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An evaluation of drug intervention group work with Hispanic adolescent gang members

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An Evaluation of Drug Intervention Group Work with Hispanic Adolescent Gang Members

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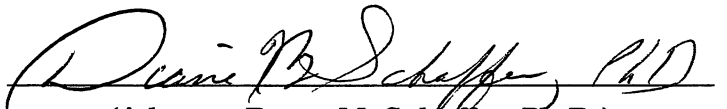

(Advisor: Diane M. Schaffer, Ph.D.)

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(Second Reader)

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Chapter I

Introduction

This project was a pilot study measuring the effectiveness of an eight week drug intervention group with Hispanic adolescent gang members. The study was a practice evaluation that employed a single-group ABA design and used two instruments to measure group effectiveness. The first was the Drug Addiction Screening Test (DAST), a questionnaire, that measures negative consequences of drug abuse in the subject's life. The second instrument was the Drug Severity Index (DSI). It is a mathematical formula that assigns values to types of drugs and frequency of use yielding a score representing the severity of the subject's drug abuse. Both instruments have been used in the drug treatment field and are reported as valid and reliable in drug treatment research (Douglas, G., 1989, Skinner, 1982 & 1986, Douglas, S., 1990, Friedman, 1986).

The evaluation was performed at Youth Services, a private non-profit adolescent and family counseling center. All subjects were Hispanic, between the ages of 15-17, and had a history of drug use, delinquency, and at least marginal gang affiliation. Many were mandated to attend counseling by the Santa Cruz County Juvenile Probation Department.

Three subjects completed the group and their DAST and DSI scores on pre-test, post-test, and three month follow-up were analyzed. A Wilcoxon Signed Ranks Test showed that score differences between pre-test and follow-up were statistically significant. Drug use was reduced in all three subjects that completed the study by an average of 31%, based on DSI scores.

Chapter II

Context of Services: Youth Services, Inc.

Agency Description

Youth Services is a private non-profit counseling agency with centers in Santa Cruz and Watsonville. It is a component of a larger social service agency, Santa Cruz Community Counseling Center. Other components include Si Se Puede and Sunflower House which are residential drug treatment programs, Alto Counseling Center an out-patient drug treatment program, Stepping Out Services a dual diagnosis drug treatment and mental health center, and Head Start children's child care and educational programs.

Youth Services offers 24 hour crisis intervention with temporary foster homes available for emergency placement of youth. Counseling services include individual and family counseling for youth and support groups for parents and teens. The centers also have out-patient drug treatment programs with county alternative school components. These programs include daily group therapy and individual and family counseling once a week. (See Appendix A for an organizational chart of the agency.)

The site of this evaluation was the Watsonville center. This center deals with a variety of clients and issues including runaways, gang members, family conflict, substance abuse, depression, and sexual abuse. The majority of client families are second generation Hispanics, immigrants, and farm workers.

The agency targets youth from age twelve to seventeen for intervention and counseling. Watsonville youth experience several negative environmental stressors that make early identification and counseling critical to resolution of family conflict, drug abuse, or gang affiliation. These youth and families face high levels of unemployment, inadequate housing, poor access to health care, local gang violence, high teen birth rates, and ready availability of street drugs. School failure, drug abuse, gang violence, running away, and parental defiance are the presenting problems reported by the majority of clients.

The Watsonville Youth Services center has a diverse clinical staff. The center has a program manager, a part-time licensed clinical supervisor, an intern supervisor who oversees three clinical interns, two community liaisons, two drug treatment counselors, a family counselor, a gang counselor, and a teacher with one aide. The staff value flexibility and most facilitate groups in addition to their individual and family caseload. Counselors generally maintain a caseload of ten to fifteen clients and one or two groups a week. The program manager supervises both clinical and office staff and meets in weekly manager meetings to coordinate services and other program issues with the Santa Cruz center.

Policy Context

Youth Services receives funds from a variety of state, county, city, and private sources. The major governmental funder is the state's Drug Medi-Cal Program (DMC) which provides about fifty-seven percent of the agency's budget. This program funds out patient drug treatment services including individual, family, and group counseling.

Cities within the county contract with Youth Services to offer general family counseling services. A major emphasis of these contracts involves out of control teenagers, runaways, and minors committing misdemeanor or status offenses. These contracts provide about nine percent of the agency's budget.

Santa Cruz County's Health and Human Services Agency also contracts with Youth Services to deal with runaway and crisis cases involving minors. Delegation of these clients is vital to the county since County Mental Health realigned its services to only serve the chronically mentally ill, serious crisis cases, and juvenile wards of the court. This contract for services makes up an additional twelve percent of the agency's budget.

Counseling and support staff for the Watsonville on site school component are funded through a CSAT, Center for Substance Abuse Treatment, three year start-up grant. These programs also provide individual, family, and group counseling to its day treatment population. CSAT's evaluation component CAL Research reports that the Watsonville day treatment program is one of the most successful and culturally competent programs in the state based on program design, staff competency, client retention, and reduction in client drug usage (CAL Research, 1995). CSAT funding makes up sixteen percent of the budget.

Grants from the County Office of Education, client fees, fundraising, private agency grants, and United Way funding make up the final six percent of Youth Service's budget. (For a detailed account of Youth Services' funding refer to Appendix B.)

Current Evaluation Process

Youth Services conducts outcome studies at six months after client discharge. These studies show substantial improvements in reduction of alcohol and other drug usage, criminal justice system involvement, and school or vocational performance. Unfortunately, this evaluation procedure does not categorize client involvement by presenting problem, age or race of client, type of treatment modality, or length of time in treatment. Therefore, it is not possible to analyze relationships between types of treatment and client improvement. (Refer to Appendix C for the 1995 Service Evaluation Report.)

Chapter III

Description of Target Population: Drug Intervention Group

All six drug intervention group participants were Hispanic, between the ages of 15 and 17, and residents of Watsonville. In addition, all subjects had a history of drug use, gang involvement, delinquency, and were on probation for arrests ranging from drug possession and shoplifting to gang related assaults and resisting arrest. The major issues addressed in group were the member's drug usage and gang involvement. These issues are strongly interrelated. The following sections include background information regarding drug and gang related issues relevant to the working with this population.

Gang Structures in the Watsonville Area

There are basically two types of Hispanic gang structures: Norteño and Sureño. Norteño gangs are generally identified by the color red, the letter "N", and the number 14. The number stands for the fourteenth letter of the Latin alphabet "N" and for the adult prison gang Nuestra Familia. Sureño gangs are generally identified by the color blue, the letter "M", and the number 13. This number stands for the thirteenth letter of the Latin alphabet "M" and for the corresponding adult prison gang for the Sureño structure: the Mexican Mafia

Norteño and Sureño mean north and south respectively. Generally those individuals born above Bakersfield, California, are considered Norteño and those individuals born below Bakersfield are considered Sureño. However, gang affiliation is not clear cut, individuals coming from

Mexico are also considered Sureño though they are not born in the United States. In addition, some gang members live in opposing gang territories.

Opposing gang structures control different neighborhoods (barrios) in a city. This constantly fuels conflict between gang members at all age groups. Gang membership is often dictated by one's immediate barrio and family history of gang affiliation.

The following table illustrates the gang structures in Watsonville.

Table 1. Watsonville Gang Structures

Affiliation	Norteño	Sureño
Color/ Number	Red, 14, XIV, X4	Blue, 13, XIII, X3
Gang Names and Initials	NSW: Northside Watson CHW: City Hall Watson CML: Clifford Manor Locos VGV: Varrio Green Valley VLP: Varrio La Posada River Rats Las Lomas 21 Anna Street	PS, PSW: Poorside Watson
Members	250-300	80-100

It is immediately evident that Norteños outnumber Sureños about three to one. Sureños claim only a very small part of the city. This area has the lowest income housing that is often over crowded and in poor condition. There are no schools, theaters, medical clinics, or parks in Sureño territory. There is one community center in their area but Sureños are discouraged from attending because a child care center is located next door and there is a possibility of violence or shooting due to gang rivalry. In addition, there are few businesses that can employ Sureño youth in the

area. Norteños have more opportunities available to them including private schools, employment, recreation, and a vocational training facility.

These territoriality issues isolate Sureños from socially and institutionally positive opportunities. Due to this isolation many Sureños stay in their homes or neighborhood and hang out, drink, and use drugs. In addition to high alcohol and cannabis usage there has been a sharp rise in Sureños that use heroin. Some local school officials have reported thirteen year old youth smoking heroin. There are no counseling or drug treatment centers located in Sureño territory. The few that exist are in Norteño territory and therefore generally inaccessible to Sureño youth.

The cumulative effect of these social conditions is an extremely depressive, frustrating, and oppressive atmosphere. It is understandable that Sureño youth use drugs in an attempt to escape these emotionally depressing conditions. These conditions not only effect Sureño youth but also their families. Though there is usually little animosity between adult family members of different gang affiliations, unless they are gang involved themselves, some families have been attacked or harassed because they had gang youth with them.

Environmental Stressors Specific to this Population

Mexican-American youth in this area face several negative environmental stressors. The major problem in this area is the abuse of illicit street drugs and gang involvement. Several other stressors accompany these problems including family conflict and violence, early pregnancies, academic failure, negative legal involvement, poverty, unemployment, discrimination, prejudice, gang involvement, limited

opportunities for constructive recreation, and poor access to adequate housing and health care.

These stresses contribute to the development of substance abuse in the youth of this area. Youth report that there is little to do in Watsonville for entertainment. Many youth start associating with gangs for excitement and this facilitates their involvement with drugs. Once youth join gangs they find themselves caught in a cycle of drug use, violence, academic failure, and delinquency that will continue even if they try to leave the gang. Youth that attempt to leave a gang are harassed and assaulted. Youth are assaulted by other gang members when they enter or leave a gang. This is termed "getting jumped in" or "getting jumped out".

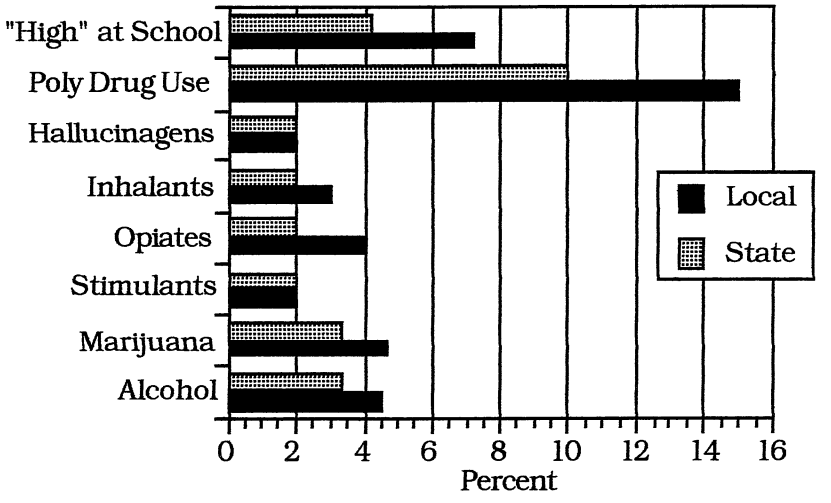
Eventually, gang violence and drug abuse may lead to expulsion from the school district. Once expelled they must attend a school outside the district or the local court and community school for four to six months to return to any local high school. The population of the only local court and community school is nearly entirely Norteño. Sureños members cannot attend for fear of retaliation. Some youth seen at the center have not been to school in well over a year.

The Problem of Drug Abuse among Watsonville Hispanic Youth

Figure 1, on the following page, compares the drug usage among Watsonville youth to California state averages (Manov, 1992). The information was compiled from statewide drug use surveys administered in schools. Watsonville clearly exceeds the averages on six of eight categories. It is important to note that Watsonville youth have a much higher rate of opiate (heroin) and poly drug use. This type of use is liable

to lead to greater judgmental impairment and violent behavior. In addition, Youth Services and other community agencies report that many of they youth involved in poly drug use are under the age of fifteen.

Figure 1. Local Adolescent Drug Use Characteristics



Even though the local population shows marked increases in several areas it is suspected by local drug intervention specialists that some of the information is underestimated. Many drug abusing and gang youth may not be present in school and available to participate in the survey. Watsonville Sureño youth often stop attending school due to low grades, poor attendance, embarrassment over special education placement, and gang harassment and violence. Therefore, Sureño drug use profiles are likely to be higher. Their use of heroin, intravenously and smoked, is high in Watsonville and surely underestimated. Watts (1990) explains how assessments of drug use can be underestimated.

> ...self-report investigations underrepresent serious delinquents and, therefore, do not adequately reflect the full range of delinquent and criminal behavior. Simply surveying high

> school students will not capture that range. Inclusion of an adjudicated delinquent sample in the survey permits a more complete representation of drug use and delinquent youth with sample construction weighted toward youth who are more likely to be violent in order to capture a broad range of both behaviors.... Further, it is unlikely that many truly violent individuals will be found on any day in the average public high school. Most violent delinquents who have not dropped out will be expelled, suspended, absent, or in jail or reform school. This is especially true of Mexican-Americans in Texas, where the dropout rate for this ethnic group is 45 percent, with the majority dropping out in the ninth grade. (p. 154)

Generally, gang youth experimenting with drugs are more likely to lead to abuse and addiction. In this author"s experience gang youth using even one drug began experiencing family, school, or legal problems after two or three months of consistent use. Drug use is strongly reinforced as part of the gang culture. Unfortunately, drug use severely effects the psychological development of youth creating a "developmental lag." This lag impedes judgment and motivation which negatively effects school, social, an family interaction. Cavaiola (1989) provides a brief explanation of this impairment.

> Baumrind and Moselle (1985) provide an excellent overview on the impact of chemical abuse on the developing adolescent. They point to the concept 'developmental lag' as explaining how this impediment occurs. Here, it is hypothesized that alcohol and drugs interfere with growth by obscuring differences between work and play contexts; promoting a false sense of reality; reinforcing a sense of being 'special' or having limitless possibilities; enabling avoidance of realistic confrontations with the demands of society; obscuring social reality, rules and mores; maintaining homeostasis within the family while pretending to be moving towards independence and separation. The chemically dependent adolescent essentially lives in a world mostly made up of fantasy and personal fables. (p. 18)

Applicability of Substance Abuse or Dependence Diagnosis

All subjects seen in the intervention group met the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) clinical criteria for substance abuse or dependence. The two disorders are similar in that the both involve the continued use and preoccupation with substances that create cognitive, behavioral, and physiological symptoms in the user despite significant substance related problems (American Psychological Association, p. 176).

Such problems include major impairment in the client's ability to function in personal, family, work, or school roles. Many of the youths seen at Youth Services have committed crimes while under the influence of drugs or alcohol. Typically they have been arrested for carrying weapons, aggravated assault, burglary, petty theft, grand theft auto, or possession or sales of illicit drugs. The fact that many youth continue using drugs and alcohol despite the danger and adverse consequences of these behaviors indicates that they at least meet the clinical criteria for substance abuse.

Substance dependence involves the additional criteria of the development of drug tolerance and withdrawal. Tolerance is the individual's need to increase the amount of substance used to achieve the desired effect. Withdrawal is a group of negative physiological or psychological symptoms experienced when the substance used is terminated or reduced. Withdrawal is physiological when their is evidence of the development of tolerance, or psychological when there is no evidence of tolerance and drug usage is characterized by a pattern of compulsive use (American Psychological Association, p. 179).

Drug use has a wide spread effect on the lives of youth. Often, once the youth has been using drugs steadily for a few months their lives begin a process of steady deterioration. Family conflicts increase in frequency and intensity often escalating to the point of violence and scholastic performance drops steadily eventually leading to expulsion from school. Furthermore, drug use can cause or mask depression, lower motivation, and mimic learning disabilities (Fox, 1991). In addition, gang involvement often involves fighting, theft, and drug abuse eventually leading to arrest and probation.

Psycho-Social History of Subjects

Of the twelve clients scheduled six attended the initial group. All group members were Mexican-American, on probation, and poly-drug abusers. All subjects had at least marginal involvement with Norteño gangs. None had an individual or family history of mental illness and all presented normally. The following are specific client profiles. (The three subjects noted in bold print completed the study.)

S_1 CC; 16 year old male. His school performance is fair but often arrives late to classes or misses school all together. States he would like to graduate and work with computers. Started using marijuana at 14 and drinking at 16. Currently on probation for repeated citing and arrests for possession of alcohol and drugs. He reports no history of abuse or neglect. He is marginally gang involved and most friends are gang members. He currently lives with his mother and two older siblings. Father and older brother drink heavily. Whereabouts of father are unknown.

S_2 PB; 17 year old male. His school performance is good. He is attending an alternative high school. He states he would like to graduate and go to college. Currently on probation for being under the influence of alcohol and assault and battery on a police officer. He is gang affiliated. He reports no history of abuse or neglect. He is living with both parents and an older brother. There is no history of problematic drug use in the immediate family.

S_3 EP; 16 year old male. His school performance and grades are poor. He has been suspended from the school district for possession of drugs on campus. He started using marijuana at 14 and has since been using alcohol, crank, cocaine, and paint. He is on probation for possession of alcohol and assault and battery. He is gang affiliated and assaults leading to arrest were gang related. He reports no history of abuse or neglect. He lives with both parents and several siblings. There is no history of problematic drug use in the immediate family.

S_4 AC; 16 year old female. She is extremely thin due to heavy amphetamine (crank) use. Her performance in school is poor. She is attending an alternative high school after expulsion from the school district due to possession of crank and marijuana. She started drinking alcohol at 13, marijuana at 14, and started heavy cocaine and crank use at 15. She is on probation for possession of drugs, being under the influence in public, and shoplifting. She is marginally involved in a local female gang. She reports no history of abuse or neglect. She lives with mother and younger siblings. Mother drinks heavily. Whereabouts of father are unknown.

S_5 JG; 15 year old male. Was expelled from the school district for nonattendance for several months. He is presently trying to enroll in alternative high school. He has a long history of poly drug use including alcohol, marijuana, amphetamines, cocaine, and hallucinogens. He is presently on probation for being under the influence of drugs, assault and battery, and resisting arrest. Is involved in violent Santa Cruz street gang. He claims no history of abuse or neglect but admits mother would leave him alone for days or weeks. He was placed in foster care from age three to nine. He was moved through several foster homes because of violent and defiant behavior. Entire family has history of heavy drug abuse. Whereabouts of father are unknown. Mother uses amphetamines (crank) regularly and is currently on probation for misdemeanor legal offenses. Older brother uses heavily and sells drugs. Brother was also placed in foster homes and group homes due to delinquent and criminal behavior.

S_6 EM; 17 year old female. She is in poor health due to heavy amphetamine (crank) use. She is attending a local high school but is doing poorly. She has a long history of poly drug abuse beginning in early teens. She is presently on probation for shoplifting and assault. She is a member of female gang. She claims no history of abuse or neglect. Both parents live in the home and have no problematic drug or alcohol use. Older siblings have history of gang involvement and drug abuse.

Chapter IV

Theoretical Foundations and Literature Review on Adolescent Drug Abuse

Etiology of Substance Abuse in Minority Adolescents

The most recent and specific research on the etiology of drug abuse with adolescent minority populations was performed by Walter, Vaughan, and Cohall (1993). They compared the explanatory power of three theoretical models of substance use in a survey of 919 students (59% Black, 34% Hispanic, and 7% White) in three New York high schools. Data was collected on the percentage and frequency of use of three gateway drugs (alcohol, cigarettes, and marijuana) by gender and race.

The three models included the socialization, stress/strain, and disaffiliation model. All the models were supported in previous drug abuse and addiction research literature. These three models incorporate the vast majority of factors associated with the development of drug abuse and dependence.

The socialization model involved the assessment of beliefs regarding drug use of the students, their parents, and other student peers. Scales questioned the youth's values regarding involvement with drugs as well as that of their peers and families. The stress/strain model assessed psychological constructs such as depression, anxiety, hopelessness, and reactions to adverse life circumstances. The disaffiliation model assessed three constructs: academic failure, religious disaffiliation, and poor parental support.

Analysis of the data found that the socialization model of substance use was far more powerful, than the two additional models, in explaining the subject's past years drug usage (Walter, 1993). However, the stress/strain and disaffiliation models were important risk factors for subject's level of frequent use. The following table from Walter (1993) outlines the standardized regression coefficients for all three models by substance used.

Table 2. Standardized Regression Coefficients for Past-Year Substance Use Given Variable Sets Comprising Each of the Three Theoretical Models

	Alcohol	Cigarettes	Marijuana
Socialization Model			
Norms			
Friends use	0.23*	0.24*	0.40*
Parents use	0.07**	0.09**	0.06**
Peers use	0.17*	---	---
Values			
Friends sanction use	0.18*	0.08**	0.10***
Parents sanction use	---	---	0.07**
Beliefs about abuse risk			
Occasional use not risky	---	0.10***	0.09**
Frequent use not risky	---	---	---
Self-efficacy (refusal skills)			
Not sure could refuse offers to use	0.10***	0.09**	---
R^2	0.28	0.20	0.34
Stress/Strain Model			
Depression	---	0.09**	---
Anxiety	---	---	---
Hopelessness	---	---	---
Adverse life circumstances	0.10***	0.08**	0.10***
R^2	0.05	0.05	0.04
Disaffiliation Model			
Academic failure	0.17*	0.17*	0.21*
Religious disaffiliation	---	---	---
Poor parental support	0.16*	0.08**	---
R^2	0.08	0.05	0.06

Note: * $p<0.001$, ** $p<0.05$, *** $p<0.01$.

The socialization model was viewed as the most effective explanation for the results. It was correlated with between one quarter and one third of the response differences. Components of the other models had less explanatory power yet certain constructs such as adverse life circumstance and academic failure were valid across all three substances studied. (Additional data from the study regarding use by gender and race is summarized in Appendix D.)

Walter (1993) reports that the response rate of the student body was high enough that the results are generalizable to similar populations. However, she noted that youth with high levels of drug usage would probably not be in school and therefore not part of the study.

This study was conducted on gateway drugs: alcohol, cigarettes, and marijuana. Most drug involved clients at Youth Services report using one or all of these drugs before moving onto harder drugs such as amphetamines, cocaine, or heroin. The study cites many of the experiences of these gang youth including parental and peer usage, depression, adverse life circumstances, academic failure, and poor parental support. Youth whose parents and peers use drugs develop a belief system where drug use and other associated drug use behaviors such as assault, robbery, burglary, and drug dealing are acceptable.

In addition to social and environmental factors genetic factors also influence the development of drug abuse and addiction. Frances (1991) addresses the role serotonin may play in the development of alcoholism in youth.

> Goodwin (1985) has suggested that children of alcoholics may be deficient in serotonin or may have an increased level of serotonin in the presence of alcohol. The 'addictive cycle' - a pattern in which a person initially drinks to feel good, and then later has to resume drinking after an abstinence period in order to stop feeling bad - may result from such a problem with serotonin. (p. 328)

Frances (1991) further discusses specific genetic links between alcoholic fathers and sons.

> There appear to be two genetic pathways to drug abuse: one through antisocial personality (and indirectly from biologic parents with anti-social behavior) and the second from biologic parents with alcohol problems to individuals who themselves are not antisocial. Adoption studies support this approach by introducing the male-limited alcoholism (Type 2) model... Type 2 alcoholism is found exclusively in young males (teenage/early adulthood onset), and is strongly correlated with severe alcoholism and criminality in the biological father. The investigation of Type 2 alcoholism among adults demonstrates that the natural history of these male adolescent alcohol abusers is characterized by continuity to adult alcohol abuse. (p. 328)

Type 2 alcoholism is prevalent among the majority of male gang youth seen at Youth Services. Many of the gang youth with drug problems have parents with extensive legal and substance abuse problems. The combination of genetic and environmental influences acting on adolescent gang members is difficult to counteract and requires multiple modes of therapeutic treatment.

Dynamics of Gang Involvement, Drug Abuse, and Violence

The problem of gang involvement and drug abuse is more than an individual problem for adolescents and their families. Use of alcohol, barbiturates, cocaine, heroin, and PCP have been shown to correlate highly

with violent behaviors in adolescents (Watts, 1990). In addition, Watts (1990) discusses how peer drug use has consistently shown to be an important predictor of drug use among adolescents.

> Youth in nonconforming peer groups that share deviant values mutually enhance their solidarity and cohesiveness, thereby reinforcing deviance and progressive drug use. The greater the proportion of friends who use drugs, the greater the likelihood that respondents report drug use themselves. Drug use provides a behavioral bond for the group and involvement in deviance shared with others. The harder the drugs used, the greater the potential involvement with drug-related violence of all types. (p. 141)

Brounstein (1990) conducted a study of fifteen violent behaviors committed by adolescents involved with drugs. The sample population of the study is comparable to the Watsonville adolescent population. The study shows high rates of crimes against adults and other youths committed by youth that sold and youth that sold and used drugs. Such crimes included drug sales, theft, burglary, intimidation, assault, and murder. (The complete table from the study is in Appendix E.)

Developmental and Societal Factors Influencing Adolescent Gang Membership

Forming and participating in groups is a natural stage in adolescent development. The group serves as a micro-society in which the youth can further develop identity, autonomy, and intimacy with others. This is a transitional type of group formed in adolescence or young adulthood. Once such tasks have been attempted the individual can move on using the skills developed in the group. However, this experience may not be the same for minority youth who experience negative labeling, prejudice and

discrimination. Youth gangs may be a response to the social stigmatization that minority youth experience. Minority youth may find gangs far more supportive than their immediate social environment.

Group or gang involvement can be considered a transitional phenomenon between childhood and adulthood. Erikson (1968) has clearly emphasized that adolescence is a time of great stress and anxiety. The youth is dealing not only with physical changes but is attempting to differentiate themselves from parents and family. The group offers a ready-made identity that the youth may adopt during the adolescent identify formation.

The peer group is a distinctly different and supportive emotional and social environment for the youth. Often the youth may completely immerse themselves in almost every aspect of the group. For example, youth may adopt different clothing, attitudes, vocabulary, diet, and activities. Erikson refers to this complete immersion in a group as "totalism." This dynamic is evident in the typical dress, slang, and mannerisms associated with gang membership.

Winnicott's (1965) position is similar to Erikson but focuses deeper on the actions of the adolescent within the group. Winnicott discusses how antisocial acts are involved in the development of identity.

> ...since adolescents have not yet established a sense of an existing self they do so by forming groups through which they are able to engage in antisocial acts. The group membership allows them to identify with others, and the antisocial acts generate social reactions, both of which enable the adolescent to feel both real and cohesive. (p. 131)

However, social experiences are not comparable among all youths. Other factors such as race, culture, socioeconomic status, and experiences of prejudice and discrimination may further compound the stress of this developmental period. Schinke (1988) discusses the effect of stress on Hispanic youth.

> Social milieu stressors for urban American Hispanics are poverty, unemployment and underemployment, and racial discrimination. These stressors correlate with several psychosocial problems. Cognitive stressors for Hispanic youth are helplessness perceptions, fatalism, and low self-esteem...cognitive stressors also contribute to personal and interpersonal problems. (p. 812)

These experiences may emotionally isolate the youth and interfere with the youth's ability to assimilate to schools, communities, or other socially sanctioned groups and institutions. The gang then represents a safe and culturally familiar environment. Rejection is unlikely to occur in these culturally homogeneous groups.

In addition, there are a wide variety of societal factors that influence and maintain gangs. Howard S. Erlanger (1979) and Joan W. Moore (1985) offer excellent commentaries on the effect of social estrangement, isolation, stigmatization, and racism on the Hispanic culture and Chicano youth gangs. Erlanger (1979) writes, "...feelings of powerlessness, exclusion and absence of control over the conditions of one's existence can be summed up as estrangement... This estrangement fosters a strong identity with the peer group in the immediate neighborhood (barrio) because the peer group is the most readily available source of identity." Erlanger (1979) noted reduced gang violence during the "Chicano

movement" when the Hispanic community experienced a higher level of political involvement and a reduced level of estrangement.

Moore (1985) speaks to the dynamics of stigmatization and labeling.

> Stigma involves a stereotype, and for minorities the stereotypes include perceptions of deviance. The larger society certainly does label some minority persons, a priori, as 'probably deviant.' Thus to be young, male, and black or Chicano in white America is to be a suspect person. To be a visible member of a population that many Anglos associate with violent crime is to evoke hostile and fearful responses. I would like to call this 'ascribed deviance,' and to distinguish it from the 'achieved deviance' of the criminal or the drug addict. The ascription of deviance is based, of course, on generalized stereotypes, but is focused on a particular segment of the minority population. Ascribed deviance, then, is deviance that is ascribed to minority young men on the basis of visible characteristics (...ascriptive characteristics)... The targeted ascription of deviance by Anglos - to young minority males - generates processes inside minority communities which are very different from the consequences of general discrimination - ascriptive labeling makes those same minority people mad at other minority people. (p. 2)

The stresses experienced by minority youth may be considerably greater than that of minority populations in general. The developmental stresses of youth are compounded by the experiences of powerlessness, stigmatization, ascribed deviance, and social stressors such as unemployment, and negative school experiences. The ascribed deviance described by Moore (1985) further isolates minority youth within their own culture. Under these conditions the most accessible source of support are homogeneous peer groups and such groups surely include gangs.

The dynamics of prejudice and racism have both clear and subtle effects on the family. A family's mistrust of the majority culture reinforces gang involvement. The youth learns certain prejudices in the family; that

certain races and classes are not to be trusted. Wright (1985) explains how these family attitudes may be transferred to youth.

> Clinical experience of working with minority group members whose parents and grandparents have suffered discrimination and persecution clearly suggests that this fear of the majority culture is not derived solely from the immediate personal experience of the individual patient but rather often appears to have its roots —at least partially— in the experience of the patient's ancestors. This experience of fear and deep insecurity about the safety of the world seems to have been passed on from one generation to the next, almost as if a 'family unconscious' has been developed and is being transmitted from one generation to the next. (p. 163)

Therefore, though the family may attempt to keep a youth out of a gang they have communicated that the gang, in being culturally similar, is actually safer than the majority culture. A youth is caught in a cycle of drawing himself away from the family at this developmental stage and having limited choices for positive group involvement due to class, discrimination, environment, and the "family unconscious."

Treatment Issues Regarding Substance Abuse Group Therapy

The facilitation of a drug intervention group for Hispanic gang members is an immense challenge to the therapist. Specific clinical techniques and at least a fundamental knowledge of drug treatment and gang intervention are required. The facilitator will encounter strong resistance and manipulation from the group members and can be easily overwhelmed. For this reason it is important to have a co-facilitator. Milgram (1992) notes twelve mechanisms of resistance the group may employ to block the therapeutic process.

- Anger at the mandating agency
- Denial (or minimizing) of drug use or associated crimes
- Superficial compliance
- Testing the limits (minimizing group involvement)
- Silence
- Monopolizing the session
- Externalization of the problem
- Devaluation of the leader
- Devaluation of the group
- Avoidance collusions (side talking)
- Helplessness (over dependence on group leader)
- Changing the subject (to avoid individual disclosure or authentic group process) (p. 106)

Milgram (1992) states that the most effective way for the facilitator to overcome the group's resistance is to maintain a strong stance of authenticity, not authority, within the group. The facilitator presents their expertise as group therapy and the group's expertise as drug addiction. This curtails direct confrontations of the facilitator for not being an ex-addict and empowers the group leading to greater involvement and participation. Milgram (1992) also notes nine characteristics of authenticity important group facilitators.

- Directness
- Acceptance
- Empathy
- Respect
- Self-disclosure
- Nonjudgmental attitude
- Honesty
- Openness to suggestion (flexibility)
- Subordination (maintaining role as group facilitator and relinquishing role of authority on addiction) (p. 107)

Respect and self-disclosure are key issues in working with gang members. Respect is a value members can generalize from their gang culture. It is important to include respect in the group rules among confidentiality and safety. It is appropriate to expect respect if you give

respect in the gang culture. If a group member continues being disrespectful he should be removed from group and his dismissal processed.

It is important to clarify a cultural dynamic in the group; that the group leader is trying to help the group members. He is an "ayudante" or helper. Such people receive respect for their efforts in the Mexican culture. This is a deep value of many of the parents of group members. Framing it in this fashion may help present the group leaders efforts more positively.

Many of the group members have seen school counselors or clinicians before due to their behavior. The therapist's level of self disclosure is what will set them apart from other counselors. This population values trust very highly. Greater self-disclosure will deepen the therapeutic bond because it shows mutual trust.

Another gang value that can be utilized is loyalty. If clients show respect and "take care of business" by showing for individual and group sessions the therapist promises to advocate vigorously on behalf of the client if needed because the therapist has positive information to impart. Many group members realize the importance of participating in counseling because of the weight counselor's opinions carry with probation officers.

An important technique used with this population is a "Check-In" where members briefly discuss how things are going in their personal and family relationships, at school and work, with probation, and how they are feeling at that very moment. This bases the group in the "Here and Now" and begins an interactive group approach as described by Matano and Yalom (1991) and Yalom (1985).

Seemingly, a check-in would not appear to be a difficult task. However, the youth generally found in this type of intervention group have a limited capacity for insight. This may be due to effects of drug usage and limited social interaction other than with drug using peers. The development of insight is a vital task of the group. Without insight genuine group interaction is limited and the members find the group experience frustrating.

Focusing on the immediate interaction and feelings in group is recognized as interactional group therapy (Matano and Yalom, 1991). Its value is that it develops awareness of self and their reactions to external events. This is valuable to the majority of group members that are simply reactionary to their environment and have a limited awareness of the internal processes they are experiencing such as stress, frustration, anger, or other emotions. With out this capacity group members will have difficulty maintaining successful relationships with friends, family, or significant others. Their relationships will be plagued with displaced anger and frustrations.

Taking into account the sociological and clinical theories and Milgram's (1992) resistance tactics several group tasks were developed in addition to the curriculum. These tasks are intended as underlying themes carried through the entire group experence. They involve building group member's capacity for pride, insight, and better interaction with others. This list was developed in conjunction with William Zaragoza, lead drug treatment counselor, at Youth Services.

GROUP TASKS

Regarding Individual, Family, and Culture

- Improve self concept and self awareness
- Increase self-control through mood management
- Identify stress points in their lives and learn effective coping techniques
- Challenge dysfunctional belief systems and maladaptive behaviors of group members
- Develop sense of the "Here and Now" - awareness of present emotions and motivations for behavior, how past and present events effect emotions and actions
- Identify patterns of abuse, addiction, and violence in their life and family history
- Develop sense of the future; appropriate goals and priorities
- Capacity for self disclosure and acceptance of feedback
- Identify harmful and dysfunctional patterns in their lives
- Accepting the responsibility and consequences for their behavior
- Learn more about their culture and develop sense of cultural pride
- Develop capacity for reality testing
- Develop problem solving skills

Regarding Interaction with Others

- Develop capacity for empathy
- Deal effectively with authority figures and the "system"
- Respect for self and others
- Improve communicate skills
- Develop, use, and model social skills including: communication, empathy, anger control, impulse control, respect, courtesy, acceptance of positive feedback.
- Introduce the concept of developing a peer group that values productive activities and recovery.

Regarding Drug Use

- Challenge denial of drug use and prioritize recovery
- Discuss the Hispanic recovery community and how it specifically supports recovery
- Develop skills regarding drug refusal, minimizing drug cravings, dealing with depression, and effective coping strategies

These tasks address several key issues regarding adolescents using drugs. Self-concept is often negatively impacted by depression and the "developmental lag" discussed earlier. In addition, drug usage often

increases aggressive or defiant behavior. These emotions and behaviors are discussed in group and how they contributes to difficulties with school and the law.

The tasks above have usually not been taught or modeled among group member's family or peers. The capacity to handle stress and social relationships is a vital skill for these adolescents. Schinke states, "the experience of strained social relationships and a heightened sense of powerlessness/helplessness may induce adolescents to rely more heavily on substance use as a means of emotional regulation."

Efficacy of Adolescent Substance Abuse Treatment

Specific research on drug intervention groups with Hispanic populations was not readily available. However, Catalano, et al (1991), has written the most comprehensive and current article regarding the evaluation of adult and adolescent drug treatment programs. Unfortunately, he expresses that though there may be many programs for treating adolescent substance abuse their effectiveness has not been extensively examined.

> A review of controlled evaluations of adolescent and other drug abuse treatment programs concludes that some treatment is better than no treatment, that few comparisons of treatment method have consistently demonstrated the superiority of one method over another, that posttreatment relapse rates are high, and that more controlled studies of adolescent treatment which allow evaluation of the elements of treatment are needed. (p. 1086)

However, he cites several factors associated with relapse: lack of school involvement, associating with peers that use drugs, poor drug

refusal skills, non-productive leisure activities, lack of empathy, impulsiveness, and interpersonal skill deficits. These issues are directly addressed in the group curriculum and tasks in a culturally sensitive manner.

Chapter V

Design of the Evaluation Study: A Single Group ABA Design

A single group ABA design was used to evaluate the effectiveness of an eight week drug intervention group on Hispanic youth with histories of drug abuse and gang involvement. Intervention groups have a specific purpose in drug abuse treatment. They are primarily used as the first intervention with individuals that have a drug abuse history. The group is designed to inform youth about characteristic effects of different types of drugs on the mind and body.

At Youth Services the majority of group members are mandated by Santa Cruz County Juvenile Probation or the Pajaro Valley School District. Because group members are forced to attend their attitudes are often resistant and oppositional requiring specialized group therapy techniques.

The evaluation of this group involved two measurement instruments: the Drug Abuse Screening Test (DAST) and the Drug Severity Index (DSI). The DAST measured the degree of negative experiences the adolescent is experiencing due to their drug abuse. The DSI rendered a score representing the severity of the subject's current drug usage. Both instruments were used as pre-test, post-test, and three month follow-up measures.

ABA Design

An ABA design was used in this project. The entire group of six subjects took the DAST and DSI before the initial group to establish a drug use baseline. However, only three subjects completed the group and all

measures. Scores for both instruments, at the three testing periods, were analyzed by a Wilcoxon Signed Ranks Test.

Measurements

Measuring the effectiveness of any therapeutic intervention is vital for the continued development and refinement of effective counseling efforts with specific populations. Youth Services does not employ a specific procedure for evaluating group effectiveness. It is hoped that the agency will continue to use this group evaluation format in order to develop the most effective drug intervention group possible.

The most basic measurement of a drug intervention group's effectiveness is the reduction or elimination of drug use in its members. Friedman and Glickman (1986) developed the Drug Severity Index (DSI), a simple method for assessing subject's drug usage. The DSI formula multiplies assigned numeric values of types of drugs by frequency of use. The following quote from Friedman (1986) explains the procedure for calculating a client's DSI score.

> Opiates, sedatives, amphetamines, tranquilizers, PCP, hallucinogens, and inhalants were assigned a score of 3; cocaine was assigned a score of 2; and marijuana, hashish, alcohol, and over-the-counter drugs were scored a 1. For measuring frequency of use, a 9-point code was developed (e.g., once per week = 4; three or more times a day = 9). The index score was derived according to the following formula:
>
> (Risk level score of the primary drug of abuse x frequency of use of the primary drug) +
> (Risk level score of the secondary drug of abuse x frequency of use of the secondary drug) +
> (Risk level score of the tertiary drug of abuse x frequency of use of the tertiary drug). (p. 672)

This procedure is valuable because it offers a simple numeric method to classify the severity of drug usage. Difference scores were calculated for each subject by subtracting the pre-group from the post-group and follow-up scores.

The second instrument used was the Drug Abuse Screening Test (DAST) developed by Harvey Skinner (1982). It is a 28 item self-report test that samples various behaviors and consequences of drug abuse in the client's life. The DAST was based on the earlier Michigan Alcoholism Screening Test (MAST), a widely used and clinically supported assessment instrument in alcoholism treatment evaluation and research. The DAST score is computed by summing all items that endorse increased drug usage.

Skinner (1982) reports that in a major study involving 256 adult drug and alcohol abuse clients the DAST's internal consistency reliability estimate was .92. Furthermore, Staley and El-Guebaly (1990) report;

> The Drug Abuse Screening Test appears to be a useful instrument for measuring drug involvement and problems associated with the abuse of drugs other than alcohol. The DAST evidenced high internal consistency reliability and good item-total scale correlations in a diverse psychiatric patient population... (p. 262)
>
> The diagnostic validity analysis indicated that the DAST attained a maximum overall accuracy of 89% in classifying patients according to DSM-III Substance Abuse diagnosis. High sensitivity, high specificity and overall accuracy rate above 85% were maintained between DAST cutoff thresholds (scores) of 5/6 through 10/11. (p. 257)

This author adapted the instrument in order to make it more appropriate for Youth Service's client population. Most of the changes were minor adapting concepts and vocabulary to adolescents. Such

changes included changing the terms "job/work" to "school" and "spouse" to "girlfriend." "Abuse" was changed to "use" in order to have the instrument appear less judgmental and encourage honest responses from the youth. In addition, I included "alcohol" in the questionnaire in order to measure all drug use. This is an important issue due to the fact that many delinquent youth often do not consider drinking as "using."

The time frame assessed by the revised DAST was changed from the last year to the last thirty days in order for it to be used as a pre-test, post-test, and follow-up instrument. In previous research cutoff points between five and eleven were shown to be 85 percent accurate in classify subjects under the DSM-IV drug abuse diagnosis. A DAST cutoff threshold of eight was chosen as an appropriate midpoint.

It is expected that subject's DAST and DSI scores will drop conjointly. If this relationship is borne out in the results the DAST can be used as an ongoing measure of progress in addition to screening. (Both original and revised versions of the instruments and scoring protocols are available in Appendixes F, G, and H.)

A disadvantage of these instruments is that they are not constructed with a scale or component to detect deception on behalf of the subject. Many of the clients that enter the drug intervention group are suspicious of authority figures and agencies in general. They may not believe that information regarding their drug usage will remain confidential and so may lie about their actual usage. For this reason, confidentiality is strongly emphasized in group. It is hoped that the group leader's genuine rapport with group members is sufficient for them to report their usage honestly.

Intervention - Time Limited Drug Intervention Group

This study used a drug intervention group as the independent variable. The dependent variable was the group's effect on its members as evidenced by lower DAST and DSI scores at later testing periods. The group ran for eight weeks and was closed after the first two sessions. The group was held once a week for one and a half hours.

A general profile of intervention group members consists of Mexican-American youth between 15 to 17 years old. The group is open to both males and females. Though, in the past few females have attended. Many of the group members have personal and family histories of severe substance abuse, gang involvement, and are currently on juvenile probation. In addition, members are generally resistant to attending group because it is mandated by the court or school district, as a condition of expulsion. Students expelled by the district may not re-enter the school district until they attend counseling and another public school for atleast one semester.

An added dynamic is that many group members are in local gangs. Opposing gang members may aggress toward each other during the group which interferes with the development of safety and cohesion. Some members may refuse to attend due to gang rivalry. Histories of personal and family drug abuse, the effects of their current drug abuse, resistant attitude, and gang membership make this type of group a difficult challenge for facilitators.

The group was co-facilitated with William Zaragoza, lead drug treatment counselor. A key point in facilitating this group is control. Group members will often exhibit resistance by talking over others or

aggressing towards them. Such behavior is confronted and processed immediately.

Group members are usually unfamiliar with speaking openly on sensitive subjects as their self-esteem, family history, interpersonal coping skills, and drug usage. It is important for the group leaders to model open and genuine communication. The group experience also serves to familiarize them with the therapeutic process they will experience later if they remain clients at the center. Issues such as safety, confidentiality, and respect are strongly emphasized throughout group process.

The major goal of the group is to educate the youth on the negative role of drug use in their lives. A wide variety of subjects are discussed in the curriculum such as personal and family history of drug use, the effect of drugs on one's personality, experiences of failure due to use, feelings of depression, alternative coping strategies, and drug refusal skills. The following curriculum has been developed by William Zaragoza at Youth Services.

Session 1: Orientation

1) Goals, rules, confidentiality, respect, and expectations of group behavior
2) Curriculum overview
3) Activity: Introductions
    a) Why are you here (who is responsible)?
    b) How do you feel about being here?
4) Assignment: What is your relationship to alcohol and drugs?

Session 2: Patterns of Alcohol and Drug Use

1) Discuss member's drug use pattern
2) Discuss various "relationships" to alcohol and drugs
    a) substance use
    b) substance abuse
    c) substance dependence/addiction
3) Activity: discuss pros and cons of drug use
4) Assignment: Why do people use drugs?

Session 3: Why do People use Alcohol and Drugs?

1) Discuss various reasons for using alcohol and drugs
    a) peer pressure - because everyone is using it
    b) self-esteem - because it makes me feel better
    c) stress - it relaxes me
    d) family - because my parents do it
    e) psychological/physiological dependence - I need it
2) Discuss alcohol and depressant effects
    a) on brain, body, personality
3) Assignment: Identify a feeling you have just before using?

Session 4: Feelings and Communication

1) Discuss group members feeling just before using. Discuss feelings experienced in school, home, street, and in relationships.
2) Discuss relationship between alcohol/drugs and feelings
    a) psychoactive mood altering chemicals
    b) use of drugs to numb awareness of feelings
3) Activity: role play communication of feelings
4) Discuss effects of cannabis
    a) on brain, body, personality
5) Assignment: Identify a feeling you have difficulty with?
6) Broach subject of staying clean for the next two weeks of group

Session 5: Mood Management

1) Have members discuss a feeling and situation they have difficulty with
2) Discuss concepts of stress, coping, and self-esteem and their relationship to alcohol and drugs
3) Activity: role play coping strategies
4) Discuss effects of cocaine and stimulants
    a) on brain, body, personality
5) Assignment: What are you good at and name a goal?
6) Ask members to give a commitment to staying clean for next 2 weeks of group.

Session 6: Self-Esteem and Goals

1) Have members discuss experience of discrimination or prejudice and how it frustrated goal attainment and effected self-esteem. Have members discuss something they are good at and a goal
2) Discuss relationship between self-esteem/goals and substance abuse
3) Activity: map out the future
4) Discuss effects of hallucinogens, inhalants, and PCP
    a) on brain, body, personality
5) Assignment: How do you see drugs and alcohol effecting your goals and self-esteem?
6) Have members discuss trying to stay clean. Discuss denial, addiction, coping skills, drug refusal skills, amount of support they received from family and peers while trying to quit.

Session 7: Dangers of Alcohol and Drugs

1) Discuss participants perceptions of how drug use effects their goal attainment and self-esteem
2) Discuss risks associated with alcohol and drug use
    a) addiction
    b) accidents (DUI), victim, or perpetrator of violence
    c) STD's and AIDS
    d) pregnancy/fatherhood
    e) crime and incarceration
    f) personality changes (Jonzin')
3) Activity: guest speaker regarding STD's, AIDS, and pregnancy from Planned Parenthood
4) Discuss effects of heroin and opiates
    a) on brain, body, personality
5) Have members discuss trying to stay clean. Discuss denial, addiction, coping skills, drug refusal skills, amount of support they received from family and peers while trying to quit, what "exactly" queued you to use, obstacles to staying clean.
6) Assignment: Do you need help?

Session 8: Recovery, Resources, and Empowerment

1) Discuss with participants whether they need help
2) Discuss about recovery
    a) process of recovery, slips, slides
    b) AA, NA, MA, 12 step fellowship, sponsors, program
    c) commitment to program and self
3) Discuss about resources
    a) health care, community clinics, Planned Parenthood
    b) counseling programs, residential drug treatment centers
    c) vocational programs, job training
4) Discuss process of change and empowerment
5) End of group ceremony (focus on accomplishment and hope)

The curriculum of the group is designed to help the adolescents understand the role that drugs or alcohol play in their lives. It moves from general information on drugs to specific dynamics in the youth's life such as self-esteem, depression, anger, regret, communication, and an awareness of addiction. It is important that the material be culturally specific for Mexican-American youth. Themes of culture, family, tradition, cultural identity, and gangs are woven into the curriculum. Many youth have reported that the group has been their first experience in discussing their culture.

The initial phase of the group involves the first three session. These sessions are general and include basic drug information. During these sessions group facilitators are reinforcing the safety of the group and building cohesion among the group members. A task in this stage of the group is to "set the tone." This involves helping the group to develop its own personality and boundaries. However, the co-facilitators must always maintain the safety of the group.

The middle phase of the group, sessions four through six, involve having the group members examine their concepts of themselves and their ethnic and gang cultures. Issues such as cultural identity, self-esteem, feelings, goals, and a sense of the future are points of focus. Group members are expected to share more in the group by this time. Personal issues, family history and gang involvement are discussed in the group.

In the fifth session a commitment is asked from the group. Members are asked to abstain from using alcohol or drugs for the next two weeks of the group. Members are free to not take up the challenge. The group facilitator discusses the power of addiction. Addiction is defined as the continued use of alcohol or drugs even when negative consequences are experienced. The process of trying to stop using will be examined among the group. This will be an opportunity for members to look at their "denial" and lack of control over their drug usage.

This period is used to increase cohesion and support within the group. Group members are asked to support each other in not using. The dynamics of interpersonal support within gangs is discussed and applied to sobriety. The group is challenged to use their experiences to help other members of the group.

It is expected that many group members do not have the skills to support each other in sobriety. Adapting the issue "gang loyalty" to a constructive behavior such as support for someone trying to stop using is also probably bound for failure. This is where group members begin to see the dysfunctionality of the gang - it cannot support healthy productive behaviors.

The final phase involves sessions seven and eight. The group returns to practical information regarding drugs and recovery. Individual's commitment and ability to stay clean for the last two weeks is the focus of much of these groups. Guest speakers from the community are brought in to speak on drug and recovery issues. The group leader stresses respecting these community members and challenges the group's inclination to be disrespectful toward authority figures.

The group ends with a small ceremony; group members are acknowledged for their participation in the group. It is important to instill a sense of achievement in all group members. Some of the subjects of the last group are empowerment and recovery. The group leader attempts to instill hope for the future by discussing what they have accomplished so far in the group and the resources available if they wish to begin or continue their recovery. It is made clear that the agency and group facilitators are available for members that wish to continue to work on their drug or personal issues.

Strengths and Weaknesses of the Design

The strength of the design is that it uses two instruments specifically developed for drug treatment populations. The use of two instruments, administered at three points in time, increases the construct validity of the design. Unfortunately, the instruments have no component to detect deception on behalf of the subjects.

This quasi-experimental pilot study does not have a true control group. Pre-tests were administered to establish a baseline for the client's drug use. This baseline acts as a control in the design. It may be questionable to attribute post treatment differences solely to treatment effects. The difference in scores may reflect regression to the mean or an external variable such as the threat of legal sanctions from probation officers if subjects continue their drug use. A three month follow-up is a more accurate measure of the group's effect on members. This follow-up measure was included to increase the validity of the pilot study.

Test reactivity is a threat to the design's validity. Group members expressed a concern that their responses may be given to probation officers. Some subjects may have minimized their usage on the instruments due to that concern. However, facilitators were familiar with the drug use habits of the subjects through self disclosure and talk among group members outside the group. Facilitators felt that responses on the instruments were accurate.

Difficulties may arise from the subject's resistant attitudes and the chaotic nature of their lives. In the past, some subjects have been assaulted, hospitalized, or incarcerated during the course of the group. Many group members are from migrant families and move out of the area

on a seasonal basis or do not attend group when work is available. Subject's resistant attitudes often lead to sporadic attendance or withdrawal from the group. This may lead to small group sizes or early termination.

Chapter VI

Results

Three subjects completed the eight week group and their DAST and DSI scores on pre-test, post-test, and three month follow-up were analyzed. A Wilcoxon Signed Ranks Test performed on the scores showed that the DSI pre-test to post-test differences were statistically significant as well as pre-test to follow-up differences for both the DAST and DSI.

Table 3. Wilcoxon Signed Ranks Test Tables

DAST: Pre-Test x Post-Test				
	Pre-Test	**Post-Test**	**d**	**Rank of d**
S_1	14	15	-1	1
S_2	13	6	7	2
S_5	17	17	0	0

N=2, T^-=1, T^+=2, results not significant

DAST: Pre-Test x Follow-up				
	Pre-Test	**Follow-up**	**d**	**Rank of d**
S_1	14	9	5	2
S_2	13	4	9	3
S_5	17	14	3	1

N=3, T^-=0, T^+=6, results significant at p<.125

DSI: Pre-Test x Post-Test				
	Pre-Test	**Post-Test**	**d**	**Rank of d**
S_1	12	13	-1	1
S_2	14	12	2	2
S_5	60	48	12	3

N=3, T^-=1, T^+=5, results significant at p<.250

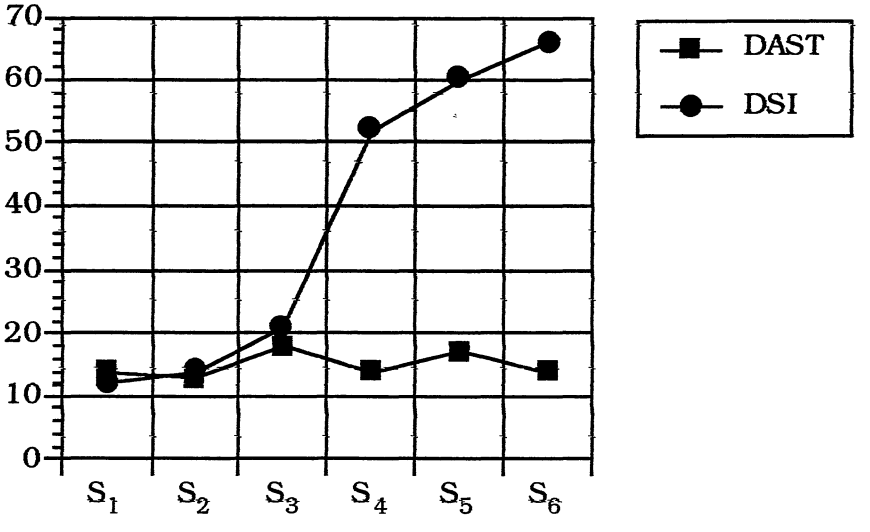
DSI: Pre-Test x Follow-up				
	Pre-Test	**Follow-up**	**d**	**Rank of d**
S_1	12	10	2	1
S_2	14	8	6	2
S_5	60	40	20	3

N=3, T^-=0, T^+=6, results significant at p<.125

Drug use was reduced in the three subjects that completed the study by an average of 31%, as calculated by averaged pre-test and follow-up DSI scores. Actual reduction in usage among subjects was 17%, 43%, an 33% respectively. (The subject's scores for both instruments are available in Appendix I.)

The greater discriminative power of the DSI is evident in figure 2. It would be expected that a higher degree of usage would also involve greater problems associated with drug usage. However, the DAST scores were virtually a straight line, with a score range of five, while the DSI scores showed greater variability with a with a score range of 54.

Figure 2. Group's Pre-Test DAST and DSI Scores



DAST scores did not vary with drug use severity because the DAST did not quantify the information it sampled. For example, it asked if the subject had missed school due to drug usage but not how many days. However, the DAST is still a valuable instrument because it establishes a behavioral baseline by measuring problematic drug use behaviors of

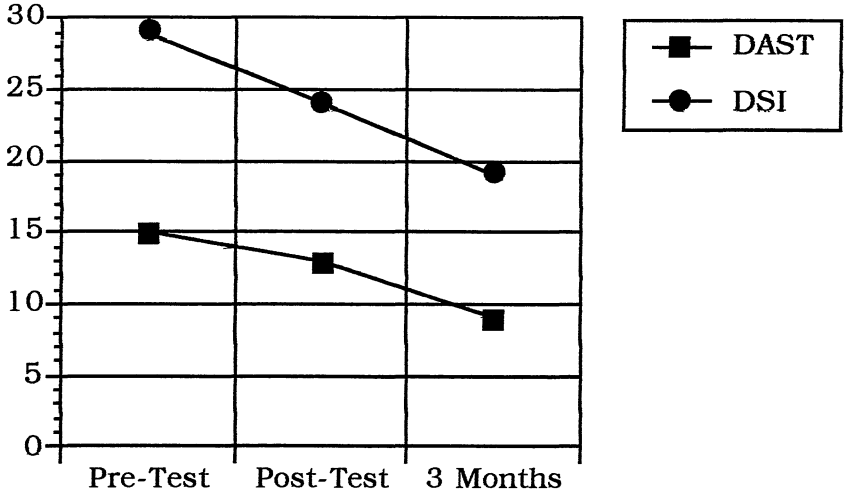
subjects. The combination of these two instruments validated one another increasing overall design validity.

In addition, figure 2 shows that the pre-test DSI scores were separated into two distinct groups. The first group (S_1, S_2, S_3) had a mean of 15.7 and were 21 points below the median for total DSI scores. The second group (S_4, S_5, S_6) had a much higher mean of 59.3 and were 22 points above the median for total DSI scores.

Taking into account that only three subjects completed the study it can be tentatively stated that subjects below the median are more likely to complete the group and reduce their usage than subjects above the median. This hypothesis, if supported in replicated studies, would begin to yield predictive validity to the DSI regarding this specific group format and client population. The DSI could therefore be used to screen higher scoring youth for placement in more intensive groups and as a measure of client progress and program effectiveness.

Most instruments show a reduction in drug use during the treatment periods. However, these changes cannot be confidently attributed to treatment effects. They may reflect regression to the mean, an inclination to please the researcher, or fear of consequences while involved in the study or program. In general, follow-up reports are more reflective of actual treatment effects. All subjects showed a steady decline in drug usage and problematic behaviors from initial group through the three month follow-up period. The subject's reduction in drug usage throughout the study is illustrated in figure 3.

Figure 3. Subjects 1, 2, & 5 Averaged DAST & DSI Scores



Though the DAST did not initially appear to correlate with the DSI figure 3 above shows that averaged instrument scores dropped conjointly. DSI scores dropped 34 percent between pre-test and follow-up while the DAST dropped 40 percent during the same period. This indicates that both instruments correlate highly and are accurately measuring the different aspects of subject's drug abuse: usage and behavior. The instruments showed a Pearson's *r* correlation of .98. Because these statistics were drawn from a subject group of three they are tentative and not generalizable. However, the high correlation between the instruments is promising and gives the project design high construct validity. Issues of reliability of the instruments and curriculum with this population can only be addressed through replication of the study.

In general this pilot study can be considered successful because all subjects who completed the study reduced their drug usage from pre-test to follow-up. The instruments used were developed specifically for drug treatment populations and showed a strong correlation throughout the

study. These factors give the design high content, criterion, and construct validity. Though the statistics were drawn from a small sample size of three they are encouraging. It appears that the group curriculum and instruments are effective in working with this population.

Chapter VII

Discussion

This special project was a pilot study regarding the effectiveness of a drug intervention group with gang involved Hispanic adolescents. The project was successful in that subjects completing the group reduced their drug usage by an average of 31 percent at the three month follow-up period. This is a considerable victory for these youth considering their life circumstances and history of drug use. As is often the case these youth had no medical insurance available to them. Treatment options such as residential drug treatment or intensive out-patient services are not available to the majority of youth in Watsonville. Available drug treatment through non-profit organizations must be refined and maximized to serve community youth. The results of this study show promise in Youth Services' ability to intervene in the cycle of drug abuse and gang affiliation that involve many youth around the country.

Research in drug treatment with minority youth is clearly lacking. The majority of gang intervention research does not address the subject of drug abuse. This author has found that the dynamics of drug abuse and gang involvement are strongly linked. Expansion of the curriculum and involvement of the parents may increase the efficacy of this drug intervention group.

Working with this population requires clinical expertise in various areas including drug treatment, group therapy, gang intervention, depression, sexual and physical abuse, communications, and mood and anger management. A proven group curriculum and proper training can

reduce clinician burnout and provide effective and culturally appropriate therapy to drug and gang involved youth.

The major challenge of the group was the high subject drop out rate. This is a constant problem with this population. In the past, subjects have cited several reasons for not completing the group including incarceration, difficulty getting to the center due to gang conflicts, flight from police or probation, having to work or help parents, and moving out of the area. Increasing group attendance may be accomplished through recreational activities. However, this requires a greater financial commitment from the supporting agency.

Additional efforts can be directed toward expanding the group curriculum, increasing group member retention, and recruitment of parents into intervention groups. Such efforts may lead to greater reductions in subject's drug usage, commitment from parents to support their youth's sobriety, and the eventual development of a clean and sober youth community in Watsonville.

Recommendations for Study Replication

An important design issue is to continue to modify the DAST to simplify its administration and increase the probability of honest responses. Subjects complained that the 26 item DAST was to long. Skinner (1982) reports that a shorter 20 item DAST showed a high internal consistency rating of .95 for total subjects and .86 for a subsample excluding subjects with only alcohol problems. The 20 item DAST includes items 1, 2, 3, 4, 5, 8, 9, 10, 12, 14, 15, 16, 17, 18, 21, 22, 23, 24, 25, 27. Items from the modified DAST should be used because they have been

adapted for this adolescent population. Shortening the DAST would probably increase response accuracy because group members could complete the form more quickly. In addition, the shorter DAST may be less intimidating and reduce subject's anxiety and resistance to the instrument.

Expansion of the Curriculum and Intervention Efforts

Though the curriculum appears to be effective with the drug intervention group members research by Catalano (1991) indicates there may be additional issues that warrant inclusion. In a major study of adolescent drug abuse treatment programs Catalano (1991) found that the majority of clients reduce their drug usage while in any treatment program and that relapse is high for both adolescent and adult populations. He cited three major factors leading to relapse. The first is the adolescent's inability to cope with drug cravings or capacity to refuse drugs offered by peers. The second factor was minimal involvement in productive activities like school and work. The final factor was minimal involvement in satisfactory active leisure activities.

Catalano (1991) also lists internal dynamics and social skills deficits common to youth involved in drug treatment including high impulsivity, external locus of control, poor interpersonal communication and social skills, lack of empathy, poor coping and problem solving skills, and poor anger control and moral reasoning. Though the majority of these relapse factors and social skills deficits are addressed directly in the group curriculum specific group sessions can be developed to address impulsivity, anger control, drug refusal skills, and recreational activities.

William Zaragoza, lead drug treatment counselor, is currently developing a specific "Probation Group." This group focuses on drug treatment, working with authority figures, anger management, and moral reasoning. The latter subject is particularly valuable with this population. Many group members have adopted dysfunctional and gang oriented value systems which perpetuate delinquent behaviors and drug abuse. Directly challenging these belief systems in a group setting has been successful with several group members.

Involving Parents in Drug Intervention Groups

Though the youth finishing the study did well several familial stress factors were not addressed in the course of the group. It would be more effective to have parents attend a concurrent intervention group to discuss issues such as drugs abuse and addiction, gang affiliation, and the concept of clean and sober household. Other issues that contribute to the development of drug abuse such as family conflict and parental drug and criminal involvement could also be addressed. Aguilar, et al, (1991) have developed a comprehensive curriculum regarding chemical dependency and codependency.

It would probably be most advantageous for parents to meet with the youth for the final two sessions. Though an ongoing multi-family group has specific strengths in comparison to a drug intervention group youth are less likely to disclose their drug use habits with parents present. Youth finishing the intervention course could move onto an ongoing early sobriety group while the parents could meet in a bi-weekly or once a month support group. Improvement in the family system could be

measured by a variety of scales such as the Family Environmental Scale. Friedman and Utada (1992) have written an excellent article addressing the use of three different scales with families of drug abusing adolescents.

Unfortunately many families have been resistant to attending groups in the past for various reasons. Some parents to not want to be confronted regarding their drug use. Other parents work two jobs or late into the evenings and are unable to attend groups. In any event the involvement of family is important to prioritizing recovery from drugs or alcohol in the family system and should remain a priority for group facilitators.

Increasing Retention of Clients

Retention of subjects is an important issue in continuing the group. A strategy to improve attendance may include working closer with the probation department to pressure subjects to attend as many groups as possible. In the first few sessions subjects are informed that probation has the right to inquire about their attendance and progress. (Though counselors give no detailed information without the permission of the client.) Compulsory attendance does not necessarily negatively effect treatment outcomes. All three subjects completing this study were on probation.

Catalano, (1991), cites a study that states that compulsory referral in itself did not lead to a perceived lack of choice at intake and was positively correlated with completing the treatment program. It may be advantageous to forward a weekly attendance sheet to probation officers working with the clients.

Another strategy to increase retention may be to include active recreational activities as part of the group curriculum. Subjects attending eighty percent of the groups would be eligible to attend a major recreational activity. Such activities may include camping, fishing, beach trips, or attending athletic events. Subjects that had previously successfully completed the group may also be eligible to attend. Networking current and past group members would decrease various relapse factors by building a sober and clean peer group. Positive recreational activity not involving drugs would be modeled by previous group members.

The key to an effective drug and gang intervention program for adolescent minorities is the development of a clean and sober peer group. Presently, there are only a handful of youth in recovery in the Watsonville area.

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Appendixes

Youth Services Organizational Chart

Santa Cruz Community Counseling Center (SCCCC)
Administrative office for the components below. This office houses executive director, component directors management team, community board of directors, agency budget comptroller, funder reporting and billing responsibilities, and employee payroll and benefits.

SCCCC Components

Alto Counseling Center
An out-patient drug treatment program for adults. Also conducts county DUI (driving under the influence) classes

Head Start Children's Programs
12 community child care and educational programs in Santa Cruz County

Si Se Puede
Residential drug treatment program specifically for Hispanic adult males

Stepping Out Services
Out-patient dual diagnosis counseling center; mental health and drug treatment

Sunflower House
Residential drug treatment program for adult males

Youth Services, Inc.
Adolescent and family therapy centers; Santa Cruz and Watsonville

Specific programs in the Watsonville center:
Broad-based Apprehension, Suppression, and Treatment Alternatives (BASTA): Gang member and youth at risk counseling program.
Center for Substance Abuse Treatment (CSAT): Adolescent and family out-patient drug treatment program with on site county alternative school program.
Drug Medi-Cal Out-Patient Program (DMC-OP): Individual, family, and group out-patient therapy.
24 Hour Adolescent Crisis Program: Crisis intervention, individual and family counseling, temporary foster care family placement. Funder: HHS; Health and Human Services.
Individual and Family Counseling Program: Non-crisis or drug related counseling services. Funder: United Way and specific city grants.

Youth Services Projected 1995-1996 Budget

Funder	Budget	% of Budget
Health Services Agency: Drug Medi-Cal Day Treatment (DMC-DT) & Out-Patient (DMC-OP)	616,900	57 %
Center for Substance Abuse Treatment (CSAT)	176,400	16 %
Health & Human Services (HHS)	129,600	12 %
Santa Cruz City Grant (SC)	77,200	7 %
Client Fees/Discretionary	20,000	2 %
County Office of Education (COE)	20,000	2 %
United Way Grant (UW)	20,800	2 %
Watsonville City Grant (WAT)	10,400	1 %
Capitola City Grant (CAP)	5,700	.5 %
Consultation, Training, & Education	4,000	.4 %
Fundraising	2,000	.2 %
Scotts Valley City Grant (SV)	1,000	.1 %
Total Revenue	1,084,000	100 %

Note: Projected budget is for both Youth Services centers, Santa Cruz and Watsonville. Youth Services is a component of Santa Cruz Community Counseling Center (SCCCC). Other component funds or contracts are not represented or calculated into Youth Services' budget.

Youth Services, Inc.
1995
Annual Outcome Evaluation

January 30, 1996

Bill Manov, Alcohol and Drug Programs
Health Services Agency
1080 Emeline
Santa Cruz, CA 95061

Dear Bill,

Enclosed, please find our Annual Outcome Evaluation completed January, 1996. Results are reported on a sample of clients who had received any of the counseling services offered by Youth Services, and also on a subsample of clients who only participated in drug treatment.

We are quite pleased with this years results; outcomes exceeded goal across all indicators. We believe that the expansion and maturation of our drug treatment programs at both program sites is one factor in the positive outcomes this year.

Sincerely,

Walter Guzman
Director

Jeanette Reed
Program Coordinator

EVALUATION OF EFFICACY OF SERVICE PROVISION

January 30, 1996

Methods and Sample

Standardized telephone interviews were completed with a total of 115 client-families (see appendix A for the breakdown of youth only, parent only, and youth-parent completed contacts). 95 clients out of the total sample had completed counseling between April 1995 and April 1994, leaving 6 to 18 months between termination of treatment and participation in this survey. Data was obtained on another 20 clients who continue to received services. These clients are all clean and sober youth who participate in our Day Treatment Programs and are long-term clients who have remained active a year or more.

In the interviews clients and their parents were asked to assess 1) improvement in school performance, and 2) changes in work status since termination of counseling. They are also asked to evaluate 3) the degree of satisfaction with counseling services received.

Information on recidivism/arrests was obtained independent of client report through access to probation records. For a total of 214 clients, history of illegal violations prior to counseling were compared to the same up to 18 months after completion of counseling.

Results are reported on the total client sample, as well as on the subsample of only clients who participated in Drug Treatment, (N=54).

Results - Total Sample

Objective A - To reduce the rate of recidivism and/or arrests by 60% of the clients.

Results: 70% of clients who had problems with the law prior to counseling did not have further arrests or violations recorded. (see Appendix A, Table 2 for numerical results).

Objective B - To improve school or vocational performance by 60% of clients.

Results School Performance:

70% of clients reported improved school performance, 4% reported no change, and 26% claimed that school performance had worsened.

Results Vocational Performance:

43% of clients reported improved employment status, 54% reported no change, and 3% declared that their work situation had gotten worse. (See Appendix A, Table 3 for numerical results).

Objective C: To receive 75% positive evaluations from clients 6 months after treatment.

Results - 91% of the client reported satisfaction with services received, 3% were neutral, and 6% had some dissatisfaction. (see Appendix A, Table 4 for numerical results).

Results - IISA, Drug Treatment Subsample

Objective A - To reduce the rate of recidivism and/or arrests by 60% of clients.

Results: 66% of clients who had problems with the law prior to counseling did not have further arrests or violations recorded (see Appendix B. Table 2 for numerical results).

Objective B - To improve school or vocational performance by 60% of clients.

Results School Performance -

73% of clients reported school improvement, 3% reported no change, and 24% claimed that school performance had worsened.

Results Vocational Performance -

43% of clients reported improved employment status, 42% reported no change and 15 % claimed that their work situation had gotten worse. (See Appendix B, Table 3 for numerical results).

Objective C - To receive 75% positive evaluations from clients 6 months after treatment.

Results: 92% of the clients reported satisfaction with services received, 4% were neutral and 4% of the clients said they were dissatisfied. (See Appendix B, Table 4 for numerical results).

(All Clients)

Table. 1 Breakdown of Completed Contacts

Youth only	13
Parent only	42
Youth & parent	60
Total N	115

Table 2. Number of clients with legal violation six months after completion of counseling by prior legal history.

Before Counseling	After Counseling	
yes	no	65
yes	yes	28
no	no	113
no	yes	8
Total N		214

Table 3. Changes in school and vocational performance

	School	Work
Improved	80	50
No Change	5	62
Got Worse	30	3
	115	115

Table 4. Client satisfaction with services received

	Youth	Parent	Total
satisfied	70	90	160
neutral	0	5	5
dissatisfied	3	7	10
	73	102	175

(HSA Drug Treatment Clients Only)

Table 1. Breakdown of completed contacts

Youth only	8
Parent only	26
Youth & parent	40
Total N	74

Table 2. Number of clients with legal violations six months after completion of counseling by prior legal history

Before Counseling	After Counseling	
yes	no	37
yes	yes	19
no	no	53
no	yes	3
		112

Table 3. Changes in school and vocational performance

School	Work
54	32
2	31
18	11
74	74

Table 4. Client satisfaction with services received

	Youth	Parent	Total
Satisfied	45	60	105
Neutral	0	4	4
Dissatisfied	3	2	5
	48	66	114

Gateway Drug Use Reported by Gender and Race

Results of the Walter, Vaughan, & Cohall (1993) study comparing three theoretical models of substance use among urban high school students.

Percent Students Using Alcohol During the Past Year					
	Male	Female	Blacks	Hispanics	Others
None	31	31	34	22	44
Experimental [a]	33	42	36	44	31
Occasional [b]	26	25	25	27	20
Frequent [c]	10	3	5	7	5

Percent Students Using Cigarettes During the Past Year					
	Male	Female	Blacks	Hispanics	Others
None	72	72	77	65	67
Experimental [a]	14	15	13	19	10
Occasional [b]	7	7	6	7	10
Frequent [c]	7	6	4	9	13

Percent Students Using Marijuana During the Past Year					
	Male	Female	Blacks	Hispanics	Others
None	86	90	89	87	92
Experimental [a]	5	5	5	6	2
Occasional [b]	4	3	4	3	2
Frequent [c]	5	2	2	4	4

Note: [a] Once or twice a year, [b] Less than once a month to three times a month, [c] Weekly to daily.

Self-Reported Delinquent Behavior (Ever) by Involvement with Drugs in Past Year
(Frequency of occurrence in past year is reported in parentheses)
by Brounstein (1993)

		Drug Involvement in the Past Year			
Delinquent Behavior	Total	Neither used/sold	Used Only	Sold Only	Used and Sold
Unlawful use of a vehicle	9% (3.7)	6%a (1.4)	14%a (2.0)	23%a (9.2)	27%a (3.7)
Breaking and entering	5% (1.9)	4%a (1.3)	0%a (0)	11%a (3.0)	7%a (0)
Burglary	6% (5.3)	2%a (3.0)	14%a (13.0)	17%a,b (2.6)	40%b (1.5)
Part of a group that attacked or threatened an individual	22% (5.7)	16%a (5.4)	28%a,c (6.6)	60%b (5.8)	47%b,c (6.0)
Carrying a concealed weapon	28% (23.0)	21%a (13.1)	31%a (37.8)	71%b (2.6)	67%b (47.5)
Individually attacked another youth so that a doctor was needed	13% (2.8)	9%a (1.9)	14%a (2.0)	29%b (3.0)	27%b (7.0)
Vandalism	17% (9.4)	15%a (5.2)	17%a (30.5)	29%a (19.4)	27%a (4.0)
Dealt in stolen goods	17% (17.3)	9%a (2.7)	31%b (37.9)	48%b (17.9)	60%b (35.8)
Driving under the influence	3% (5.6)	1%a (1.0)	14%a (4.0)	3%a (4.0)	20%a (9.3)
Selling drugs	16% (45.3)	35%a (0)	17%a (0)	100%b (40.1)	100%b (57.2)
Robbery	9% (10.1)	6%a (3.6)	7%a (41.0)	17%a (14.6)	33%b (15.0)
Sexual Assault	0.5% (0)	0%a (0)	0%a (0)	0%a (0)	13%a (0)
Assaulted an adult	11% (3.3)	9%a (1.9)	7%a (0)	31%b (5.5)	7%a (4.0)
Use of a weapon to threaten another	11% (8.1)	6%a (3.1)	14%a,c (26.3)	40%b (6.5)	33%b,c (16.2)
Shot, stabbed or killed someone	5% (7.4)	3%a (15.7)	3%a (1.0)	14%a (1.0)	13%a (1.5)
Number in sample	387	308	29	35	15

Note: Different subscript letters, in the same row, indicate statistically significant differences ($p<.05$) between groups. Similar subscript letters, in the same row, indicate no significant differences among groups.

Drug Abuse Screening Test (DAST); by Harvey Skinner, 1982.

1. Have you used drugs other than those required for medical reasons?
2. Have you abused prescription drugs?
3. Do you abuse more than one drug at a time?
4. Can you get through a week without using drugs (other than those required for medical reasons)?
5. Are you always able to stop using drugs when you want to?
6. Do you abuse drugs on a continuous basis?
7. Do you try to limit your drug use to certain situations?
8. Have you had "blackouts" or "flashbacks" as a result of drug use?
9. Do you ever feel bad about your drug use?
10. Does your spouse (or parents) ever complain about your involvement with drugs?
11. Do your friends or relatives know or suspect you abuse drugs?
12. Has drug abuse ever created problems between you and your spouse?
13. Has any family member ever sought help for problems related to your drug use?
14. Have you ever lost friends because of your use of drugs?
15. Have you ever neglected your family or missed work because of your drug abuse?
16. Have you ever been in trouble at work because of drug abuse?
17. Have you ever lost a job because of drug abuse?
18. Have you gotten into fights when under the influence of drugs?
19. Have you ever been arrested because of unusual behavior while under the influence of drugs?
20. Have you ever been arrested for driving while under the influence of drugs?
21. Have you engaged in illegal activities in order to obtain drugs?
22. Have you ever been arrested for possession of illegal drugs?
23. Have you ever experienced withdrawal symptoms as a result of heavy drug intake?
24. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?
25. Have you ever gone to anyone for help for a drug problem?
26. Have you ever been in hospital for medical problems related to your drug use?
27. Have you ever been involved in a treatment program specifically related to drug use?
28. Have you been treated as an out-patient for problems related to drug abuse?

Youth Services Intervention Group Survey

Your Initials: _____

Instructions: answer the following questions in regard to the last month. Circle "Y" for yes and "N" for no. Please answer all questions carefully and honestly.

Y N 1. Did you use drugs other than those required for medical reasons?
Y N 2. Did you abuse prescription drugs?
Y N 3. Did you use more than one drug at a time or use alcohol and drugs together?
Y N 4. Could you have gotten through a week without using drugs or alcohol (other than medications required for medical reasons)?
Y N 5. Were you always able to stop using drugs or alcohol when you wanted to?
Y N 6. Did you use drugs or alcohol on a continuous basis?
Y N 7. Did you try to limit your drug or alcohol use to certain situations?
Y N 8. Did you have any "blackouts" or "flashbacks" as a result of drug or alcohol use?
Y N 9. Did you feel bad about your drug or alcohol use?
Y N 10. Did your girlfriend or parents complain about your involvement with drugs or alcohol?
Y N 11. Did your friends or relatives know or suspect you use drugs or alcohol ?
Y N 12. Did drug use ever create problems between you and your girlfriend?
Y N 13. Did any family member ever seek help for problems related to your drug or alcohol use?
Y N 14. Did you lose friends because of your drug or alcohol use?
Y N 15. Did you neglect your family or miss school because of your drug or alcohol use?
Y N 16. Did you get in trouble at school because of drug or alcohol use?
Y N 17. Were you expelled from school because of drug or alcohol use?
Y N 18. Did you get into a fight when under the influence of drugs or alcohol?
Y N 19. Were you arrested, ticketed, or have your probation violated because of unusual behavior while under the influence of drugs or alcohol?
Y N 20. Were you arrested for driving while under the influence of drugs or alcohol?
Y N 21. Did you do anything illegal in order to get drugs or alcohol?
Y N 22. Were you arrested, ticketed, or have your probation violated for possession of illegal drugs or alcohol?
Y N 23. Did you experience withdrawal symptoms as a result of not having drugs or alcohol?
Y N 24. Did you have any medical problems as a result of your drug or alcohol use (for example: memory loss, hepatitis, convulsions, vomiting, bleeding, over dose, etc.)?
Y N 25. Did you go to anyone for help with a drug or alcohol problem?
Y N 26. Did you go to the hospital for medical problems related to your drug or alcohol use (for example: passing out, hallucinations, seizures, vomiting, bleeding, over dose, etc.)?

Please check the box regarding your drug use during the last month

	1 x month	2-3 x month	1 x week	2-3 x week	4-6 x week
Alcohol					
Marijuana					
Speed, CR					
Paint/Glue					
Cocaine					
Heroin					
LSD/PCP					

Scoring Protocols for Drug Abuse Screening Test (DAST) and Drug Severity Index (DSI)

DAST Scoring Protocol:

A subject's DAST score is the number of responses that endorse drug usage. The following is the key to the DAST questions. Subject's responses that match the key are counted toward the subject's DAST score.

1. Y	8. Y	15. Y	22. Y
2. Y	9. N	16. Y	23. Y
3. Y	10. Y	17. Y	24. Y
4. N	11. Y	18. Y	25. N
5. N	12. Y	19. Y	26. Y
6. Y	13. N	20. Y	27. N
7. N	14. Y	21. Y	28. N

The cutoff score for DSM-IV Drug Abuse classification is 8 positive responses.

DSI Scoring Protocols:

The complete DSI instrument is at the bottom of the survey, in appendix G. Subjects check the box that best represents their drug usage. The numeric values of the drug and frequency of use are multiplied for each drug. If a subjects writes a different drug in the last box provided the researcher determines which type of drug it is similar to and gives that selection the same numeric value.

For example, if a subject writes down "shrooms" or "mushrooms" they may be considered a hallucinogen and scored the same as LSD.

Scores for each drug are added together to determine the overall DSI score.

Drug	Value
Alcohol	1
Marijuana	1
Speed, CR	3
Paint/Glue	3
Cocaine	2
Heroin	3
LSD/PCP	3

Frequency	Value
1 x month	2
2-3 x month	4
1 x week	6
2-3 x week	8
4-6 x week	10

Subject's DAST and DSI Scores

	DAST			DSI		
	Pre-Test	**Post-Test**	**Follow-up**	**Pre-Test**	**Post-Test**	**Follow-up**
S_1	14	15	9	12	13	10
S_2	13	6	4	14	12	8
S_5	17	17	14	60	48	40