

# **A Comprehensive Therapeutic Community Approach for Chronic Substance-Abusing Juvenile Offenders: The Amity Model**

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*The development of a joint public/private cooperative program involving Amity, an **Arizona nonprofit agency specializing** in substance abuse services, and the **Arizona Department of Corrections**, is described. The Amity model addresses the multiple risk factors of chronic adolescent substance abusers who have committed crimes. The **traditional** adult-oriented therapeutic **community modality** has been modified for work with adolescent delinquents. The principles and operational components of the model are summarized.*

## INTRODUCTION

**In March 1989 Frederick Goodwin, M.D., Director of the U.S. Alcohol, Drug Abuse, and Mental Health Administration, said that, while the total number of young people a,using drugs seems to be falling, "the social**

pathology induced by drugs and alcohol is getting worse, and users are getting younger in this highly vulnerable population." While a number of surveys show a national decline in the use of illicit drugs by youth, those youngsters who enter the juvenile justice system appear to be more chemically dependent than ever before. Frequently, they have been born into families that neglected or abused them, or that have failed to provide conditions for normal development. Without successful intervention, many of these youth will become increasingly involved in substance abuse, pursue adult criminal careers, and be at high risk for HIV/AIDS infection and transmission.

With the widespread availability of "crack" and other powerful drugs at relatively low prices per dose and easily administered through smoking, adolescent substance abusers can now become rapidly addicted and enmeshed in a life of drug *use*, drug dealing, other criminal activities, violence, sexual abuse and prostitution. Intervention for such youth cannot be a half-measure; it must be intense and long term to meet their multiple needs. Many cannot be *rehabilitated* because they have not yet been habilitated by family, school and other social institutions. Cooperative efforts between criminal justice agencies and private treatment providers offer one method of providing the extensive services needed to help these youngsters adjust successfully to living in society and avoid further involvement with the justice system. This chapter describes the development of a joint public/private cooperative effort between Amity, an Arizona non-profit agency specializing in substance abuse services, and the Arizona Department of Corrections (ADC). The Amity model addresses the multiple risk factors of chronic adolescent substance abusers with criminal involvement. It has modified the traditional adult-oriented therapeutic community modality to work with adolescents, specifically those who *have*: (1) been incarcerated in ADC juvenile institutions; (2) been identified by ADC as "dependent" and/or "abusive" in regard to their use of drugs and alcohol, and (3) have histories of violence, gang involvement and prostitution.

## RESEARCH FINDINGS

### Etiology

Research evidence over the past few years clearly establishes that serious, persistent delinquency and chronic use of illicit drugs by adolescents have common etiological roots. Frequently identified factors are:

- a family history of alcoholism or drug abuse;
- family management problems (poorly defined rules; disorganization; inconsistency, negative communications; and ineffectiveness);
- early antisocial behavior;
- favorable family attitudes toward drug or alcohol *use*;

- early use of drugs;
- academic failure;
- adolescent antisocial behavior;
- association with drug-using peers; and
- favorable attitudes towards drug use (Hawkins et al., 1987;

Brunswick

and Boyle, 1979; Kandel, Simcha-Fagan and Davies, 1986; Donovan and Jessor, 1984; Elliott, Huizinga and Ageton, 1985; Jessor and Jessor, 1987).

Dembo and associates (1987, 1988, 1989) studied several groups of male and female detainees entering a Florida juvenile detention center. These studies showed that among both males and females there was a high percentage of physical and sexual abuse. A total of 51% of those interviewed claimed to have been seriously physically abused by an adult in more than three ways; 46% were sexually victimized one or more times, and for 83% of these youths the victimization first occurred at age 13 or younger. This abuse was significantly correlated with lifetime frequency of use of illicit drugs and other deviant behavior. Dembo poses a "development damage" view of the effects of child physical and sexual maltreatment that views these experiences as important factors in leading adolescents to become disengaged from conventional norms and behavior, and to initiate various patterns of deviant behaviors, particularly when the youth come from high-risk environments that include poverty and poor parenting.

High rates of physical and sexual victimization among adolescents referred to the juvenile justice system constitute risk factors that have not been given adequate consideration in the etiology of adolescent drug addiction (Dembo et al., 1987, 1988, 1989). Because clinical experience reveals that often youth (or adults) will not reveal details of physical or sexual victimization to an interviewer, it is quite likely that Dembo's data significantly underreport this phenomenon.'

Alice Miller, a Swiss psychoanalyst who has written a number of books exploring the relationship between child-rearing practices and later adult behavior, has made a convincing argument that the anger that abused children cannot direct toward their abusers is stored in the unconscious. This leads to uncontrolled discharge of anger through self-destructive behavior (such as drug addiction, abusive relationships and suicide), as well as through outbursts (violence, cruelty and child abuse) directed toward others as they become older (Miller, 1983). Her paradigm is consistent with the clinical experience of many practitioners working today with adolescents.

The Drug/Crime Connection

In asking the "chicken-or-egg" question about drugs and crime, Speckart and Anglin's 1985 review of the research literature concluded that addiction

In 1986, the U.S. National Institute of Justice set up the Drug Use Forecasting (DUF) program, taking voluntary and anonymous urine samples from and conducting interviews with arrestees in the central booking facilities of the largest cities across the U.S. and making it possible to determine the prevalence of drug use among criminal justice populations. DUF data demonstrate that drug use and criminal behavior by adults were completely intertwined. In 21 major cities, 50% to 85% of all arrestees have tested positive for illicit drugs at the time of arrest. DUF has also found that 74% and 45% of all arrestees charged with violent or income-generating crimes tested positive for a drug (US. National Institute of Justice, 1989).

While the DUF system has not yet included data from teenage arrestees, there is sufficient evidence to conclude that drug use and criminality are similarly coexistent for this population. Elliott and Huizinga (1984) discovered that almost half of serious juvenile offenders also used multiple illicit drugs. Another study showed that half of the juveniles adjudicated for violent crimes used alcohol or drugs prior to their violent behaviors, and 40% reported using drugs immediately prior to their offense (Hartstone and Hansen, 1984). In the past few years, crack cocaine has become widespread, changing the face of drug abuse nationwide. While few studies have focused on the criminality of adolescent crack users, recent work by Inciardi on 600 Miami youths who were "seriously delinquent" showed that most were habituated to marijuana by age 11 and to crack before age 13. These adolescent drug users confessed to an average of 702 crimes per individual in the previous year, with their first crimes beginning at a mean age of 11. Ninety percent had been arrested, almost half had been incarcerated, but only 13.4% reported any drug treatment (Inciardi and Pottieger, in press). In addition, 88.4 % of the sample reported carrying weapons most or all of the time, with more than half carrying handguns. Those who were both dealers and users of crack were the most violent, committing 50% more major felonies per offender than nonusing crack dealers. In addition, this group committed 500% more felonies than youthful drug users with no participation in crack dealing (Inciardi, 1989). Because many studies have demonstrated that controlling addiction significantly reduces crime, the question for policymakers in regard to these young but extremely active drug-using criminals is no longer "What does it cost to treat them?" but rather "What does it cost not to treat them?" (Wexler, Lipton and Johnson, 1988; Anglin and McGlothlin, 1984).

Because research has substantiated that adolescents who come into contact with the criminal justice system are at high risk of becoming antisocial, drug-abusing, criminal adults, (Dembo et al., 1987), it is particularly important to intervene with these youngsters in an intense and effective manner in order to maximize their opportunity to overcome dysfunctional patterns of behavior, adjust successfully to living in society, and develop social networks in the community that support their newly acquired positive values and behavior. As Hawkins (1984) has said, "A comprehensive system of

interventions holds the greatest promise...treatment and control approaches of increasing intensity are needed to deal with youth already experiencing serious multiple problems."

## Therapeutic Communities

The self-help therapeutic community (TC) is one of the most substantial intervention mechanisms developed in the past three decades for changing the behavior of drug abusers. It takes a holistic approach to the problem of drug abuse, seeing it as a symptom of a disorder of the entire person, with a need for a global change in lifestyle, including sobriety, elimination of antisocial activity, employability, and adoption of prosocial attitudes and values. "The TC views drug abuse as deviant behavior reflecting impeded personality development and/or chronic deficits in social, educational and economic skills. Its antecedents lie in socioeconomic disadvantage, poor family effectiveness, and in psychological factors" (DeLeon, 1981).

### History of TCs

TCs for drug addiction (in contrast to Maxwell Jones's programs that democratized mental hospitals) were born out of Alcoholics Anonymous (AA), just as AA was itself inadvertently conceived from Dr. Frank Buchman's Oxford Groups of the 1920s. In 1958 Charles Dederich, former alcoholic and AA zealot, discovered in conducting his own brand of extremely confrontative encounter groups that some heroin addicts attending the groups stopped using drugs (Rom-Rymer, 1981).

While keeping the self-help orientation of AA, Dederich moved away from its religious overtones and instead emphasized self-reliance in a highly structured community where residents lived and worked 24 hours a day. His Synanon approach specified an autocratically controlled "family" that promoted positive peer pressure for an anti-drug lifestyle based on hard work, caring for other members of the "family," confrontation of bad behavior and brutal honesty in encounter groups. Because other treatments of opiate addicts had been failures and addicts were widely regarded as hopeless, Dederich's Synanon drew national attention for its success, grew rapidly, and inspired the formation of Daytop Village, Phoenix House, Odyssey House and other similar programs in New York City to combat the heroin crisis of the 1960s.

By the early 1970s over 2,000 drug treatment programs could be traced to Synanon (DeLeon and Beschner, 1976). The original Synanon/Daytop/Phoenix House model was characterized by its: (1) focus on adult, mostly male, opiate addicts; (2) rigidity in structure and procedures; (3) harsh discipline for serious program violations; (4) separation of residents from

family and community; (5) ex-addict staff (trained "on the job" in the TC); (6) hierarchical structure, usually male-dominated, that equated progress in the program with moving up the "ladder" of program responsibilities; (7) an implicit acceptance of a very high dropout rate in the initial stages of treatment; and (8) an anti-psychological, anti-medical (disease model) orientation toward drug addiction (groups were called "games" to distinguish them from group therapy).

By the mid-1970s, however, mutation had begun. Many TCs were larger, better established and reaching out to adolescent substance abusers, polydrug abusers, women with children, criminal justice clients who came to the TC as an alternative to incarceration and school-aged children through prevention programs. The autocratic leader, thought to be an absolute prerequisite, produced some embarrassing abuses, and TCs began to move toward a less authoritarian style of management. Many TCs began to involve the family or other relatives of the client from the moment of entry into the program, while others recognized the need to work with codependence issues, and offered family therapy in addition to supportive orientations and family meetings. TCs began to recruit academically trained professionals to work alongside their ex-addict staff as demands for special services increased, and to meet the requirements of funding sources who were frequently skeptical about the competency of ex-addicts. The heavy confrontation and rigid discipline that had worked for males clients who were in their thirties and forties were not accepted by younger clients, females and adolescents, and many programs became more plastic. Some conducted outcome research and discovered that increased time in treatment invariably resulted in a greater likelihood of post-treatment success (DeLeon, Wexler and Jaindill, 1982; Coombs, 1981; DeLeon, 1988).

There was also an increasing recognition that the TC needed to devote more effort to preparing clients for successful reintegration into the community. Sophisticated vocational training programs began to augment the normal chores of maintaining program facilities, and reentry programming became common to reduce the number of post-treatment relapses. Some of the larger TC programs became human service conglomerates that provided: prevention programs for school aged youth; intervention services; out-client programs; employee assistance programs; programs for special populations; methadone maintenance programs; and programs designed especially for criminal justice clients, in addition to traditional TC programs (DeLeon and Beschner, 1976).

In the past 15 years, the TC model has spread worldwide and flourished in South America, Europe, and Asia. Recent innovations include treatment of dual-diagnosed clients, application of TC methods to methadone clients, AIDS prevention and treatment of HIV-infected drug abusers (Nebelkopf, 1989; Yablonsky, 1989; Sugarman, 1987).

## Adaptations for Corrections

### *Stay'N Out*

Because drug abusers are by definition criminals, and because various studies have shown that addicts engage in four to 20 times more crime when addicted than not, it was to be expected that TCs would eventually be adapted to work specifically with the criminal justice system (Speckart and Anglin, 1985). A particularly successful model that developed in the late 1970s is Stay'N Out, which provides a 9-12 month intensive program, staffed by ex-addicts and ex-offenders, that works hand in hand with correctional officials within a medium-security New York State prison. Outcome research sponsored by the U.S. National Institute on Drug Abuse has shown significant reductions in post-treatment drug abuse, criminality and recidivism, while simultaneously demonstrating improved parole outcomes, employment and other prosocial behavior (Wexler, Lipton and Foster, 1985; Wexler, Falkin, Lipton, Rosenblum and Goodloe, 1988). This disproved the declaration that "nothing works" in correctional drug treatment (Lipton, Martinson and Wilks, 1975; Wexler and Williams, 1986). Many so-called prison TCs were indeed failures, but, on examination, it is clear that many never followed the basics of the model and were poorly implemented (Camp and Camp, 1989).

### *Amity/Pima County Jail Project*

As part of comprehensive drug abuse legislation passed by Congress in 1986, the Bureau of Justice Assistance of the U.S. Department of Justice issued a call for proposals for "national models" for drug abuse treatment in jails. Amity had been providing limited services in the Pima County Jail in Tucson, AZ for over five years and submitted a joint proposal with the Pima County Sheriff's Department to modify the Stay'N Out model for the jail setting.

The Amity/Pima County Jail' Project created a strong, positive, anti-drug environment within an isolated unit of the direct supervision jail for sentenced offenders who were serving a minimum of 45 days. All inmates are informed about the drug treatment program at the time of intake, and are selected on the basis of a history of substance abuse and a voluntary commitment to abide by program norms. The program uses standard TC techniques, structure and activities, but because few inmates stay longer than four months, the program gears much of its efforts to preparing program participants to continue their drug treatment after leaving the jail. Over 50% of participants go on to community-based drug treatment after completion of their sentence, with approximately 25% transferring voluntarily to Amity's long-term residential TC. The jail program is staffed by a team of treatment professionals (most of

whom are ex-addicts trained by Amity) that works closely with corrections officers in the unit; the program is managed by two coordinators—one a corrections officer and the other an experienced Amity treatment director. This demonstration of partnership sets a standard for cooperation within the program, now over two years old (Arbiter, 1988).

While Amity had worked with both adult and juvenile probation and parole for many years, the jail project was the first opportunity for the program to take responsibility for providing seven-day-a-week treatment within a correctional institution, meeting the needs of the offenders *and* addressing the concerns of security officers and jail administrators. The success of the program has given Amity valuable information now being used in developing institutional programs in ADC juvenile institutions.

#### Amity/IPS Program

In addition to the jail program, Amity has been involved with intensive probation supervision (IPS) for four years. The Pima County Superior Court, in cooperation with the Pima County Adult Probation Department, has sent over 70 men and women to Amity as an alternative to prison. Recent studies from the Rand Corporation indicate that many IPS programs are experiencing violation rates as great or greater than regular probation (Turner, 1989), thus failing to relieve prison overcrowding. However, the length of stay among Amity IPS clients surpasses that of other Amity residents. Because length of stay has been the most important predictor of post-treatment success in all major outcome studies, it is not surprising that of the 40 residents who have remained in the program for longer than 180 days, only four were rearrested from 1985 through 1988. This project indicates the effectiveness of using criminal justice sanctions to hold probationers in treatment, and the effectiveness of TC treatment in altering behavior.

Currently, two IPS officers handle the Amity caseload, working closely with counselors so that expectations are congruent and post-treatment follow-up is compatible with treatment plans developed by clients, IPS and Amity. Officers and counselors credit this cooperation as the key ingredient for the success of the program. The lessons learned from this project—specifically regarding the necessity for communication, cooperation, shared methods, and expectations between juvenile parole officers, corrections administrators, and Amity treatment staff—have been valuable in the design of the adolescent treatment model, and are expected to be invaluable in the implementation of the project.

#### Adaptations for Adolescents

While several existing TCs mix adults with adolescents, and report good *success* with adolescent clients during and after treatment, none of these programs accept younger adolescents (aged 15 and under). With most state

licensing authorities, insisting that adults in treatment be separated from adolescents, the more common practice among current TC programs is to provide separate facilities for juveniles, as well as separate staff and program activities designed particularly for adolescents.

#### Phoenix House

Phoenix House is a traditional TC, one of the two largest in the U.S. It has several separate adolescent facilities, the largest a 250-bed facility in New York City. A recent study by DeLeon shows that adolescent Phoenix House residents achieved positive post-treatment outcome results similar to those for adult residents even though these adolescents have much more serious criminal histories than adolescents referred to outpatient settings (DeLeon and Deitch, 1985). DeLeon also found that adolescent early dropouts did not achieve the same degree of success as early adult dropouts; he concluded that adolescent clients needed a minimum of a year in residential treatment for post-treatment success.

Phoenix House adolescent facilities use the same treatment methods with adolescents and adults, facilitating "self-help" change through sequenced stages of learning, characterized as "growing up" or "maturation." Its social organization is a family surrogate model, vertically stratified (DeLeon and Deitch, 1985). Phoenix House: moves its clients through progressive phases; features a highly structured daily regimen; relies on residents to manage the community under staff supervision; has a hierarchical job-responsibility system; centers its therapeutic activities around peer encounter groups; and uses ex-addict staff as the primary clinical staff. In the latter stages of the program, youth may hold jobs outside the community, attend public school and make visits home. The "cardinal rules" of "no use of drugs or alcohol," and "no violence or threats of violence" are the same as for adult residents, but to this is added "no sex." Violation of cardinal rules is serious and can be cause for expulsion. The feeling of safety in the TC environment depends upon the no violence/no threats norm.

DeLeon and Deitch note that adolescent residents are different in some ways from adults (earlier use of drugs, higher incidence of family deviance, shorter criminal histories, greater responsiveness to extrinsic—usually legal—pressures, and beset by the normal turbulence of adolescence) and go on to list some adaptations Phoenix House has made to accommodate them in the TC:

- more attention to breaking down "images" associated with negative **social** functioning;
- greater focus on the need to confess guilt feelings about negative behavior, thus interrupting negative peer processes and providing the basis for new social learning;
- minimization of activity, both didactic and therapeutic

approaches to clarify sexual issues, and resolutions of feelings about aberrant sexual histories;

- increased supervision to prevent absconding and antisocial behavior, and to reduce negative peer activities;
- more recreational opportunities to promote leisure skill-building and to prevent boredom;
- greater family involvement while the adolescent is in treatment, and family training to support behavioral and value changes;
- five hours daily of academic classes until high school diploma or GED is earned; and
- enhanced aftercare to promote continued family participation and placement of those youngsters who cannot return home, but need further support (DeLeon and Deitch, 1985).

#### Abraxas

In the early 1970s, the Abraxas program in Pennsylvania began providing adult TC services. It gradually abandoned its adult TC activities and modified itself to serve adolescent clients only. Abraxas now has several adolescent programs following the same modified TC model, and is particularly interesting because it operates almost exclusively as an alternative to incarceration for adolescent male drug and alcohol abusers involved in the juvenile justice system. Almost all Abraxas clients are under court order to receive treatment. Abraxas recruitment staff, many of them former juvenile probation officers, are known as "court liaisons"; they work closely with probation officers and judges, and regularly facilitate intensive training experiences at the Abraxas campus to help court personnel understand the program.

Abraxas operates a three-phase program. The first phase is at a remote rural facility, where new clients participate in various forms of structured therapy, advance in a job privilege hierarchy and complete their secondary education within a nine-month time period. They then transfer for three to six months of transition in a smaller urban facility, followed by several weeks of support in the community.

Pompi and Resnick (1987) found that client retention was significantly higher for Abraxas clients than for a comparison group of clients from nine other TC programs whose population of adults had significantly fewer court referrals. Pompi and Resnick attribute the high retention of Abraxas clients to court pressure. This is consistent with the findings of other researchers (Leukefeld and Tims, 1988; Condelli, 1987). Abraxas administrators also state that dramatically increasing the number of program staff, removing female clients,<sup>3</sup> and designing the physical environment of the program specifically for the needs of adolescents has improved retention and post-treatment success (Pompi, 1989).

## THE AMITY ADOLESCENT THERAPEUTIC COMMUNITY

### History

Responding to the pleas of local probation officers, Amity\* began accepting a few older (all close to their 18th birthday) male adolescents into its adult TC in the early 1980s. When program evaluation showed that these adolescents had a considerably lower length of stay than adult residents,<sup>5</sup> separate program activities and living quarters were arranged in the adult facility, although many activities were still shared. Retention for adolescents improved strikingly as a result of these changes. In 1983, Amity responded to a request for proposal from the ADC to provide residential services for youngsters aged 12 to 18 incarcerated in juvenile institutions and determined to have substance abuse difficulties. For several months, Amity took ADC youth directly from institutions to the adult program site. While youth and adults slept in separate quarters and participated in many different program activities, the youth often worked with adult clients on projects, ate with them and were in encounter groups together. The response by youth to this arrangement was immensely positive. Closeness to adults who were involved in the process of change and who were honest about their mistakes gave the youth credible role models and reduced their *dependence* upon negative peer role models. As the program grew and the ages of referrals became younger, it was determined that a separate facility was needed for the adolescent program. Additionally, accepting referrals from agencies other than ADC required a license that could only be obtained if adolescents and adults were completely separated.<sup>6</sup>

In the spring of 1985, the adult and adolescent programs were separated when a new facility—a former private school on 60 acres in direct proximity to the adult facility—was secured. Amity then began accepting referrals from Arizona juvenile courts, several Arizona Native American tribes, the Department of Economic Security and private sources. For several months after the separation from the adult program, the adolescent program struggled. The absent-without-leave rate jumped dramatically as adolescents "voted with their feet" regarding their disappointment at being separated from the adult residents and shared activities. Eventually, the program stabilized, and it has served between 30 and 45 adolescent residents continuously for the past four years. Some of the programmatic observations made during that period were:

- It was essential for youth to "buy in" to the program before they entered. (This was particularly important for ADC-referred youth, who not only often knew each other from the "streets" but formed negative institutional bonds; frequently those who made the most earnest pleas for entrance had arranged "split contracts" with other ADC-referred youth and left within days of entry.)

- ADC-referred youth did not respond well to academically trained counselors or to counselors who did not share similar backgrounds. While "recovering role models" have been the foundation of adult therapeutic communities, concern by Arizona state licensing authorities about having ex-felons in contact with children *has* brought severe restrictions? However, particularly at the beginning of treatment, these youth only accepted as credible those counselors who shared similar family, ethnic, and social backgrounds and who had experienced "life on the street" as they had. Because these recovering role models had obviously made the journey from the streets to mainstream social values and lifestyles, they demonstrated that it was possible. They also were not awed by the drug culture and street sophistication of the youth.
- Transition and aftercare services were essential (most of the youth served went back into the same environment that they came from before treatment, with no supportive services).
- An increased staff-to-youth ratio was needed to replicate the sense of "family" and community that had occurred when the youth were living at the adult facility. Continuity of staff was crucial; rapid staff changes triggered insecurity, absconding and antisocial activity.
- Families needed to be met and assessed much earlier in treatment. Because many families refused to attend orientations or see their youngsters while in treatment, counselors often left family assessment until late in the program, discovering too late that their information on families was not accurate and that post-treatment plans often had to be dramatically altered. In many *cases*, families were too abusive or criminogenic for youth to return home.)
- Stable funding was important to ensure that the program did not take wild economic plunges when funding sources changed their priorities or failed to be funded adequately by the state legislature.
- Separation of boys and girls, except for occasional program activities, increased retention for the girls significantly (the boys' retention declined moderately).
- Some homosexual activity (especially among female juveniles) appeared to be based on institutional learned behavior designed to upset the supervising adults; ignoring it caused almost immediate cessation. Excessive "sexual posturing" on the part of boys or girls usually indicated a history of sexual victimization.
- Having more than 45 youngsters living together produced negative peer effects almost immediately and made the program much harder to manage. These effects included more antisocial behavior, attempts to abscond, and influence of negative peer models in the program, and less respect for staff members).

### The Amity/ADC Model

ADC officials commissioned an evaluation of all their "purchase-of-care" contracts, which was completed in the spring of 1988. The report confirmed conclusions already reached by ADC Juvenile Services/Purchase of Care: (1) Many programs had such a high runaway rate that ADC was operating a "revolving door" between ADC institutions and community placements. (2) Many programs did not effectively meet the social/psychological needs of their clients. (3) ADC needed to design its request for proposal (RFP) and contracting process to develop services for its youth, not merely to accept the services that already existed (EMT Associates, 1988).

ADC had also conducted its own substance abuse survey of incarcerated youth, which confirmed by self-report that not only were 25% currently addicted or serious abusers, but another 25% were "marginally dependent, abusive," and 49% of the most severe substance abusers received no treatment services at all (Baumgardner, 1988). ADC officials frankly admitted that the services that were provided were completely inadequate. ADC had met officially and unofficially with community providers for over two years to redesign its approach to community services. In the spring of 1988, it issued two RFPs: one for comprehensive services for adolescent substance abusers, and another for sex offenders. The contracts would be to one agency (or a consortium of agencies under unified management) to provide all of the services throughout Arizona for ADC wards. Substance abuse services were to begin within juvenile institutions, move to residential care, then to transitional homes in Tucson and Phoenix, and finally through an aftercare component that would provide supervision and support in the community to ensure that those who had completed the program did not relapse.

Amity was already looked upon favorably by ADC because of its relatively low runaway rate and reasonable per diem cost, focus on severe substance abusers, willingness to work closely with ADC, and ability to work with the most seriously impaired youth in the juvenile system. In September 1988 the contract for comprehensive substance abuse services was awarded to Amity, but because of ADC administrative difficulties almost a year passed before program implementation could begin. The residential program, which Amity has been providing for over five years, is continuing and expanding. The first institutional program began in October 1989, and the planned completion of implementation is November 1990. Thus, what is described here is very much a "work in progress," with many implementation issues yet to be resolved.

### Principles and Characteristics of the Model

- The target population for this program represents an immediate high risk to society through its delinquent/criminal activities in the

and a long-term risk if not resocialized to function appropriately. If these juvenile offenders are not positively changed by their contact with ADC, its mission of "protecting the public" will not be fulfilled. Beginning the program in a secure institutional setting takes advantage of incarceration time for starting the treatment process, protects the public, and provides meaningful consequences for antisocial behavior.

- The target population suffers from multiple disabilities and needs services that are holistic, intensive, and long term to be successfully habilitated. Episodic interest by the system based only on antisocial behavior is not adequate. The program must address chemical dependency, as well as family, social, vocational and educational needs. It must also address sexual behavior and reduction of HIV/AIDS risk.
- The program acknowledges a developmental model of behavior (Kohlberg et al., 1987), which presumes that needs not fulfilled in childhood must be met and that childhood trauma must be resolved before psychological, social, and moral growths can occur. Because most offenders come from dysfunctional families, the program must act as a strong alternate family, with positive values to *which* program participants can bond.
- Treatment must be both phased and flexible. Movement through the program is based on increased freedom of action tied to increased responsibility and internalization of program goals. Progress through the program is expected to be inconsistent. Expulsion from the program is not desirable except under extreme circumstances; participants who are unable to meet expectations in one phase of the program will be returned to a more restrictive phase until they have developed the skills and attitudes that allow them to move forward.
- Continuity in philosophy and in day-to-day operations is crucial. Treatment and correctional staff must work closely together throughout the program to ensure that expectations are congruent.
- Positive relationship-building skills are crucial to normal functioning in all aspects of living. Learning these skills is a crucial factor for post-treatment success in the community.
- Most important, the youngsters in the program represent an important social asset. They can be changed from social burdens to productive citizens.

#### Goals of the Program

- Resolution of underlying problems/dynamics fueling dysfunctional behavior so that return to antisocial, drug-abusing and criminal behavior after treatment is minimized or eliminated.
- Bonding to positive adult role models, positive peers, and positive and

**Table 1: AMITY, Inc. Age Group 12-18 years  
Amity/Catalina Mountain Project\***

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<b>N = 28</b>
<b>33% Hispanic</b>
<b>45% Caucasian</b>
<b>3% Black</b>
<b>19% Native American</b>
• <b>Divorced parents: 42%</b>
• <b>Parents that have been incarcerated: 39%</b>
• <b>Physical abuse: 585</b>
• <b>Average age first alcohol use: 9.3</b>
• <b>Average age first drug use: 9.5</b>
• <b>Average age first offense: 7</b>
• <b>Average age first arrest 11.5</b>
• <b>Average age first incarceration: 12 ,•</b>
<b>Chronic substance use prior to present arrest: 52%</b>
• <b>Drug distributor 53%</b>
• <b>Chronic 'crack' use: 45%</b>
• <b>Average number of reported misdemeanor offenses 12 months prior to present incarceration: 550</b>
• <b>Average number of reported felony offenses 12 months prior to present incarceration: 191</b>

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\*Catalina Mountain Project is the Amity drug treatment project within the Catalina Mountain Juvenile Institution. All data in Table 1 were collected in November 1989. The data were reported by the incarcerated adolescents themselves. While it is too early to make representations about accuracy, it is interesting to note that these data are *consistent* with Inciardi's findings in Miami (Inciardi and Pottleger, in press).

- Acquisition of needed skills: education (schooling); impulse control; vocational training; recreation and leisure skills; positive relationship-building skills; problem-solving skills; relapse prevention and coping; consequential thinking; and drug-refusal skills.
- Control of program participants to prevent drug use or criminal activity while in the program (protection of the community).
- Successful reintegration into society with a strong support network involving family (if available), significant others, employers and positive peers.
- Follow-up evaluation to demonstrate that the program has altered the course of offender behavior in a way that provides a significant benefit to society by reducing criminal activity and drug abuse, and improving employment skills, educational achievement, and overall functioning.

© Establishment of a superior working relationship between Amity treatment staff and ADC staff at the administrative level, within the institutions and with parole to improve case management of offenders and enhance positive parole outcomes. Regular cross-training of ADC staff by Amity and Amity staff by ADC is required (40 hours per year minimum, additional training as needed).

Developmental Needs

The observations underlying the entire Amity model are that most, if not all, of the youngsters referred to the program come from very dysfunctional homes. Many have been physically or sexually abused; others were simply not wanted or were victims of a chaotic family *life* in which their normal developmental needs were not met. While these youngsters are usually quite "streetwise" and sophisticated beyond their years, they are still developmentally arrested. It is our observation that they cannot grow psychologically, socially or morally until their developmental needs are met. Further, the Miller (1983) hypothesis assumes that the repressed rage and pain experienced in childhood must be expressed now, as it was experienced as a child, in an irrational, emotional manner. Although the behavior modification aspects of the program will probably *be* effective in changing behavior while in the program, if repressed emotions are not expressed and directed to the source, the individual will continue out of control and will act self-destructively and/or compulsively to hurt others. Skill building is important, but no amount of skills can substitute for uncovering the underlying psychogenetic material in order to resolve compulsive, out-of-control behavior.

Staffing

The quality, enthusiasm, dedication and continuity of the staff are the most important ingredients of the Amity program. While the TC model often talks about programs being "peer-run," with mature adolescents (many of whom are at the developmental level of small children), affectionate staff who relate to youth without psychological mumbo-jumbo are a respite from peers who are often inconsistent, angry and out of control. When peers act out, the emotional ties to staff keep the entire peer group from being negatively affected. Staff are instructed to forget "professional distance." The Amity motto is, "If you are not close enough to the youngsters to get your feelings hurt, you are not close enough to do any good." Condelli (1987) found that a significant factor for retention in treatment by adolescents was their perception of staff "wanting them to stay" for the full duration of the program. Amity staff members are expected to have positive and high, but realistic, expectations for all the youth they work with; other requirements follow.

Staff are expected to understand the psychodramatic aspects of their

- hurt and rage to their own parents will, as part of their growth, express those feelings to the staff member who bonds with them most closely.
- Training emphasizes that relationships formed with youth must go beyond the confines of working hours or adolescents' formal participation in the program. The relationships formed must be "real" and perceived as such by residents.
- Staff are selected on the basis of their previous experience with youngsters, or on the basis of their enthusiasm and willingness to be trained. Staff are academically trained professionals, workers from other human service agencies or former addicts who have completed an internship program and who have *received* their certification as professional counselors from the Therapeutic Communities of America Credentials Committee or as Certified Addictions Counselors.
- Staff are balanced to reflect the ethnic, cultural and racial makeup of the residents.
- Staff members must, as a condition of employment, participate in two week-long training sessions per year in addition to other regular staff training programs held on and off the facility. The intense workshops focus on family dynamics. Amity's experience is that many staff (not only recovering addicts and alcoholics) who are motivated to work with youth are themselves from dysfunctional families and often inadvertently begin to recreate dysfunctional dynamics with the youth in the TC.
- Staff members are expected to work closely together, to communicate well, and to share the values of the TC, no matter what their background. All members of the staff— administrative, custodial and secretarial—are considered part of the therapeutic environment, and must participate in meetings and trainings. Training emphasizes that they are the "surrogate family" and mini-community for the juvenile residents, and that in order to play that role they must form strong bonds among themselves.
- Staff participate regularly in encounter groups with each other to resolve differences, get to know one other better and demonstrate to the residents that the encounter group is a powerful learning tool used by role models, not just a technique imposed on youngsters *because* they are "sick." Most TC programs emphasize positive peer culture and the establishment of strong bonds between positive peers. However, few stress strong bonds to/staff though it is unlikely that peers, no matter how positive, can fulfill the developmental need for a "parental" bond to a strong, affirming adult.
- Low staff turnover is crucial for the Amity program. Youth *come* from chaotic homes and neighborhoods where there is no consistency, adults are not stable and expectations are constantly changing. Staff turnover or staff movement can precipitate anxiety and the feeling that Amity is

## 228 INTENSIVE INTERVENTIONS WITH HIGH-RISK YOUTHS

another in the long line of institutional placements to which these youth have been referred. A primary task of the adolescent program director is to meet the needs of the staff and weld them into a strong "family/community," with shared values and consistent expectations for themselves as a group and individually so that youth have access to them as adult models and surrogate family members to meet their developmental needs. While regular encounter groups, social activities and good staff benefits have counteracted moderate salaries to keep Amity staff turnover lower than many youth programs,<sup>9</sup> the coming year will be a challenge as the program moves to several different sites and as many new staff members are added.

### Physical Environment

If the staff and the daily routine of the program (including daily and weekly ceremonies) are two legs of a tripod, the third is the physical environment. Few programs give physical environment much emphasis, and many programs for adolescents look, smell, and feel like institutions. Because many of the youth came from home environments that did not "feel" like home, it is particularly important that all program components have a home-like ambiance. Ideally, facilities should be designed and built from the ground up to reflect the needs of the program and its residents, but, in actuality, cost constraints dictate that existing facilities must be modified for program activities. With the exception of the institutional components of the program, which are governed by ADC rules and standards, Amity has refused to acquire facilities that cannot be modified to feel more like homes than institutions. The current adolescent facility is an old Arizona guest ranch with many small rooms that include private bathrooms. For many of the youngsters, fresh from dormitory living in a juvenile institution, these are the most pleasant living arrangements they have ever had. The facility also has many large community rooms for meetings and community activities. Further, program staff arrange the environment to reflect all of the many cultural backgrounds of residents. Individual rooms are made to reflect the culture and the interests of the occupants, with no two looking alike *except* for neatness. The residential facility has a nondenominational outdoor pavilion decorated with ornaments from a variety of cultures.

### Work

Many sociologists have pointed out that in our attempts to protect the young, we have completely excluded them from the adult world, which is to a great extent the world of work. Unlike earlier times, when children not only had necessary chores within the family but were able to see their parents and other adults involved in the work roles they would soon assume, today's youth are as mystified about what adults do as their elders are about youth interests.

### Rod Mullen, Naya Arbiter and Peggy Glider 229

One of the greatest socializing influences on youth—the adult workplace—is no longer available. Adolescence, a social condition that did not exist two centuries ago, is prolonged, and physically mature youngsters have an extended childhood in which irresponsibility is culturally sanctioned (Coleman, 1972). Particularly for the juveniles who come to Amity from the ADC, the notion of work is foreign. In some cases, their parents or adult role models were on welfare or engaged in criminal activities to support themselves. These antisocial youngsters have often modeled themselves after dysfunctional adults or older peers, and have learned how to support themselves by dealing drugs, stealing, or prostitution—productive work is considered "square" and a sign of acculturation to despised conventional values.

One of the most important jobs of the TC is to integrate delinquents into functional community roles that move them toward adulthood (Missakian and Mullen, 1974). This is *achieved in* the following ways:

- At all Amity components, everyone has "chores" to help in the maintenance of the facilities.
- Many staff members have skills and are not only "counselors." They assume responsibility for physical areas of the facility and teach youngsters how to work.
- Prevocational skills are emphasized. While there is a strong vocational program, not all juveniles at Amity will learn a marketable skill while a resident. But if they learn discipline by working with others on common tasks and learn the attitudes necessary at the workplace, they will be much more likely be able to find a job, hold it and be an attractive trainee than if their skills were significant but their ability to follow directions, cooperate, and work hard was minimal.
- Whenever possible, residents are involved in the work of building, maintaining and operating the facility. This gives them a feeling of ownership and takes them out of the passive "child/dependent" role.
- Work offers juveniles an opportunity to socialize with adults and learn how adults work, how they think, and what their standards and expectations are. "Bonding" often occurs at work.

### Groups, Retreats, Workshops and Psychodrama

While the peer encounter group has been and remains the center of therapeutic activity for the TC, it is **important for adolescents that the group not be left entirely to peers, who are capable of using the notion of "anything goes in group" to perform psychological attacks on the weakest members, or who completely subvert the purposes of encounter groups by avoiding the kind of emotional honesty that leads to out-of-group behavioral change. For the group to be effective, it has to be safe for its participants to talk about painful or embarrassing things,** as well as to use the group for peer confrontations. While many juvenile's become sophisticated group facilitators after *many months in the program, it is not uncommon for other youngsters to*

have a difficult time accepting the advice or authority of a peer and to become subversive. Much more than adult TCs, encounter groups must be carefully structured, seeded with adolescents who have good group facilitation skills, and usually attended by staff members who have extensive encounter group experience and understanding of adolescent needs. Mature and understanding leadership is particularly important for making the encounter group "safe" for adolescents to talk about "family secrets," embarrassing sexual encounters and other sensitive personal matters.

"Retreats" lasting two or three days are scheduled several times a year. The events involve encounter groups, teaching sessions, art activities, field trips and other workshop activities. The activities always involve the senior staff of the adolescent program and put them in direct contact with the residents in a very personal manner. Frequently, these groups, with their concentrated time together, are the settings in which youth feel safest to talk about their most difficult and painful experiences. These experiences are commonly enjoyed by youngsters and looked forward to with anticipation as an emotional adventure—the equivalent of an emotional wilderness challenge experience.

Psychodrama has long been used in the TC. In fact, the first book written about the TC was by Yablonsky, a student of Moreno, the inventor of psychodrama. Moreno called the TC "residential psychodrama—an opportunity for all in the community to role play for each other" (Yablonsky, 1989). Frequently, in intense encounter groups psychodramatic incidents occur spontaneously; staff are trained to know how to take advantage of these opportunities in order for residents to express deeply buried feelings and then to "de-role" the participants and help explain the content of the psychodrama. In the 1950s, Corsini (1951, 1958) wrote a series of articles describing adaptations of Moreno's psychodramatic techniques in prisons and with incarcerated adolescents. His observation that both adult and adolescent populations were trapped in roles and interactions that were completely misunderstood by them has lost little potency in 30 years.

Psychodrama is effective because it takes the real life events of each student and integrates behavioral, cognitive, and *effective* methods of teaching social skills and resolving problems. Psychodrama can be as profound as dealing with an incestuous relationship, and as ordinary as dealing with conflict among peers or a counselor by role playing. Most importantly, psychodrama emphasizes spontaneity and the "teachable moment"—no classroom is required, and the opportunity exists in the moment to develop new, healthy social relationships based on new responses to old situations.

The popularity of retreats among adolescent residents emphasizes the need for ritual and ceremony—absent in their lives and in the lives of most in modern society. Such simple rituals as morning wake-ups, the standard TC "morning meeting," formal dining, and an end-of-day ceremony or bedtime stories, give a sense of wholeness and substance to lives that have been devoid of such formality and repetitiveness. One of the appeals of youth cults and minas is the meaning and stability provided by ceremony and ritual.

### Education

Amity provides its own on-site school at the residential facility. The school is staffed by credentialed teachers (Amity employees) and features small individualized classes, special education—classes for the learning disabled and emotionally handicapped—and GED preparation. Most students have a learning disability and almost all are considerably below their grade level (see Table 2).

ADC provides teachers and regular classes for all students while in ADC juvenile institutions. Amity staff support the institutional academic program, and prepare both the student and residential program to continue academic instruction when the adolescent transfers to the residential phase of the program.

Small classes, adult and peer support, and sanctions for nonattendance or indifferent performance all help to make significant academic progress the rule, not the exception. Additionally, teachers participate in encounter groups with students where issues of resistance, "learning is not hip" images, and other blocks to academic progress can be addressed and discussed by teachers,

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**Table 2: AMITY, Inc. Age Group 12-18 years  
Educational Achievement Levels at Entry**

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Average age:	15.5*
Average years formal education:	8.1
Percent students with handicapping conditions: (documented or suspected)	
Learning disabled:	39%
Emotional handicap:	26.8%
Educable mentally handicapped:	0.4%
Average grade equivalents based on achievement test scores:	
Reading:	8.6
Language:	7.7
Math:	7.4
Percent of students below grade level at entry:	
Reading:	61%
Language:	85.4%
Math:	78.1%
Average increase of grade equivalents in achievement test scores from entry to 7-12 months in treatment:	
Reading:	1.9
Math:	1.8

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\*Data compiled on 41 students who attended school at AMITY January-November 1988

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peers, and other staff members. While most youngsters cannot completely reach their age-appropriate grade levels while at Amity, many have taken their GED and gone on to junior college. The most important lesson learned is that they *can* function adequately in a classroom environment.

#### **Active Leisure and Physical Competence**

All program components have an *exercise* program that not only improves attitudes but prepares juveniles for participation in sports and other active leisure activities. Frequently, residents have "written off" physical *exercise* and physical activities as inconsistent with their self-image. In other cases, physical activity has become limited to ritualized weight lifting or a form of basketball called "institutional ball" that recreates many *aspects* of running the gauntlet. In Amity, most find regular exercise—another ritual—enjoyable and stabilizing. Program staff find that youth who rise early and exercise hard are less likely to get into trouble during the day and more likely to sleep well at night; this alone has made the exercise program popular with staff.

In general, discipline and teamwork are best taught through physical activities because attention spans for cognitive tasks are often short, particularly at the beginning of the program. In the institutional segment of the program, ADC instructors teach youth to march and regularly participate in competitions.

Research literature (Beschner, 1986; Schneider, 1989) has repeatedly shown a correlation between adolescents who score high on risk-taking behavior and adolescent substance abuse. For this reason, there has recently been a resurgence of interest in challenging outdoor activities and wilderness experiences. Amity staff are currently developing an outdoor wilderness experience as a regular part of the curriculum's residential component. All youth are taught a variety of recreational and leisure activities, including horseback riding, swimming, hiking, baseball, basketball and football. Because Arizona weather provides opportunities for year-round outdoor activity, these skills become important in designing post-treatment recreational outlets.

#### **Involvement of Family, Significant Others**

Beschner (1986) cites several studies that urge family participation from the beginning of drug abuse treatment in order to improve the post-treatment success of adolescents. This is echoed by Kumphier and DeMarsh (1986). Condelli (1987) shows that perceived pressure by family or significant others is a salient factor in legal constraints as well as retention in treatment programs for adolescent substance abusers. The Amity program makes phone contacts with parents and in-home visits when juveniles are first assigned to the institutional program. In many cases, the family of origin may not have a functioning, positive parent who can be involved and

change on the part of the adolescent. Occasionally, a relative, sibling, foster parent or even an involved neighbor may be the "significant other" who can become involved in orientations, trainings, family support groups, workshops and family therapy.

With the target population that Amity has served ("high-risk adolescents" with chronic patterns of substance abuse, dysfunctional families, childhood physical and sexual victimization, and significant criminal histories), however, it is often the youth receiving treatment who extends himself or herself to a sibling or a parent. Not infrequently an adolescent's example of accepting help inspires the parent. To the extent that it is financially possible, Amity has offered its services to family members of adult or adolescent residents. As a result of such outreach, several parents or older siblings have entered the adult TC, and some younger siblings have attended activities through Amity's prevention program, Matrix Community Services. When family support is available, efforts are made by program staff in the Enrollment and Family Services Department to encourage the supportive individual(s) to become immediately involved. Often, the immediate effort is to have the family member be involved in training activities with other supportive family members, and not with the adolescent in treatment. This gives the adolescent the opportunity to break negative ties and to reveal "family secrets," if there are any, and gives the parent the opportunity to identify with other parents who have had similar experiences.

For those juveniles who are to be reunited with their families, the period of transition is one more intense training for family members so that they can become completely supportive of the goals of treatment. Family members go through the relapse prevention strategy with the Amity staff, the parole officer and the juvenile so that they understand the relapse triggers and can identify "high-risk" situations. For those who do not have families to return to, the emphasis is on developing supportive relationships in the community. Significant others, often adult Amity graduates, play a surrogate parent role and go through the same training as parents.

#### **Transition Aftercare and Relapse Prevention**

Most of the current research literature on adolescent treatment emphasizes the need for well-developed transition services. While there is good evidence that juvenile offenders can perform well while in treatment programs under close supervision, there is considerably less evidence showing that they are able to maintain the gains they have made without support. After residential treatment, Amity program participants will go to small (six to ten youth) transition homes in urban settings where they will: (1) perform community service and restitution **activities**; (2) begin to reintegrate with family or to develop a support network of peers and adults consistent with their new **behavior and attitudes**; (3) begin **employment or full-time education**; and (4)

engage in a very intensive program of relapse prevention similar to that outlined in the Haggerty monograph on Project ADAPT for reintegration of adolescent offenders into the community (Haggerty et al., 1989).

Parole officers will work with family or significant others, Amity treatment staff and the adolescent to develop a post-treatment plan that all agree on. This will include identifying high-risk situations, support groups (12-Step or other programs), key relationships, frequency of involvement with Amity staff and the parole officer, frequency of groups, and "emergency procedures" for episodes when the adolescent is losing control.

After transition is completed, the participant will move to supervised aftercare. Contact with parole and treatment staff will be frequent for the first weeks (or months) until it is clear that plans developed at transition are being adhered to. Gradually, the parolee will be supervised less and less. Whenever possible, those leaving transition and not moving home will be encouraged to live together in groups of two or three to support each other's recovery and fill the need for positive peer relationships. Frequent visits by or to "bonded" staff members will help to ensure maintenance of treatment gains.

For those adolescents who at transition are too young to live independently and who do not have an intact home to return to, Amity will develop a stable, long-term living arrangement (therapeutic foster care) that will allow them to continue their progress until they are old enough to live on their own.

### Special Needs

Adolescent programs are frequently designed and implemented by the dominant culture for the dominant culture. Ethnic minorities often find that the staff, physical environment, and program activities do not reflect their own background and further derogate their own experiences. Amity hires and trains staff who are culturally sensitive, and arranges the environment to reflect the variety of cultures of the residents. In many *cases* minority youth are ignorant of their own culture. Amity makes an effort to teach the cultural heritage of each of the cultures of the residents. Celebrations include black, Native American, Jewish, Hispanic, and civic and religious holidays; each celebration is taken as an opportunity to teach all of the youth the contribution of each culture and ethnic group. This approach was particularly successful with Native American youth, most of whom had no acquaintance with their culture. A medicine man came to the program and taught both staff and youth several simple ceremonies that all youth in the program participated in; the pride that Native American adolescents *felt* was reflected in their very high retention rates in the program.

Both the criminal justice system and treatment programs tend to be first adult driven, then male driven. The needs of women are repeatedly neglected or relegated to secondary importance. However, there is evidence that when

the needs of female clients are met, not only are their outcomes favorably influenced but male program participants are helped too (Stevens, Arbitr and Glider, 1989). The adolescent females referred to Amity by ADC have very distinctive needs (see Appendix A).

- They are disproportionately victims of early childhood sexual abuse. Many have had experience as prostitutes, have been raped, and need female counselors and role models who can help them talk about their sexual victimization. They also need to understand that they can get affection and affirmation from the opposite sex without exercising their sexuality.
- Many of these adolescent females have had abortions; for most this is a traumatic and usually a shameful experience.
- Increasing numbers of girls referred to the program have young children. Interestingly, they appear to be much more highly motivated to be good parents than adult female residents in Amity's adult therapeutic community. Arrangements are made for children to visit frequently, and parenting classes are provided.
- Sex education, for these young women is critical. Most have regularly engaged in high-risk behaviors for HIV infection or transmission. While to date there have been no known instances of HIV-infected adolescent residents, this is a short-lived phenomenon.

### SUMMARY

Amity, working with ADC, has helped to design and is currently implementing a program which targets juvenile offenders incarcerated in ADC institutions and identified by ADC as being chemically dependent. Both the research literature and many years of program experience dictate a response to these juveniles that is intensive, long-term, and comprehensive and that addresses the many deficiencies that they *have*. While these young offenders pose a significant threat to the communities they live in because of their active criminality, it is important to recognize that they are disproportionately victims of dysfunctional, maladaptive, and often physically or sexually abusive families. One of the unique aspects of this comprehensive approach is that it draws on the TC model, one of the most powerful interventions developed for chronic adult addicts, and adapts it for an adolescent population. Further, the model expects to uncover and help to alleviate the root causes of antisocial and self-destructive behavior. The program will serve over 250 youth simultaneously at several program components when program implementation is completed.

## APPENDIX A

**Belinda: A Case Study**

The most confusing aspect of working with criminally involved, substance-abusing adolescents is that they may be at different developmental levels simultaneously. Thus, a 15-year old Hispanic girl, Belinda, may be developmentally arrested at the point where her prostitute mother allowed a "trick" to sexually molest her, so that the mother could get a "fix," and did not protect Belinda (who was unable to express her hurt because of her age, her mother's lack of interest or sympathy, and her fear of losing her mother's affection).

Belinda *has* prostituted for two years. Further, she has a child of her own, and has both strong maternal feelings and rage/hatred toward the child, who demands of her what she never *received* from her own mother and forces her further away from her own developmentally necessary period of individual role experimentation. At Amity, Belinda is involved in the following activities:

- She plays baseball on the Amity team. Belinda is an enthusiastic player, practicing every day. She has never had an opportunity to play before. She began to learn while in the Amity program in the juvenile institution, where she was incarcerated for four months; this was her fourth ADC incarceration.
- Belinda has two friends made while in the institutional program. One of the staff members she was fond of moved from the institutional program to the residential program shortly after Belinda was transferred.
- She spends time with a 23-year old female, Hispanic staff member who grew up in the barrio near her neighborhood. The *staff* member was a prostitute and an addict, has been drug-free for three years and is now getting married. Belinda relates to the older woman partly as "mom," partly as "sister," partly as "best friend." Belinda finds that she can sometimes talk about painful and degrading experiences with the staff member; and then, feeling "safe" because of the acceptance and understanding, share those experiences and feelings with other girls in the program.
- Belinda is spending time on the weekend with her daughter, who is brought to the program by her grandmother. Grandmother is caring for the baby and is impatient for Belinda to leave the program to relieve her of the responsibility. Mom is in jail for prostitution, and Belinda's grandmother is attending parent/significant-other orientations every month. Since she has been attending, she has put less pressure on Belinda to leave. Belinda is also involved once a week in a class on parenting skills; she seems proud of what she has learned and feels that she will be a better parent.
- She looks forward to bedtime stories every night, read by one of the staff

members who lives at the facility. She never had that kind of experience when she was at home.

- Belinda is going to school consistently for the first time in five years. She is learning how to read and write. Classes are very small and individualized so that she is not overly embarrassed by her lack of ability. She works with another girl in her dorm who is at the same level.
- Her job assignment is in the kitchen. Her grandmother taught her to cook, and she is somewhat egotistic about her abilities. Several times Belinda was put in charge of the kitchen and supervised a crew of her peers in preparing a special meal for the facility. Everyone praised her, and she felt she was making an adult contribution to the community. Belinda thinks that she may become a cook when she completes the program. The Amity cook has offered to teach her menu planning and food ordering as well as to expand her repertoire beyond Mexican cuisine. She knows that she must be able to read and calculate in order to organize menus, and that has helped to motivate her at school.
- Belinda sometimes attends mixed encounter groups with boys. She is fond of Alex, and has occasionally talked with him outside of the group. Although she was a prostitute for two years, and used heroin and cocaine intravenously before smoking crack, she is very shy around Alex and finds it difficult to communicate. She has never tried to talk to someone of the opposite sex without being high or without sex being the ultimate object of the encounter.
- Belinda is just learning about AIDS. Since she has been at Amity, she learned that four friends from her neighborhood in Phoenix are infected and that one has already died. The nurse is talking to all the young people about AIDS. Belinda is frightened. She realizes that she may be infected. She is ambivalent about being tested, but all the staff were tested a year ago (to reduce the residents' fears of testing), and it is now easier for her to consider being tested.
- Belinda has an uncontrollable hatred directed toward the program director; she does not know why. When *he* observed her one day drawing a "jail-house" tattoo on her thigh with pen, ink, and matches—and confronted her in a loud voice—she lost control of herself, threw herself at him, bit him and kicked him. She never knew her father, but was molested by a series of men brought by her mother to the apartments they lived in while the mother was prostituting. The program director is working with program staff to set up a "retreat" for a dozen of the girls in the program. He is working with the clinical director to arrange a psychodrama to see if Belinda can express and direct her rage toward her molesters—and toward her mother.
- Belinda and other girls have been attending seminars regularly to talk about family dynamics and how they affect behavior. The girls are seeing videotapes by Claudia Black about how children of alcoholics or drug

abusers develop shame and feel that they are defective. After seeing the videotapes and talking with the staff and her peers, Belinda has started to remember details about her childhood. When she came to Amity she could not remember anything before the age of nine—the age at which she went to live with her grandmother.

This one example illustrates some of the different developmental needs of a typical Amity resident.

## NOTES

1. Our clinical observation *has* been that for a majority of clients with histories of physical or sexual victimization it often takes months or even years for the client to reveal the incidents. Often there is an unwillingness to attribute anything "bad" to an idealized parent. Even more frequently, the client has completely submerged the memory of victimization. Since these incidents are shameful, there is further reason to be unwilling to reveal them casually; for a child whose only physical affection from a father was incest, there is often the feeling as an adult that one "caused" and promoted the incestuous relationship.

2. While Synanon was the original TC, it never accepted government support (remaining true to its AA roots) and, by the late 1960s, considered itself a "social movement" that cured drug addicts as a by-product of engaging in a healthy lifestyle. Synanon was involved for many years in a variety of program experiments to improve treatment of drug addicts. However, none of the data were *ever* published, and little is known except by Synanon administrators and program participants. By the end of the 1970s Synanon had turned away from drug treatment, and became embroiled in a criminal case and several civil cases concerning illegal activities by Dederich and his associates. At the time of this writing, Synanon is not involved in drug rehabilitation.

3. Abraxas does have females in transitional facilities, but not in the main facilities. Mixing males and females was found to *be* too disruptive.

4. Amity, Inc. provides a variety of substance-abuse related services: (1) An adult TC for 175 residents. (2) A prevention/intervention program that contacts 25,000 high-risk youth per year. (3) A National Institute on Drug Abuse-funded AIDS outreach/research program, intervening with intravenous drug abusers and their sexual partners. (4) The Amity/Pima County Jail Project, serving approximately 70 men and women incarcerated in the Pima County Medium Security Addition. (5) The adolescent TC described in this chapter.

5. Average length of stay for the Amity adult TC between 1981 and 1987 was 297 days for men and 279 days for women. For TCs nationally, the average is between 90 to 120 days (DeLeon, 1989). Because length of stay is the most important predictor of post-treatment success, this appears to indicate significant improvement in an area (retention) that is receiving increasing attention by both researchers and practitioners.

6. While licensing considerations and governmental funding preclude any real consideration of mixing adult and adolescent populations for most programs, this remains an important and unresolved issue. Stratification into age-peer groups is a significant problem—a legacy of our recent transition from agrarian to industrial to post-industrial society. When the peer group is further condensed into

impulse control, inability to delay gratification and criminal histories, the possibility of orienting them toward positive societal values becomes a task worthy of Hercules. Haggerty et al.'s (1989) Adapt program points out that delinquent youth need opportunities for involvement in conventional activities and interactions with conventional others. Being restricted to an entire population of juvenile deviants makes that a very difficult task to accomplish, hence the criminogenic properties of both adult and adolescent correctional institutions. TCs have specialized in converting social deviants to conventional values, which, like new converts, they preach with a zeal unmatched by those who have been born to normalcy. However, with youngsters, who are in the perplexing period of adolescence (not to mention accompanying substance abuse problems), it is more difficult to "convert" to adult values—indeed part of normal adolescent behavior is rebellion against adult values. While there are some difficulties and dangers in treating adults and adolescents together, the benefits of having adult role models may, in a carefully managed TC that can provide separate programming specifically for adolescent needs, outweigh the difficulties. Recovering adults espousing conventional values with a very strong antidrug, anticrime orientation may be the only credible and available adult role models available for these youngsters during their own recovery (Haggerty et al., 1989).

7. In 1987, the Arizona State Legislature passed a law forbidding anyone ever convicted of one of 16 listed felonies (including robbery, burglary and sales of drugs) to ever work with youngsters in facilities licensed by the state. Amity, being the only organization in the state that explicitly used ex-addicts as role models with youngsters, found itself with many of its key clinicians sidelined. For example, a decorated Vietnam veteran was convicted of possession of cocaine in the 1970s. He served a short sentence and soon thereafter began working with youth. His record was expunged. Over the next ten years, he managed several successful youth programs. However, when he was fingerprinted in Arizona, his old conviction came up, and he was forbidden to work at the adolescent facility. Amity worked with state legislators for two years to change this law. It was changed in 1989 so that "exceptions for good cause" can be made.

8. Kohlberg's work on moral development provides a useful paradigm for adolescent or adult substance abusers and criminals. Based on a solid foundation of developmental research, Kohlberg sees maturation as moving from pre-conventional norms, which are excessively self-centered, to conventional norms centered on supporting society and the status quo, to post-conventional morality—the recognition of a "higher authority." Put in these terms, the job of socializing institutions is no more or less than moving clients from pre-conventional morality to conventional morality. Kohlberg suggests that the key ingredients for moral development are: credible role models demonstrating moral levels slightly above the participant; moral conflict that reveals the flaws in current moral reasoning and practice; opportunities to play many social roles, and sustained responsibility for others. At Amity, Kohlberg's work is presented regularly in staff training, and both staff and residents are encouraged to view the program as "a school for moral development"

9. Over the years we have found that a cynical attitude is corrosive for adolescent and adult clients, probably because it echoes early childhood messages of self-derogation and negativity. Counselors and other staff who work with adolescent clients must be emotionally tough. They cannot fall apart when they are tested or deceived by youth, but they also must have a positive outlook—a "romantic" *view* of the possibilities for improvement by each adolescent. More than any other factor, youth respond to *expectations* to "become their best" by adult role models to whom they are emotionally

10. This is based upon the observation of the authors in visiting youth programs across the country. At many programs, a 50% staff turnover rate is not infrequent during the course of a single calendar year.

#### REFERENCES

- Anglin, M. and W. McGlothlin (1984). "Outcome of Narcotic Addict Treatment in California." In *Drug Abuse Treatment Evaluation: Strategies, Progress and Prospects (NIDA Research Monograph 87)*, edited by F. Tims and J. Ludford. Washington, DC: U.S. National Institute on Drug Abuse.
- Arbiter, N. (1988). "Drug Treatment in a Direct Supervision Jail: Pima County's Amity Jail Project" *American Jails* 2(2):35-40.
- Baumgardner, T. (1988). "Substance Abuse Survey of juvenile Institutional Population." Unpublished report prepared for the Arizona Department of Corrections.
- Beschner, G. (1986). "Treatment for Childhood Chemical Abuse." In *Childhood and Chemical Abuse: Prevention and Intervention*, edited by S. Griswold-Ezekoye, K. Kumpfer and W. Bukoski. New York, NY: Haworth.
- Brunswick, A. and J. Boyle (1979). "Patterns of Drug Involvement: Developmental and Secular Influences on Age at Initiation." *Youth and Society* 11(2):139-162.
- Camp, G.M. and C.C. Camp (1989). *Budding on Prior Experiences: Therapeutic Communities in Prisons*. (Report prepared for Narcotic and Drug Research, Inc.) New York, NY: Criminal Justice Institute.
- Coleman, J. (1972). "The Children Have Outgrown the Schools." *Psychology Today* 5(9):72-75, 82.
- Condelli, W. S. (1987). "Client Evaluations of Therapeutic Communities and Retention." In *Therapeutic Communities for Addictions*, edited by G. DeLeon and J.T. Ziegenfuss. Springfield, IL: Charles C Thomas.
- Coombs, R. (1981). "Back on the Streets: Therapeutic Communities' Impact Upon Drug Users." *American Journal of Drug and Alcohol Abuse* 8(2):185-201.
- Corsini, R. J. (1951). "Psychodramatic Treatment of a Pedophile: The Case of Manuel." *Group Psychotherapy* 4:166-171.
- (1958). "Psychodrama with a Psychopath." *Group Psychotherapy* 11(1):33-39.
- DeLeon, G. (1989). Personal communication with the Research Director, Therapeutic Communities of America.
- (1988). "Legal Pressure in Therapeutic Communities." In *Compulsory Treatment of Drug Abuse: Research and Clinical Practice (NIDA Research Monograph 86)*, edited by C. Leukefeld and F. Tims. Washington DC: U.S. National Institute on Drug Abuse.
- (1981). "The Role of Rehabilitation." In *Drug Abuse in the Modern World: A Perspective for the Eighties*, edited by G.G. Nahas and H.C. Frick. New York, NY: Pergamon.
- and G. Beschner (1976). "The Therapeutic Community." In *Proceedings of the Therapeutic Communities of America Planning Conference*, edited by George DeLeon and George M. Beschner. Washington, DC: U.S. National Institute on Drug Abuse.
- and D. Deitch (1985). "Treatment of the Adolescent Substance Abuser in a Therapeutic Community." In *Treatment Services for Adolescent Substance Abusers*, edited by A.S. Friedman and G.M. Beschner. Washington, DC: U.S. National Institute on Drug Abuse.

- H. Wexler and N. Jainchill (1982). "The Therapeutic Community: Success and Improvement Rates Five Years After Treatment" *International Journal of the Addictions* 17(4):703-747.
- Dembo, R., M. Derdce, L LaVoie, S. Borders, M. Washburn and J. Schmeidler. (1987). "Physical Abuse, Sexual Victimization and Illicit Drug Use: "A Structural Analysis Among High-Risk Adolescents." *Journal of Adolescence* 10:13-33.
- L Williams, E. LaVoie, E. Berry, A. Getreau, E. Wish, J. Schmeidler and M. Washburn (1989). "Physical Abuse, Sexual Victimization, and Illicit Drug Use: Replication of a Structural Analysis Among a New Sample of High-Risk Youths." *Violence and Victims* 4(2):131-138.
- E. Wish, M. Dertke, E. Berry, A. Getreau, M. Washburn and J. Schmeidler (1988). "The Relationship Between Physical and Sexual Abuse and Illicit Drug Use: A Replication Among a New Sample of Youths Entering A Juvenile Detention Center." *International Journal of the Addictions* 23(11):1102-1123.
- Donovan, J. and R. Jessor (1984). *The Structure of Problem Behavior in Adolescence and Young Adulthood, Research Report No. so-YoungAduk Follow-up Study*. Boulder, CO: Institute of Behavioral Science, University of Colorado.
- Elliott, D. and D. Huizinga (1984). "The Relationship Between Delinquent Behavior and ADM Problems." Paper presented at the ADAMHA/OJJDP State of the Art Research Conference on Juvenile Offenders with Serious Drug, Alcohol and Mental Health Problems.
- S. Ageton (1985). *Explaining Delinquency and Drug Use*. Beverly Hills, CA: Sage.
- EMT Associates, Inc. (1988). *Final Report for the Evaluation of Juvenile Residential Group House and Day Support Contract Services, Report Submitted to Arizona Department of Corrections Purchase of Care Unit, May 1988*. Sacramento, CA.
- Haggerty, K. P., E. A. Wells, J. M. Jenson, R. F. Catalano, and J. D. Hawkins (1989). "Delinquents and Drug Use: A Model Program for Community Reintegration." *Adolescence* 24(94):439-456.
- Hartstone, E. and K. Hansen (1984). "The Violent Juvenile Offender: An Empirical Portrait." In *Violent Juvenile Offenders: An Anthology*, edited by R.A. Mathias et al. San Francisco, CA: National Council on Crime and Delinquency.
- Hawkins, J. (1984). *Drug Abuse, Mental Health, and Delinquency: Summary of Proceedings of Practitioners' Conference on Juvenile Offenders with Serious Drug, Alcohol and Mental Health Problems*, Washington, DC: Office of Juvenile Justice and Delinquency Prevention, Department of Justice.
- D. M. Lishner, J. M. Jenson and R. f. Catalano (1987). "Delinquents and Drugs: What the Evidence Suggests About Prevention and Treatment Programming." In *Youth at Risk for Substance Abuse*, edited by D. M. Lishner et al. Washington, DC: U.S. National Institute on Drug Abuse.
- (1989). *The Crack/Violence Connection Within a Population of Hard-Core Adolescent Offenders*, National Institute on Drug Abuse *Technical Review on Drugs and Violence*. Rockville, MD: National Institute on Drug Abuse.
- Inciardi, J.A. and A. Pottieger (in press). "Kids, Crack and Crime." *Journal of Drug Issues*.
- Jessor, R. and S. Jessor (1977). *Problem Behavior and Psychosocial Development: A Longitudinal Study of Youth*. New York, NY: Academic Press.
- Kandel, D., O. Simcha-Fagan and M. Davies (1986). "Risk Factors for Delinquency and Illicit Drug Use From Adolescence to Young Adulthood." *Journal of Drug Issues* 60( 1 ):67-90.

- Kohlberg, L, R. DeVries, G. Fein, D. Hart, R. Mayer, G. Noam, J. Snarey and J. Wertsch (1987). *Child Psychology and Childhood Education: A Cognitive-Developmental View*. New York, NY: Longman.
- Kumpher, K. and J. DeMarsh (1986). "Family Environmental and Genetic Influences on Children's Future Chemical Dependency." *Journal of Children in Contemporary Society* (1/2):49-83.
- Lipton, D., R. Martinson and J. Wilks (1975). *The Effectiveness of Correctional Treatment*. New York, NY: Praeger.
- Leukefeld, C. and F. runs (1988). "Compulsory Treatment A Review of the Findings." In *Compulsory Treatment of Drug Abuse: Research and Clinical Practice*, NIDA Research Monograph 86, edited by C. Leukefeld and F. Titus. Washington DC: National Institute on Drug Abuse.
- Miller, A. (1983). *For Your Own Good: Hidden Cruelty in Child-Rearing and the Roots of Violence*. New York, NY: Farrar, Straus, Giroux.
- Missakian, E. and R. Mullen, (1974). "The Productive High School." Paper submitted to the Career Education Program of the U.S. National Institute of Education.
- Nebelkopf, E. (1989). "Innovations in Drug Treatment and the Therapeutic Community." *International Journal of Therapeutic Communities* 10(1):39-52.
- Pompi, K. (1989). Personal communication.
- and J. Resnick (1987). "Retention of Court-Referred Adolescents and Young Adults in the Therapeutic Community." *American Journal of Drug and Alcohol Abuse* 13(3):309-325.
- Rom-Rymer, J. R. (1981). "An Empirical Assessment of Mowrer's Theory of Psychopathology Applied to a Therapeutic Community." Doctoral dissertation, Florida State University. Ann Arbor, MI University Microfilms International.
- Schneider, P. (1989). *Promising Approaches for the Prevention, Intervention and Treatment of Illegal Drug and Alcohol Use Among Juveniles: Assessment Report*. (Research Report #1, prepared for the U.S. Office of Juvenile Justice and Delinquency Prevention.) Bethesda, MD: Pacific Institute for Research and Evaluation.
- Speckart, G. and M. Anglin (1985). "Narcotics and Crime: An Analysis of Existing Evidence for a Casual Relationship." *Behavioral Sciences and the Law* 3(3):259-282.
- Stevens, S., N. Arbiter and P. Glider. (1989) "Women Residents: Expanding Their Role to Increase Treatment Effectiveness in Substance Abuse Programs." *International Journal of the Addictions* 24(5):425-434.
- Sugarnan, B. (1987). "Structure, Variations and Context A Sociological View of the Therapeutic Community." In *Therapeutic Communities for Addictions*, edited by G. DeLeon and J. T. Ziegenfuss. Springfield, IL: Charles C Thomas.
- Turner, S. (1989). Personal communication at the "What Works" Conference, sponsored by the Narcotic and Drug Research Institutes, New York, NY.
- Wexler, H., G. Fain, D. Lipton, A. Rosenblum and L. Goodloe (1988). "A Model Prison Rehabilitation Program: An Evaluation of the 'Stay 'N Out' Therapeutic Community." (Unpublished report prepared for the U.S. National Institute on Drug Abuse). New York, NY: Narcotic and Drug Research, Inc.
- D. Lipton and K. Foster (1985). "Outcome Evaluation of a Prison Therapeutic Community for Substance Abuse Treatment: Preliminary Results." Paper presented at the American Society of Criminology Annual Meeting, San Diego, CA.
- and B. Johnson (1988). *A System Strategy for Treating Cocaine/Heroin-Abusing Offenders in Custody*. Washington, DC: U.S. National Institute of Justice. (Issues

- and R. Williams (1986). "The Stay'N Out Therapeutic Community: Prison Treatment for Substance Abusers." *Journal of Psychoactive Drugs* 3:221-229.
- U.S. National Institute of Justice (1989). "Drug Use Forecasting: January to March, 1989 Data." Washington, DC.
- Yablonsky, L. (1989). *The Therapeutic Community: A Successful Approach for Treating Substance Abusers*. New York NY: Gardner.