6

Table 2.2 Evaluation Consent Procedures 2-7

CHAPTER 3

Table 3.1 Reasons for Unsuccessful Discharge From Program 3-4

Table 3.2 Program Milestones, October 2004 – September 2008 3-5

Table 3.3 Staffing Changes, October 2004 – September 2008 3-9

Table 3.4 Clients' Self-Reported History of Ever Using Substances 3-11

Table 3.5 Clients' Current Drug Preferences and Perceived Need for Treatment 3-12

Table 3.6 Clients' Self-Reported Abuse History 3-14

Table 3.7 Clients' Self-Reported Delinquency-Related Activities in the Past 12 Months 3-15

Table 3.8 Eligible for Criminal History Data Collection 3-15

Table 3.9 Violation Type for Prior Highest Sustained Petition 3-17

Table 3.10 Treatment Dosage for ACCESS Clients 3-19

CHAPTER 4

Table 4.1 Protective and Risk Factors for ACCESS Clients at Intake and Exit 4-7

Table 4.2 Clients' Self-Reported Delinquency Related Activities in the Past 90 Days 4-8

Table 4.3 Clients' Self-Reported Substance Abuse in the Past 90 Days 4-11

LIST OF FIGURES

PAGE

EXECUTIVE SUMMARY

Figure 1 Recidivism by Discharge Status 7

Figure 2 Average Change in Protective, Risk, and Resiliency Scores by Exit Status 8

CHAPTER 3

Figure 3.1 Client Ethnicity 3-10

Figure 3.2 Prior Referrals, Sustained Petitions, and Institutional Commitments 3-16

CHAPTER 4

Figure 4.1 Clients' Housing at Follow-Up 4-4

Figure 4.2 Average Change in Protective, Risk, and Resiliency Scores by Exit Status 4-6

Figure 4.3 ACCESS Clients' Recidivism at 6 and 12 Months Post-Release from Institution 4-9

Figure 4.4 Recidivism by Discharge Status 4-10

Figure 4.5 Clients' Descriptions of Their Peer Substance Use at Intake and Follow-Up 4-12

Figure 4.6 Clients' Self-Reported Physical and Mental Health at Intake and Follow-Up 4-13

Figure 4.7 Clients' Satisfaction With Referral Services 4-14

Figure 4.8 Clients Reporting Accomplishment of Goals Through Program Participation 4-15

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

INTRODUCTION AND PROJECT BACKGROUND

Despite a decline since 1994 in the rate of juvenile arrests, recidivism among young offenders remains high. Some of the more significant barriers faced by formerly incarcerated youth include a lack of educational and housing options, gang affiliation, an institutional identity, dependence on alcohol and other drugs, and mental health problems. During recent years, more attention has been paid to these reentry issues facing young offenders, resulting in the development of a number of evidence-based reentry models. One of these, Assertive Continuing Care (ACC), uses intensive case management, home visits, and parental/caregiver involvement to directly target the multiple barriers to successful reentry.

In October 2004, Phoenix House of San Diego, Inc., a non-profit substance abuse treatment and prevention agency, was successful in their application and received a Young Offender Reentry Program (YORP) grant from the Center for Substance Abuse Treatment (CSAT) to fund *ACCESS: Assertive Continuing Care Ensuring Sobriety and Success*. This program addressed the needs of young male offenders reentering local communities from the San Diego County Probation Department's Juvenile Ranch Facility (JRF) and East Mesa Juvenile Detention Facility (EMJDF).

As part of the grant, both local and cross-site evaluations were required. The Criminal Justice Research Division of the San Diego Association of Governments (SANDAG) was contracted to conduct a process and impact evaluation of the ACCESS program. SANDAG also assisted in coordinating and entering the data for the cross-site evaluation. Data collection involved

ACCESS Program Highlights

Prior to Program Participation

- Clients were mostly Hispanic and average age was approximately 16 years old.
- All youth had a prior criminal history record, with almost three-quarters having a prior sustained petition and over one-third having a prior institutional commitment.
- About one-half of youth reported gang affiliation in the year prior to intake.
- Nearly four in five clients had previously been a victim of violence at some point in their life.
- Nine out of ten youth had used alcohol and/or marijuana in their lifetime, and about half had used amphetamines.
- Around half of clients said their life had been significantly disturbed by "nerve, mental, or psychological problems," or felt they could not go on at some point in their life.

After Program Participation

- Clients who successfully completed ACCESS had significantly fewer sustained petitions and institutional commitments six months post-release.
- Clients who successfully completed the program reported better parental relations, less substance use, and better communication with those around them.
- At six months, about two-fifths of clients reported abstaining from drug or alcohol use, and only one in five continued to hang out with peers who used.
- Significantly fewer clients reported being disturbed by nerve, mental, or psychological problems within the past 90 days at six months compared to at intake.
- Successful graduates had significantly higher SDRRC resiliency scores, indicating increased protective factors and decreased risk factors to buffer them from engaging in delinquency.

multiple methodologies, including initial and six-month follow-up GAIN (Global Appraisal of Individual Needs) interviews, risk assessments, satisfaction surveys, and official criminal and placement history.

DESCRIPTION OF THE ACCESS PROGRAM

The San Diego ACCESS program was designed to help that segment of the juvenile probation population that arguably is in greatest need: substance abusing youthful offenders residing in the most distressed communities of San Diego County. Originally identified as Mid-City and South Bay, these catchment areas were expanded to include parts of the eastern and northern regions of San Diego County. The program, which was implemented at JRF, an all-male detention facility in San Diego County[1], used a two-pronged approach to services: an in-custody portion that focused on reentry planning to ensure that gains achieved in treatment during incarceration were maintained after release; and 12 to 15 weeks of post-release case management, home visits, and parental/caregiver involvement to reduce the likelihood of recidivism and relapse. The program followed the Adolescent Community Reinforcement Approach (A-CRA) to alcohol and substance use treatment, which seeks to increase the family, social, and educational/ vocational reinforcers of an adolescent to support recovery and prevent relapse. Screening and assessments were conducted at intake (using the Global Appraisal of Individual Needs – Initial (GAIN-I) and San Diego Regional Resiliency Checkup (SDRRC)), and at exit (using the SDRRC) to identify protective and risk factors and provide a pre-post analysis to measure success.

[1] Reentry planning services expanded to EMJDF in July 2007 to serve clients who could not go to JRF for various reasons (e.g., medical issues, fire-setter status, etc.).

Key Program Components

- Target high-risk offenders and their families;
- Utilize assessment-based treatment planning;
- Commence services while in-custody and continue when released back to the community;
- Ensure program is accessible by providing services to youth and families in their community (e.g., at home or school); and
- Maintain a 25-to-1 client-to-staff ratio, with approximately one-half of the cases in the aftercare phase of the program.

Service Provision

ACCESS was implemented by a collaborative team made up of staff from Phoenix House of San Diego, Inc., and San Diego Youth and Community Services (SDYCS), in cooperation with Probation. ACCESS intended to serve 450 youth, ages 14 to 18, with the primary goal of helping youth maintain the gains achieved in treatment during incarceration, as well as reduce the likelihood of recidivism and relapse through reintegration in the community. The ACCESS program started accepting clients in March 2005, and the final client entered in June 2008, for a total of 330 youth participants, 282 of whom agreed to participate in the evaluation.

The first six months of the program were focused on startup activities, including hiring staff, attending the national trainings and meetings, obtaining Institutional Review Board (IRB) approval, and solidifying the program procedures. The first client exited the detention facility in April 2005. Upon release, the Phoenix House of San Diego, Inc., case manager conducted 12 to 15 structured home visits, at least once per week, with the client and his family in accordance with the ACC protocol. Case managers provided the following services:

- Assessment-based case management, including providing linkages to services in the community.
- Alcohol and substance use treatment through the A-CRA behavioral intervention model.
- Material assistance such as food, transportation, work clothes, etc.
- Aftercare upon completion of the 12 to 15 weekly sessions, which consisted of phone contact to provide a step-down transition and safety net.

Case managers were expected to carry a maximum caseload of 20 to 25 clients, with the understanding that about half of these would be in the aftercare phase of treatment at any given time and, thus, require less intensive contact. To graduate successfully from the program, youth needed to complete all of the A-CRA sessions and those youth who left the program early, either due to their own behavior (e.g., nonparticipation) or circumstances beyond their control (e.g., moving), were considered unsuccessful (i.e., did not receive the full dosage of treatment). Of the 282 clients who received services, 33 percent were successful graduates, 60 percent did not complete the program, and 8 percent were still in the program at the end of data collection. Analyses of those factors that may predict whether a youth completed the program successfully revealed that gang membership 12 months prior to intake decreased the odds of a youth successfully completing the program by 55 percent. Similarly, the odds of a youth graduating successfully decreased by 70 percent for those youth who had the lowest SDRRC resiliency scores at intake (i.e., with more risk and fewer protective factors).

> "The case manager was very helpful [with] my needs and gave a lot of positive advice [about] my problems. [I] actually ... solve[d] some of them due to this program. Thanks!"
>
> *ACCESS graduate, age 17*

Program Challenges and Changes

Overall, the original program model was implemented as designed, with some changes in how youth were identified for the program and the length of time a youth could be enrolled in the program. As client recruitment began, program staff found that the number of actual intakes was lower than initially anticipated due to factors beyond their control. These factors included change in youth's eligibility status due to an increase in the initial time served (e.g., due to violating rules or behavior issue while in custody), reassignment by Probation to a different treatment program, and misunderstanding on the part of the Probation assessment team of program eligibility criteria (i.e., not assigning gang-involved youth). In an effort to address these issues and increase the number of referrals to the ACCESS program, program staff met with Probation staff and implemented the following changes in the recruitment process, which positively impacted the number of youth referred to the program and strengthened the partnership.

- **Increased the catchment area to include more communities.** At two points in time, the area served in the County was increased to include parts of East County and later sections of North County.
- **Increased involvement of program staff in the Probation assessment process.** Program staff started to attend the assessment meetings, as well as the related Probation caseload meetings, in order to address any questions about the program and/or eligibility criteria.
- **Expanded services to an additional detention facility.** ACCESS reentry services were expanded to the EMJDF in an effort to serve those youth who could not go to JRF for various reasons (e.g., medical issues, fire-setter status, etc.).

In regard to changes in the length of the program, as noted earlier, the original design was to provide 12 to 15 weekly A-CRA sessions over the course of three months. However, because of the level of involvement in the juvenile justice system and prior gang involvement these youth had, the program chose to expand the time allowed to complete the sessions in an effort to increase the opportunity for youth to complete the program. More specifically, if a youth was re-incarcerated, either due to a probation violation or new offense, the program assessed on a case-by-case basis whether to extend his time in the program. As for gang involvement, because nearly one-half of the youth were gang involved, it became prohibitive to conduct sessions at some of the youth's homes and also limited the feasibility of the program to bring together ACCESS clients who were affiliated with rival gangs to participate in recreational activities. This not only increased the time it took to set up appointments and meet with the youth, it also significantly decreased participation in the recreational component of the program. As a result, all clients (regardless of exit status) were in the program for an average of 6.90 months, with graduates enrolled an average of 8.14 months compared to an average of 6.22 months for those who were terminated unsuccessfully.

CLIENT CHARACTERISTICS AND NEEDS

The ACCESS program served its intended target population, namely young male offenders at high risk for substance abuse relapse and recidivism. On average, clients were 15.8 years old, over half were Hispanic (59%), and the majority (63%) were living in the custody of a single parent at time of intake. Analyses of intake assessment data revealed a clientele that entered treatment with a multitude of issues to overcome. These included living in environments that placed them at risk for victimization, early substance use initiation, troubling mental health symptoms, and a history of delinquency. Below is a summary of the youths' characteristics that clearly illuminates the complexity and challenges associated with providing effective treatment that can intervene and bring a halt to both the substance use and the criminal activity of this particular population.

> "I thought this program was helpful to me. The weekly meetings have helped me get issues off my chest and better relax. When I am out now I think before [I act]."
> *ACCESS graduate, age 18*

- Consistent with the program's focus on youth with drug and alcohol dependence, clients were 12 years old, on average, when they first used drugs/alcohol and 85 percent had previously attended a self-help recovery group.
- Over two-thirds (68%) of clients said their family had a history of problems related to alcohol use, and more than half (57%) had a family history of problems due to drug use.
- About one-quarter (28%) said at least one individual in their home was currently involved in illegal activity.
- All clients had prior contact with the juvenile justice system and 67 percent were or had previously been a 602 ward of the court at the time of the instant offense.
- Clients self-reported engaging in a variety of criminal activities in the year prior to intake. Four out of five were involved in some type of property crime (86%), violent act (83%), and/or delinquent act (83%). Additionally over one-half participated in a drug activity other than use (60%).

- Nearly half (49%) of clients said they were a member of a gang in the year prior to intake.

- Nearly four in five (79%) clients had previously been a victim of violence at some point in their life, such as being attacked by someone with a gun, knife, or other weapon, and/or struck or beaten to the point of injury.

- Around half (52%) of clients said their life had been significantly disturbed by "nerve, mental, or psychological problems," or felt they could not go on at some point in their life.

PROGRAM OUTCOMES

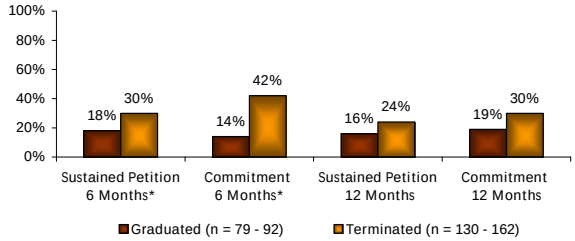
As part of the impact evaluation, both self-report and official records were used to measure change over time. A key focal point of the analyses was to examine any difference between those youth who successfully completed the program (i.e., received the full dosage of treatment) compared to those who did not. While different degrees of positive change were found for all clients, those youth who did complete the program were more likely to demonstrate positive change in their behaviors, compared to those who were terminated.

Criminal Behavior and Associations at Follow-up

Background data on the target population clearly showed youth who were the most entrenched in the juvenile justice system. The information also underscored the need for interventions that could address the plethora of challenges these youth face, including gang affiliation, which is highly correlated with criminal behavior. Examinations of both official criminal records and self-report data showed that youth who received all of the treatment provided by the ACCESS program were less likely to continue their criminal activity than those that did not. The following results indicate that ACCESS has a positive impact in supporting youth to make different choices in regard to delinquency.

- Successful graduates were significantly less likely to have a sustained petition six months post-release into the community compared to those who were terminated (18% versus 30%, respectively). Additionally, about three times as many terminated clients received an institutional commitment (42%) at the six-month mark compared to those who graduated (14%), also a significant difference (Figure 1).

Figure 1
RECIDIVISM BY DISCHARGE STATUS



Significant at the p < .05 or lower.

NOTE: Cases with missing information not included.

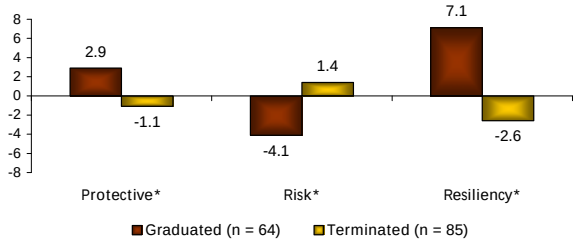
SOURCES: SANDAG; Probation Case Management System (PCMS) Records, 2008

- In terms of criminal history, there was no statistically significant difference between the two groups at the 12-month mark, with 16 percent and 24 percent, respectively, having a sustained petition and 19 percent and 30 percent, respectively, having an institutional commitment (Figure 1). This lack of difference at 12 months suggests that a youth is most vulnerable for reoffending during the time immediately following release from the institution.

- Between intake and exit, average protective, risk, and resiliency scores improved significantly for clients who completed the program successfully and

were significantly worse for clients who were terminated. Graduates had an average increase of 2.9 protective factors (from a score of 7.8 at intake to 10.7 at exit), compared to an average decrease of 1.1 (from 4.7 to 3.6) for clients who were terminated; an average decrease of 4.1 risk factors (from 20.0 to 15.9), compared to an increase of 1.4 (from 22.6 to 24.0) for terminated clients; and an average increase of 7.1 in resiliency (from -12.2 to -5.1), compared to a decrease of 2.6 (from -17.9 to -20.5) for terminated clients (Figure 2).

Figure 2
AVERAGE CHANGE IN PROTECTIVE, RISK, AND RESILIENCY SCORES BY EXIT STATUS



** Significant at the p < .05 or lower.*

SOURCES: SANDAG; San Diego Regional Resiliency Checkup, 2005 –2008

- Significantly fewer successful graduates reported being affiliated with a gang at the six-month follow-up, compared to those who did not graduate (36% versus 59%, respectively).
- At six months post release, less than one-third (29%) of the clients reported that, during the past 90 days, most or all of the people they regularly socialized or hung out with were involved in illegal activities (versus 46% during the past 12 months at intake).

Substance Use at Follow-up

Along with reducing recidivism, ACCESS aimed to support a youth's recovery. As with criminal behavior, ACCESS clients were already deeply involved in substance use when entering treatment and, on average, started using substances at an age (i.e., average 12 years old) that significantly increased their risk for future dependence. Unlike delinquency behavior, no significant differences were found between those youth who successfully completed the program and those who did not. Unfortunately, change over time could not be directly compared because the questions on the intake and follow-up referred to different time frames. However, considering the clients used, on average, four different types of substances in their young lives, nearly all had reported using alcohol (96%) and/or marijuana (97%), and nearly one-half used amphetamines (49%); the percentage reporting use at the six-month follow-up reflected a positive change. That is, a smaller percentage of youth overall reported using substances in the past 90 days at the six-month follow-up, with just over one-half (55%) saying they drank alcohol, about one-third (34%) using marijuana, and 15 percent using amphetamines. At six months, about two-fifths (37%) of clients who had the opportunity to use (i.e., were out of incarceration for at least one day during the 90-day period) reported abstaining from drug or alcohol use altogether in the past 90 days.

Additionally, given the influence a youth's peers have in his life, having the youth change who he socialized with was an important piece in supporting his overall recovery. At the six-month follow-up, fewer youth reported socializing with substance using peers, with one in five reporting that most or all of the people they regularly hung out with used any drugs in the past 90 days (22% versus 48% at intake) or got drunk weekly (21% vs. 42% at intake).

Table 1
CLIENTS' REPORTED SUBSTANCE USE

	Life Time Use at Program Intake	Past 90 Days Use at Six-Month Follow-Up
Marijuana	97%	34%
Alcohol	96%	55%
Amphetamines	49%	15%
Cocaine	25%	5%
Crack	22%	3%
TOTAL	**278 - 279**	**157 - 158**

NOTE: Cases with missing information not included.

SOURCES: SANDAG; Global Appraisal of Individual Needs (GAIN), 2005 - 2008

Mental and Physical Health at Follow-up

One of the more disturbing findings of the study was the large percentage of youth entering ACCESS who had directly experienced violence and victimization, as well as suffered from some type of mental health problem. However, at the six-month follow-up, significantly fewer clients reported being disturbed by nerve, mental, or psychological problems within the past 90 days compared to intake (13% compared to 27%).

As for physical health, a similar percentage reported that they were in "good" or better health (91% at six-month follow-up compared to 83% at intake). However, significantly more clients did report being bothered by health problems in the past 90 days at follow-up (39%) compared to intake (6%). Interestingly, this difference was also seen between those who graduated from the program (50%) and those that were terminated (33%). One explanation for this difference could be that those youth who were terminated were more likely to be incarcerated and have access to medical care, compared to those who graduated and were living back in the community.

Satisfaction With the Program

At program exit, clients were asked to complete a questionnaire rating their satisfaction with the program using a five-point scale (from "liked it a lot" to "disliked it a lot"). While overall the majority of youth who completed the survey expressed satisfaction with the program and appreciated the help they received from staff, those who graduated reported a significantly higher level of satisfaction.

- Of the 119 respondents (59 graduates and 60 non-graduates), nearly all of the graduates (92%) and four-fifths of the non-graduates (82%) said they liked the program.

- Significantly more graduates than non-graduates felt their case manager was helpful (95% and 81%, respectively), and that the program targeted their needs (91% and 73%, respectively) and helped them stay out of legal trouble (93% and 47%, respectively), cut down on their substance use (90% and 66%, respectively), become more involved in their community (78% and 54%, respectively), communicate better with those around them (90% and 71%, respectively), and improve their relationship with their parent(s) (88% and 66%, respectively).

> "This program and [my case manager] helped me a lot. I thought I was never gonna change, but now I feel like a whole different person. In a good way! Thanks!"
> *ACCESS graduate, age 18*

RECOMMENDATIONS

Based upon the results of the process and impact evaluations, the following recommendations for future program efforts are provided.

- **Examine Means to Increase Engagement in Program:** The positive results that were realized by youth who were able to complete the full dosage of treatment (i.e., successfully complete the program) reflect positively on the potential for the ACCESS program. ACCESS clients were some of the highest-risk youth in the juvenile justice system, with a history of relapse and reoffending. Analyses revealed at least two factors significantly related to the odds of a youth not completing the program: gang involvement and a low resiliency score. Identifying those youth up front that are at greatest risk of not graduating would allow the program to explore additional support mechanisms that could possibly be put in place to help mitigate the additional challenges these youth face.

- **Incorporate Trauma-Related Treatment in the Model:** Because of the large proportion of youth who reported being a victim of violence at some point in their lives, examining best practices in addressing victim and trauma needs might be a beneficial addition to the treatment mode.

- **Provide Resources to Centralize the Evaluation Responsibilities:** While the program staff did the best they could collecting the data for the evaluation, a significant amount of follow-up data was lost due to staff turnover and competing priorities. The evaluation revealed positive results, and providing resources to support a more rigorous design would increase the opportunity to provide outcomes that are in alignment with current evidence-based standards.

- **Maintain Designed Staff-to-Client Caseload Ratio:** Due to factors often beyond the staff's control, case managers were burdened with carrying a larger caseload than designed. This reduced the time available to meet with the client and/or family. Ensuring steps are taken to adhere to the intended caseload ratio would increase program fidelity.

CHAPTER 1
INTRODUCTION AND PROJECT BACKGROUND

CHAPTER 1
INTRODUCTION AND PROJECT BACKGROUND

INTRODUCTION

In the late 1980s and early 1990s, the United States experienced an alarming rise in juvenile crime and delinquency. A peak was reached nationally in 1994, at which point juvenile arrest rates began to decline. However, recidivism among young offenders remains quite high to this day. As youth return to the community after incarceration, they are often faced with significant barriers to effective reintegration, including lack of educational and housing options, limited skills, gang affiliation, an institutional identity, substance abuse and mental health problems, a lack of community support and role models, language and cultural barriers, and legislative barriers limiting access to education, cash assistance, and public housing.

More attention has been paid to these reentry issues in recent years, which has resulted in the development of a number of evidence-based reentry models, including Assertive Continuing Care (ACC). ACC uses intensive case management, home visits, and parental/caregiver involvement to engage the youth in continuing care, incorporating pro-social skill-building and relapse-prevention activities that directly target the multiple barriers to successful reentry these youth face.

In response to the need to provide more intensive aftercare services for the higher-risk youth exiting juvenile justice institutions, the San Diego County Probation Department reached out to one of its community partners to develop a new reentry program. Specifically, in 2004 Probation approached Phoenix House of San Diego, Inc., a non-profit substance abuse treatment and prevention agency, to submit a grant application to the Center for Substance Abuse Treatment (CSAT) for funds to address the needs of young offenders reentering local communities from Probation's all-male Juvenile Ranch Facility (JRF) and the East Mesa Juvenile Detention Facility (EMJDF). Phoenix House of San Diego, Inc. was successful in its application and received a Young Offender Reentry Program (YORP) grant from CSAT to fund *ACCESS: Assertive Continuing Care Ensuring Sobriety and Success* in October 2004.

As part of this process, Phoenix House of San Diego, Inc. contracted with the Criminal Justice Research Division of the San Diego Association of Governments (SANDAG) to conduct a process and impact evaluation of the ACCESS program. In addition to the local evaluation, CSAT required a cross-site evaluation that was conducted by Chestnut Health Systems, Inc., an organization specializing in behavioral health care and developer of the assessment tool used for the cross-site evaluation. SANDAG also assisted in coordinating and entering the data for the cross-site evaluation.

PROJECT DESCRIPTION

Using the ACC model, the ACCESS program was designed to provide an intensified level of service to that segment of the juvenile Probation population that arguably is in greatest need: substance-abusing youthful offenders residing in the most distressed communities of San Diego County,

originally identified as Mid-City and South Bay, and later expanded to include a greater portion of the City of San Diego and parts of East and North Counties.

The ACCESS program began accepting clients in March 2005 and aimed to serve 450 youth ages 14 to 18 through the end of the grant period in September 2008 (90 youth in the first year and 120 youth in each additional year). Program services were provided by Phoenix House of San Diego, Inc., in cooperation with Probation and San Diego Youth and Community Services (SDYCS). ACCESS was designed to help youth maintain gains achieved in treatment during incarceration, as well as reduce the likelihood of recidivism and relapse through reintegration into the community.

The program consisted of two parts: 1) reentry planning during the three-month incarceration period, and 2) six months of continuing care intervention, utilizing the ACC protocol, in cooperation with Probation supervision in the community. During incarceration, youth worked with the Assessment/Reentry Counselor (an employee of SDYCS) to complete a detailed assessment and recovery plan in order to identify post-release service needs and participated in a reentry curriculum covering topics such as healthy recreation, coping with change, and responsible decision making. The client also completed a locator form to enable follow-up staff to more easily contact him.

Upon release, the Phoenix House of San Diego, Inc. ACCESS case manager conducted 12 to 15 structured home visits, at least once per week, with the client and his family in accordance with ACC protocol, providing the services below.

- Case management, including ongoing assessment and reassessment of service needs. Services included linkage to outpatient substance abuse treatment, recovery group, education and vocational training, employment and housing, and other services as needed, as well as pro-social activities, crisis management, social support, advocacy, college tours, Job Corps tours, community service, and random drug testing to ensure clients stayed on track.

- Community reinforcement through a behavioral intervention, the Adolescent Community Reinforcement Approach (A-CRA) to alcohol and substance use treatment, which seeks to increase the family, social, and educational/vocational reinforcers of an adolescent to support recovery and prevent relapse (Chestnut Health Systems, Inc., 2002).

- Material assistance, such as transportation, tattoo removal, California identification, groceries, and work clothes, in order to eliminate barriers to needed services and facilitate success.

- Aftercare provided upon completion of the 12- to 15-week ACC protocol, during which time case managers maintained phone contact with clients to ensure progress was maintained and new needs were addressed.

In addition, ACCESS clients were invited to participate in sober fun activities, including holiday parties; bowling; movies; and outdoor activities such as surfing, rock climbing, and snowboarding through Outdoor Outreach, a local nonprofit organization that provides outdoor programming to at-risk and underprivileged youth.

Case managers were expected to carry a maximum caseload of 20 to 25 clients, with the understanding that about half of these would be in the aftercare phase of treatment at any given time and, thus, require less intensive contact.

REPORT OVERVIEW

This final report provides information regarding the process and impact of the ACCESS program through September 2008. Specifically, details are provided regarding how the program was implemented and what changes were realized by the targeted youth over time. Chapter 2 outlines the research methodology and analysis plan; Chapter 3 describes in detail how the program was implemented and managed, the characteristics of the youth, treatment intensity, and stakeholder partnerships; Chapter 4 outlines any changes in behavior between clients who both successfully completed the program and those who were terminated; and Chapter 5 summarizes the findings and documents lessons learned for future endeavors.

CHAPTER 2
EVALUATION METHODOLOGY

CHAPTER 2
EVALUATION METHODOLOGY

INTRODUCTION

To determine whether Phoenix House of San Diego, Inc.'s Assertive Continuing Care Ensuring Sobriety and Success (ACCESS) program was implemented as planned and what effect program participation had on clients and their families, both process and impact evaluations were conducted. Efforts were directed at documenting the level and type of services provided and whether positive outcomes, such as decreased substance use, improved mental health, reduction in criminal activity, and improved family functioning were achieved. The following chapter describes the research design, research questions, data collection efforts, and the analysis plan for the process and impact evaluations.

RESEARCH DESIGN

Process Evaluation

As noted in Chapter 1, ACCESS is based on the best practice model Assertive Continuing Care (ACC) and is designed to provide intensive, accessible, case management reentry services to youth and their families. To determine if Phoenix House of San Diego, Inc. implemented the program as planned, the Criminal Justice Research Division of the San Diego Association of Governments (SANDAG) utilized several methods to address the research questions noted below. Because the local evaluation was part of a larger cross-site evaluation, the primary measurement tools (i.e., GAIN-I, GAIN M90, and GPRA[2]) were selected by the national evaluator. In addition, to help reduce the costs of the evaluation, program staff were charged with collecting a substantial portion of the data, including conducting one-half of all follow-up interviews.

Research Questions

The process evaluation was designed to answer the following questions.

1. How closely did implementation reflect the design model?
2. What modifications to the design model were made and why?
3. What effect did the modifications have on the planned intervention and evaluation?
4. What were the characteristics and needs of clients at intake?
5. Were individualized services provided to clients to address their needs?
6. What was the nature of partnerships among stakeholders? Did this partnership enhance or detract from service delivery?

[2] These tools are fully described later in this chapter.

Data Collection Procedures

In order to address research questions 1, 2, 3, and 6 above, evaluators attended and took minutes at monthly project meetings to document project development and growth. In addition, this level of contact allowed the evaluators to track staffing changes that affected service provision.

Review of the intake interview (GAIN-I) and standardized risk assessment (SDRRC) allowed evaluators to describe client demographics and needs at intake, answering question 4 above. These instruments are described below.

- **The Global Appraisal of Individual Needs-Initial (GAIN-I)**: The GAIN-I is a standardized assessment designed by Chestnut Health Systems, Inc., and was required for the cross-site evaluation. It measures client self-report information in eight core sections (Background, Substance Use, Physical Health, Risk Behaviors and Disease Prevention, Mental and Emotional Health, Environment and Living Situation, Legal, and Vocational) (Chestnut Health Systems, Inc., no date). The Core version, which includes fewer items than the full version, was used for this project. This interview was completed with the client by the Assessment/Reentry Counselor upon exit from incarceration, entered into Chestnut's Assessment Building System (ABS), and sent to Chestnut electronically on a monthly basis. Chestnut staff cleaned the data and provided Statistical Package for the Social Sciences (SPSS) software files to the evaluators.

- **The San Diego Regional Resiliency Checkup (SDRRC)**: The SDRRC is a two-page, research-based assessment tool that has been used across systems (Probation, law enforcement, schools, service providers, etc.) in San Diego County since May 1998. As part of this assessment, youth are rated on 30 risk items and 30 protective factors, each of which is grouped into six dimensions: family, peer, individual, education, delinquency, and substance use. Each factor can be rated as "yes," "somewhat," or "no." For the analyses presented here, a client was rated as having a risk factor if "yes" or "somewhat" was coded because there still was room for improvement. Similarly, he was categorized as having a protective factor only if "yes" was coded. The SDRRC was completed by the case manager at the beginning of treatment and hard copies were provided to the evaluators. These data were entered into SPSS by evaluation staff.

In order to answer question 5 above, evaluators reviewed treatment tracking forms completed monthly for each client by the case managers. Case managers provided the date and amount of time spent at each session with the client, parent, both client and parent, or phone intervention in the categories of Adolescent Community Reinforcement Approach (A-CRA) and Case Management. They also provided dates of recreational activities the client attended and additional notes. These forms were also provided to the evaluator, who entered them into SPSS for analyses.

Analysis Plan

Analysis for the process evaluation is primarily qualitative in nature. Descriptive information gained from these data collection efforts is summarized in Chapter 3 to serve as a framework for the results from the impact evaluation.

Impact Evaluation

To determine any impact the ACCESS services may have had on the behavior of the target population, family functioning, and recidivism, a pre-test/post-test single sample design was used and data were collected at several different points in time.

Research Questions

The impact evaluation was designed to answer the following questions.

1. Did clients report more stable school, employment, and housing?
2. Did clients maintain a crime-free lifestyle and were contacts with the juvenile justice system reduced?
3. Did clients maintain a drug-free lifestyle?
4. Were positive changes realized in terms of clients' mental and physical health?
5. Were clients satisfied with services they received?

Data Collection Procedures

In addition to the instruments previously described, the following tools were used to answer research questions 1 through 4.

- **The Global Appraisal of Individual Needs-Monitoring 90 Days (GAIN-M90)**: In order to answer the first four impact evaluation research questions above, program and evaluation staff conducted follow-up interviews using the GAIN-M90 six months after intake[3]. As with the GAIN-I, the core version was used and these data were entered into ABS, cleaned by Chestnut, and provided to the evaluator in SPSS files. These self-report interviews allowed the evaluators to determine what changes clients made and identify challenges faced upon clients' return to the community.

- **Probation Case Management System (PCMS)**: Question 2 was also supplemented with criminal history and placement information collected from PCMS (i.e., Probation records) and entered into SPSS by evaluation staff. This information was collected from the time of the client's first contact with Probation through one year after exit from the Juvenile Ranch Facility (JRF) or the East Mesa Juvenile Detention Facility (EMJDF). Information collected included number and type of referrals to Probation and sustained petitions, number of probation violations, and number and length of incarcerations.

A second SDRRC was also completed by the case manager at program exit to supplement the outcome information for the first three questions. These forms were provided to evaluation staff and entered into SPSS.

[3] The GAIN-M90 was also completed 3 and (initially) 12 months after intake. Due to difficulty locating clients, the time periods used in a number of three-month interviews overlapped with those of the six-month interviews and, therefore, three-month interviews are not included in this evaluation. Twelve-month interviews were replaced with a required discharge interview by CSAT in April 2005, and were discontinued in February 2008 as the scope of the project did not allow for an additional follow-up period.

Finally, clients were asked to complete the ACCESS Youth Survey (a satisfaction questionnaire) after program completion to provide evaluators with information to answer question 5. In order to protect client confidentiality, these questionnaires were completed by the client and placed in a signed, sealed envelope which was given to the case manager at the last meeting. The case manager then provided these envelopes to evaluation staff. In some cases when the case manager was unable to retrieve the questionnaire, it was administered after program completion by follow-up staff. These forms were also entered into SPSS.

In addition to the data collected to answer the research questions above, discharge status forms were completed by the case managers and entered into the Center for Substance Abuse Treatment's (CSAT) on-line Government Performance and Results Act (GPRA) tool. Information on program completion status from these forms is included in this evaluation.

As noted earlier, Phoenix House of San Diego, Inc. staff were responsible for collecting much of the data, including one-half of the follow-up interviews. These tasks were completed in addition to their service provision responsibilities and, although separate Phoenix House of San Diego, Inc. follow-up staff conducted the interviews, as turnover occurred all staff were forced to take on additional responsibilities. While program staff were extremely conscious of collecting and tracking data, staff turnover sometimes affected the data collection process, as did the fact that the target population was difficult to locate for follow-up interviews. As such, an 80 percent follow-up rate was not achieved and, in some instances, the timing of the three- and six-month follow-ups overlapped, precluding any measurement of change during that period.

Table 2.1 shows the data that were utilized in the evaluation, including the number and type of assessments completed at each point in time.

Table 2.1
NUMBER OF ASSESSMENTS COMPLETED AT EACH TIME POINT

	Intake	6-months	Discharge
GAIN-I	282	N/A	N/A
GAIN-M90	N/A	173	N/A
GPRA	282	200	257
SDRRC	226	N/A	161
ACCESS Youth Survey	N/A	N/A	119

SOURCE: SANDAG's ACCESS: Assertive Continuing Care Ensuring Sobriety and Success Final Evaluation Report

Additionally, the GPRA tool was completed as part of the intake, three-, and six-month follow-up interviews and entered on-line to meet CSAT reporting requirements. However, these data are not included in the analysis for this evaluation as the tool was not designed to measure change over time.

Analysis Plan

The analysis plan to measure impact was developed to determine if the program met the intended outcomes. Because random assignment to an experimental and control group was not feasible, comparisons were made between participants as a function of their exit status (i.e., successfully discharged versus terminated) and over time (baseline and 6-months post-release). Both bivariate and multivariate analyses were run to determine which factors influenced a youth's behavior. In addition to presenting data frequencies, measures of central tendency and cross-tabulations are included. Logistic regression analysis was conducted to determine what factors influenced a youth reoffending. The two variables of interest were receiving a new sustained petition and receipt of an institutional commitment at 6- and 12-months post-release. A p value of .05 was used for all statistical tests. When a result is statistically significant, it means that the difference is real and not due to chance variation or error. Because of the challenges noted above with conducting follow-up interviews, analysis was limited to 6-months post-release from commitment for all data except those data collected from official Probation records.

Consent Procedures

Because of the cross-site evaluation and the involvement of at-risk youth, SANDAG sought and received IRB approval. To be included in the study, a consent to participate was required; however, youth who refused to participate in the study were still eligible to receive ACCESS services. Because of their status as minors, consent from the parent/guardian was also obtained. Consent forms were available in English and Spanish.

There were two methods to obtain consent for participation in the evaluation. The first method was for the case manager to meet with the parent prior to the youth's incarceration at JRF or EMJDF, either during the Probation assessment or in a separate meeting if the parent/guardian did not attend the assessment. The case manager explained the program and evaluation to the parent and asked them to sign a consent form granting the evaluators permission to include their child's information in the evaluation. If the parent gave consent, the form was forwarded to the Assessment/Reentry Counselor, who explained the evaluation and obtained consent from the client prior to conducting the first interview (Option 1 in Table 2.2). However, parents/guardians were not always available to the case managers prior to the client's intake interview. In these cases, the Assessment/Reentry Counselor obtained the client's consent first. Because the clients were incarcerated at intake, Probation acted as guardian until the case manager could meet with the parent/guardian in the community after the client's release from incarceration and obtain consent (Option 2 in Table 2.2).

Table 2.2
EVALUATION CONSENT PROCEDURES

Option 1	Option 2
Parent/guardian signs consent form at Probation assessment or meeting with case manager ↓ Client signs consent form prior to intake interview	Client signs consent form prior to intake interview ↓ Parent/guardian signs consent form at first meeting with case manager

SOURCE: SANDAG's ACCESS: Assertive Continuing Care Ensuring Sobriety and Success Final Report

In cases in which the client was 18, and therefore legally an adult at intake, parent/guardian consent was not obtained. When a client turned 18 during the evaluation period, he was asked by follow-up staff or the case manager to sign a new consent form prior to completing additional evaluation instruments.

There were 282 clients who gave consent and participated in the evaluation. An additional 48 clients received program services, but did not participate in the evaluation.

POSSIBLE STUDY LIMITATIONS

As is the case when conducting action research, there are a number of ethical and practical factors that limit the implementation of research. Below is a list of possible limitations for this evaluation study and steps taken by research staff to address them.

- **Lack of Experimental Design:** As noted earlier, random assignment was not feasible for this study and a quasi-experimental pre/post design was implemented. As such, cause-effect conclusions are difficult because other possible influencing factors (confounding variables) cannot be eliminated and any statements about causality should be avoided. However, the quasi-experimental design did permit analysis over time (pre and six-month involvement) and by program exit status, which allowed the program to examine the influence full participation in the program had on youths' behavior.

- **Self-Report Data:** Reliance on self-report data has its limitations, especially in respect to underreporting. While self-report was the primary source to obtain substance abuse and mental health information, the program and evaluators utilized the GAIN, which has been shown to be both valid and reliable. In addition, staff were required to participate in extensive training prior to administering the tool and criminal history data was also collected from official records, providing two sources of information.

- **Reliance on Program Staff to Collect the Data:** While program staff were very diligent in their data collection efforts, dividing the data gathering responsibilities between program and research staff impacted the quality and quantity of data collected. Although program staff received the same GAIN training as research staff, they were not as experienced in administering evaluation tools and in locating clients for follow-up. This resulted in fewer follow-up interviews being completed than planned and also extra time spent in quality controlling the data. In addition, because of the staff turnover often associated with non-profits, there were instances when GAIN certified staff left the program, creating extra work for the remaining staff as they tried to complete all of the interviews while another staff member was trained. The strong partnership between research and program staff helped mitigate some of these issues by research staff being available for questions and helping advise on locating clients.

SUMMARY

SANDAG was contracted by Phoenix House of San Diego, Inc. to conduct both process and impact evaluations of the ACCESS program, as well as participate in the cross-site evaluation. During the period of October 2004 to September 2008, 282 youth and their families participated in the ACCESS program and consented to be in the study. A pre/post design was utilized and data were collected from several different sources, including interviews, official Probation Department records, treatment tracking, and the SDRRC. Process analyses described the characteristics of the youth and families and the intensity of treatment; and the impact analyses focused on measuring any change over time and between those who successfully completed the program and those who did not. This is the final report detailing the outcomes of the evaluation.

CHAPTER 3
PROCESS EVALUATION

CHAPTER 3
PROCESS EVALUATION

INTRODUCTION

The current chapter provides information pertaining to the process evaluation, which addresses the research questions outlined in the previous chapter. Specifically, key program milestones, program modifications and the resulting impact on implementation, and client characteristics are presented.

IMPLEMENTATION OF AND MODIFICATIONS TO THE DESIGN MODEL

Program Design

As noted earlier, Phoenix House of San Diego, Inc.'s Assertive Continuing Care Ensuring Sobriety and Success (ACCESS) program implemented the best practice Assertive Continuing Care (ACC) model to address the reentry of youth exiting the Juvenile Ranch Facility (JRF) and the East Mesa Juvenile Detention Facility (EMJDF). The ACC model focuses on providing an assessment-based, intensive level of services to youth and their families that are accessible (i.e., at home or another location, such as a restaurant, in their home community), and places the responsibility for making sure sessions occur on the clinician rather than the client. ACCESS staff started program services while the youth was still detained and continued aftercare for six months post-release. Program participation included a reentry group at both facilities to prepare clients for release, intensive case management services with one of three ACCESS case managers once the client was back in his community, and a period of less intensive aftercare with the case manager. Because the target population was high-risk, it was not uncommon for a youth to be re-arrested or violate probation and be sent back to the institution. In these circumstances, the case manager continued to meet with the youth if possible (unless their caseloads were too large or the youth received a long-term institutional commitment) and continued the Adolescent Community Reinforcement Approach (A-CRA) once he was back in the community.

> "The case manager was very helpful [with] my needs and gave a lot of positive advice [about] my problems. [I] actually ... solve[d] some of them due to this program. Thanks!"
> *ACCESS graduate, age 17*

During the period of October 2004 to September 2008, 282 youth and their families participated in the ACCESS program and consented to be in the study. Clients were in the program for an average of 6.90 months (SD = 2.82). Of these youth, 33 percent completed the program successfully; that is, attended all required sessions; 60 percent were terminated (i.e., unsuccessful completion); and 8 percent were still receiving services at the end of the data collection period (not shown). The clients who were terminated were grouped into two categories, those who made satisfactory progress and those who did not. Table 3.1 shows the reasons clients were terminated.

Table 3.1
REASONS FOR UNSUCCESSFUL DISCHARGE FROM PROGRAM

	Satisfactory Progress	Unsatisfactory Progress
Involuntary discharge	N/A	34%
Left on own against staff advice	8%	4%
Referred to other program	6%	7%
Incarcerated on new offense	15%	21%
Moved	N/A	4%
Other	N/A	2%
TOTAL	**168**	

SOURCE: SANDAG's ACCESS: Assertive Continuing Care Ensuring Sobriety and Success Final Evaluation Report

Program Implementation and Modifications

For the most part, the original program model was implemented as designed, with some changes as described below. ACCESS was implemented by a collaborative team made up of staff from Phoenix House of San Diego, Inc. (including the Program Director, Program Coordinator, Data Manager, and three case managers) and San Diego Youth and Community Services (SDYCS) (the Assessment/Reentry Counselor), in cooperation with Probation. Although there was staff turnover, this collaboration remained intact throughout the grant.

Table 3.2 provides a timeline of milestones that occurred during the grant period. The first six months were focused on startup activities, including hiring staff, attending the national trainings and meetings, obtaining IRB approval, and solidifying the program procedures. The program started providing services in the spring of 2005 and expanded its target area in July 2005 and then again in November 2006. The final client entered ACCESS in June of 2008 and the program ended in September of that same year.

Table 3.2
PROGRAM MILESTONES
October 2004 – September 2008

October 2004	Phoenix House of San Diego, Inc. receives Youthful Offender Reentry Program (YORP) grant award from the Center for Substance Abuse Treatment (CSAT)
December 2004	Program Director, Project Coordinator, and Principal Investigator attend grantee workshop
January 2005	Assessment/Reentry Counselor and Evaluation Project Manager attend Global Appraisal of Individual Needs (GAIN) instrument training
March 2005	Institutional Review Board (IRB) approval received and reentry groups begin at Juvenile Ranch Facility (JRF)
April 2005	First client released from JRF and case management in the community begins
June 2005	Catchment area increased to include a broader area of the City of San Diego and South County, as well as parts of East County
July 2005	Follow-up begins
January 2006	Program Director, Project Coordinator, and Evaluation Project Manager attend grantee workshop
October 2006	Program Director, Project Coordinator, and Evaluation Project Manager attend grantee workshop
November 2006	Catchment area increased to include parts of North County
January 2007	Case managers begin attending Probation assessments
July 2007	Reentry groups begin at East Mesa Juvenile Detention Facility (EMJDF)
October 2007	Program Director, Project Coordinator, and Data Manager attend grantee workshop
March 2008	Final client assessed to receive ACCESS services
June 2008	Final client enters ACCESS program
September 2008	Program Director, Project Coordinator, and Data Manager attend grantee workshop; Data collection for evaluation completed

SOURCE: SANDAG's ACCESS: Assertive Continuing Care Ensuring Sobriety and Success Final Evaluation Report

Program Start-Up Delays and Challenges Enrolling Clients

From the beginning, due to issues beyond program staffs' control, ACCESS faced challenges in meeting their projected target numbers. The program initially planned to begin serving clients in January 2005, but was delayed as evaluators worked to resolve concerns from the IRB about sharing confidential information between ACCESS and Probation. As client recruitment began, program staff found that the number of actual intakes was lower than initially anticipated due to factors beyond their control. Below are the various challenges that delayed and ultimately reduced the number of youth eligible to receive ACCESS services.

- **Increase in Time Served at JRF**. The ACCESS intake process entailed Probation initially identifying eligible clients upon incarceration and the ACCESS Assessment/Reentry Counselor completing the intake interview (i.e., Global Appraisal of Individual Needs-Initial (GAIN-I)) with the client a week or two before his scheduled release back to the community. However, sometimes during the time between identification and intake, the identified youth were administratively removed from JRF due to behavioral and/or other issues, causing them to remain incarcerated rather than being released to the community on their assigned date. This could result in the youth no longer being eligible for the program or being released at a time when case mangers had a full caseload, forcing the staff to see more clients than dictated by the program design. Also, when a youth was placed on home supervision upon release from incarceration, the case manager was not allowed to meet with him for at least two weeks post-release, again delaying starting the A-CRA sessions.

- **Reassignment by Probation to Different Treatment:** In some of these incidences when a youth was detained longer than expected, he was reassessed by Probation to receive a higher level of care and, therefore, did not enter ACCESS.

- **Misunderstanding of Eligibility Criteria During Probation Assessment:** A third issue that reduced the number of youth being assigned to receive ACCESS services was a misunderstanding of what disqualified a youth from the program. For example, during the first months of service, youth who were gang involved were not being referred to ACCESS during the Probation assessment process due to a misunderstanding about which clients were eligible.

In attempts to address these issues and increase program intakes, the program worked closely with Probation to find possible solutions to increase the ACCESS numbers. One solution was to widen the program catchment area to include more communities across the County. This was done twice, in June 2005 to increase the areas in the City of San Diego and South County served and add parts of East County, and in November 2006 to add parts of North County. A second solution was to have case managers become more involved in the initial Probation assessment process, beginning in January 2007, in order to answer any questions from parents about the program and ensure there was no confusion about which clients were eligible for ACCESS. A third solution was to expand the reentry services to another detention facility. In July 2007, ACCESS reentry groups were started at EMJDF to serve clients who could not go to JRF for various reasons (e.g., medical issues, fire-setter status, etc.). Though these changes allowed the program to increase monthly intakes, they were unable to make up for anticipated target numbers that were missed during the initial period.

These changes also had some impact on the program model, most notably decreasing the time available for case managers to meet with clients in the community. For instance, by broadening the catchment area, case managers had a larger geographic area to cover to visit their clients, which resulted in less time to meet with multiple clients per day[4]. In addition, it was not uncommon to have unbalanced caseloads because of more clients living in one area than another. Efforts to reduce the caseloads by spreading the cases out among case managers resulted in an increase in travel time across the County.

[4] San Diego County is the size of Connecticut and covers 4,261 square miles. While the entire County was not targeted, the different communities are spread throughout the County, requiring significant travel time.

Another factor impacting the caseloads was having case managers attend the Probation assessments and additional Probation team meetings to identify eligible youth. This was not part of the original program design and removed case managers from the field one day per week or an average of three to four days a month and impacted their availability to visit clients. However, the benefits of this change were an increased role by ACCESS staff in client assignments and improved communication with Probation partners.

Starting reentry classes at EMJDF also impacted program staff time. Because of the geographic distance (approximately 45 miles) between JRF and EMJDF, the Assessment/Reentry Counselor could not run reentry groups at both facilities, so the EMJDF class was run by the Project Coordinator. This impacted the time she had for her regular duties, such as supervising staff and meeting with project partners, as well as duties she took on as turnover occurred, such as training new staff and conducting intake and follow-up interviews. When the Project Coordinator left the program in March 2008, the responsibility for the EMJDF groups shifted to the case managers on a rotating basis. However, this did not affect their time in the field because the program stopped accepting new intakes in preparation for the end of the grant and they were able to stop attending Probation assessments at this time.

> "Talking in a group was helpful. People could relate to you."
> *ACCESS client, age 16*

Change in Length of Treatment

The original design model called for six months of continuing care intervention in the community after release from incarceration. As noted previously, this was to consist of 12 to 15 weekly A-CRA sessions with the clients and/or families, as well as three months of aftercare. However, this client population had a high incidence of recidivism and AWOL (absent without leave) from probation and these interruptions in contact with the client made it difficult for case managers to complete A-CRA in the planned three-month period. In fact, some clients took up to eight months to complete the required number of A-CRA sessions and, in some cases, had to start over after time away from treatment. This increase in time to complete A-CRA in the community led to higher caseloads for case managers as clients did not exit as planned and new clients continued to enter the program[5].

An additional change to the model was a direct result of the risk associated with this particular target population and their involvement in gangs. In 2006, there was an increase in gang violence, not only among clients but also in some of the neighborhoods where they lived. This gang-related violence resulted in a decrease in the social events because a number of program clients were gang-involved and could not attend events together. Additionally, it was not safe for case managers to visit the homes of those youth actively involved in gangs without an armed Probation Officer and safe alternatives had to be found (e.g., picking up and dropping off clients at school or another safe area and conducting meetings at restaurants, libraries, etc., outside their communities), which posed another challenge to meeting in general. Follow-up staff also attempted to meet with youth in safe environments or outside the neighborhood. However, this made it difficult to obtain follow-up interviews, especially for the evaluators, who were responsible for roughly half of the follow-ups. Specifically, the evaluators could not drive clients anywhere due to insurance issues. Clients often had trouble finding transportation or were unwilling to leave their neighborhoods to meet the interviewers.

[5] The original plan was for approximately one-half of each 20 to 25 client caseload to be in the third phase of the program and only require minimum contact.

Staff Turnover and Maintaining Consistent Client Contact

A common issue that many non-profits grapple with is frequent staff turnover. This was no different for Phoenix House of San Diego, Inc., with ACCESS experiencing staff turnover, particularly among case managers in the beginning of the program. There was a total of ten case managers over the four-year life of the program, one of whom was replaced before client contact began. During February and March 2006, the three case managers who originally met with clients left the program; two of their replacements had also left by the end of that year, for a change in all three of the original case mangers. These changes meant that many clients finished the program with a different case manager than they had started with, which in some cases made it difficult to establish rapport. Often, the program was unable to find replacements before exiting case managers left the program and, therefore, could not help facilitate the transition for the client to a new case manager. It also placed an extra burden on remaining staff, forcing case managers to take on higher caseloads, the Program Coordinator to step in and manage clients in addition to her other duties, or case management to be put on hold while the Data Manager maintained phone contact until a case manager was available. However, during the program's final year, a core team of case managers provided continuity and consistent services to the participants. They were also responsible for solidifying the relationship with Probation to increase the number of referrals to the program.

> "Clients did not respond well to staff changes and often stopped participation. This is common with this particular population who are typically mistrustful of staff and slow to buy into the treatment."
> *ACCESS case manager*

Transitions among the program staff who conducted intake and follow-up interviews (i.e., the Assessment/Reentry Counselor and Data Manager) were particularly difficult for the data collection due to the amount of time required for training on the Global Appraisal of Individual Needs (GAIN) instrument. The Assessment/Reentry Counselor position changed during the course of the project, first in May 2006 and again in July 2007. Because of the intensive training associated with the GAIN interview, it took months for replacement staff to be certified to conduct GAIN interviews on their own. During this time, the Project Coordinator and Data Manager helped conduct intake interviews, as well as training new staff and reviewing interviews they conducted. However, doing these additional tasks reduced the time available to attend to their other duties. The Data Manager, who was tasked with conducting follow-up GAIN interviews, also changed twice, in November 2006 and March 2008. However, both times this position was filled by current Phoenix House of San Diego, Inc. staff members who had already begun working toward GAIN certification and the changes had less impact on data collection. Finally, the Program Coordinator left in March 2008, as mentioned previously, as did one case manager. However, existing program staff were able to fill these roles and train with the departing staff before they left, making this transition smoother than those in the past.

> "I would like to thank all of the people who helped me and talked with me over the time we were having."
> *ACCESS client, age 17*

The staffing changes described in the above section are outlined in Table 3.3.

Table 3.3
STAFFING CHANGES
October 2004 – September 2008

	Number of Positions	Number of Individuals Over Time
Case manager	3	10
Assessment/Reentry Counselor	1	3
Data Manager	1	3
Program Coordinator	1	2

NOTE :Cases with missing information not included

SOURCE: SANDAG's ACCESS: Assertive Continuing Care Ensuring Sobriety and Success Final Evaluation Report

As is the norm in organizational development, the program had growing pains in the beginning but was able to overcome them over the course of the grant. During the program's final year, many of the issues discussed above were resolved and Probation had a better understanding of the program, more clients were referred, and the case managers had a strong working team.

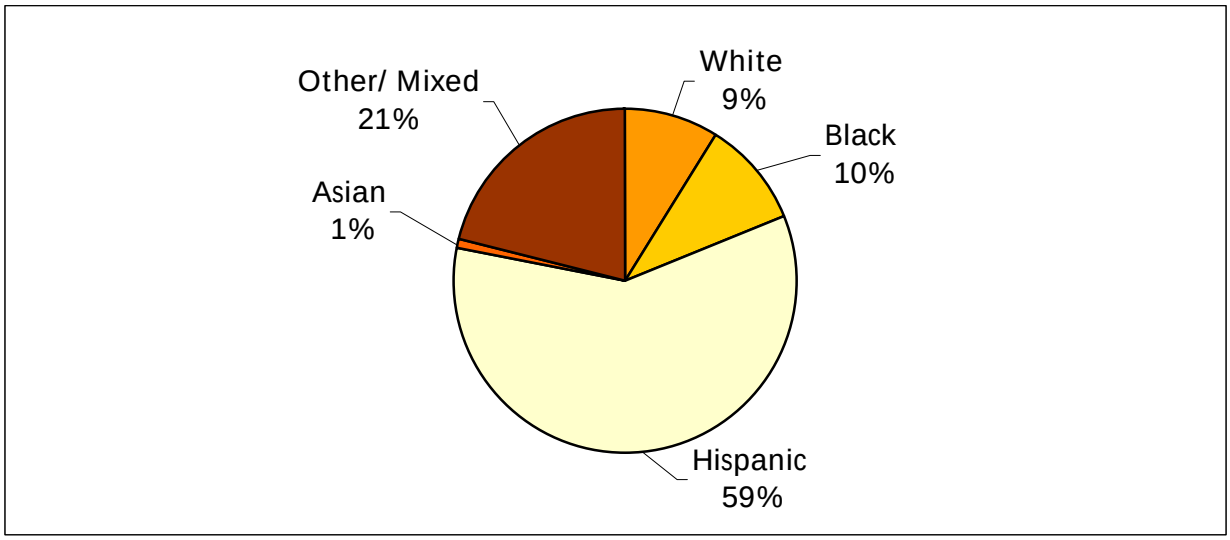
CHARACTERISTICS AND NEEDS OF CLIENTS AT INTAKE

There were 282 clients who received ACCESS program services and consented to have their information included in the evaluation. Of these, over half (52%) lived in the City of San Diego, 17 percent each lived in East and South Counties, and 14 percent lived in North County. A further description of the demographics and needs of these clients is provided below.

Demographics

Because of the program requirement that all clients have prior incarceration at the male-only Juvenile Ranch Facility (JRF), all of the clients in the study were male, with a mean age of 15.8 years old (range 13 to 18, SD = 1.09) (not shown). As Figure 3.1 shows, over half (59%) of the respondents were Hispanic, 21 percent were Other/Mixed, 10 percent were Black, 9 percent were White, and 1 percent were Asian.

Figure 3.1
CLIENT ETHNICITY



TOTAL = 279

NOTE: Cases with missing information not included.

SOURCES: SANDAG; Global Appraisal of Individual Needs (GAIN), 2005 - 2008

In respect to living situation when not incarcerated, nearly two-thirds (63%) of the respondents reported that a single parent had custody of them and 7 percent reported having been homeless at some point in their lives. In addition, 23 percent reported having gotten somebody pregnant and 8 percent reported having at least one child of their own (not shown).

During the 12 months prior to the intake survey, respondents reported regularly living with an average (median) of 4 people (range 1 to 150[6], SD = 9.82) in addition to themselves. Over one-quarter (28%) of the respondents reported that at least a few of the people they regularly lived with were involved in some form of illegal activity, 36 percent reported that at least a few of the people got drunk weekly or had five or more drinks per day, and around one-quarter (22%) reported that at least a few of the people had ever received alcohol or drug treatment. Over two-thirds (68%) of the respondents reported having a family history of problems with alcohol use and over half (57%) reported a family history of problems with drug use (not shown). These data highlight the challenges these youth face on a daily basis in their homes and living environments. This is especially difficult for youth with addiction issues who are trying to maintain sobriety as they return home post-release from detention and treatment.

> "This program helped me a lot and made thing[s] in me and my home better."
> *ACCESS graduate, age 17*

[6] The large range in number of people clients lived with is due to some youth being incarcerated or in a treatment facility or group home most of the time during the 12 months prior to intake.

Substance Abuse

Given the target population, prior substance abuse was prevalent among the clients. On average, respondents reported being 12.0 years old (range 5 to 17, SD = 1.99) the first time they ever got drunk or used any illicit drugs. This average is similar to results from Substance Abuse Monitoring (SAM), another local study focusing on incarcerated individuals, in which youth reported first using alcohol at age 12.7 and marijuana at age 12.8, on average (Burke, 2008), but is much lower than the national average of 15.7 years old for alcohol and 16.2 years old for drugs (SAMSHA, 1999). In some studies, age of first use below 14 has been shown to be a significant predictor of future drug or alcohol abuse (DeWit, et. al., 2000). Additionally, ACCESS clients reported having ever used an average of 4.0 different substances (SD = 2.41, range 0 to 12) during their life and, as Table 3.4 shows, marijuana (97%), alcohol (96%) and amphetamines (49%) were the three most commonly used.

Table 3.4
CLIENTS' SELF-REPORTED HISTORY OF EVER USING SUBSTANCES

Marijuana	97%
Alcohol	96%
Amphetamines	49%
Other cocaine	25%
Crack cocaine	22%
Painkillers	20%
Hallucinogens	17%
Inhalants	17%
Downers	16%
PCP	14%
Other drugs	12%
Tranquilizers	6%
Heroin	4%
Street methadone	4%
TOTAL	**278 - 279**

NOTES: Cases with missing information not included. Clients who reported using "Other" substances specified abuse of asthma inhalers, Coricidin, salvia, and Seraquil.

SOURCES: SANDAG; Global Appraisal of Individual Needs (GAIN), 2005 - 2008

Similarly, the majority of respondents reported marijuana (62%), alcohol (23%), or methamphetamine (8%) as being the substance they currently liked to use the most, as well as for which they needed treatment (Table 3.5). Forty-one percent (41%) of the respondents felt that they did not need treatment for their alcohol or other drug use. Again, these data are similar to findings from the SAM project, in which youth were asked how bad they felt specific substances were (e.g., alcohol, marijuana, etc.). Only 40 percent of youth who used alcohol and 32 percent of those who used marijuana thought the substance was bad for them (Burke 2008). While almost all of the ACCESS clients had used alcohol (96%) and marijuana (97%), only about one-quarter felt they needed treatment for alcohol (23%) and about one-third for marijuana (36%).

Table 3.5
CLIENTS' CURRENT DRUG PREFERENCES AND PERCEIVED NEED FOR TREATMENT

	Like To Use Most	Need Treatment For
Marijuana	62%	36%
Alcohol	23%	23%
Methamphetamine	8%	11%
Cocaine	2%	3%
Hallucinogens	<1%	1%
PCP	<1%	1%
Opiates	0%	1%
Tobacco	0%	1%
Sedatives	0%	<1%
None	4%	41%
TOTAL	**282**	**280**

NOTES: Cases with missing information not included. Substance categories based on verbatim responses from clients. Clients could name up to three substances for which they felt they needed treatment.

SOURCES: SANDAG; Global Appraisal of Individual Needs (GAIN), 2005 - 2008

Regarding the level of substance abuse treatment prior to their current treatment, at some point 85 percent of respondents reported having attended Alcoholics Anonymous (AA), Cocaine Anonymous (CA), Narcotics Anonymous (NA), Social Recovery (SR), or another self-help group for their alcohol or drug use; 11 percent had been admitted to a detoxification program; and 4 percent had stayed overnight in a recovery home or sanctuary (not shown). Additionally, 20 percent had received a more intensive form of treatment. Specifically, 15 percent of the respondents reported having been admitted to an outpatient program; 7 percent having been admitted for at least one night to a residential, inpatient, or hospital program; and 2 percent reported having been treated in an emergency room for their alcohol or drug use problems (not shown). The combination of their home environments, their young age of substance use initiation, current use, and past treatment experience paint a picture of a population that has many obstacles to overcome to be successful in sobriety.

Physical and Mental Health

Analysis of the self-report physical health indicators offers two different sides of these youth. That is, while over half (58%) of the respondents reported having been to the emergency room at some point in their life for injuries or other physical health problems (with just over one-third (35%) of the respondents having been admitted to a hospital overnight), the majority of respondents (84%) reported that their general physical health overall during the past year was "good," "very good," or "excellent" (not shown). This difference between perception of health and visits to the ER could be attributed to the different time periods in the questions (i.e., lifetime versus past year). However, according to program staff, the difference may be related to the risks these youth take on a regular basis and the gang violence they engage in. For example, one youth broke both ankles jumping from a building when fleeing the police after tagging a building.

Many of the respondents reported experiencing a variety of significant mental health issues at some point during their life. About half (52%) of the respondents reported having had their life significantly disturbed by "nerve, mental, or psychological problems," or felt they could not go on at some point prior to their intake interview. Related to this, one quarter (23%) of the respondents reported having been treated at some point in their life for a mental, emotional, behavioral, or psychological problem by a mental health specialist, in an emergency room, hospital, or outpatient mental health facility, or with prescribed medication. Additionally, during the past year, 12 percent of the respondents reported having had thoughts about killing or hurting someone else and 2 percent (6 respondents) reported having had thoughts about ending their own life or committing suicide (not shown).

Overall, the majority of the respondents reported a high level of violence in their background, with about four in five (79%) reporting having been, at some point in their life, attacked by someone with a gun, knife, or other weapon, and/or struck or beaten to the point that they had injuries. Additionally, 17 percent reported ever having been abused emotionally, 2 percent sexually, and the average age at first abuse of any kind was 12.3 (range 2 to 17, SD = 2.87). Important to note here is the correlation with average age of first drug/alcohol use which, as previously discussed, was 12.0 years. About one-quarter (23%) of respondents reported that they were currently worried that someone might attack them with a weapon and about one-fifth (18%) worried about being hurt by striking or beating. Just over one-third (36%) of those with a current worry had received help to deal with the problem (not shown).

Table 3.6 outlines the details of the violence respondents experienced during their lifetime. Specifically, of those who were victims of violence or abuse, four in five (80%) reported that more than one assailant was involved and over half (58%) reported that the abuse happened several times or over a long period of time. One-third (33%) of respondents reported that they had been afraid for their life or that they might be seriously injured. About one-fifth (21%) reported that at least one person involved was a family member or someone else they trusted and 15 percent were not believed and/or helped by the people they told.

Table 3.6
CLIENTS' SELF-REPORTED ABUSE HISTORY

Prior Abuse	
More than one assailant involved	80%
Happened several times or over a long period of time	58%
Respondent was afraid for his life/seriously injured	33%
One or more assailants was/were family member/trusted person	21%
People respondent told did not believe or help him	15%
TOTAL	**229 - 230**

NOTES: Restricted to respondents who answered yes to one or more abuses. Cases with missing information not included.

SOURCES: SANDAG; Global Appraisal of Individual Needs (GAIN), 2005 - 2008

These data on the participants' physical and mental health provide an even more concerning picture of the multiple layers of challenges these youth face when entering treatment.

Crime and Delinquency

As noted earlier, delinquent behavior was measured using both self-report data and official data gathered from Probation records. Self-report data included a standardized assessment (i.e., GAIN-I) in which respondents were asked a series of questions regarding their involvement in various illicit activities. Individual acts that had taken place during the previous 12 months were regrouped into four categories: property crimes (such as stealing a car), delinquent activities (such as skipping school or gambling), violent acts (such as rape, physical fights, or use of a weapon), or activities involving drugs or alcohol (other than use, such as driving under the influence or selling drugs). During the previous year, the vast majority of the respondents admitted to participating in various property crimes (86%), delinquent activities (83%), violent acts (83%), and/or drug- or alcohol-related activities (other than use) (60%) and nearly one-half (49%) were a member of a gang[7] (Table 3.7). Additionally, four out of five (81%) clients reported having been picked up by police at least once in their lifetime (excluding the instant offense, i.e., the offense that qualified them for ACCESS services) (not shown).

[7] The actual percentage may be higher but, due to the structure of the interview, only those individuals who admitted to doing something illegal were asked about gang affiliation.

Table 3.7
CLIENTS' SELF-REPORTED DELINQUENCY-RELATED ACTIVITIES IN THE PAST 12 MONTHS

Property crimes	86%
Delinquent activities	83%
Violent acts	83%
Activities involving drugs/alcohol	60%
Member of a gang	49%
TOTAL	**277 - 282**

NOTES: Percentages based on multiple responses. Cases with missing information not included.

SOURCES: SANDAG; Global Appraisal of Individual Needs (GAIN), 2005 - 2008

Crime data were also gathered from official crime records at three points in time, including all criminal activity prior to program intake and 6 and 12 months post-release from JRF or EMJDF. Table 3.8 illustrates the number of clients available for data collection. Data were only collected for those clients that completed the data collection period or who were not detained for the entire data collection period (i.e., 14 clients had not been out of incarceration for 6 months by the end of data collection September 30, 2008, and 70 had not been out for 12 months).

Table 3.8
ELIGIBLE FOR CRIMINAL HISTORY DATA COLLECTION

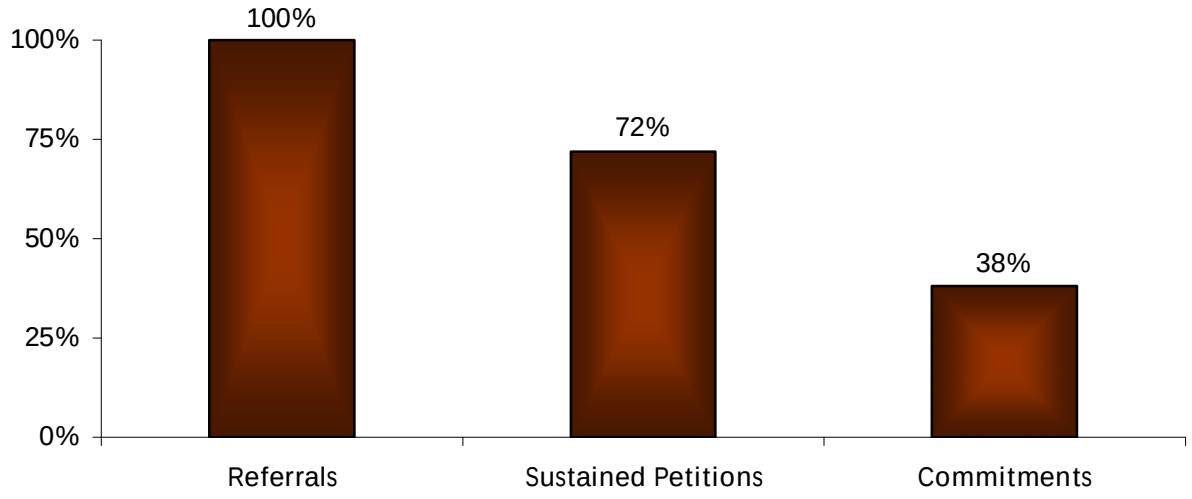
Prior Criminal History (Pre-Commitment to Incarceration for Instant Offense)
↓
282
6 months Post Incarceration Release
↓
268
12 months Post Incarceration Release
↓
212

SOURCES: SANDAG; Probation Case Management System (PCMS) Records, 2008

The instant offense for almost half (43%) of the 282 ACCESS clients was a felony, over one-third (35%) were picked up for a probation violation on a previous offense, about one-fifth (21%) were charged with a misdemeanor, and one client was committed and became eligible due to a status offense (e.g., curfew) (not shown). The most common type of instant offense was a probation violation, followed by a property offense (29%), a violent offense (18%), an other misdemeanor (7%), a drug offense (6%), an other felony (4%), and a status offense (<1%) (not shown).

Given that ACCESS targets high-risk youth, it was not surprising that clients had a lengthy criminal history record. Excluding the instant offense, all of the youth had prior contact with Probation, having an average of 3.58 (SD = 2.25) referrals, and 72 percent had a prior sustained petition (avg. = 1.64, SD = 1.05) (Figure 3.2). The average age of first referral was 13.79 years old (SD = 1.64) and 14.59 years old (SD = 1.42) when a client was first adjudged a 602 ward of the court (not shown). In terms of prior commitments, 38 percent of the clients had at least one previous institutional commitment (avg. = .59, SD = .94)[8], with 60 percent having the longest commitment order for 181 to 365 days.

Figure 3.2
PRIOR REFERRALS, SUSTAINED PETITIONS, AND INSTITUTIONAL COMMITMENTS



TOTAL = 282

SOURCES: SANDAG; Probation Case Management System (PCMS) Records, 2008

[8] Institutional commitments included detainment in Juvenile Hall, JRF, and/or Camp Barrett due to an order of the Juvenile Court.

Of those clients with a prior sustained petition, nearly two-thirds (62%) had a highest sustained petition for a felony-level offense and over one-third (35%) had a misdemeanor-level offense as the high charge (not shown). Most of the clients were found true on a property (48%) or violent (29%) offense (Table 3.9). In addition, 67 percent were or had previously been a 602 ward of the court at the time of the instant offense (not shown).

Table 3.9
VIOLATION TYPE FOR PRIOR HIGHEST SUSTAINED PETITION

Property	48%
Violent	29%
Other (misdemeanor or felony)	15%
Drug	6%
Status	3%
TOTAL	**204**

SOURCES: SANDAG; Probation Case Management System (PCMS) Records, 2008

School and Vocation

In examining the respondents' backgrounds regarding school and work, on average, the last grade or year completed in school was ninth grade (range 5 – 12, SD = 1.19), the average grades received were Cs, and less than half (43%) of the respondents had been employed at a job at some point in their life (not shown). School attendance could be very complicated for this population. Specifically, program staff noted that for some youth school was not a safe environment because of gang affiliation and/or youth were pressured to choose employment over school by their families.

> "A parent requested that her son be able to work instead of going to school because she was getting a divorce and needed the money."
> *ACCESS case manager*

Given the role a youth's peers have in his life, it was important for case managers to understand who the youth were spending time with and address that in treatment. When respondents were asked about their peers, just under half reported that during the past 12 months, most or all of the people they regularly socialized/hung out with were employed or went to school full time (46%), were involved in illegal activities (46%), and/or got drunk weekly or had five or more drinks in a day (42%) (not shown). These data were consistent with the risky behaviors youth themselves admitted to participating in prior to entering treatment and indicated one more layer that needed to be addressed in a youth's efforts to change his negative influences and behaviors.

LEVEL OF SERVICE PROVIDED TO CLIENTS

Length of Time in Program

As noted earlier, the ACCESS model provides accessible services that target the entire family. As such, services were provided by ACCESS case managers at client homes and in the community and included meetings with the client, the parent, and the client and parent together, as well as phone interventions as clients were in their final phase of the program. The program consisted of three types of interventions, A-CRA, case management, and recreational activities, and was designed to engage clients in treatment for at least six months. Analysis of staff treatment tracking forms demonstrates that the program was successful in accomplishing this goal. Specifically, all clients (regardless of exit status) were in the program for an average of 6.90 months (SD = 2.82), with program graduates (e.g., those who received the full dosage of treatment) enrolled an average of 8.14 months (SD = 2.31), which was significantly longer than those who were terminated, who participated for an average of 6.22 months (SD = 2.85) (not shown).

Because the clients were active on probation and at risk for reoffending, it was not uncommon for a client to spend part of their program time in custody[9]. Specifically, 73 percent of clients spent, on average, 114.21 (SD = 86.74) days of the 12-months post-release detained, with those who did not complete treatment spending significantly more time in-custody than those who successfully completed the program (average 137.89 days, SD = 90.97 versus 67.41 days, SD = 54.80) (not shown). This time spent in custody accounts for the difference between time in the program and the average time youth actually received services. That is, although clients were in the program for six months or more, they only received A-CRA services for three months on average (range 0 to 8, SD = 2.06). Case management services were provided for an average of four months (range 0 to 12, SD = 2.38). While recreational services were part of the program, they were not regularly attended, with only 13 percent of clients participating in pro-social recreational activities through the program.

Intensity of Services to Client and Parent

Additional analysis was completed to measure intensity of treatment by examining how many hours of service youth actually received during their time in the program. As Table 3.10 shows, program graduates participated, on average, in significantly more treatment hours than those who were terminated. Specifically, successful clients participated in almost three times more A-CRA hours of services (8.63 hours, SD = 3.38 versus 3.28 hours, SD = 3.02), and about twice as many case management hours (6.39 hours, SD = 6.08 compared to 3.49 hours, SD = 3.97) and recreational hours (.65 hours, SD = 1.88 versus .32 hours, SD = 1.22)[10].

[9] Being reincarcerated was not a reason alone for termination from the program.

[10] Additional services may have been provided but not included on the treatment tracking forms as tracking forms were not always completed consistently during the first year of the grant.

Table 3.10
TREATMENT DOSAGE FOR ACCESS CLIENTS

	Graduates	Terminated	Total
Total A-CRA Hours*	8.63 (SD = 3.38)	3.28 (SD = 3.02)	5.27 (SD = 4.05)
*Individual Hours**	*7.89 (SD = 3.09)*	*3.01 (SD = 2.81)*	*4.84 (SD = 3.75)*
Parent Hours	*.11 (SD = .34)*	*.06 (SD = .23)*	*.08 (SD = .27)*
*Parent & Youth Hours**	*.52 (SD = .83)*	*.18 (SD = .39)*	*.29 (SD = 60)*
*Phone Intervention Hours**	*.10 (SD = .35)*	*.03 (SD = .17)*	*.05 (SD = .24)*
Total Case Management Hours*	6.39 (SD = 6.08)	3.49 (SD = 3.97)	4.38 (SD = 4.85)
*Individual Hours**	*3.56 (SD = 4.70)*	*1.81 (SD = 2.36)*	*2.36 (SD = 3.37)*
Parent Hours	*.38 (SD =.91)*	*.33 (SD = .87)*	*.33 (SD = .87)*
Parent & Youth Hours	*.30 (SD = .56)*	*.18 (SD = .44)*	*.21 (SD =.48)*
*Phone Intervention Hours**	*2.15 (SD = 1.85)*	*1.17 (SD = 1.50)*	*1.47 (SD = 1.65)*
Total Recreational Hours*	.65 (SD 1.88)	.32 (SD = 1.22)	.49 (SD = 1.60)
TOTAL	**89 - 92**	**166 - 168**	**276 - 282**

**Significant at the p < .05 or lower.*

NOTE: Cases with missing information not included. Sum of categories may not equal total due to rounding.

SOURCE: ACCESS Treatment Tracking Forms, 2005 - 2008

As noted earlier, services could have been provided to the youth alone, the youth and parent, or just the parent. Analysis of who received which interventions and at what intensity revealed that for both A-CRA and case management, the youth was the primary recipient of services, receiving an average of 4.84 hours (SD = 3.75) of A-CRA and 2.36 hours (SD = 3.37) of case management. Parents alone received, on average, about 10 minutes of A-CRA services (.07, SD = .27) and half an hour of case management (.33, SD = .87). Similarly, parents and youth together received approximately half an hour of A-CRA (.29, SD = .60) and just over 20 minutes of case management (.21, SD = .48). In addition, case managers reached out to youth by phone, providing approximately five minutes of A-CRA (.05, SD = .24) and one-and-three-quarters hours of case management (1.47, SD = 1.65). Consistent with the overall dosage level, youth who graduated received significantly more individual A-CRA (7.89, SD = 3.09 versus 3.01, SD = 2.81 for terminated clients) and case management (3.56, SD = 4.70 versus 1.81, SD = 2.36 for terminated clients) hours, and client and parent together received significantly more A-CRA hours (.52, SD = .83 versus .18, SD = .39 for terminated clients). In addition, graduates received significantly more hours of phone intervention (.10, SD = .35 A-CRA and 2.15, SD = 1.85 case management) compared to terminated clients (.03, SD = .17 A-CRA and 1.17, SD = 1.50 case management) (Table 3.10).

> "I thought this program was helpful to me. The weekly meetings have helped me get issues off my chest and better relax. When I am out now I think before [I act]."
> *ACCESS graduate, age 18*

NATURE OF PARTNERSHIPS AMONG STAKEHOLDERS

ACCESS relied on collaboration among the Probation Department and two community-based organizations (Phoenix House of San Diego, Inc. and SDYCS) that had not worked together prior to this project. Both programs had worked closely with Probation in the past, providing services to youth involved with Probation, but not directly with each other. However, partnering with SDYCS was a natural fit given their experience and role in operating the Breaking Cycles program, from which ACCESS clients were drawn.

As with any collaboration, growing pains were experienced during the first year. The primary obstacle was addressing the misperception that the two programs were competing for the same clients. This was accomplished by clarifying the purpose of ACCESS and also making adjustments in how clients were referred to the program. For example, in November 2005, ACCESS began assigning clients to case managers based on the client's ZIP code rather than clinical issues. This allowed the case managers to join a team of Probation Officers and counselors from other Probation subcontractors working in a particular region. These teams met weekly to discuss clients and any issues that arose. The teams also allowed the ACCESS case managers to establish rapport with the other professionals working with their clients. This closer working relationship between partners improved delivery of services to program clients and also helped build trust and improve communication among the staff. In addition, the Program Coordinator attended monthly partner meetings with Probation and SDYCS supervisors to discuss and resolve any issues.

SUMMARY

As part of the process evaluation, the Criminal Justice Research Division of the San Diego Association of Governments (SANDAG) documented changes in program implementation, the resulting impact on the design, and client characteristics upon entering the program. In general, the ACCESS program was implemented as designed, with the primary differences having to do with reduced client enrollment and shifting in caseload sizes due to staff turnover and program adjustments in an effort to increase client enrollment. On average, clients participated in the program for six months, receiving both A-CRA and case management services. Of the 282 clients who agreed to participate in the study, one-third completed the full dosage of treatment.

The majority of clients lived with a single parent, were Hispanic, and the average age was approximately 16 years old. As anticipated, clients entering the ACCESS program had a history of substance abuse, starting at an age that places them at increased risk for future dependency. Not only did clients have a history of involvement with the juvenile justice system, but they also had been victims of a range of violent acts. Clients also demonstrated a need for improved academic involvement, with nearly one-half only completing ninth grade. In addition, clients reported hanging out with peers who were involved in similar delinquent activities, such as engaging in illegal acts, using substances, and not attending school. Overall, the youth who received ACCESS services had very complicated backgrounds, including living in environments that placed them at risk for victimization and were not necessarily supportive of sobriety, being deeply involved in the juvenile justice system and substance use, and having fewer protective factors than risk factors that increased their chances of engagement in delinquent behaviors. Taken as a whole, the ACCESS program had a substantial challenge to provide treatment to address the multiple needs of these youth and their families.

CHAPTER 4
PROJECT OUTCOMES

CHAPTER 4
PROJECT OUTCOMES

INTRODUCTION

The second component of the evaluation was to measure the impact participation in the Assertive Continuing Care Ensuring Sobriety and Success (ACCESS) program may have had on a youth's behavior. The following chapter addresses the impact of research questions as outlined in Chapter 2, with the primary focus on any changes in delinquency, peers, school involvement, and substance use activity. Analyses were run comparing those clients who received the full dosage of treatment (i.e., graduated) to those who received none or partial treatment (i.e., terminated). Unless there were statistically-significant differences between these two groups, data for all clients are reported together.

Six-month follow-up Global Appraisal of Individual Needs (GAIN) interviews were completed with youth who could be located and agreed to complete the interview. A total of 173 youth completed the interview (60, or 35%, graduated, 107, or 62%, terminated, and 6, or 3%, were still enrolled as of September 2008). However, because of how some of the questions were phrased in the six month interview, many of the variables were not directly comparable to information collected at intake. This was due to differences in time frames (e.g., the past 90 days versus the past year or life time). In those cases, data are reported but statistical tests for significance were not run.

CLIENTS' DISCHARGE STATUS

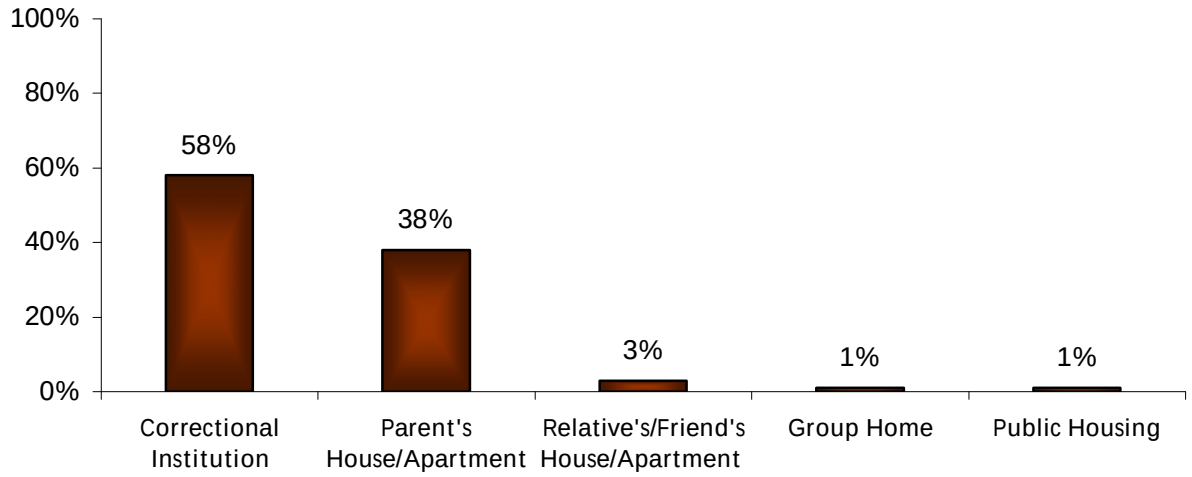
As of September 2008, of those who had agreed to participate in the evaluation, 260 clients had exited the program (92, or 35%, graduated and 168, or 65%, terminated). As noted earlier, successful completion was based on a youth completing all of the Adolescent Community Reinforcement Approach (A-CRA) sessions, and unsuccessful completion included all those youth who left the program, for various reasons, prior to completion. As detailed in this chapter, analyses revealed that completion status had a significant effect on a youth's outcomes. That is, those youth who successfully completed the program were more likely to realize positive changes in their behaviors compared to those who were terminated or were unsuccessful. As such, additional analyses were run to determine what factors, if any, could predict successful program completion. Logistic regression analyses showed two factors that were significant in determining youths' discharge status: the intake San Diego Regional Resiliency Checkup (SDRRC) resiliency score and gang affiliation in the year prior to entering the program. More specifically, while all youth entered the program with a resiliency score that placed them in the "high"(1 to 17) or "intensive" (0 to -60) category of risk according to Probation, those youth who had a resiliency score of -29.0 to -14.0, which was just below the average intake score of -14.1 (SD = 10.8), decreased their odds of successfully completing the program by 70 percent compared to those who had a score that fell within the "high" range (Wald = 6.455). In addition, some type of gang affiliation in the 12 months prior to program intake decreased a youth's odds of graduating successfully by 55 percent (Wald = 6.010).

While the model was limited to those factors available through data collection, awareness of these two indicators offers program staff a mechanism to identify those youth entering the program who are most vulnerable of not finishing and provides an opportunity to take additional steps to implement supports that could possibly help them graduate successfully.

CLIENTS' HOUSING, SCHOOL, AND EMPLOYMENT STATUS AT FOLLOW-UP

At the time of the six-month follow-up interview, over half (58%) of the clients who completed the follow-up interview were incarcerated, over one-third (38%) were living in a house or apartment rented or owned by their parent(s), and a small number were living with a friend or relative (3%), in a group home (1%), or in public housing (1%) (Figure 4.1). It is important to note that the large percentage of youth incarcerated at the time of the interview is likely a factor of ease of locating these youth to conduct the follow-up interview. The official Probation records noted below are a more accurate reflection of the percentage that were incarcerated because they are based on the entire sample and not just those that could be located for a follow-up interview.

Figure 4.1
CLIENTS' HOUSING AT FOLLOW-UP



TOTAL = 173

NOTE: Percentages do not equal 100 due to rounding.

SOURCES: SANDAG; Global Appraisal of Individual Needs (GAIN), 2005 - 2008

Given that the youth were susceptible to being picked-up for probation violations (because they were active on Probation) and also being reincarcerated, it is not surprising that employment and school activity was interrupted and showed continued need for improvement. At the six month follow-up interview, about one-quarter (23%) of clients had been employed within the past 90 days. About one-third (36%) of the respondents reported getting into trouble at school or training within the last 90 days, and nearly two-thirds (62%) of the respondents reported that they had missed school or training for any reason (including suspension) during the past 90 days (not shown).

> "[My case manager] was good. [She] helped me try to get a job by taking me to the mall and stuff. Thanks for the program."
> *ACCESS graduate, age 17*

Though a direct comparison cannot be made due to differences in the time periods referred to in the interviews (past 12 months at intake and past 90 days at follow-up), at follow-up, about two-thirds (65%) of the clients reported that, during the past 90 days, most or all of the people they regularly socialized or hung out with were employed or went to school full-time (versus 40% during the past 12 months at intake) (not shown).

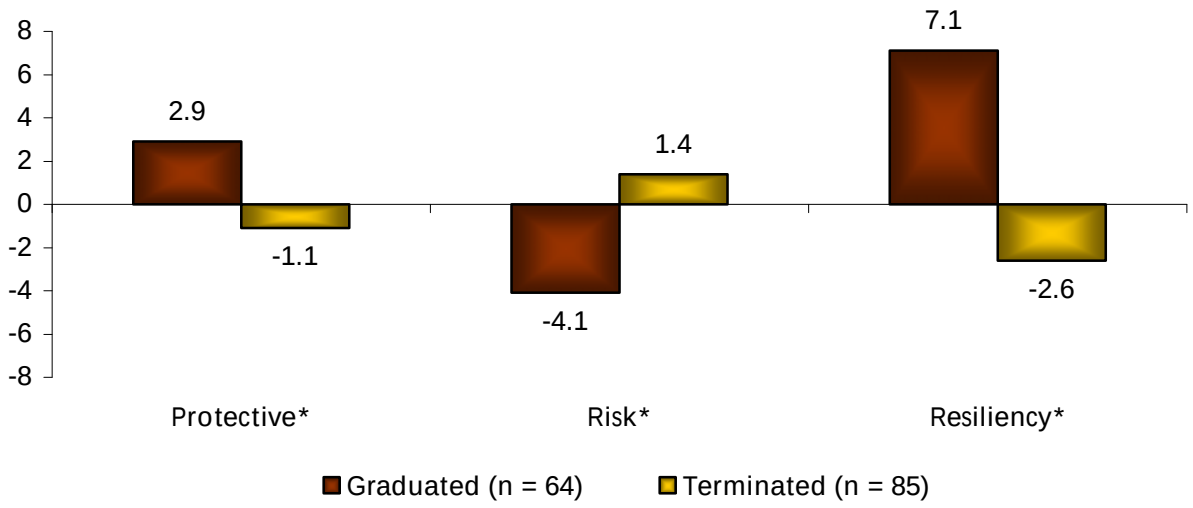
CLIENTS' DELINQUENT AND CRIMINAL ACTIVITY AT FOLLOW-UP

Risk and Protective Factors

As noted in Chapter 2, the SDRRC assessment was completed for all youth by ACCESS staff at program intake and exit to measure change in both risk and protective factors and compute a resiliency score that is the combination of the two (i.e., resiliency equals protective minus risk score). The intent of the tool is to act as a guide for staff to help youth increase those factors that can buffer them against committing delinquent acts and reduce those risk factors that increase the opportunity for delinquency. The instrument rates clients on 30 risk and 30 protective factors that are categorized into six domains. Matched intake and exit SDRRC information was available for 149 program clients (64 graduates and 85 terminated unsuccessfully).

Between intake and exit, average protective, risk, and resiliency scores improved for clients who completed the program successfully and were worse for clients who were terminated. That is, youth who graduated had significantly more positive resources to help them avoid delinquent behavior and also had significantly fewer factors in their lives that put them at risk for delinquency compared to clients who were terminated. As Figure 4.2 shows, graduates had an average increase of 2.9 protective factors (from a score of 7.8 at intake to 10.7 at exit), compared to an average decrease of 1.1 protective factors (from 4.7 to 3.6) for clients who were terminated; an average decrease of 4.1 risk factors (from 20.0 to 15.9), compared to an increase of 1.4 (from 22.6 to 24.0) for terminated clients; and an average increase of 7.1 in resiliency (from -12.2 to -5.1), compared to a decrease of 2.6 (from -17.9 to -20.5) for terminated clients.

Figure 4.2
AVERAGE CHANGE IN PROTECTIVE, RISK, AND RESILIENCY SCORES BY EXIT STATUS



** Significant at the p < .05 or lower.*

SOURCES: SANDAG; San Diego Regional Resiliency Checkup, 2005 –2008

While the protective and risk scores above comprised of sub-scores from each of the domains on the SDRRC, Table 4.1 provides more detail on the specific changes in each of the domains that affected the overall protective, risk, and resiliency scores. Specifically, the percentage of graduates with at least one protective factor increased between intake and exit for each domain, while the percentage with a risk factor decreased for each domain, except delinquency, which was 98 percent at both points in time. In contrast, the percentage of terminated clients with at least one protective factor *decreased* in every domain except education, where there was a slight increase (24% at intake to 25% at exit), and the percentage with at least one risk factor *increased* in each domain, except education, where there was a decrease (95% at intake to 91% at exit), and peer, which was 100 percent at both points in time.

Table 4.1
PROTECTIVE AND RISK FACTORS FOR ACCESS CLIENTS AT INTAKE AND EXIT

	Graduated		Terminated	
	Intake	Exit	Intake	Exit
Protective				
Family	61%	64%	63%	38%
Peer	64%	72%	58%	52%
Individual	38%	56%	28%	18%
Education	50%	67%	24%	25%
Delinquency	45%	61%	29%	18%
Substance Abuse	52%	61%	38%	33%
Risk				
Family	88%	81%	89%	98%
Peer	95%	89%	100%	100%
Individual	91%	89%	95%	98%
Education	81%	61%	95%	91%
Delinquency	98%	98%	99%	100%
Substance Abuse	97%	95%	96%	100%
TOTAL	**64**		**85**	

SOURCES: SANDAG; San Diego Regional Resiliency Checkup, 2005 –2008

Delinquent Acts and Peer Relationships

A direct comparison of the change in respondents' criminal lifestyle between intake and follow-up was not possible because of differences in the time period used in the interviews (the intake interview covers delinquent activities committed in the prior 12-month period and the follow-up interview covers only the past 90 days). However, given that all the clients had engaged in some form of illegal activity resulting in a sustained petition severe enough to receive an institutional commitment, it is valuable to examine their current activity.

Of those individuals who completed the six-month follow-up interview, a significantly smaller percentage of graduates (16%) reported being arrested for a status offense during the 90 days prior to the interview compared to those who were terminated (33%). However, there was no significant difference by discharge status in the percentage of youth who reported doing something illegal in the past 90 days prior to the six-month interview (55% graduated versus 58% terminated)[11] (not shown). Of these 99 clients who admitted to participating in activities that could get them in trouble or be against the law, those who graduated successfully were less likely to report being in a gang (36% versus 59% of those terminated) and involved in drug- or alcohol-related activities other than use, including selling drugs or driving under the influence (15% versus 44%, respectively). Approximately two thirds of youth in both groups were involved in various property (61% and 67%, respectively) and/ or violent (58% and 60%, respectively) crimes (Table 4.2)

Table 4.2
CLIENTS' SELF-REPORTED DELINQUENCY RELATED ACTIVITIES IN THE PAST 90 DAYS

	Graduated	Terminated
Property crimes	61%	67%
Violent acts	58%	60%
Member of a gang*	36%	59%
Did anything illegal while high or drunk	41%	44%
Activities involving drugs/alcohol*	15%	44%
TOTAL	**29 - 33**	**58 - 61**

** Significant at the p < .05 or lower.*

NOTE: Cases with missing information not included.

SOURCES: SANDAG; Global Appraisal of Individual Needs (GAIN), 2005 - 2008

Research has shown that youth have a tendency to commit crimes with other youth (i.e., co-offending) and those who do co-offend are more likely to recidivate and commit violent crimes (McCord & Conway, 2005). Given the strong relationship between co-offending and juvenile crime, supporting youth in choosing positive peer relations is a piece of the preventative puzzle. Addressing peer relations was part of ACCESS' treatment goals and, to understand peer relationships, clients were asked questions regarding the lifestyles of those they hung out with most, in the past 12 months at intake and in the past 90 days at six-month follow-up. Though direct comparisons cannot be made due to differences in the time periods, at follow-up fewer clients reported hanging out with people who were involved in negative activities. Specifically, at six months post-release, less than one-third (29%) of the clients reported that, during the past 90 days, most or all of the people they regularly socialized or hung out with were involved in illegal activities (versus 46% during the past 12 months at intake), and less than one-fifth (16%) reported that those people argued or fought most weeks (versus 27% at intake) (not shown).

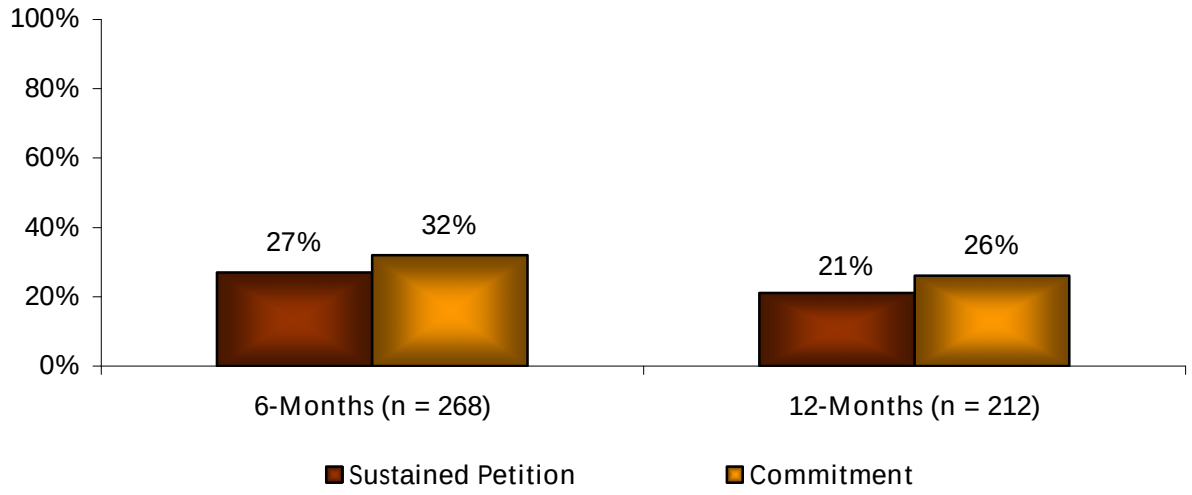
[11] It is important to note that 58 percent of the completed follow-up interviews were conducted with youth currently incarcerated and this could have impacted the total percentage reporting engaging in illegal activities.

Official Probation Records

Several factors were considered when analyzing the data gathered from the official criminal records, including discharge status, ethnicity, impact of prior criminal history, and treatment dosage. In general, the majority of ACCESS clients did not receive a new sustained petition or an institutional commitment at 6 and 12 months post-release from incarceration. As Figure 4.3 shows, during the six-month period post-release, nearly three-quarters (73%) of clients did not have a new sustained petition and over two-thirds (68%) had not received a new institutional commitment. It should be noted that, because all of the clients were 602 wards when entering ACCESS, they could receive an institutional commitment by being found true on a probation violation (and not because of a new offense). At 12-months post-release (or the second half of the one-year period) from incarceration, the proportion of clients reoffending was slightly less, with about one in five (21%) receiving a new sustained petition and about one-quarter (26%) having a new institutional commitment. While official records can reflect an underestimation of illegal activity when compared to self-report data, the difference between these data gathered from the Probation Case Management System (PCMS) on all clients as opposed to those data gathered from follow-up interviews could be an artifact of differences in the response rate and data from official records could be a more accurate reflection of illegal activity. Specifically, the self-report data is based on approximately 60 percent of ACCESS clients and over half were conducted with youth that were incarcerated at the time of the interview (i.e., easy to locate) as opposed to the official data which is based on all the clients that enrolled in the program.

> "I was all in all satisfied with my case manager and I believe the program actually has an effect on those who take it seriously. I really enjoyed working with [my case manager]."
> *ACCESS graduate, age 16*

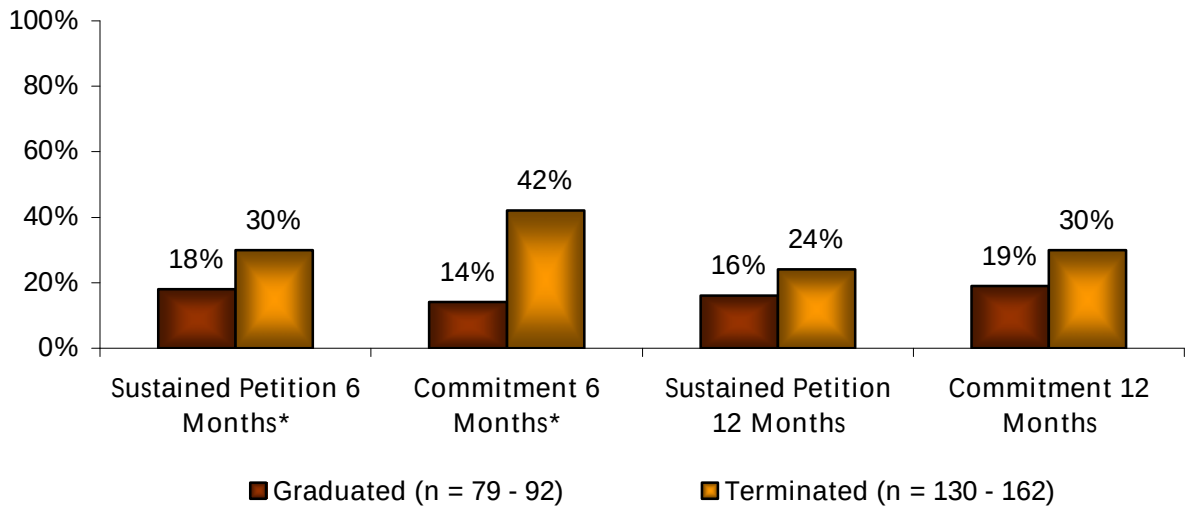
Figure 4.3
ACCESS CLIENTS' RECIDIVISM AT 6 AND 12 MONTHS POST-RELEASE FROM INSTITUTION



SOURCES: SANDAG; Probation Case Management System (PCMS) Records, 2008

When comparing those clients who successfully graduated from the program (e.g., received the full dosage of treatment) to those who were terminated unsuccessfully, the proportion of clients who received a new sustained petition or an institutional commitment varied. Specifically, youth who successfully completed the program were significantly less likely to recidivate during the first six months after being released. As Figure 4.4 shows, only 18 percent of graduates had a sustained petition, compared to 30 percent of those who were terminated. In addition, about three times (42%) as many clients who were terminated received an institutional commitment compared to those who graduated (14%). There was no statistically significant difference between the two groups at the 12-month mark, with 16 percent and 24 percent, respectively, having a sustained petition and 19 percent and 30 percent, respectively, having an institutional commitment. This lack of difference at 12 months suggests that a youth is most vulnerable for reoffending during the time immediately following release from the institution.

Figure 4.4
RECIDIVISM BY DISCHARGE STATUS



** Significant at the p < .05 or lower.*
NOTE: Cases with missing information not included.
SOURCE: SANDAG; Probation Case Management System (PCMS) Records, 2008

Because random assignment was not feasible for this evaluation, a direct causal relation between program completion and improved behavior could not be drawn. However, additional statistical analyses (i.e., logistic regression) were run to determine what, if any, other factors besides discharge status could have influenced a youth's likelihood of reoffending. That is, a logistic model was created that included other factors (e.g., ethnicity, age, SDRRC resilience score, treatment dosage, instant offense prior criminal history) that may account for a youth reoffending. To help isolate the number of additional influencing factors and create the most efficient logistic regression model, bivariate analyses were run on variables that

> "This program and [my case manager] helped me a lot. I thought I was never gonna change, but now I feel like a whole different person. In a good way! Thanks!"
> *ACCESS graduate, age 18*

could possibly influence a youth's success (such as prior criminal history, substance use, and age). Except for discharge status (which was also highly correlated to treatment dosage) these bivariate analyses did not reveal any significant differences that impacted the criminal history outcomes of the youth. As such, it was not surprising that the logistic regression model did not reveal any other variables or factors that significantly influenced whether a youth reoffended.

These findings are important because, although cause and effect cannot be determined, by eliminating some of the other factors in a youth's life that may impact their delinquent behavior, the fact that discharge status remains the primary determinate in reoffending is a positive reflection of the program in supporting change in a youth's life.

CLIENTS' SUBSTANCE USE AT FOLLOW-UP

Of the 173 clients who completed a six-month follow-up interview, 158 (91%) reported that they had the opportunity to use substances during the past 90 days. That is, they were incarcerated or in some other place where they could not use alcohol or drugs for less than the entire 90-day period. Analyses revealed no statistical differences in reported substance use between those who successfully completed the program and those who were terminated. As Table 4.3 shows, alcohol (55%), marijuana (34%), and amphetamines (15%) were the most commonly used substances. Though the two time periods cannot be directly compared, it should be noted that almost all of the clients reported having used alcohol and marijuana at some point in their life at intake and almost half had used amphetamines. At six months, about two-fifths (37%) of clients who had the opportunity to use reported abstaining from drug and alcohol use altogether in the past 90 days (not shown).

Table 4.3
CLIENTS' SELF-REPORTED SUBSTANCE ABUSE IN THE PAST 90 DAYS

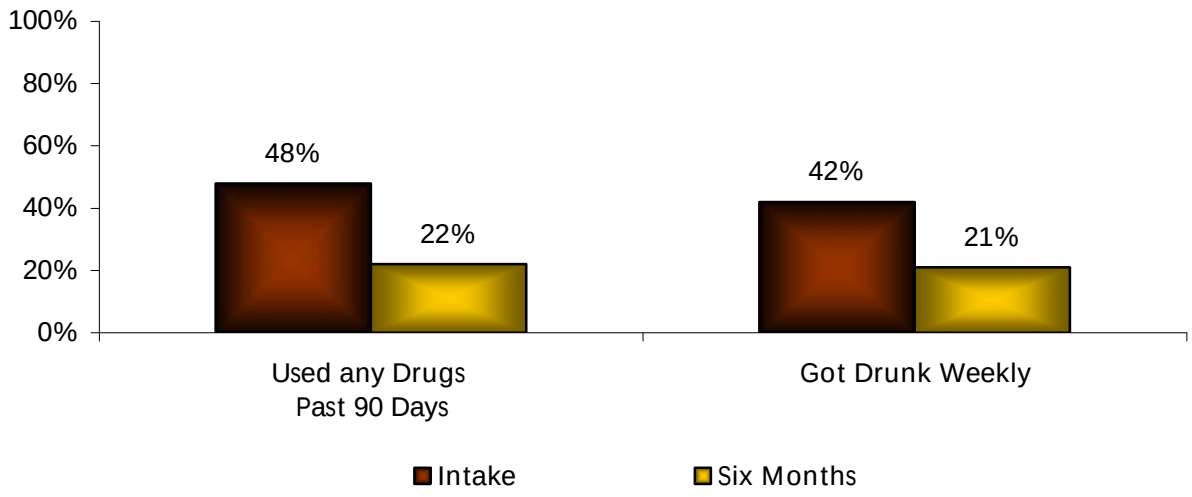
Alcohol	55%
Marijuana	34%
Amphetamines	15%
Painkillers	6%
Other cocaine	5%
Downers	4%
Other drugs	3%
Crack cocaine	3%
Hallucinogens	3%
Inhalants	3%
Tranquilizers	3%
PCP	1%
Street methadone	1%
Heroin	0%
TOTAL	**157 - 158**

NOTES: Cases with missing information not included. Clients who reported using other drugs specified abuse of Coricidin, salvia, and Nyquil.

SOURCES: SANDAG; Global Appraisal of Individual Needs (GAIN), 2005 - 2008

As with delinquent behavior, peer relationships are important in youths' sobriety due to the influence peers have over their actions. Clients were asked a series of questions regarding the substance use and treatment of those they hung out with most, in the past 12 months at intake and in the past 90 days at six-month follow-up. Fewer clients reported hanging out with people who got drunk regularly and/or used drugs at follow-up. Specifically, less than one-quarter of the respondents reported that most or all of the people they regularly socialized or hung out with used drugs during the past 90 days[12] (22% versus 48% at intake) and/or got drunk weekly or had 5 or more drinks in a day (21% versus 42% at intake) (Figure 4.5). Also of interest because it shows the youth choosing peers who may have similar sobriety goals, is that at both time points, approximately two-fifths of the respondents (46% at six months and 39% at intake) reported that at least a few of the people they regularly socialized or hung out with had at some point been in alcohol or drug treatment and about one-quarter (25% at six months and 21% at intake) of the respondents reported that at least a few of the people they regularly socialized or hung out with would describe themselves as being in recovery (not shown).

Figure 4.5
CLIENTS' DESCRIPTIONS OF THEIR PEER SUBSTANCE USE AT INTAKE AND FOLLOW-UP



TOTAL = 147 - 156

NOTE: Cases with missing information not included.

SOURCES: SANDAG; Global Appraisal of Individual Needs (GAIN), 2005 - 2008

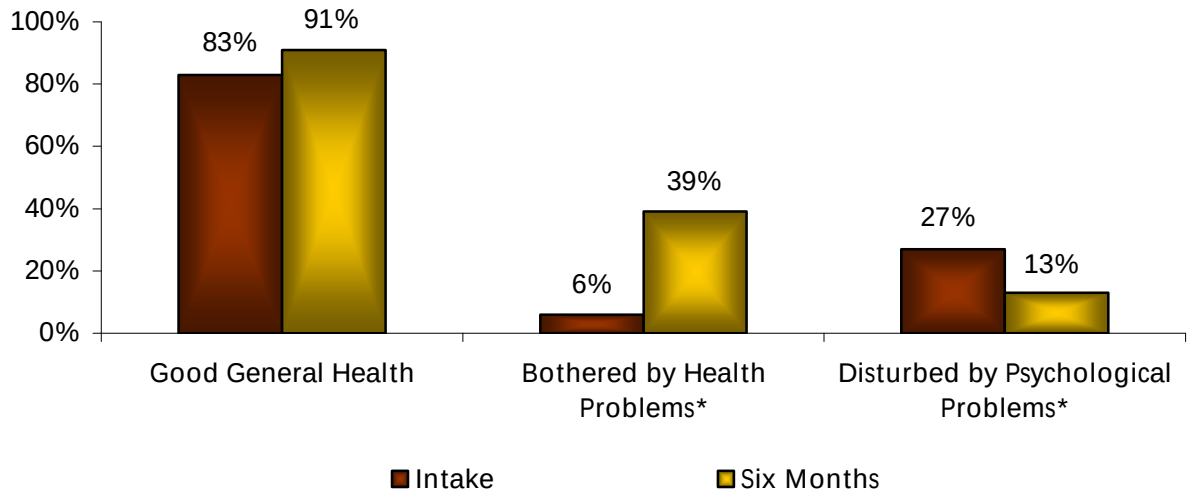
[12] At intake, this question included people the client had regularly socialized with in the past 12 months, but asked about those people's behavior in the past 90 days. At follow-up, only people the client had regularly socialized with in the past 90 days were included.

CLIENTS' PHYSICAL AND MENTAL HEALTH STATUS AT FOLLOW-UP

Surprising, given that the majority of youth reported their health as "good" or better at intake, there was not a significant difference between intake and six-month follow-up in their rating of their general physical health overall (91% compared to 83% during the past 12 months at intake). However, more than one-third (39%) of the respondents reported being bothered by health or medical problems within the past 90 days at follow-up, up significantly from 6 percent at intake. Interestingly, half (50%) of graduates reported being bothered by health problems at follow-up, compared to one-third (33%) of clients who were terminated, a statistically significant difference. Program staff provided a few reasons for this possible increase, including the likelihood that those youth who were terminated were in a controlled environment (e.g., incarcerated) at the time of follow-up in which case medical care is easily accessible and controlled environments are safer than these youths' home environments (i.e., no domestic violence, street violence, and risky activities).

Significantly fewer youth reported being disturbed by nerve, mental, or psychological problems within the past 90 days at follow-up compared to intake (13% compared to 27%) (Figure 4.6). It should be noted that respondents are given a number of examples of nerve, mental, or psychological problems at intake, while at the six-month follow-up these examples are omitted, which may affect responses.

Figure 4.6
CLIENTS' SELF-REPORTED PHYSICAL AND MENTAL HEALTH AT INTAKE AND FOLLOW-UP



TOTAL = 172 - 173

** Significant at the p < .05 or lower.*

NOTE: Cases with missing information not included.

SOURCES: SANDAG; Global Appraisal of Individual Needs (GAIN), 2005-2008

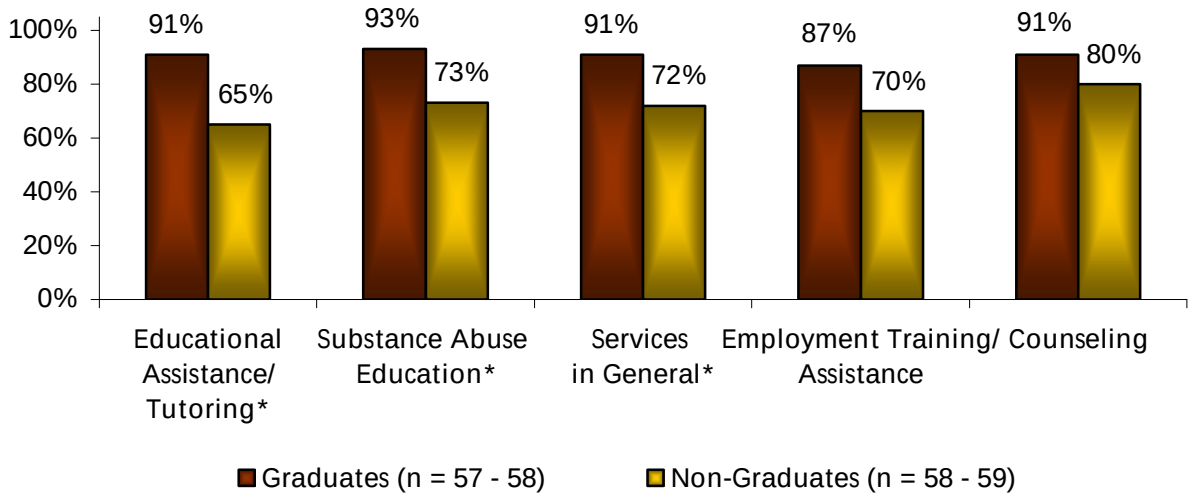
CLIENTS' SATISFACTION WITH SERVICES RECEIVED

Upon program exit, clients were asked to complete a questionnaire about their satisfaction with the program and ways in which the program had helped them achieve their treatment goals. There were 119 surveys completed (59 graduates and 60 terminated) between June 1, 2005, and September 30, 2008. Clients were asked to rate their overall experience in the program on a five-point scale, from "liked it a lot" to "disliked it a lot." There were no significant differences between responses of graduates and those who were terminated, with 92 percent of graduates and 82 percent of non-graduates saying they liked the program (not shown). However, significantly more graduates expressed satisfaction on a number of other measures as detailed below. This may indicate that clients who liked the program were more likely to be successful, or that clients who participated at the level needed to graduate were more likely to find the program beneficial.

> "It is a great program."
> *ACCESS graduate, age 15*

Clients were asked how much they liked the services they were referred to through the program on a four-point scale from "very much" to "not at all," with a "not applicable" response provided for each specific service. As shown in Figure 4.7, significantly more graduates than non-graduates said they liked educational assistance/tutoring (91% and 65%, respectively), substance abuse education (93% and 73%, respectively), the services in general (91% and 72%, respectively), and employment services (87% and 70%, respectively). There were no significant differences between the two groups in terms of satisfaction with counseling (91% of graduates, 80% of non-graduates). In addition, significantly more graduates than non-graduates felt their case manager was helpful (95% and 81%, respectively) and that the program targeted their needs (91% and 73%, respectively) (not shown).

Figure 4.7
CLIENTS' SATISFACTION WITH REFERRAL SERVICES



TOTAL = 172 - 173

** Significant at the p < .05 or lower.*

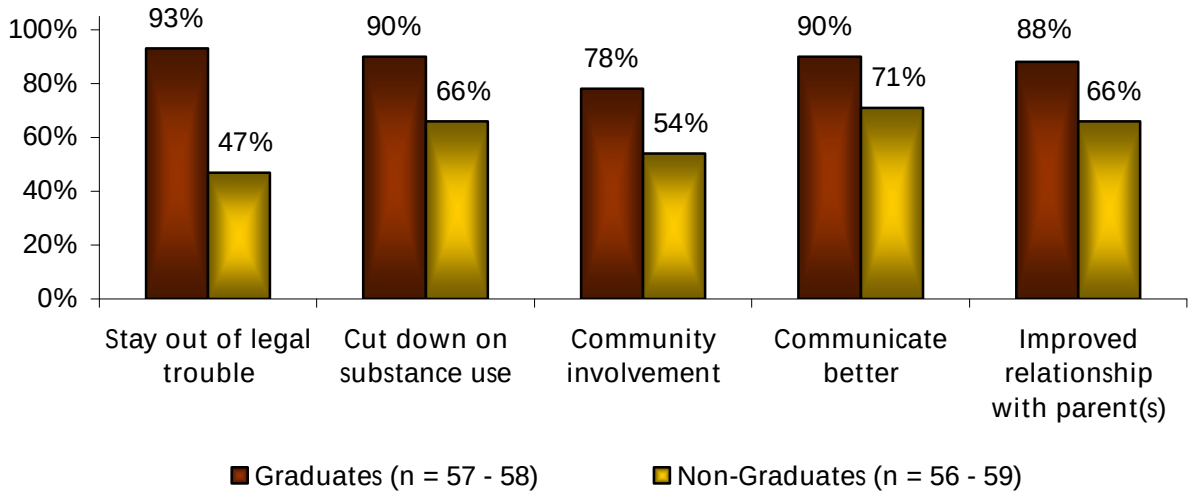
NOTE: Cases with missing information not included.

SOURCES: SANDAG; ACCESS Youth Survey, 2005 - 2008

As Figure 4.8 shows, overall, the majority of participants were satisfied with the services they received; however, graduates were significantly more likely to feel the program helped them accomplish certain goals, compared to non-graduates. On a four-point scale from "yes, definitely" to "no, not at all," almost twice the number of graduates than non-graduates felt the program helped them stay out of legal trouble (93% and 47%, respectively). In addition, significantly more graduates felt the program helped them cut down on their substance use (90% and 66%, respectively), become more involved in their community (78% and 54%, respectively), and communicate better with those around them (90% and 71%, respectively). Eighty-eight percent (88%) felt that their relationship with their parents had gotten "a lot" or "somewhat" better since they were in the program, compared to 66 percent of non-graduates.

> "Thanks for all the good things y'all done for me. I appreciate it."
> *ACCESS graduate, age 16*

Figure 4.8
CLIENTS REPORTING ACCOMPLISHMENT OF GOALS THROUGH PROGRAM PARTICIPATION*



** Significant at the p < .05 or lower.*

NOTE: Cases with missing information not included.

SOURCES: SANDAG; ACCESS Youth Survey, 2005 - 2008

SUMMARY

To measure the effectiveness of the ACCESS program, data gathered through interviews conducted with program participants by program and research staff at intake, as well as at six months after intake were used in this report. Criminal history data were also gathered from official records for clients who entered the program. Results indicate positive, with about two-fifths of the clients abstaining from drug or alcohol use, only one in five continuing to hang out with peers who used, and fewer being bothered by mental health issues. Data gathered from official records showed that only about one-third of all clients had a sustained petition and/or new commitment in the six-month period, and this was significantly lower for those clients who completed the program.

Overall, clients were satisfied with the services received, with those who graduated reporting being more satisfied with the program. Those who successfully completed the program also reported better parental relationships, improved communication, and reduced delinquent activity.

CHAPTER 5
OVERVIEW AND RECOMMENDATIONS

CHAPTER 5
OVERVIEW AND RECOMMENDATIONS

INTRODUCTION

This report detailed the results of the process and impact evaluations of Phoenix House of San Diego, Inc.'s Assertive Continuing Care Ensuring Sobriety and Success (ACCESS) program. ACCESS utilized the best practice Assertive Continuing Care (ACC) model to provide services to high-risk youth incarcerated at Probation's Juvenile Ranch Facility (JRF) or East Mesa Juvenile Detention Facility (EMJDF). The following chapter summarizes the results and presents recommendations based on the findings.

SUMMARY

Process Evaluation

Data collected through intake assessments, treatment tracking forms, and minutes confirmed that ACCESS served a very high risk population that was grappling with multiple issues and overall implemented the services as intended. Between March 2005 and September 2008, 282 clients signed consent to participate in the evaluation. Of those who had completed the program by September 2008, about one-third were discharged successfully and about two-thirds were terminated unsuccessfully.

Demographic and intake data showed that the average client was approximately 16 years old, Hispanic, and lived with a single parent. All the youth had a criminal history, with nearly three-quarters being a ward of the court prior to their current offense. One striking characteristic of the youth was the high incidence of violence in their lives, with about four in five reporting having been, at some point in their life, attacked by someone with a gun, knife, or other weapon, and/or struck or beaten to the point that they had injuries. Not surprising, given ACCESS was focused on substance abuse treatment, the majority of youth had used alcohol and drugs in their past. Almost all had also had a past experience with a self-help group and one in five received more intensive treatment.

Clients also demonstrated a need for improved academic involvement, with nearly one-half only completing ninth grade. Youth were also hanging out with peers that shared their risky behavior, including engaging in drug use, not attending school, and participating in illegal activities, and almost one-half had some type of gang affiliation.

Overall, ACCESS was implemented as designed and those youth who successfully completed the program were more likely to experience positive changes compared to those who did not complete the program. Results from the process evaluation illustrate the intensity of need and the depth of issues this target population is grappling with.

Impact Evaluation

The primary goal of ACCESS was to reduce recidivism while addressing the core issues facing the target population. These issues included substance abuse, engagement in illegal activity, lack of positive peers, and family stressors. Both bivariate and multivariate analyses were conducted to measure change and determine what factors influenced a youth's reoffending and change in behavior.

Although limited by lack of comparisons over similar time periods, the data gathered from six-month interviews indicated positive change in youths' substance use, mental health, resiliency, and peer relations. This was true more so for the youth who successfully completed the program than those who were terminated. Analysis of official records showed that the youth who successfully completed the program had more protective factors and fewer risk factors to buffer them from delinquency, and received fewer sustained petitions and institutional commitments. The primary factor influencing a youth's reoffending was his exit status (successful versus terminated). These analyses also exposed the importance of obtaining as many follow-up interviews as possible, as some of the outcomes found at six-months could be an artifact of the number of interviews completed (approximately 60% of all clients) rather than a comprehensive picture of clients' activities. For example, 58 percent of youth reported being incarcerated at the time of the six-month interview; however, only 32 percent of all youth had received an institutional commitment during that timeframe.

RECOMMENDATIONS

Based upon the results of the process and impact evaluations, the following recommendations for future program efforts are provided.

- **Examine Means to Increase Engagement in Program:** The positive results that were realized by youth who were able to complete the full dosage of treatment (i.e., successfully complete the program) reflect positively on the potential for the ACCESS program. ACCESS clients were some of the highest-risk youth in the juvenile justice system, with a history of relapse and reoffending. Analyses revealed at least two factors significantly related to the odds of a youth not completing the program: gang involvement and a low resiliency score. Identifying those youth up front that are at greatest risk of not graduating would allow the program to explore additional support mechanisms that could possibly be put in place to help mitigate the additional challenges these youth face.

- **Incorporate Trauma-Related Treatment in the Model:** Because of the large proportion of youth who reported being a victim of violence at some point in their lives, examining best practices in addressing victim and trauma needs might be a beneficial addition to the treatment mode.

- **Provide Resources to Centralize the Evaluation Responsibilities:** While the program staff did the best they could collecting the data for the evaluation, a significant amount of follow-up data was lost due to staff turnover and competing priorities. The evaluation revealed positive results, and providing funding to support a more rigorous design would increase the opportunity to provide outcomes that are in alignment with current evidence-based standards.

- **Maintain Designed Staff-to-Client Caseload Ratio:** Due to factors often beyond the staff's control, case managers were burdened with carrying a larger caseload than designed. This reduced the time available to meet with the client and/or family. Ensuring steps are taken to adhere to the intended caseload ratio would increase program fidelity.

REFERENCES

REFERENCES

Burke, C. (2008). **2007 Juvenile Arrestee Drug Use in the San Diego Region**. San Diego, CA: San Diego Association of Governments.

Chestnut Health Systems, Inc., (2002). **Description of A-CRA and AAC**. [On-line]. Available at: http://www.chestnut.org/LI/A-CRA-acc/index.html

Chestnut Health Systems, Inc., (no date). **Global Appraisal of Individual Needs (GAIN) Overview**. [On-line]. Available at: http://www.chestnut.org/LI/gain/GAIN_Overview.pdf

DeWit, D.J., Adlaf, E.M., Offord, D.R., and Ogborne, A.C. (2000). "Age at First Alcohol Use: A Risk Factor for the Development of Alcohol Disorders." **Am J Psychiatry** 157:745-750.

McCord, J. & Conway, K.P. (2005). **Research in Brief: Co-Offending and Patterns of Juvenile Crime.** Washington, D.C.: National Institute of Justice Research Reports [Online]. Available at: http://www.ncjrs.gov/pdffiles1/nij/210360.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Applied Studies (1999 CAI). National Household Survey on Drug Abuse, Appendix C: Sample-Based Estimates [On-line]. Available at: http://www.oas.samhsa.gov/NHSDA/99YouthState/appc.htm.