Comprehensive Residential Education, Arts, and Substance Abuse Treatment (Creasat): A Model Treatment Program for Juvenile Offenders

Donnie W. Watson, Lorrie Bisesi, Susie Tanamly and Noemi Mai

Youth Violence and Juvenile Justice 2003; 1; 388
DOI: 10.1177/1541204003256312

COMPREHENSIVE RESIDENTIAL EDUCATION, ARTS, AND SUBSTANCE ABUSE TREATMENT (CREASAT)

A Model Treatment Program for Juvenile Offenders

Donnie W. Watson
Lorrie Bisesi
Susie Tanamly
Noemi Mai
UCLA Integrated Substance Abuse Programs

This article describes an alternative treatment model for adolescent substance abusers confined to a residential juvenile correction facility. Substance abuse trends among youth and the connection between substance use and juvenile delinquency are explored. Essential components of effective adolescent substance abuse treatment programs are outlined with particular attention to arts-based delinquency intervention programs. Specifically, this article describes the program philosophy and program components of a model treatment program for juvenile offenders—Comprehensive Residential Education, Arts, and Substance Abuse Treatment (CREASAT). An integral piece of the CREASAT program is The Matrix Institute addictions model for adolescent treatment, which takes into account the developmental factors that initiate and/or maintain substance use. This comprehensive model is based on social learning theory, cognitive behavioral principles, and the adolescent's environment and readiness for change. Finally, the importance of cultural skills for substance abuse treatment professionals in the juvenile justice system is discussed.

Keywords: *youth drug treatment; arts programs; juvenile offenders; juvenile correctional treatment; model treatment programs*

Substance use in the general population has consistently demonstrated a downtrend since the 1980s (Johnston, O'Malley, & Backman, 1998). However, despite recent trends that suggest a decrease in substance abuse among youth in this country, the prevalence of drug abuse remains a significant problem in this population (U.S. Department of Health and Human Services [DHHS], 2000; Office of National Drug Control Policy, 2001; Substance Abuse and Mental Health Services Administration [SAMHSA], 1997). Even though reported past-month illicit drug use for the age group 12 to 17 was down between 1997 and 1999, the rate increased among young adults 18 to 25 (DHHS, 2001). During 1999, one half (51%) of the high school seniors surveyed reported using alcohol in the past month and

Youth Violence and Juvenile Justice, Vol. 1 No. 1, January 2003 388-401
DOI: 10.1177/1541204003256312

nearly one fourth (23%) reported marijuana use. Use of cigarettes, smokeless tobacco, and other drugs accounted for nearly 35%, 8%, and approximately 5%, respectively (Johnston et al., 2001). Recent surveys suggest that after 1 or 2 years of decline, overall drug use among teens remained steady among 8th, 10th, and 12th graders; marijuana is the most widely used illicit drug with annual prevalence rates in grades 8, 10, and 12 of 16%, 32%, and 37%, respectively (Johnston et al., 2001).

Other evidence exists suggesting that illegal drug use among students has increased. In this regard, for the first time in 4 years, illegal drug use among high school seniors increased in the United States. More specifically, 41% of students said they had used at least one illegal drug during the 2000-2001 school year—an increase from 40% the year before and nearly the same as the rate in the 1996-1997 school year (National Parents' Resource Institute for Drug Education [PRIDE], 2001). Further, illicit drug use, alcohol experimentation, and smoking are increasing among 12- and 13-year-olds with trends suggesting younger people are experimenting with illicit drugs, alcohol, and ecstasy (Morgan, 2001).

The Centers for Disease Control and Prevention (CDC) (2000) reported that 72% of all deaths among youth and young adults aged 10 to 24 result from only four causes: motor vehicle crashes, other unintentional injuries, homicide, and suicide. The risk is greatly increased by substance use. This report identified the following health behaviors as among the leading contributors to mortality and morbidity: tobacco use, alcohol and other drug use, and sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases (STDs) including human immunodeficiency virus (HIV) infection. The CDC 2000 Youth Risk Behavior Surveillance System of school-based surveys conducted on a national high school student population reported that risk behaviors of tobacco use, alcohol and other drug use, and sexual behaviors all worsened from 1991 to 1999 (CDC, 1999).

Substance Use and Juvenile Delinquency

The problem of substance use is more pronounced among adolescents in contact with the juvenile justice system. Recent survey results among juvenile arrestees provide evidence of illegal drug use. For example, more than half of juvenile male arrestees tested positive for at least one drug; marijuana was the most frequently detected drug (National Institute of Justice, 1999). The trend toward marijuana use among youth arrestees increased from 25% in 1991 to 62% in 1999; marijuana appears to have become the drug of choice among those youths coming of age in the 1990s that tend to get in trouble with law enforcement (National Institute of Justice, 1999). Health-related problems among youth in alternative schools that have a great percentage of youths involved in the juvenile justice system are also a major concern (CDC, 1999). This survey revealed that the prevalence of most risk behaviors is higher among students attending alternative high schools compared to regular high schools. For example, alternative school students were significantly more likely to have smoked cigarettes, drunk alcohol, used marijuana, used cocaine, had more sex partners, or had more sexual intercourse during the 3 months preceding the survey (Grunbaum et al., 1999).

Research over the last 20 years has established a substantial correlation between substance abuse and juvenile delinquency (Held, 1998). There are more than 350,000 juveniles on probation and in continuing care programs in the United States who have substance abuse histories (75%-95%) but rarely receive appropriate treatment (Center for Substance Abuse Treatment/Denver Juvenile Justice [CSAT/DJJ], 1999). Furthermore, 60% of the 1.7 million adjudicated youth in the United States each year experience some

substance abuse-related problem (Robert Wood Johnson Foundation, 2001). Systematic methods to assess the course and incidence of treatment across juvenile systems are in an early stage. However, a 1997 survey of juvenile correction facilities suggested that only 36% offered some type of substance abuse intervention (SAMHSA, 1997). It is clear that, although there is consensus that substance abuse problems exist among youth in the juvenile justice system, there is a dearth of systematic assessment and intervention. In fact, surveys of juvenile probation departments identified substance abuse intervention services as among the most critical expansion needs (National Council of Juvenile Justice, 1999). Consistent with national trends, the state of California has significant problems providing drug treatment for youth offenders because there are far too many drug-involved juveniles for available treatment slots (State of California, Department of Youth Authority, 1999). In fact, this agency indicated that 60 to 75% of California Youth Authority wards have a problem or are at risk of developing substance abuse problems. Several publications cite the effectiveness of drug treatment in reducing drug use and decreasing criminal activity during and after treatment (CSAT/DJJ, 1999; National Institute on Drug Abuse [NIDA], 1999).

Results from the National Evaluation Data Services (1997) showed that, among adolescents ages 13 to 17, substance abuse treatment reduces illegal drug use and decreases criminal activity. Treatment is cost-effective in reducing drug use and its associated health and social cost. Treatment is less expensive than alternatives such as not treating addicts or incarceration alone. There are various cost-effective models with a range of projected savings. In this regard, according to conservative estimates, every $1 invested in an addiction treatment program yields a return of between $4 to $7 in reduced drug-related crime, criminal justice costs, and theft. When savings related to health care are included, total savings can exceed costs by a ratio of 12 to 1 (NIDA, 1999). Thus, the issue is not whether treatment works but what kind of treatment approach is effective and with what types of individuals.

Essential Treatment Components

Howell and Decker's review of the literature (1999) suggests that the relationships between gangs, drugs, and violence probably fall into three categories. First, pharmacological effects of the drug on the user can induce violence. Second, the high cost of drug use often impels the user to support continued drug use by committing violent crimes (e.g., robbery, assault). Third is the existence of system violence, which refers to protection or expansion of drug territory. There are no easy answers to the complex problem of violence related to drug use and other related factors. Howell and Decker suggested that the first step is to assess the gang problem and the unique local characteristics.

It is imperative that treatment of substance abuse disorders in the United States be guided by findings from scientific literature (NIDA, 1999). In this regard, current research indicates that the most effective theoretical framework for future substance abuse treatment models for adolescents integrates a comprehensive (multimodal) family approach along with other key components (CSAT/DJJ, 1999). Some of these essential key components include the following: (a) academic/vocational training; (b) mental health/HIV/sex education/violence; (c) parenting education; (d) creative approaches including art, dance, and theater; and (e) cultural- and gender-specific approaches. The creative arts component is included because it teaches valuable skills such as logic, organizational teamwork, and patience, and it incorporates the knowledge that failure is a critical element of discovery and

learning. Integrating the creative arts into all learning experiences enhances academic, social, and personal developmental outcomes (Randall, 1997).

Arts-Based Delinquency Intervention Programs

The YouthArts Development Project, a collaborative between federal agencies, national arts organizations, and a consortium of three local arts agencies in Atlanta, Portland, and San Antonio (Clawson & Coolbaugh, 2001) found that providing youth with new skills and offering them positive feedback and recognition for their hard work led to healthier attitudes and more positive behaviors. Youth In Action (2000) suggested that arts and performances can prevent violence and delinquency by (a) educating others on the benefits of crime prevention; (b) allowing youth to use their creative talent to develop a sense of identity, independence, discipline, and self-worth; and (c) preventing or reducing violence among the young artists and performers who become involved in the arts. Lovett (2000) reported promising results from the implementation of an arts program delivered to a population of all male students in a residential corrections facility in Texas. The results indicated increased student knowledge in the art area being studied, an increase in student skill level, improved self-esteem, improved student behavior, improved coping skills, and lower recidivism as measured by reincarceration.

Comprehensive Residential Education, Arts, and Substance Abuse Treatment (CREASAT)

Program Philosophy

The CREASAT program is guided by the social development model (Catalano & Hawkins, 1996) that incorporates information on how protective factors and risk factors work together to enhance both positive and antisocial development. Our model builds on literature reviews (Botvin, 1995; Hawkins, Catalano, & Miller, 1992; Petraitis, Flay, Miller, Torpy, & Greiner, 1998) that demonstrate the efficacy of broad-focused social influence and integrated social influence approaches in addressing the complex issue of adolescent substance abuse. Ellickson (1984) found that the social learning and social influence approaches are effective in treating adolescent drug use. Theories in this category assume that adolescents acquire their beliefs about substance use and other delinquent behaviors from their role models, friends, and parents. This perspective suggests that it is important to provide adolescents with positive role models and to teach them refusal skills and arm them with the belief that they can resist drugs (Petraitis & Flay, 1995). Social learning theory (Bandura, 1994), which builds on operant principles of behavior, suggests an interpersonal process through which skills are acquired, strengthened, and maintained. Learning of new skills is facilitated when an individual is able to see models of the new behavior, receive feedback and shape behavior in their own performance of the new behavior, and receive positive social and self-reinforcement for exhibiting the new behavior. Therefore, key in the acquisition of new skills is the important mediating role of self-efficacy—the personal belief in one's ability to perform a particular behavior.

A successfully implemented intervention among juvenile delinquents (i.e., Seattle Social Development Project) (Battin-Pearson, Thornberry, Hawkins, & Krohn, 1998) is

guided by the hypothesis that states that socialization follows the same processes whether it produces prosocial or problem behavior. This hypothesis further states that development of prosocial or antisocial behavior is influenced by the degree of involvement and interaction with prosocial or delinquent peers, the skills required and the costs and rewards for that interaction (social learning), and the extent to which youth become bonded to prosocial or antisocial individuals (social control).

Program Model

The program model described here includes enhanced substance abuse services and arts programming for 120 youth over 3 years in 6-month cycles. The visual and performing arts program consists of after-school and Saturday workshops. Between 12 to 15 wards attend each workshop and are selected to participate based on their interest and satisfactory completion of probation and education requirements. Once they are released from camp, substance abuse treatment and continuing care is implemented through home-based counseling and case management for 6 months. Participants who demonstrate interest and talent in the arts are referred to community-based arts programs to continue their development in this area.

As described earlier, arts interventions have yielded promising results with this population of juvenile offenders. In this project, an enhancement component is used for the preexisting arts education component and is based on a model that was successfully implemented in the Texas Juvenile Correctional System (Lovett, 2000). The research literature on which the Texas Program is based shows that (a) the identification of risk and protective factors that can be addressed in a systematic way is important; (b) arts programs can positively affect risk factors including poor academic achievement, low commitment to school, lack of attachment to the community, and low self-perception; (c) arts programs can develop the protective factors referred to as bonding by providing students with meaningful, challenging opportunities to contribute to their communities by empowering them through instruction in skills that increase their social, emotional, and cognitive competence and by providing recognition to students for their efforts; and (d) arts programs provide youth with opportunities to develop connections, make meaningful contributions, and enhance their competencies—all of which are critical factors in fostering resiliency in youth. The results of this program found significant increases in self-esteem, decreases in behavioral problems, and reduced recidivism for the intervention group.

Target Population of Juvenile Offenders

The program model presented here offers services at a residential probation camp for juvenile offenders that is a collaborative effort of the Probation Department for the County of Los Angeles and the Los Angeles County of Education (LACOE), Division of Court and Community Schools (DCCS). This unique collaborative concurrently addresses the treatment and educational needs of the residents. The offenses that are characteristic of the target population are overwhelming committed by male adolescents (99% male in the state of California). The particular residential probation camp in which CREASAT is offered provides treatment to 125 male, Latino and African American juveniles committed for an array of offenses. The age range is 12 to 19. Youth ages 16 and 17 (i.e., 70%) comprise the largest age group. Seventy-five percent are in this residential facility for serious personal (e.g., aggravated assault, robbery) or property offenses (e.g., auto theft, burglary, or arson);

the other 25% are committed for lesser offenses (e.g., repeated curfew violations or probation violations). The racial and ethnic composition of the students is 68% Latino, 21% African American, 10% White, and 1% Asian, Pacific Islander, American Indian, or Alaskan Native. There is a self-reported 75% rate of gang affiliation.

The average reading level is fourth grade. However, residents are able to communicate with adequate verbal and written skills. The camp capacity is 125, and the average length of stay is 6 months. Because of the variations in school attendance and learning problems, youth are grouped by age for classes. Seventy percent are ages 16 to 17, 20% are 14 to 15, and 10% are 18 to 19. Approximately 200 youth are served per calendar year. Youth receive 24-hour supervision by the probation staff. These detainees are housed in dorms on the campus. This is a secure facility (i.e., locked and supervised facility). Nearly all of these youth (i.e., 95%) have substance abuse histories, and their use either directly or indirectly is a factor in their current incarceration. The probation staff ensures that the facility, juveniles, and probation and education personnel have safe living and work environments.

As part of their initial orientation to the facility, adolescents receive 90-minute educational modules on substance abuse tragedies, understanding addiction, HIV information, social skills development, family communication, gang deterrence, character development, stress management, and conflict resolution/alternatives to violence. Mental health issues and substance abuse treatments are not addressed in a systematic manner. Rather, this system depends on volunteers from the community to donate time. For example, case managers sometimes coordinate 12-step meetings on campus when they are able to get Alcoholics Anonymous, Narcotics Anonymous, and others to arrange a meeting. Otherwise substance treatment and mental health issues are usually addressed on a crisis basis.

Education is provided through accredited academic programs that provide 300 minutes of instruction per day on a year-round basis. School begins at 8:00 a.m. and ends at 2:40 p.m. There are seven classrooms on campus, and the youth receive core academics in English, math, science, and social science. Classrooms generally do not have more than 20 youth. There are eight teachers and two para-educators assigned to provide educational instruction. Youth receive credits that are transferable to their regular community high school upon release. All courses are approved by the Los Angeles County Office of Education and meet the California Department of Education requirements.

The site is a *theme-based camp*, which means that there is a heavy focus on the provision of elective after-school activities in the visual and performing arts. The calendar year consists of four consecutive, 12-week, 2-hour workshops. Each week a 2-hour workshop is presented by a highly qualified and experienced professional artist who is chosen for his or her ability to work with at-risk youth and sensitivity to young people from varied ethnic and racial backgrounds. Each 12-week session begins with a performance by professional artists. These artists offer all students in the camp the opportunity to experience appropriate, quality, live entertainment in dance, music, theater, and storytelling. Workshops end with a culminating event both to celebrate the students' efforts and to recognize their accomplishments.

Program Components

Of the target population, 95% has documented substance use problems. Intensive levels of weekly residential group therapy and twice-weekly arts activities provide a systematic way for participants to express their problem areas. Counselors meet with participants as needed to continually assess areas of immediate concern. Family nights for parents allow a

structured way for them to connect with counselors regarding their concerns. The residential structure already has a full day of educational classes. The program enhancements are systematic substance abuse groups in the after-school hours and arts programming in the after-school hours and on Saturdays. The intensity and consistency of these activities also provide an opportunity for self-expression. Review of all systems related to the functioning of the adolescent allow for a comprehensive profile of the client. This allows the program staff to meet the wards' developmental and other special needs. Treatment plans address the adolescents' cognitive, emotional, physical, social and moral development, and alcohol and drug experiences.

It is important to tailor treatment to the needs of substance-using adolescents in the juvenile justice system. Because these youth differ from adults physiologically and emotionally, treatment of these adolescents is approached by offering a comprehensive range of developmentally appropriate services (e.g., adolescent substance abuse treatment, skills training, parenting education, violence intervention, and creative arts) that has been found to be effective in substance abuse treatment of juvenile delinquents (CSAT/DJJ, 1999).

The Matrix Model for Adolescent Treatment

The Matrix Institute has an 8-year history of providing treatment for youth. The Matrix Institute addictions model for adolescent treatment takes into account the developmental factors that initiate and/or maintain substance use. The model is based on social learning theory, cognitive behavioral principles, and the adolescent's environment and readiness for change. It is a comprehensive approach that received recognition from NIDA as an evidence-based successful treatment approach (NIDA, 1999). The Matrix Institute has accreditation certification from the Commission on Accreditation of Rehabili- tation Facilities (the rehabilitation accreditation for alcohol and other drug programs, children, and adolescents). The adolescent model is currently being used in a CSAT project—Life Interventions for Family Effectiveness (LIFE)—as part of a comprehensive school- and home-based outpatient treatment project to treat adjudicated Latino and African American youth and their families.

The Matrix model is an outpatient treatment approach developed during the mid-1980s for the treatment of individuals with cocaine, methamphetamine, alcohol, and opioid disorders (Rawson, Obert, McCann, Smith, & Scheffey, 1989). This model attempts to provide a treatment method that allows providers to address the wide range of needs among different types of substance abusers. Although it is important to create flexible treatment options, programs that simply attempt to apply a set of treatment materials in an unstructured manner are less effective. This free-form approach makes it extremely difficult to create a systematic treatment process and would make replication and evaluation impossible. For this reason, the Matrix model created a single treatment framework, which produced a standardized format and allowed clinicians a consistent amount of treatment contact. Within this framework, materials are varied to address the specific needs of the different categories of substance abusers. The overall goal of the treatment model is to encourage and support total abstinence. This single treatment goal was selected, in part, for pragmatic reasons. It was important to develop a model that could be practically delivered within existing outpatient chemical dependency treatment programs. Although there may well be an appropriate clinical role for methods that use moderation as a treatment goal, it was beyond the scope of this treatment model to attempt to employ these techniques. The model attempts to create a treatment structure that is clear and consistent to all patients. The

goal is to ensure that patients are not confused and do not have mistaken expectations about the goals of the treatment program.

The model integrates treatment elements from a number of specific strategies including relapse prevention, motivational interviewing, psychoeducation, the family therapy literature, and 12-step program involvement. The basic elements of this approach consist of a collection of group sessions (early recovery skills, relapse prevention, family education, and social support) and individual sessions along with encouragement to participate in 12-step activities. The model was developed and manualized with funding though a NIDA SBIR grant (Rawson et al., 1989). The original model was delivered over a 24-week, intensive treatment period. The model was later adapted for use in 8- and 16-week programs (Rawson, Obert, & McCann, 1995). The 6-month model of intensive treatment is used for the CREASAT program.

Several research projects evaluating the treatment model have shown it to be effective in reducing cocaine, methamphetamine, alcohol, and other drug use (Huber et al., 1997; Rawson et al., 1995). In a project comparing the treatment outcomes of 224 cocaine and 500 methamphetamine users, all indicators suggested a very comparable treatment response (Huber et al., 1997; Rawson et al., 1995). The Matrix model for family intervention for adolescents with substance and conduct problems has been used for over 10 years at a YMCA setting and in a school setting; thus, the program components are already in place for the CREASAT target population. The model has been effectively used in clinical practice with a variety of patients of every ethnicity, race, sexual orientation, and gender. The fact that the model is already translated into Spanish is an added strength of model implementation. Parent education is a crucial component of the model. The structured treatment experience is designed to give families and substance abusers the knowledge, structure, and support to allow them to achieve abstinence from drugs and alcohol and initiate a long-term program of recovery. This cognitive-behavioral, structured intervention is designed to be interactive to allow the group leader to bring family members into the treatment process.

Some of the key concepts and treatment components of the Matrix model are described here. First, the classical conditioning explanation of craving that demystifies the craving experience that compels continued drug use despite conscious intentions to the contrary is made understandable (advice regarding behavior change is more compelling given the existence of this conditioned response). Second, the early recovery skills group in which simple and important information and direction is provided in the early weeks of treatment when cognitive abilities may be limited. Recurring themes within these groups promote understanding and retention of vital concepts. Third, the stages of recovery are described and the concept of protracted abstinence is conveyed so that the patients see themselves as being in a generally transitional mode. As a result, they are better able to tolerate periods of depression, irritability, and anhedonia. Finally, in describing relapse prevention, the focus on tangible behavior change and relatively simple prevention principles provides a clear, unambiguous roadmap for this group of substance abusers who may be challenged by complicated or insight-oriented approaches.

Culturally Relevant Practices

Often, the first opportunity that minority youth have to receive treatment for substance abuse is when they are identified in the juvenile justice system. However, the model

or programs available may not have been developed for or sensitive to their culture. Effective intervention should embrace culturally relative practices. This includes a careful and thorough consideration of the cultural perspectives of the youth and their families and the cultural relevance of the process of treatment (MacCune, 1999).

Cultural skills for substance abuse treatment professionals in the juvenile justice system are important for the following reasons. First, cultural diversity is present in youth populations being served as reflected in the ongoing overrepresentation of youth of color throughout the juvenile justice system (disproportionate minority confinement). Second, effective substance abuse treatment requires treatment professionals to understand the subtle and overt cultural variables that affect how substance abuse problems develop and how help may be sought and experienced by clients and families in treatment.

To better treat diverse populations, Terrell (1999) reported that the "recognition of the role of ethnocultural factors in the initiation and maintenance of substance abuse has led to the development of treatment and prevention models designed to meet the needs of specific groups of substance abusers" (p. 28). These models include incorporating cultural content through curricula and training materials that are based on the specific experiences and values of a given culture and that enhance the cultural pride of the group, providing training in culturally appropriate ways of coping with pressure, and increasing the social support networks of cultural groups.

Practice implications are that programs should make available a range of culturally specific services that (a) address the needs of juveniles of various cultures in a way that elevates and does not denigrate their culture, (b) provide access to staff and/or positive role models that represent the juvenile's cultural background, (c) are language-appropriate, (d) recognize varying degrees of acculturation and cultural conflict within the family and understand that perceptions of the majority cultures and minority cultures may differ considerably about treatment, and (e) incorporate a variety of strategies that build on cultural strengths to engage and retain the juvenile in treatment.

Program Goals

The CREASAT program is guided by the following objectives: (a) decreased recidivism among program participants; (b) decreased behavioral problems as noted by school suspension, detentions, and negative teacher reports; (c) increased numbers of clean urine analyses (UAs) and decreased numbers of dirty UAs; (d) successful interruption of the delinquency pattern—decreasing both the severity and frequency of offenses; (e) increased family functioning, especially in the areas of family communication; (f) improvement of mental health status as related to stress, anxiety, anger-management, self-esteem, and coping skills; and (g) program completion rate.

This program delivers substance enhancement to the current treatment structure as well as provides arts enhancements in the form of performances and teacher development. It is hypothesized that CREASAT will alter individual negative trajectories with this pilot population. In the aggregate or long term, CREASAT can serve as a model program for appropriate substance abuse intervention for Latino and African American adolescents who exhibit delinquent or other problematic behaviors. This will, in turn, address general disparities in health and socioeconomic outcomes for minority populations.

The American Society of Addiction Medicine (ASAM, 1996) *Patient Placement Criteria* (2nd ed.) recommends for substance use disorders that moderate-intensity engage-

ment is needed with active support from family, significant others, and legal, work, or school systems to set and follow through with clear, consistent limits and consequences. For patients who face legal consequences, court-mandated treatment might be needed. Hallmarks of the Matrix model include the fact that it is client centered and involves a strong family component. The model is sensitive to the developmental stage of the adolescent. Motivational enhancement techniques are used to initiate behavior change by helping clients to resolve ambivalence about engaging in treatment and stopping the substance use. The Matrix model tries to initiate internal change in a nonthreatening manner. The arts component of this project seeks to provide creative and healthy experiences for clients that may lead to increased social development. The CREASAT project is environmentally supportive with the full-time educational staff, probation staff, after-school substance abuse groups, and after-school arts activities. This population of adolescents is confined to residential treatment for legal, behavioral, and substance abuse problems. Understanding the challenges that they face as it relates to readiness for change is critical to effectively working with this population. These factors as well as the results of individual assessments provide valuable information that is incorporated into the treatment process.

The treatment planning process used in CREASAT is modeled after treatment of adolescents with substance use disorders. The primary therapists or treatment team, in collaboration with the youth, family, probation staff, and the education staff, develop treatment plans. The following areas are identified: (a) Target the problems of the client and family including substance abuse and other factors, (b) identify goals that help the client recognize the antecedents and alternatives to substance use, (c) establish objectives that are realistic and measurable, (d) establish time frames to achieve objectives that are reasonable, (e) ensure that interventions are appropriate and culturally relevant for involving client and family in the process, (f) select assessment measures that accurately measure outcomes, and (g) reinforce linkages between education, treatment, and probation staff on campus.

Implementation Plan

Phase One involves the enhancement of current substance interventions by adding an ongoing structured inpatient group that has 6 months of topical discussions (substance use, violence, HIV, family, transition). Substance groups are run concurrently. These groups take place Monday and Wednesday evenings and involve eight distinct cohorts of 10 clients that cycle through 6 months of treatment. In this way, at least 80 clients receive group therapy at least once a week. Individual sessions are scheduled as needed. The arts enhancement program runs twice a week and involves performances for youth divided into groups of 20. Teacher development to instruct them on how to infuse arts in their curriculum occurs during the first 6 months of the project on Saturdays.

Phase Two occurs once clients are released for reintegration into the community. These youth remain on probation for 1 year, on average, upon return to home. During this phase, 6 months of in-home delivery of the Matrix model is implemented. Previous experience with this modality in a similar project has demonstrated the feasibility of this approach with the target population (i.e., CSAT LIFE Project).

Once participants are released into the community, they are followed with in-home counseling that serves as a therapeutic change agent as well as addressing case management issues. Participants and their families are followed by the same therapists for the community continuing care component as they had for the residential treatment.

Continuing Care Component

Research has demonstrated that the interventions chosen have been effective in treating at-risk and difficult-to-treat adolescents (i.e., juvenile offender population). The Matrix model has demonstrated appropriateness with the target population. Arts programming has demonstrated efficacy, as well. Additionally, recent publications on adolescent treatment strategies strongly encourage a continuing care component (ASAM, 2001; CSAT, 2001). Experts suggesting strategies for integrating substance abuse treatment and the juvenile justice system identify continuing care as a key component of comprehensive treatment efforts (CSAT/DJJ, 1999). As mentioned earlier, counselors who begin residential treatment follow clients and their families on an outpatient basis. They also perform case management functions as needed. Clients remain on probation for at least 12 months after residential treatment. Linkage with the probation department that begins during the inpatient treatment continues. Wards' probation commitments aid in retention. Youth who demonstrate proclivity for the arts while incarcerated will be linked to community-based arts programs upon discharge. A voucher system that reimburses community-based arts programs a modest amount for tuition fees will be instituted. In addition, a bus token system will provide transportation for clients. All previous efforts have demonstrated that clients can continue this activity in the community.

Community Reintegration

Because of the nature of this collaboration, relationships with probation and with the educational system were established during residential care. Each of these systems has agreed to work with the CREASAT program staff to facilitate seamless community reintegration. Youth returning to the community are governed by the same probation and education systems that treated them while they were incarcerated. In fact, probation and education work in concert to assign students to the most viable school in their living area. The fact that the same systems are working together throughout the continuum of care is an obvious strength. The education system is familiar with community-based arts ensembles, and linkages will be made during residential treatment. In addition, program staff will assist emancipated adolescents in conjunction with probation to find housing and job opportunities through referrals to appropriate agencies and case management strategies.

Conclusion

The CREASAT Project is designed to enhance residential substance abuse treatment and arts intervention programs and to provide continuing care for a population of Latino and African American male adolescents in a juvenile correction, residential probation camp. The goals of this project are consistent with priorities of *Healthy People 2010* (DHHS, 2000) to reduce drug abuse among youth, to increase the health of low income and minority populations, and to sustain intervention efforts between community elements and schools. This innovative program model offers a promising alternative to traditional residential substance abuse treatment services for juvenile offenders.

REFERENCES

American Society of Addiction Medicine. (1996). *Patient placement criteria for the treatment of psychoactive substance disorders* (2nd ed.). Chevy Chase, MD: Author.

American Society of Addiction Medicine. (2001). *Patient placement criteria for the treatment of substance-related disorders* (2nd ed., rev.). Chevy Chase, MD: Author.

Bandura, A. (1994). Social cognitive theory and exercise of control over HIV infection. In R. J. DiClemente & J. L. Peterson (Eds.), *Preventing AIDS: Theories and methods of behavioral interventions* (pp. 25-29). New York: Plenum.

Battin-Pearson, S. R., Thornberry, T. P., Hawkins, J. D., & Krohn, M. D. (1998). *Gang membership, delinquent peers, and delinquent behavior*. Washington, DC: Office of Juvenile Justice and Delinquency Prevention.

Botvin, G. J. (1995). Drug abuse prevention in school settings. In R. H. Coombs & D. M. Ziedonis (Eds.), *Handbook on drug abuse prevention: A comprehensive strategy to prevent the abuse of alcohol and other drugs* (pp. 169-192). Boston: Allyn & Bacon.

Catalano, R. F., & Hawkins, J. D. (1996). The Social Development Model: A theory of antisocial behavior. In J. D. Hawkins (Ed.), *Delinquency and crime: Current theories* (pp. 149-197). Cambridge, MA: Cambridge University Press.

Centers for Disease Control and Prevention. (1999). *Youth Risk Behavior Surveillance—National Alternative School Youth Risk Behavior Survey, United States*. CDC, GA: Atlanta: Author.

Centers for Disease Control and Prevention. (2000). *Leading causes of mortality and morbidity in the United States, 1998*. Atlanta, GA: Author.

Center for Substance Abuse Treatment. (2001). *Treatment of adolescents with substance use disorders* (Treatment Improvement Protocol Series No. 32). Rockville, MD: Author.

Center for Substance Abuse Treatment/Denver Juvenile Justice. (1999). *Strategies for integrating substance abuse treatment and the Juvenile Justice System: A practical guide* (SMA 00-3369). Rockville, MD: Department of Health & Human Services.

Center for Substance Abuse Treatment. (2001). *Combining alcohol and other drug abuse treatment with diversion for juveniles in the Justice System* (Treatment Improvement Protocol Series, No. 21, SMA 95-3051). Rockville: MD: Department of Health & Human Services.

Clawson, H. J., & Coolbaugh, K. (2001). *The YouthArts Development Project*. Washington, DC: Office of Juvenile Justice and Delinquency Prevention.

Ellickson, P. L. (1984). *Helping adolescents resist drugs: Project ALERT* (RAND Doc. No. N-2184-CHF). Santa Monica, CA: RAND Documents.

Grunbaum, J. A., Kahn, L., Kinchen, S. A., Ross, J. G., Gowda, V. R., Collins, J. L., et al. (1999). *Youth Risk Behavior Surveillance—National Alternative School Youth Risk Behavior Survey*. Atlanta, GA: Centers for Disease Control and Prevention.

Hawkins, J. D., Catalano, R. F., & Miller, J. Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin*, *112*, 64-105.

Held, G. A. (1998). *Linkages between substance abuse prevention and other human services: Literature review*. Rockville, MD: National Institute on Drug Abuse.

Howell, J. C., & Decker, S. H. (1999). *The youth gangs, drugs, and violence connection*. Washington, DC: Office of Juvenile Justice and Delinquency Prevention.

Johnston, L. D., O'Malley, P. M., & Backman, G. P. (1998). *National survey results on drug use from the Monitoring the Future Study, 1975-1997*. Washington, DC: National Institute on Drug Abuse.

Johnston, L. D., O'Malley, P. M., & Backman, J. G. (2001). *National survey results on drug use from the Monitoring the Future Study, 1999*. Washington, DC: National Institute on Drug Abuse.

Lovett, A. (2000). *Arts programs for juvenile offenders in corrections—Why? How? So what?* Gainesville, TX: Gainesville State School.

MacCune, B. (1999). The multiple dimensions of culture in the treatment of adolescents and their families. In the Center for Substance Abuse Treatment/Denver Juvenile Justice, *Strategies for integrating substance abuse treatment and the Juvenile Justice System: A practical guide* (SMA 00-3369, p. 23). Rockville, MD: U.S. Department of Health & Human Services.

Morgan, C. (2001). *Younger children experimenting with illicit drugs and alcohol*. Princeton, NJ: Robert Wood Johnson Foundation.

National Council of Juvenile Justice. (1999). *Holding juvenile offenders accountable: Programming needs of juvenile probation departments*. Washington, DC: Author.

National Evaluation Data Services. (1997). *Adolescents and young adults in the National Treatment Improvement Evaluation Study* (NEDS Contract No. 270-97-7016). Falls Church, VA: Department of Health & Human Services.

National Institute on Drug Abuse. (1999). *Principles of drug addiction treatment: A research-based guide* (NIH Pub. No. 99-4180). Rockville, MD: National Institutes of Health.

National Institute of Justice. (1999). *Arrestee Drug Abuse Monitoring Program: 1998 annual report on drug use among adult and juvenile arrestees*. Washington, DC: Author.

National Parents' Resource Institute for Drug Education (PRIDE). (2001). *PRIDE manual*. Atlanta, GA: Pride Institute.

Office of National Drug Control Policy. (2001). *National Drug Control Strategy: 2001 annual report*. Washington, DC: Author.

Petraitis, J., & Flay, B. R. (1995). Reviewing theories of adolescent substance use: Organizing pieces in the puzzle. *Psychological Bulletin*, *117*(1), 67-86.

Petraitis, J., Flay, B. R., Miller, T. Q., Torpy, E. J., & Greiner, B. (1998). Illicit substance use among adolescents: A matrix of prospective predictors. *Substance Use and Misuse*, *33*, 2561-2604.

Randall, P. (1997). *Art Works! Prevention programs for youth & communities*. Washington, DC: National Endowment for the Arts.

Rawson, R. A., Obert, J. L., & McCann, J. J. (1995). *The Matrix Intensive Outpatient Program therapist manual*. Los Angeles: The Matrix Center, Inc.

Rawson, R. A., Obert, J. L., McCann, M. J., Smith, D. P., & Scheffey, E. H. (1989). *The Neurobehavioral Treatment manual*. Beverly Hills, CA: The Matrix Center.

Robert Wood Johnson Foundation. (2001). *Reclaiming futures: Building community solutions to substance abuse and delinquency*. Princeton, NJ: Author.

State of California, Department of Youth Authority, Research Division. (1999). *Treatment needs evaluation*. Sacramento, CA: Author.

Substance Abuse and Mental Health Services Administration. (1997). *Substance abuse treatment in adult and juvenile correctional facilities: Findings from the Uniform Facility Data Set, 1997 Survey of Correctional Facilities*. Washington, DC: Author.

Terrell, M. (1999). Ethnocultural factors and substance abuse: Toward culturally sensitive treatment models. In the Center for Substance Abuse Treatment/Denver Juvenile Justice, *Strategies for integrating substance abuse treatment and the juvenile justice system: A practical guide* (SMA 00-3369, p. 28). Rockville, MD: U.S. Department of Health & Human Services.

U.S. Department of Health & Human Services. (2000). *Healthy people 2010* (Conference ed., 2 Vols.). Washington, DC: Author.

U.S. Department of Health & Human Services. (2001). *1999 National Household Survey on Drug Abuse*. Rockville, MD: Author.

Youth in Action. (2000). *Arts and performances for prevention*. Washington, DC: Office of Juvenile Justice & Delinquency Prevention.

Donnie W. Watson, Ph.D.,is a senior research scientist at the University of California, Los Angeles (UCLA), Integrated Substance Abuse Programs and Friends Research Institute. He has published extensively on the topic of interventions for adjudicated youth and their families. He is a core faculty member at the UCLA Integrated Substance Abuse Programs and a principal investigator at the Friends Research Institute.

Lorrie Bisesi, M.S., is a project coordinator for the University of California, Los Angeles, Integrated Substance Abuse Programs.

Susie Tanamly, B.S., is a research associate for the University of California, Los Angeles, Integrated Substance Abuse Programs.

Noemi Mai, B.A., is a research assistant for the University of California, Los Angeles, Integrated Substance Abuse Programs.