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# sidential Substance Abuse Treatment (RSAT) in Prison: Evaluation of the Maryland RSAT Program

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## Maryland Residential Substance Abuse Treatment Program (MDRSAT)

### *Executive Summary*

For over the last two decades, Maryland has had several drug treatment programs in one or more of its correctional institutions. Senate Bill 272 (Hollinger Bill) mandates that the state provide such services and funding from federal block grants (e.g., Residential Substance Abuse Treatment-RSAT) in 1994 provided the impetus to implement the legislation (Senate Bill 272). The RSAT block grant was premised on using the findings from the scientific literature to guide the components of the program. The literature supports the use of programs that are 6 to 12 months in duration, have a separate living facility, and provide treatment towards the end of the inmate's stay in prison (Wexler & Williams, 1986; Lipton, 1995). Drug testing was also a mandated requirement for jurisdictions to receive other federal funds. Although the federal RSAT funds can not be used for continuing treatment services in the community, the RSAT program guidelines encouraged jurisdictions to provide aftercare in the community as a means of continuing client involvement in treatment and in order to maintain the results achieved during prison-based treatment (Taxman and Spinner, 1996; Lipton, 1995; Wexler, Falkin, & Lipton, 1999).

This process evaluation examined the implementation of the Maryland RSAT program by observing the therapeutic community program in the prison, conducting structured interviews with treatment and administrative staff members, and tracking client progress through both the treatment and criminal justice systems. This evaluation provides the opportunity to understand how the prison based-RSAT TC was

implemented. It features observations of the treatment program in the prison setting in order to understand the nature of the substance abuse services offered and how the programs address the inmates' cognitive, behavioral, social, and vocational skill development. Overall, the evaluation found that the mechanics of the in prison program were implemented but that the delivery of treatment services, (i.e., transition into the community) were not.

## A. Overview of the Treatment Program

**Findings on Program Structure, Services, and Implementation**. The RSAT model encompasses the need to develop a seamless system of care between the prison and the community treatment programs. The underlying premise is that the treatment provider, prison, and probation/parole agencies would work together to develop a coordinated service delivery system to implement the RSAT model. RSAT, although appearing simplistic in concept, organizationally requires alignment in both policy and operational practice to implement lengthy drug treatment services in prison with continued involvement in treatment after release from the facility. The integration of drug testing and sanctions also requires the prison and probation/parole services to be partners in the treatment services. Although the Department of Public Safety and Correctional Services operates the prison and supervision agencies, the evaluation found that there was no continuum of care among offenders, moving from the prison program to work release to aftercare services involved in parole supervision. That is, the program had no continued involvement beyond the clients' residential treatment experience.

**Separate Facility/Housing Area.** The RSAT program was successful in providing a separate treatment space at the facility but was not successful in securing a

separate *living* area for the RSAT clients apart from the general population. The separate housing area also housed non-program inmates, which affected the ability of the offenders in treatment to form a community. It is important to note that without a separate living facility for RSAT inmates, this program failed to implement a critical component of the TC model.

**Staffing.** Many of the counselors in this program were new to both the RSAT model and substance abuse counseling in general. Five of the counselors had earned Bachelor's degrees in a field related to counseling, although two held degrees in unrelated fields. None of the supervisors or counselors held advanced degrees. Additionally, three of the counselors had no previous counseling experience of any kind. It is apparent that it is difficult not only to fill the contractual counselor positions with qualified staff but also to retain them. The pool of applicants is not as strong as it could be if the job's compensation (e.g., benefits, etc.) was more desirable. As a result, the program was unable to hire skilled and effective treatment staff.

**Components of the Treatment Program**. In general, the program could be classified as a modified therapeutic community with an emphasis on developing the cognitive and social skills of the offender as a tool to obtain and retain recovery; however, they failed to implement many TC components (e.g., separate living unit, role models, structured interactions). The observations revealed that the program emphasis (i.e., measuring the program's philosophy of drug addiction and treatment) was on self-help (focus on the idea that the client is the only one who can change his/her behavior), and contemplation of change (focus on building client's awareness that a problem exists

and that they must seriously think about overcoming it, though they have yet to make a commitment to take action).

The most widely used treatment topics were subjective learning (learning through examination of issues in terms of the client's own personal values) and social relatedness (the essential social experience that directly reflects clients' relationships with others), while the most widely relied upon treatment activities were peer encounter groups (the interaction with the community or therapeutic group is used to heighten individual awareness of specific attitudes or behavioral patterns to be modified), and sharing experiences (clients share their drug experiences with the group in attempts to help other clients examine their substance abuse patterns). The most frequently used treatment styles were formal (planned/scheduled activities) and interactive (clients are active in treatment activities). Finally, the most widely used view of the residential community (i.e., how the program uses the group as an agent of change) was collective formats (the individual engages in the process of change primarily with peers), open communication (clients feel open to express feelings, experiences, and discomforts), and participants (individuals contribute directly to all activities of the daily life in the TC).

**Quantity of Services**. The program had a relatively extensive schedule to provide treatment, offering several treatment activities per day. These activities included community groups, and therapeutic and educational activities related to drug addiction and recovery; however, the schedule did not allow for any community-run activities. These types of activities would have enhanced the program by providing more structure and discipline to address community organization and prosocial value issues. The process evaluation found that while the program offered an extensive schedule of

treatment activities, they were inconsistently delivered due to staff absences. In addition, the activities the staff actually conducted were often unproductive.

**Drug Testing.** Of the 324 clients in RSAT, 260 were drug tested. The prison drug tested the clients but the treatment staff were not involved in the drug testing process. The lack of involvement of the treatment staff in the drug testing process is an example of the inadequate communication between the treatment and correctional staff. Results of this data revealed that few of the offenders tested positive during their involvement in the RSAT program.

**Aftercare or Continuing Care.** The RSAT administrative staff did not develop any transitional planning process for clients leaving the program. The RSAT program had three stages: in-prison treatment, treatment in work release, and treatment in the community. Upon graduation, program staff gave clients a referral for work release or community treatment; however, the evaluators found that few offenders received any type of aftercare services. Despite work release as a component of the in prison program, the program did not provide clients with any further community based programming after graduation. Parole agents were not involved in the transition process, nor did the program work to develop client transition or discharge plans. It is thus not surprising that few clients (3 were reported) were placed in treatment services after release from the Central Laundry Facility (CLF).

**Supervision Services After Release**. The RSAT model assumes an inter-organizational strategy for ensuring that offenders in prison-based drug treatment services continue drug treatment in the community to support recovery and abstinence. The Department of Public Safety and Correctional Services was not able to implement an

inter-organizational approach or seamless system of care as part of this program. This type of approach would have transcended organizational boundaries and facilitated transitional planning and post-release supervision.

**Client Participation Results**. Despite several other shortcomings, the MD RSAT program was successful in obtaining clients for the in-prison program and retaining them for six months (the in-prison program reported few dropouts).

**Participants Characteristics**. Overall, the offenders were in their late 20's and had fairly lengthy criminal histories with multiple arrests and convictions. For the majority of the offenders, crack/cocaine was the drug of choice. Many of the offenders had prior treatment experiences.

**Length of Stay in Treatment/Completion from Treatment**. The average offender stayed in the RSAT program for 161 days in both 1997 and 1998, with a range of 4 days to 474 days. Thus, the program was generally successful in maintaining clients in treatment in CLF.

**Program Compliance/Graduated Sanctions**. Of the 324 clients served in this program, treatment staff reported that 41 had committed an infraction. These 41 clients committed a total of 61 infractions during the observation period. According to submitted data, staff imposed a total of 74 graduated sanctions (more than one per infraction) in response to these infractions. However, the researcher observed no sanctions during the 12-week evaluation program.

**B. Status of the Program**

**Accomplishments.** The Department of Public Safety and Correctional Services was able to develop and implement a six-month residential substance abuse treatment

program and retain a high number of clients in the program, despite several shortcomings. For instance, even though the living space was designated for offenders in special services, not all of this space was designated for offenders in the RSAT program. The facility's success in implementing a random drug testing policy, as evidenced by the large number and high rate of drug tests performed on the clients in the RSAT program. While closed groups are usually difficult to achieve, the MD RSAT program established a process whereby clients entered and completed the treatment cycle together. If the treatment were theoretically sound, the closed groups would have been effective, but because the treatment was poorly delivered, they were not.

**Drawbacks.** In the RSAT program, much more attention is needed to several crucial aspects of program implementation, including the delivery of services, staff qualifications, use of behavioral management (graduated responses), and the continuation in follow-up treatment programs after release from this prison program. One important suggestion for improving the existing program is the use of a much more clearly defined, formalized treatment curriculum. The specific tasks to be accomplished in each meeting and at each program phase should be made clear to the clients at their entrance into treatment, as should the need for them to participate in appropriate aftercare treatment. The program would likely benefit from a more consistent use of structured, cognitive-behavioral and pro-social skills development activities, rather than its current practice of presenting treatment activities in a relatively unstructured and often unproductive manner. More generally, the program administrators need to work to clearly define the goals and objectives of this six-month program, focusing it on hard-core offenders (those most likely to need and benefit from an intensive, residential intervention).

Another equally important issue is the hiring, training and retention of qualified and dedicated treatment staff. Effective treatment staff should be knowledgeable enough to deliver an intense, short-term program with therapeutic integrity (e.g., delivered as designed). The staffing issues raised in this evaluation include low levels of prior clinical experience, inadequate academic qualifications, nonexistent clinical supervision of treatment-related activities, and a generally inefficient use of staff time between treatment activities. Extensive training of the existing staff and improved selection of future staff (based on adequate prior academic and clinical experience) are critical to improving the quality of this program.

Furthermore, the RSAT program should substantially increase the utilization of graduated punishments and rewards. Structured rules and behavioral expectations for participants will likely improve clients' involvement in and compliance with the treatment regime. At the same time, improved rule setting and enforcement would communicate to the clients a sense that substance abuse recovery and desistance from criminal behavior are important goals of the program. If treatment staff would consistently monitor and sanction client misbehavior in a fair manner, then clients might realize that these issues are important for their eventual recovery.

As mentioned above, the program could also benefit from the development of a more consistent program discharge process, including the use of parole officers to transition clients to needed community-based aftercare treatment. In order to improve client access to and participation in aftercare treatment, the program needs to fully integrate the multiple supervision and service agencies involved with these criminal justice clients. The residential treatment providers, correctional staff, traffic officers,

parole officers, and community service providers need to work together at both the policy and operational levels to achieve a continuum of care.

MD's RSAT program had some of structural features needed for an effective program (e.g., separate treatment area, partially separated living area, closed groups, client retention). Taking advantage of these features by improving the clarity, consistency, and fidelity (to the TC model) of the program's implementation will increase the likelihood of reduced recidivism and drug use.

## Chapter 1 - Literature Review

In 1994, the Crime Bill contained a special grant program for states to implement therapeutic communities in their prison system. The purpose of the Residential Substance Abuse Treatment (RSAT) program is to assist the states in developing sound treatment programs for drug involved offenders based on the findings of Stay 'n Out program (Wexler & Williams, 1986) and Key/Crest (Martin, Butzin, & Inciardi, 1995). The RSAT block grant provides funding for therapeutic communities in a prison setting. The Correctional Program Office (CPO) of the Office of Justice Programs (OJP), U.S. Department of Justice used science-based results to guide the components of the RSAT block grants. The program requirements stipulated that the RSAT program in prison should be: 1) a minimum of six months in duration; 2) offenders should participate at the end of their prison terms, just prior to release; 3) offenders should be drug tested; and, 4) the treatment program should use graduated sanctions to address non-compliance issues. Although federal block grant dollars cannot be used for aftercare in the community, the CPO/OJP program requirements emphasize the importance of continuing treatment in the community for another six months as well as using drug testing and graduated sanctions.

In this paper, researchers attempted to measure the effectiveness and quality of treatment services, and to examine the integrity in the Maryland Residential Substance Abuse Treatment (MD RSAT) program, a prison-based modified therapeutic community (TC). The first chapter will provide TC characteristics, as well as review studies of TC's and their effectiveness.

## I. Changing Behaviors

In terms of changing addictive behavior, and in other forms of individual change, Prochaska, DiClemente, and Norcross (1992) suggest that people progress through five stages of change. In addition, they propose that the process of change is not a linear one, but instead frequently involves movement back and forth between stages. In particular, this type of flexible model may help explain why people with addictive behaviors often relapse after making substantial progress. The amount of time that people spend in these stages varies. The authors suggest that matching a person's stage of change (e.g., their readiness for different types or levels of treatment activity) to the type of treatment provided can result in more effective treatment and less subsequent relapse. The five stages, as described by Prochaska et al. (1992), are outlined below:

1) Precontemplation Stage - The person does not recognize that there is a problem so they have no intention to change in the near future;
2) Contemplation Stage - The person recognizes that there is a problem but has not committed to a solution;
3) Preparation Stage - The person plans to take action in the next month but has not been successful in conquering the addiction in the past year;
4) Action Stage - The person begins to make behavioral changes to conquer the addiction. This is the first stage in which the change process moves from "thinking" to "doing" and as a result requires larger amounts of time and energy;
5) Maintenance Stage - The person works on relapse prevention and maintenance of a new lifestyle, without the addictive behaviors, for more than six months.

As noted above, people with addictive behaviors often may relapse and regress to earlier stages, before finally conquering their addiction. Frequently, clients will move between the contemplation or preparation stages. In addition, clients may at times drop out of the treatment/change process altogether. Recognizing this common trend, the authors point out that "relapse is the *rule*, rather than the exception" (p. 1104). In addition to the

sometimes poor match between client's stage of change and type of treatment activity, they also cite "inadequate motivation, resistance to therapy, defensiveness, and inability to relate" (p. 1102) as some of the reasons for client relapse. On the other hand, Prochaska and colleagues (1992) found that if a person progresses from any one stage of change to another in his/her first month of treatment, then he/she is twice as likely to reach the "action stage" by the end of six months in treatment. Thus, successfully navigating the early stages of treatment appears to improve the probability of success in later stages.

In developing a TC, it is important to define the stages of change and determine into which stage one's clients fall before they enter the program. Thus, the assessment division could more thoroughly assess clients before they enter the program. Additionally, once the client enters the program, the stages through which he/she progresses should be monitored in order to adjust the type and level of treatment.

## II. What is a Therapeutic Community?

### A. Definition of a TC

Therapeutic communities are the most structured treatment interventions. There are several components of TC's that make them unique from other treatment programs. First, TC's are made up of closed groups, meaning that a group or cycle enters the program together and, if all are successful, graduate together. Members are not brought into the group after the first entrance date (except peer group members). Additionally, the members of a TC typically share living quarters only used by members of the TC. The basis of the TC is that the members of the group become a community and work with

each other to achieve recovery and accept mainstream values. The members of the TC determine the direction of the group and their path to recovery.

A therapeutic community is a prison-based drug treatment program in which the offender along with his/her treatment group defines the recovery process. One of the goals of this approach is that participants feel comfortable working within the group framework, so that they can confront any problems that arise within the group. The group is a community that addresses and resolves its own problems. The entire group enters the program at the same time and if completed successfully, all graduate together.

**B. Characteristics of a TC**

The TC is an environment where members relate to each other and the goals of the *community*, not just their personal goals. De Leon (1994) claims that the most important emphasis of a TC is the community. He describes the aims of the TC as follows: "the primary psychological goal is to change the negative patterns of behavior, thinking, and feeling that predispose drug use; the main social goal is to develop a responsible, drug-free lifestyle" (p. 21). He also defines several broad assumptions regarding recovery in the TC: recovery is a developmental process, focused on building client motivation, emphasizing self-help and mutual self-help, and employing social learning techniques. The characteristics and features described below are the basis of the instrument used to evaluate the Maryland RSAT program.

De Leon (1994) describes fourteen basic components of the TC approach:

1) Community separateness (an individual area for the members of the community: living quarters and/or classroom sessions);
2) A community environment (e.g., signs within the TC facility that describe the purpose and goals of the program);
3) Community activities (treatment services are provided within the community and in collective formats);

4) Staff roles and functions (staff, who should be a combination of recovering or conventional professionals, guide the direction of the treatment community);
5) Peers as role models (clients should emulate other "clients who demonstrate the expected behaviors" (p. 25));
6) A structured day (organized daily activities help put order in clients' disordered lives and leave less time for drug use and anti-social behavior);
7) A phase format (each level of the treatment program should reflect a step closer to recovery);
8) Work as therapy and education (clients are responsible for the daily maintenance of the facility);
9) TC concepts (the organized curriculum reinforces the TC perspective);
10) Peer encounter groups (the core style of TC therapy, they are used to heighten awareness of inappropriate attitudes or behaviors);
11) Awareness training (teaching the relationship between one's own behaviors on others, as well as the effects of other's behaviors on individual clients);
12) Emotional growth training (teaching clients to openly express and understand feelings);
13) Planned duration of treatment (length of treatment must be consistent with the goals of the clients' phase of recovery); and
14) Continuity of care (treatment which extends to aftercare in the community) (p. 24-26).

De Leon (1994) explains the types of interventions employed in the TC model, as well, which include activities that "are designed to produce therapeutic and educative effects" (p.27). He claims that there are three classes of interventions: 1) therapeutic and educative effects, which can be group or individual and encourage expressing one's emotions; 2) community and clinical management, which protect the psychological and physical safety of the community; and 3) community enhancements, which prepare the individual for release into the community. De Leon also identifies four characteristics of these interventions: 1) interactive interventions—the impact of the intervention is effected in its interaction with other activities; 2) formal and informal interventions—sessions can be planned or unplanned and run by either staff or residents; 3) community

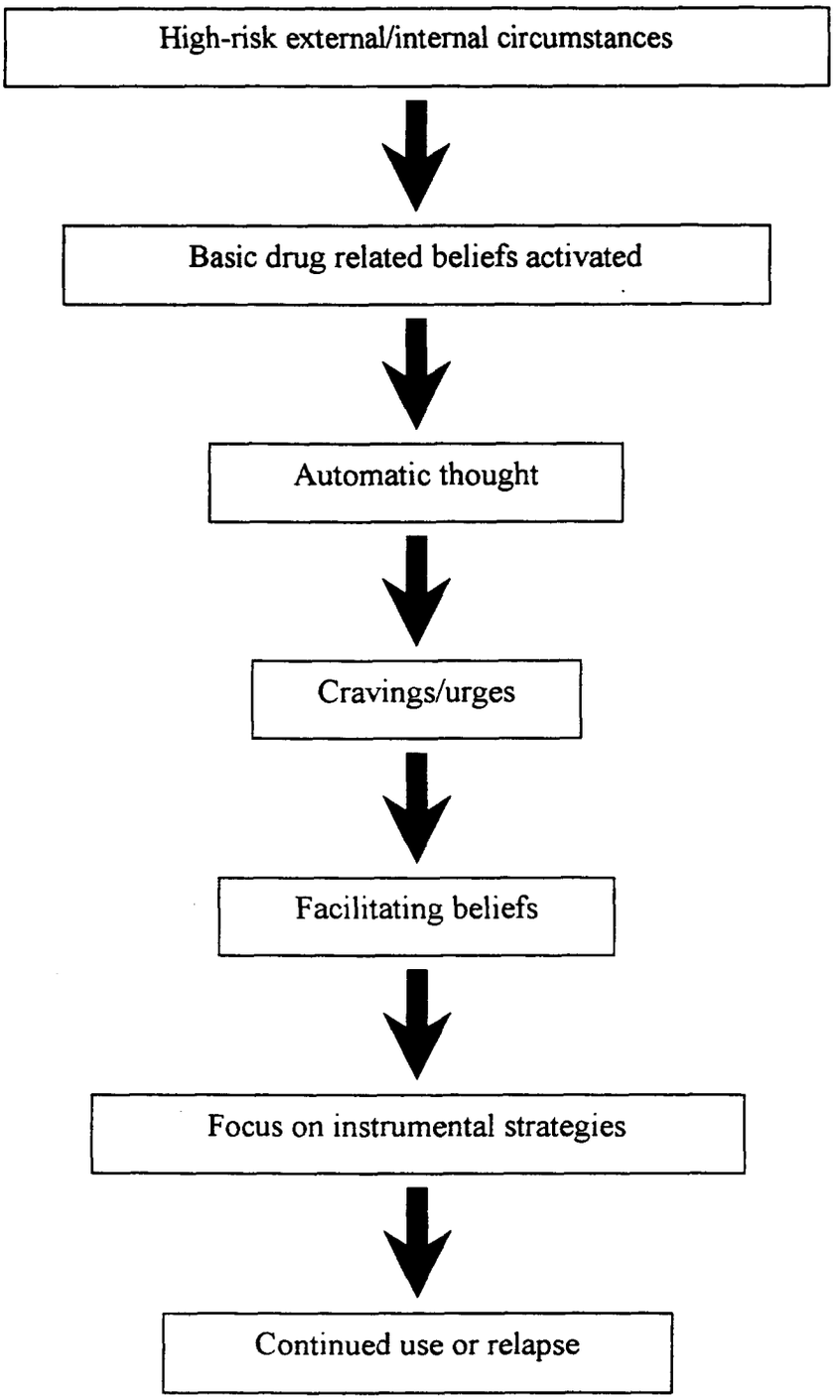
interventions—activities aimed at the general membership to the group; and 4) individually oriented interventions—activities dependent on the individual's behavior.

### C. Cognitive-Behavioral Approach Within a TC

Recently, there has been a change from the typical, yet less effective, TC based on the confrontational approach (tear the client down in order to build him/her back up), to the cognitive-behavioral approach. Wright, Beck, Newman, and Liese (1993) describe one form of cognitive-behavioral treatment, suggesting that beliefs are a central factor in the use and abuse of drugs and are thus crucial to a successful treatment approach. Specifically, Wright et al. (1993) propose, "The way an individual feels and behaves is largely determined by the way he or she construes his or her experiences"(p. 138). The following chart on page 7 describes Wright et al.'s (1993) cognitive behavioral model.

The chart shows that in the model, substance abusers' exposure to high-risk situations, such as exposure to drugs, can lead to continued use or relapse through the activation of drug-related beliefs (e.g., drugs can cure boredom), automatic thought to use drugs, cravings/urges to use, facilitating beliefs (e.g., everyone else uses drugs so it's acceptable), and instrumental strategies to acquire the drugs (e.g., find the drugs as quickly and easily as possible). This type of cognitive behavioral approach focuses on changing attitudes and beliefs from the anti-social to the prosocial.

# Cognitive Model of Substance Abuse
# (Wright et al., 1993, p. 140)



Because people who have addictive behaviors tend to progress and regress through these stages of change, Rawson, Obert, McCann, and Marinelli-Casey (1993) emphasize the importance of relapse prevention. The relapse prevention approach has been developed from a cognitive-behavioral framework and Rawson et al. (1993) describe seven specific content areas:

1. Psychoeducation;
2. Identification of high risk situations for relapse and the warning signs of relapse;
3. Development of appropriate coping skills;
4. Development of new, prosocial lifestyle behaviors;
5. Increased self-efficacy;
6. Dealing with relapse—Avoiding the "Abstinence Violation" effect; and
7. Drug/alcohol monitoring (p. 285-6).

A traditional relapse prevention model incorporates some or all of these content areas into its curriculum. Variations of the relapse prevention model have also been adopted. For instance, descriptive models that utilize case studies and clinical observations are used for a variety of substance abuse behaviors; drug-specific protocols target specific substance abuse disorders where the treatment outcomes are measured with standardized measurements; and integrated outpatient models that combine the above methods. Relapse prevention can be achieved through the continuum of care where latter phases tend to focus on triggers and high-risk situations. For example, concluding phases can consist of sessions that teach clients how to avoid situations (e.g., people, places, etc.) that will make it difficult to avoid relapse. Additionally, sessions can teach the client to identify his/her triggers, those things that will encourage the client to use.

## III. Effectiveness of TC Components

TCs have been discussed as being effective, although confrontational methods are not the favored method. Wells, Peterson, Gainey, Hawkins, and Catalano (1994)

compared the efficacy of relapse prevention programs with that of twelve-step recovery programs using alternative assignment in an outpatient group setting. They found that cocaine use for participants in both of these groups decreased over time. They also found that marijuana and alcohol use decreased for both treatment groups although there was a greater change in alcohol use in the twelve-step group at the six-month follow-up. Additionally, the authors examined the proportion of those participants abstinent at three time points: 1) after intake but before treatment; 2) twelve weeks following the start of treatment; and 3) six months post-treatment. They found that after controlling for baseline differences, the twelve-step group had a larger percentage of participants who were abstinent from alcohol at the twelve-week follow-up than those in the relapse prevention group. However, they also found that the participants in the twelve-step group increased their alcohol use from the twelve-week to six-month follow-up.

Condelli and Hubbard (1994) examined the findings of two studies on therapeutic communities: the Drug Abuse Reporting Program (DARP) and the Treatment Outcome Prospective Study (TOPS). Arrest rates and incarceration rates decreased for participants in both of these TCs after they completed the programs. They also found that the longer a client spent in a TC, the more likely they were to be employed full-time. Ultimately, they found that for every month that a TOPS client spent in the program, "there was a 6-percent reduction in the odds of their using heroin during the follow-up year" (p. 91).

Wexler, De Leon, Thomas, Kressel, and Peters (1999) compared the reincarceration rates of 715 male volunteers assigned to four different treatment groups and a control group. Inmates were randomly assigned to either a group intended to receive treatment and a control group. The control group consisted of those who had

volunteered but had not been selected for treatment. The TC treatment consisted of three phases. The initial phase, orientation and assessment, lasted 2 to 3 months, the second phase, increased responsibilities in the TC through hard work, lasted 5 to 6 months, and the third phase, preparation for return to community, lasted 1 to 3 months. Both the prison TC and the community TC used formal curriculum, psychodrama groups, video playback, and "lifers" as staff.

The four treatment groups consisted of: 1) prison TC dropouts (those who entered the prison treatment but did not complete it); 2) prison TC completers (those who completed the prison treatment but chose not to parole to the out of prison TC); 3) prison TC completers/aftercare TC dropouts (those who completed the prison treatment but did not complete the aftercare); and 4) Prison TC completers/Aftercare TC completers (those who completed both the prison treatment and the community treatment).

The researchers found that the "intent-to-treat group" had significantly lesser rates of reincarceration than the control group at both the 12- and 24-month follow-ups. Those in treatment group four (both prison and community TCs) had the lowest level of reincarceration for both of these time periods - 8.2% and 14% respectively. Wexler et al. (1999) also found that inmates who participated in any of the treatment groups "were 48% less likely to be reincarcerated within 12 months after release into the community" (p.161) and 37% less likely at 24 months. Of those participants who did return to prison, those in the control group had fewer days from release to reincarceration than those in the "intent-to-treat group." Wexler et al. (1999) concluded, "completing aftercare remained the largest and most significant predictor of positive outcomes regardless of client

contribution" (p. 162). They also concluded that the greater amount of time spent in a TC results in better outcomes.

Anglin, Longshore, and Turner (1999) evaluated a case management program, Treatment Alternatives to Street Crime (TASC), which "facilitates treatment for drug-using offenders as part of an overall strategy to control drug use and associated criminal behaviors" (p. 168). TASC is a community-based alternative for those who may become increasingly involved in the criminal justice system. In comparing TASC to the control group, Anglin et al. (1999) maintain that TASC was superior in reducing drug use at three of five sites. However, they did not find that TASC reduces property crime. The researchers do suggest TASC for those offenders whose behavior is a more serious problem in the criminal justice system.

**IV. Unanswered Questions**

While many evaluations of TC programs have found results suggesting that these approaches to drug treatment are effective in reducing criminal recidivism and subsequent drug abuse (Simpson, Savage, & Lloyd, 1979; Bale, Van Stone, Kuldau, Engelsing, Elashoff, & Zarcone, 1980; Lockwood, Inciardi, and Suratt 1996; Condelli & Hubbard, 1994; Martin, et al., 1995; Prendergast, Wellisch, and Wong, 1996; Nemes, Wish, and Messina, 1998) several questions remain regarding exactly how these programs achieve these positive outcomes. Even more important is the question of how these programs integrate a consideration of the change process with their interventions and program orientations.

As De Leon (1994) points out, the proliferation of programs calling themselves TC's confounds program evaluation results, as some of these programs are no doubt

substantially different (including many additional services and program components) from the traditionally conceptualized TC model. While evaluations of TC's commonly provide superficial descriptions of the program "on paper," few attempts have been made to quantify what actually occurs in these programs. Nor have attempts been made to examine how the use of these various TC components (as well as the more recent program additions) relate to various positive program outcomes. This longitudinal study spanning a six-month period records and evaluates what actually occurs in the TC as well as relating the TC components to program outcomes.

## Chapter 2 - Data Collection Methods

The process evaluation of the Maryland Residential Substance Abuse Treatment (RSAT) employs both systematic social observation (SSO) and traditional data collection methods to examine the implementation of the program longitudinally. The systematic social observations of the program provide an understanding of the nature of services delivered, whereas the empirical data yields an understanding of basic implementation of the program. Together the two provide a picture of the implementation of the RSAT program in this correctional facility in Maryland. This chapter describes the research methods used in this study. The first section details the SSO methodology, while the second section summarizes the methods used to collect client level data for this evaluation.

### I. Systematic Social Observation

Systematic observation in the field of criminology has been used to evaluate the social climate of correctional institutions (Moos, 1968), the efforts and culture of police (Reiss, 1971), and the development of a catalog of signs of physical and social disorder on city streets (Raudenbush, 1997; Taylor, 1997). Developed from the ethnographic methods of those working from the "Chicago School" tradition of sociology and criminology (Shaw, 1930; Sutherland & Conwell, 1937), systematic social observation attempts to record, in an objective, quantifiable manner the characteristics of a given social environment. According to Mastrofski, et al., 1998:

> The main procedures for SSO...include selection of problems for investigation, preliminary investigation by direct observation (optional), definition of the universe to be observed, sampling for observation, development of instruments to collect and record observations systematically, provision of measuring error,

> pretesting instruments, organization for direct field observations, processing observations, and quantitative analysis (p.3).

Systematic social observation differs from traditional ethnography in its requirement that the data is observed and gathered in a structured format based on previous experience with the phenomenon in question, or by existing theoretical constructs. Traditional ethnography is suited to the initial exploration of a phenomenon, and the qualitative data derived from it are better used to form initial hypotheses about the potential relationships between observed events. As noted by Mastrofski et al. (1998), the data developed from SSO, which can be coded and subsequently quantified, are better suited to the testing of such hypotheses.

Mastrofski et al. (1998) suggest that the initial step in SSO is to determine and explore the area under observation. Particularly for policing studies, early, unguided observation of police work helped researchers define those areas of exploration that would be of interest. For example, the exercise of informal police discretion has been a widely researched topic in the policing literature (see Reiss, 1971; Smith, 1986 as examples), however this issue might not have been considered important had early ethnographic studies of police behavior revealed that the practice was common. Fortunately, in the field of correctional substance abuse treatment, the areas for observational study have been well defined by prior evaluation research and theoretical work describing the proposed internal and external mechanisms contributing to recovery and rehabilitation. Thus, the current study was able to use prior research as a base from which to begin defining the scope and content of the issues to be studied through systematic observation (see the introduction for a sample of the specific studies).

In discussing the application of SSO to the study of police behavior, Mastrofski and colleagues review the advantages and disadvantages of SSO over other traditional survey or archival data methods. In particular, they note that SSO data is gathered independent of any influence of the subjects under study. For instance, when using archival data on police behavior, such as arrest data or complaints filed against officers, the recording processes of officers themselves are allowed to influence the quality and reliability of the data that is stored and eventually analyzed. In SSO, the officers' behavior is observed firsthand and the effects of such official filtering are diminished. Similarly, SSO allows for the study of subjects, and their behavior, in the natural setting, rather than asking about hypothetical situations or using artificial laboratory simulations. Finally, researchers using the SSO method can make and record their observations using systematized procedures that other scientists could replicate. In this way, many researchers could ideally be employed to study the same phenomenon, and their results could be assumed to be comparable and reliable, rather than a single observer having to conduct all the observations.

Regarding potential disadvantages of the SSO method, at least regarding police behavior, Mastrofski and colleagues suggest that subject's reactivity (to being observed) may potentially invalidate the observational data. The researchers, however, report that from their own experience police officers generally acclimate to being observed relatively quickly. As support for this claim, they cite incidents in which police officers have been observed to commit minor, and in some instances, major acts of misconduct while accompanied by a trained observer. This same issue is obviously a potential problem for evaluations of correctional environments as well, as both clients and staff

may be expected to have motivations to present themselves or their programs in certain, biased ways. Mastrofski et al. (1998) suggest that assurances of, and conspicuous adherence to, standards of confidentiality are effective ways to reduce potential reactivity biases.

Mastrofski et al. (1998) also point out that the nature and extent of the observation requirements can be a potential problem affecting the accuracy and reliability of the data gathered. For instance, observers are often expected to attend to multiple aspects of complex human social interactions, as might occur between police and citizens or suspects. Keeping clear all the possibly relevant factors to be examined (and eventually coded) can become an onerous task that can overwhelm even the most highly trained observers. In observing correctional treatment environments, this is no less likely to be a problem. For example, observers may be required to observe the actions and interactions of counselors, jail staff, and treatment clients, as well as rate various qualities of the physical and social environment and the treatment program. Clear and sometimes relatively extensive training in the observation methodology, such that the observers become familiar and comfortable with the underlying concepts of interest and the specific instruments to be used, can help to reduce the demands on observers' attention.

Aside from the extensive work by authors such as Mastrofski et al. (1998), Reiss (1971), and others in the field of policing, several other noteworthy attempts have been made to apply SSO techniques to the study of other criminological issues. In one of the earliest attempts to quantify characteristics of the social environment in correctional setting, Moos (1968) developed the Moos Social Climate Scale. This paper-and-pencil survey was developed after trained observers first rated various characteristics of several

different types of correctional institutions. Scale items were derived from these structured observations (as well as interviews with residents and staff, and prior empirical work on the functioning of these units) and were eventually administered to both facility residents and staff. This scale was found able to effectively differentiate several types of correctional institutions (e.g., boys' training schools from juvenile detention halls), based on several important characteristics commonly associated with the social environment in each type of facility.

In another example of the application of systematic social observations, Raudenbush (1997) attempted to apply the technique to the measurement of variables related to social disorganization theory. Raudenbush makes the important point that psychometric procedures for assessing the validity and reliability of paper-and-pencil personality measures, for instance, have not been applied to observational measures of the environment. Raudenbush and colleagues then attempted to apply the techniques typically used to assess these desirable characteristics of psychological measures to an objective, observational method used to quantify signs of social and physical disorder in several areas of Chicago. Raudenbush's data collection method included sending two trained observers to several randomly selected "neighborhood clusters" in Chicago. These observers not only completed in-person ratings of various physical and social disorders, but they also videotaped each side of the street as they drove slowly by each block of these "neighborhood clusters" in a van.

After a team of ten trained researchers coded data from the videotape regarding items such as the presence of garbage on the streets (an example of a physical sign of disorder) or the number of adults seen loitering on the street (a social sign of disorder),

Raudenbush and colleagues were able to compare the two scales in terms of reliability and validity, using various techniques. For instance, Raudenbush found that the physical disorder scale tended to exhibit better psychometric properties than the social disorder scale. In particular, many items on the social scale were rarely rated as present in the neighborhoods (only one item, adults loitering was commonly seen), while the occurrence of physical signs of disorder demonstrated much more variability. For example, cigarettes in the street were seen frequently, while the presence of gang graffiti was relatively less common. Across scales, items that were less commonly observed were inferred to be more severe indicators of disorder. These authors also found that the two scales were significantly correlated ($r = .58$); however, they did not appear to represent a single dimension. In general, Raudenbush and colleagues found that the physical disorder scale behaved better psychometrically, was more reliable, and its items exhibited more variability than did the social disorder scale.

Overall, while several attempts have been made to utilize systematic social observation techniques in criminology, the use of this technique could easily be described as in its infancy. The technique has been infrequently used basically due to its newness and cost. Similarly, Mastrofski et al. (1998) suggest several policy-relevant applications for this type of technique, particularly in regards to the study of police behavior. To the extent that traditional correctional treatment program outcome evaluations have made little use of structured observational techniques (particularly in assessing the relationship between specific program characteristics and recidivism/substance abuse outcomes), they may have missed a potentially invaluable source of data. Indeed, the prior review of drug abuse treatment outcome studies (see Chapter One) revealed that few of these evaluations

provided detailed, objective descriptions of the day-to-day activities incorporated into these programs. The current study reports on the development and implementation of one such methodology for objectively quantifying characteristics of these correctional programs.

## II. Observation Methodology

### A. Purpose of the Observations

The purpose of these observations was to examine the integrity of this modified therapeutic community longitudinally, over a six-month period. Researchers attempted to measure the effectiveness and quality of treatment services. The observer measured several aspects of the residential treatment program that were drawn from the literature describing the TC model of drug treatment. These treatment aspects included the program emphasis, the philosophy of addiction and approach to treatment; view of the residential community, the manner in which the community itself is used as a treatment tool; treatment activities, the types of activities conducted; treatment topics, the topics discussed in treatment meetings; treatment style, the manner in which treatment activities were conducted; and items tapping the individual counselor's style. The observation instrument was developed specifically to measure the above concepts as they are implemented in a prison-based residential substance abuse treatment program.

### B. Observation Instrument

After reviewing the literature on the purpose and intent of a Therapeutic Community (TC) for the treatment of drug-involved offenders, as discussed in Chapter One, the evaluators developed an observation coding-sheet, which tapped the critical components of the theoretical model of the TC. Theoretically, the goal of a TC is to use

the peer community to assist offenders/addicts in acquiring prosocial values. The instrument was developed to tap into areas of programming that are designed to achieve this goal: Program Emphasis, Treatment Topics, Treatment Activities, Treatment Style, and View of the Residential Community (see Table 1 for a description of the areas included on the instrument). Within each area, several items were selected which reflect the specific category. Within each of these categories, several specific variables were assessed (see Appendix A for a copy of the instrument and Appendix B for a copy of the operational definitions of each item).

Table 1

Five Components of the Structured Observation Instrument

| Category | Definition |
|---|---|
| **Program Emphasis** | Describes the program's philosophy of the substance abuse disorder (e.g., free will vs. deterministic; disease vs. moral failing, etc.) and the specific stage of recovery the program concentrates on. Focuses on techniques and methods the client will use to change his/her behavior. |
| **Treatment Topics** | Describes the types of material presented to the client to assist in the recovery process, such as a discussion of recent incidents on the living unit, emotional skill development, psychological safety issues, value clarification, etc. |
| **Treatment Activities** | Describes the use of different mediums to engage the client in the treatment process, such as video tapes, check-ins, peer encounter groups, relapse prevention exercises, diaries, good-bye letters, etc. |
| **Treatment Style** | Describes the use of formal or informal styles of interventions to assist the client in making changes. Also includes items such as whether the program employs interactive or introspective approaches. |
| **View of the Residential Community** | Describes the use of specific roles and responsibilities for members of the treatment community, as well as assessing how the group works as a community. Common roles may include group leader (e.g., runs the treatment sessions and maintains order), orientation guide (e.g., acquaints new members to the TC), and facilitator (e.g., organizer of all activities). |

### C. Coding of Observation Items

Items from the five scales on the instrument were rated on three dimensions: use, consistency, and effectiveness (each on five point Likert scales)[1]. The "use" dimension refers to the degree to which a particular program component was used in a given treatment session, where a score of "1" indicates the item was used only briefly, while a rating of "5" indicates the item was used heavily throughout the meeting[2].

[1] The preliminary results from an examination of the "use" ratings are presented in the current paper. Consistency was defined as whether the item was implemented in a manner consistent with the goals of the TC; specifically, was the item implemented in a way that emphasized the peer group and the development of prosocial values. Effectiveness was defined as whether the item was implemented in a manner judged to be thorough and productive.

[2] Variables assessing counselor style measured how much the observers perceived the counselor to exemplify each of several stylistic descriptions (e.g., confrontational, experienced, lax) using a seven point Likert scale. In this case, a "1" indicated that the counselor was perceived as "not at all like" the adjective, while a "7" indicated that the counselor was perceived as very much like" the specific descriptive term.

These observation dimensions are designed to assess both the frequency of use, as well as provide a qualitative assessment of how well each item achieves the intended purpose of a TC. Thus, we hope to address the question of whether certain aspects of the TC are presented, as well as whether their presentation fulfilled the goals of the theoretical TC program. A key concern here is assessing the emphasis on the traditional goals of the TC and the extent to which information and program materials are thoroughly processed during treatment activities.

**D. Observation Schedule**

A single rater attended meetings involving program participants and recorded her observations in each of the five areas (plus counselor style) on the observation code sheet. The rater sat in treatment sessions, but did not participate in the meetings themselves. At the first meeting, the observer introduced herself to the group members, who in all cases had been informed that their meetings would be observed beforehand. Introductions informed the TC participants that the observer was there to observe the program to understand how a TC program operates. In addition, the members were assured that the observer would observe strict rules of confidentiality and would not identify any of them by name.

The program was observed for a 12-week period (the amount of time to complete a single treatment cycle, Phase I), as well as three sessions in the last three months of the program (Phase II). A program schedule was obtained prior to the start of the site visits and the observer attended 2 to 3 meetings per day, during Phase I. For the first four weeks of the program (Phase I, Level A), the researcher observed, on average two sessions a day, four days a week, along with community meetings when possible. For the

remaining eight weeks of Phase I, the researcher observed three classes a day, twice a week, along with community meetings when possible. In Phase II, the researcher observed classes once a month for the remaining twelve weeks of the program, including the graduation ceremonies.

At times, staff absences interfered with the observation of planned meetings. While disruptive to the planned observation schedule, these types of disruptions to the program themselves provide useful information about the environment in which these programs operate. Thus, while it was not possible to observe every scheduled treatment activity over the entire 12-week period, the length of the site visit itself helped ensure that a relatively representative sample of each type of meeting (e.g. educational, clinical, community-run) offered by the program was observed.

**E. Multiple Observations and Inter-Rater Reliability**

By nature, the ratings of how much a topic or activity is "used" are likely to be more reliable across raters, as they require less potentially biased, individual judgment, relative to ratings of "consistency" and "effectiveness". Reliability analyses were computed for several meetings in which a second rater was used. However, the majority of observations included in the final data set were observed and rated by a single observer. Issues regarding inter-rater reliability are discussed further in the Results section that follows.

A second observer rated several meetings so that reliability analyses could be conducted on the reliability of the observation method. Table 2 displays a measure of the inter-rater reliabilities associated with each set of "Use" ratings. To create this measure of reliability, each item in the five subject areas was compared across raters. The

percentages associated with each subject area represent how often the two observers' ratings agreed. The criteria for agreement was set at one Likert scale-point, with the assumption that ratings within one point of each other represented at least agreement on which end of the Likert scale (high or low) the item should have been rated. As expected, it appeared easier for the raters to reach a consensus upon some items than others. In addition, many of the items were not rated by either rater, thus while correlations cannot be run on non-existent data, these similar patterns of "non-rating" themselves provide evidence of inter-rater reliability.

Comparisons of topic areas show that there is a high percentage of agreement between both observers for all five-topic areas. Thus, the reliability of the measures is high.

Table 2

Percent of Scale Items Rated Within 1 Scale Point by Both Raters

| Scale Name | Number of Items | Percent in Agreement |
|---|---|---|
| **Program Emphasis** | 11 | 100.0% |
| **Topics** | 18 | 88.9% |
| **Treatment Activities** | 18 | 94.4% |
| **Treatment Style** | 10 | 80.0% |
| **View of Residential Community** | 9 | 77.8% |

### F. Analysis of Observational Data

The average rating for "use" of each item across all meetings, by program phase, was calculated as a measure of the extent to which the RSAT program utilized various program characteristics. In order to assess the change in the utilization of each of these

characteristics, t-tests were conducted comparing the difference in means from Phase IA to IB. These results are presented in Chapter 5.

Examining the pattern of results allows us to begin to understand the types of activities and treatment topics employed at the site and also how the program changed from Phase IA to Phase IB. In addition, information gathered from the structured interviews, along with the data reported by the site regarding characteristics of the offenders (recidivism rates, length of stay in treatment, etc.), is included in Chapter 4 to further describe the characteristics of the program. Similarly, the summary (Chapter 6) reviews general conclusions and makes recommendations for the future of this type of program.

## III. Other Evaluation Methodologies

In addition to the structured observation methodology, RSAT staff completed and submitted to the evaluators various data forms pertaining to several aspects of the RSAT program (e.g., graduated sanctions, drug testing, continuum of care). The observer also conducted semi-structured interviews with the clinical director and the inpatient coordinator, over the course of the 12-week observation period. Finally, the observer compiled daily field notes describing the treatment interventions and other anecdotal information regarding the operation of the program.

### A. Data Collection on Client Characteristics and Program Practices

The researchers also used traditional data collection methods to examine the implementation of the RSAT program in this facility. The program submitted monthly information on each client participating in the RSAT program. These monthly forms were designed to measure various aspects of the program, including drug testing, graduated sanctions, the continuum of care, as well as client demographic, criminal

history and drug use characteristics. Data collection began in January 1997 and continued until June 18, 1999.

- Client Characteristics: The characteristics include: age, gender, ethnicity, sentence information, criminal history, treatment history, and drug of choice.
- Treatment Entrance and Discharge: Treatment movement data refers to the date of entrance into RSAT, discharge date, discharge reason, and continuation into programs in the community.
- Sanctions: The data indicates type of infraction behavior and type of responses by the treatment program or correctional staff.
- Drug Testing: This information contains date of drug testing, type of drug and result of drug test.

From this data, the researchers calculated the length of time in the program and the continuum of care rate. The continuum of care rate reflects the unique aspects of RSAT, which is designed to begin the treatment process in prison and continue in the community after release from the facility.

In addition, the researchers collected information on incarceration and arrests. The incarceration information includes the date of entrance and discharge from the prison. Arrest information contains the date of the arrest and nature of the arrest. This data was used to assess re-arrest rates after participation in the RSAT program.

**B. Structured Interviews**

Interviews were conducted with the clinical director and inpatient coordinator. In general, the interview instrument asked subjects about their impressions of the purpose of the prison and the TC within the prison setting. In addition, general information about the size of the program, the average length of stay, the types of activities used, and whether the subject felt any changes could be made to the program was solicited during the interview. Similarly, subjects were asked to relate any problems that were encountered in setting up or running the program, as well as information regarding the

cooperation and relationship between the security and treatment program staffs. Appendices C and D contain the Clinical Director and Inpatient Coordinator interviews, respectively.

## Chapter 3 - Site and Program Design Overview

This chapter will describe the program and the facility, as well as how the program is implemented. In particular, the chapter describes the physical setting, the program schedule and curriculum objectives. In addition, the chapter reviews various RSAT practices, including client requirements and selection processes, client incentives, aftercare, and drug testing procedures.

### I. Site and Program Description

The Maryland Residential Substance Abuse and Treatment (RSAT) program is located at the Central Laundry Facility (CLF) in Sykesville, Maryland and is designed to provide treatment services to eligible prison inmates who are substance abusers. The CLF is a 498-bed minimum-security prison and as of January 11, 1999 housed 496 male inmates. This facility was opened in the late 1960s and the RSAT program began in October 1997. Over the course of the observation period, there were no specific limits set on the number of clients that could be served in the RSAT program. As of January 6, 2000, the RSAT program had funding for thirteen treatment providers.

#### A. Physical Setting

In December 1998, the RSAT treatment program's assigned classroom space was moved from within the facility itself to a new trailer located on the prison grounds. The classroom trailer is connected to the main prison complex (Building B, where most of the RSAT inmates are housed) by an outdoor walkway. Clients are only allowed in the trailer when they have either individual or group treatment sessions. When treatment activities are scheduled, officers send the clients from their living units to the trailer. Clients must sign-in with the correctional officer when they enter the trailer. Whenever

treatment staff members are in the trailer, a correctional officer is posted at the door with a telephone and radio. Typically, a different officer is posted to the program unit each day.

There are three classrooms in the trailer and all are in use at the same time during the program. Each cycle (group) meets in their own classroom whenever they come for a group session. The first classroom is approximately 20x20 feet and has no windows. It is arranged with about 20 plastic chairs set up in a circle along the walls. There is a TV/VCR and sometimes a portable chalkboard in the room and inmates' poems from other cycles are hung on the walls. This first classroom is separated from the second classroom by a divider. The second room is similar to the first, except that it has a 2' x 4' window and a portable "dry-erase" board. Three tables are arranged in a U-shape with chairs around both sides. Similar to the first room, there is a TV/VCR cart and participants' poems on the walls. The third room is about the same size as the other two. It has a portable chalkboard and three tables in an 'L' shape, with chairs around both sides of it. There is a door to outside of the trailer with a small window in it. The inside doors to the classrooms are usually closed at the start of the session, but are sometimes left open.

**B. RSAT Staff Qualifications**

In order to be eligible for employment as an Addictions Counselor II, potential applicants must have graduated from high school or possess a GED. Additionally, they are required to have three years experience providing counseling in health care or at a treatment center, with one of these years involving drug and alcohol treatment. The remaining two years can be substituted with an Associate's degree or a minimum of sixty

credits, eighteen of which must be in health and human services, education or behavioral science. This position was designed to be contractual with no benefits. These MD RSAT counselor qualifications are identical to the qualifications for other state of Maryland clinical services programs.

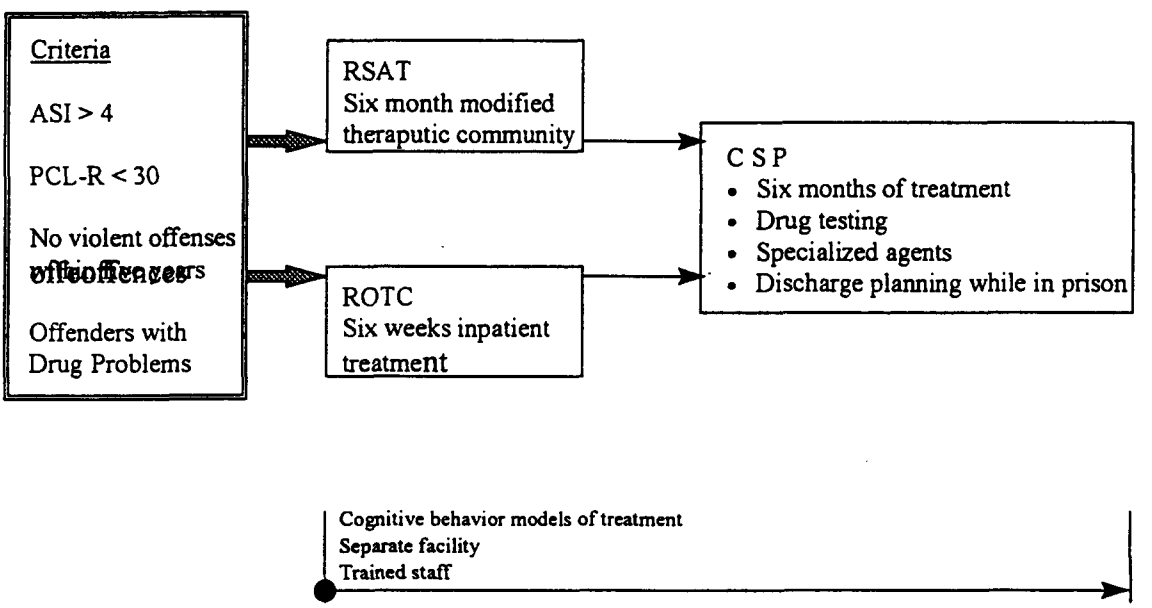
### C. Intended Program Design

According to the stipulations of the Maryland RSAT grant the program is to have the following components:

1) Designated living and treatment space in a separate minimum security facility;
2) A minimum of 20 hours of treatment a week;
3) Discharge planning by the parole agent;
4) Treatment placement in the community and intensive supervision through the Department of Probation and Parole/Clinical Services Division;
5) Drug testing in the community;
6) Cognitive-behavioral and social skills approach.

The following figure charts the process that a prisoner in the Maryland prison system would follow for treatment within this system.

# THE MARYLAND TREATMENT STRUCTURE FOR PRISONERS




### 1. Program Phases

There are two phases and four levels in the six-month RSAT program. Each phase is twelve weeks long. Phase I consists of levels A and B. Level A is scheduled to last eight weeks and Level B for four weeks. In Phase I, the program is designed to deliver twelve hours of group counseling and one hour of individual counseling each week. Phase I of the program is also designed to educate the inmates about drugs and alcohol, to teach them the adverse effects of their substance abuse, and to motivate them to change. Table 1 displays information on the schedule of treatment activities. According to Table 1, the emphasis in Phase I is on Feelings, Recovery, Social Skills, and Anger Management.

Table 3

Number and Type of Classes Offered to Maryland RSAT Clients

| **Program Phase** | | | | |
|---|---|---|---|---|
| | **IA** | **IB** | **IIC** | **IID** |
| Hours of Group Sessions Per Week | 12 | 12 | 3 | 3 |
| Hours of Individual Sessions Per Week | 1 | 1 | 1 | 1 |
| **Type of Session** | | | | |
| Crime and Drugs | XX[1] | | | |
| Feelings | XX | XX | | X |
| Denial | X | | | |
| Recovery | XX | XX | | |
| Anger Management | XX | X | | |
| Social Skills | XX | XX | | |
| Decisions | X | X | | |
| Abuse | | X | | |
| Family Issues | | XX | | |
| Drug and Alcohol Education | | X | | |
| Stress/Time Management | | | X | |
| Employment Readiness | | | X | |
| Relapse Prevention | | | X | X |
| Community/Family Support | | | | X |
| Community Meetings | XX | XX | X | X |

[1] One 'X' equals one meeting per week.

In Phase I of the program, inmates are paid $.90 a day (at the beginning of the following month) for attending RSAT classes.

Phase II consists of Levels C and D, which are also eight and four weeks long, respectively. In Phase II clients attend a community meeting once a week. Phase II is designed to deliver three hours of group counseling and one hour of individual counseling each week. These activities are conducted during evening hours so that the program participants can work during the day. The emphasis in Phase II is on teaching

the inmates to maintain sobriety, as well as to adjust to life out of prison, by having them participate in a structured daily routine. According to Table 3, in Phase II there is a focus on Relapse Prevention. By working during the day and attending treatment sessions in the evening, the program attempts to help inmates develop a similar lifestyle to the one they will ideally have when they get out of prison.

If the prison has jobs available, inmates are required to work in either sanitation, on the road crew, at the training academy, police barracks, barber shop, weigh station, or the laundry. The only exception occurs when the inmate is participating in the GED program. An inmate cannot participate in both the GED program and work. In Phase II clients are paid between $.85 and $2.55 a day, depending on their type of job.

**2. Curriculum Objectives**

The goals and objectives of four classes listed below are directly from the Clinical Services Program Module Contact Notes. The program has no written goals and objectives for the remaining eleven of fifteen sessions, which includes the community group[3]. The RSAT program does not have its own curriculum. The unanswered question is how the RSAT program differs from the six-week ROTC program.

**Phase I**

1) Social Skills—To teach participants more socially appropriate behaviors. It does this by increasing each participants (sic) awareness of social mores and expectations, as well as the impact their personal styles have upon others in the group. Upon completion of this module, participants should be more comfortable and more adept with situations they are likely to encounter within the community to which they'll return.

2) Decisions—To teach participants to think ahead. Many ROTC [RSAT] patients never developed the capacity to anticipate the future consequences of

[3] After the draft of the report was completed (2/17/00), program staff produced contact notes for the other eleven modules.

their behavior, or to plan accordingly. Patients who have completed this module are expected to structure their time more effectively and constructively, avoid repeating old mistakes, understand the relationship between emotions and judgment, and to maintain better control of their tempers.

3). Drug and Alcohol Education—To teach participants about the *effects* of drug and /or alcohol abuse. Patients who have completed this module are expected to have a *better understanding* of the harmful effects of drug/alcohol abuse, and as a result, be better able to *resist* future use.

**Phase II**

4) Relapse Prevention—To teach participants about the *triggers and cues associated* with drug and/or alcohol use. It is focused upon physical, psychological, and social/community factors. Patients who have completed this module are expected to have a *better understanding* of the *temptations* of drug/alcohol abuse, and as a result, be better able to *resist* future use (Clinical Services Division, 1999).

## II. RSAT Implementation

The RSAT program is run by the Clinical Services Program of the Department of Public Safety and Correctional Services which has three components: the treatment delivery component (treatment program); the Assessment Division; and the Traffic Office. The Assessment Division assesses potential clients for suitability for various treatment components using the Addiction Severity Index (ASI) and the Hare Psychopathy Checklist (PCL-R). The Traffic Office is a part of the Division of Clinical Services and manages and tracks all inmates through the treatment system. The DOC Case Management staff collaborates with the Clinical Services staff to admit inmates to the RSAT program.

### A. Selection of Clients

All Maryland prisoners are assigned a case manager when they enter the prison system. Case managers have the responsibility of screening inmates for substance abuse

problems. If the case manager deems it necessary, the Assessment Division will assess the inmate and then provide the results to the Traffic Office. The Traffic Office determines an inmate's eligibility for various programming within the prison system from this initial assessment and places the inmate into an appropriate clinical services program (e.g. RSAT). According to the inpatient coordinator (Sato, Personal Communication, April 27, 1999), RSAT program staff have no input in the client selection/assignment process for the RSAT program.

Usually, the inmates in the RSAT program serve a sentence at another facility and then are sent to the CLF to participate in the RSAT program. Clients can be re-assigned to an RSAT cycle even after they have participated in, but not graduated from, a prior treatment cycle in the RSAT program (Sato, Personal Communication, April 27, 1999). Client participation in this program can be either voluntary or mandated[4]. For example, the program can be mandated for those who have a parole stipulation or the Traffic Office can recommend it. Inmates learn of the program either through other inmates or if their parole officer suggests it prior to their release.

**B. Placement Procedures**

When a new RSAT cycle begins, the RSAT inmates are put in dormitories with available bunks that house all inmates. The staff tries to place all of the RSAT inmates in the B Building on both levels but non-RSAT inmates also occupy this area. The RSAT inmates do not have separate living quarters but can socialize with each other at all times (except at "lock-down" and at "count times"). While in the CLF, the inmates are allowed to wear their own street clothes, shoes, and jewelry.

[4] According to Senate bill 61, since October 1, 1999, the program is mandatory for those who are recommended.

### C. Client Requirements for Participation in RSAT

There are several characteristics that inmates must have in order to be considered for the RSAT program. First, the male inmate must be between ten and twenty-four months of his release from prison. He cannot be serving a life sentence or a life sentence without parole. Also, he must be able to be classified as minimum-security status to be admitted to a pre-release facility. Next, potential participants must be able to benefit from group treatment, which excludes those inmates with psychopathy. The Clinical Director cites research that suggests that psychopaths do not do perform well in group settings. The inmate must have a PCL-R score less than 30 and an ASI score greater than three for severity of drugs and alcohol use. An ASI score above three indicates a substance abuse problem. Anyone who is to be considered for the RSAT program must reside in Maryland after his or her release.

### D. Program Size

As of December 31, 1998, 209 clients had participated in the RSAT program. Of these 209 clients, 101 had been discharged and 73 were still at CLF. Disposition data were unavailable for the remaining 35 clients. At the time of the observation (January 11, 1999), there were 89 inmates in the RSAT program (42 in Phase I and 47 in Phase II) and seven counselors, including six female counselors (five African American) and one male counselor (African American).

### E. Incentives for Client Participation

Many inmates are willing to start the RSAT program because, like many prison-based programs, they either receive diminution ("dim") credits (toward the lessening of their sentence) or are paroled early because they were in a treatment program. If an

inmate completes the six-month RSAT program, between 53 and 60 dim credits are awarded (depending on the day of the month that they started the program). These credits can be used for early release if an inmate is released on a mandatory sentence. If they are released on parole, they do not need these credits because they will get out of prison before their mandatory release dates comes up. These credits can also be taken away if the inmate receives a "ticket" (infraction) for poor behavior. Some inmates are released after the six-month program, while others return to the general population at CLF or back to the facility from which they came.

**F. Drug Testing Procedures**

Inmates are randomly drug tested at least twice a month in both phases of the program (Sato, 1999). A positive test at any time during the program results in immediate dismissal from the program, as well as a transfer from the correctional facility to a more secure facility. Thus, once a client tests positive for drugs, the treatment program has no control over the situation, as it becomes a correctional matter.

**G. Aftercare Procedures**

As part of the RSAT program, clients are required to attend six months of outpatient treatment after their graduation from prison-based treatment. Shortly before graduation, the RSAT counselors complete a discharge plan for each client. The discharge plan includes a recommendation for outpatient treatment placement in either an Intensive Outpatient program (IOP) or a residential facility. This plan is then shared with the appropriate community treatment providers, however the counselors have no direct contact with the aftercare treatment providers. The counselors' responsibility for treating these offenders ends once they move to the IOP or residential facility. The CSP's Traffic

Office maintains tracking of these offenders' progress. Thus, the RSAT staff have no knowledge of the progress of their clients once they leave the program.

The traffic officer keeps track of when clients will be released from prison and places them in an aftercare treatment program, based on the counselor's recommendation. The counselor specifies the type of treatment, while the traffic officer determines the location of treatment. Clients have no choice in the type of treatment but may have a choice in the location of treatment. According to the Clinical Director, ninety percent of the clients are placed in IOP. Clients may also go to a Reentry Aftercare Center (RAC) if there is an available space in the RAC in their jurisdiction. RAC is a three to six month outpatient services program. Also, according to the Clinical Director, only those clients who have a substance abuse problem will be referred to a halfway house. Thus, the absence of a job or a residence is not a factor in placement in a halfway house (Spingarn, Personal Communication, April 13, 1999).

## Chapter 4 - Results- Program Implementation and Client Characteristics

This chapter contains information on the manner in which the program was implemented, particularly the schedule of treatment activities, as well as the characteristics of the clients involved in the program. In addition, information on various program activities such as drug testing, the use of graduated sanctions, and the transition of clients to subsequent treatment services are also provided. Much of this information was collected using various forms completed by the program staff.

### I. Treatment Schedule and Meeting Types

The observer followed one cycle (Cycle 15) over the six-month observation period and attended classes solely with this group. Because one researcher observed the same cohort for the entire six-month period, the participants became comfortable with the observer and adapted to her being there. As of January 11, 1999, the average group consisted of 13 clients. Soon after the entrance of Cycle 15, the coordinators began to make the groups larger in order to increase the number of inmates receiving the program's services. When this cycle entered RSAT, they were unusually large at 17 clients, however at their graduation, 14 participants remained. Cycle 15 started the RSAT program January 11, 1999 and graduated on June 23, 1999. They began Level B on March 8, Level C on April 5, and Level D on May 31. Their last day of treatment was June 24, 1999.

During the first six classes over the first two days of the program, clients received instruction from six different counselors. While an orientation meeting was conducted on the Friday before this first week of treatment, on the first day of treatment the inmates did not yet know the counselors well, nor were the counselors familiar with the clients at this

time. In fact, over the first few months the counselors frequently did not know the clients' names, which in many instances appeared to upset the clients.

### A. Phase I

In Phase I, the RSAT participants attended classes three times a day, four days a week. According to the stipulations of the grant that funded this program, clients were to be offered 20 hours of treatment per week. The typical treatment meeting lasted for one hour, for a total of 12 hours of group treatment per week. Despite the program design, which calls for one hour per week of individual counseling, the counselors were not observed to meet with their clients for individual sessions of an hour a week, in either phase of the program. More often than not, these meetings were scheduled for (and lasted) less than half an hour. The individual sessions are usually scheduled for half-hour increments. In addition to these scheduled group treatment activities and individual session, clients participated in two "community meetings" per week, each of which generally lasted for less than 15 minutes. Overall, the program provided a total of approximately 13 hours of treatment per week, in contrast to the 20 hours per week of treatment the program was designed and funded to provide.

As of January 11, 1999, the inmates attended one-hour classes at 8:30 a.m., 10:30 a.m., and 1:30 p.m. Monday, Tuesday, Thursday, and Friday as well as approximately fifteen-minute community meetings on Monday at 11:30 a.m. and Wednesday at 3:45 p.m. Each week during Level IA, clients attended the following classes: Crime and Drugs (twice weekly); Feelings (twice weekly); Denial (once weekly); Recovery (twice weekly); Anger Management (twice weekly); Social Skills (twice weekly); and Decisions (once weekly). During Level IB clients attended classes on: Abuse (once weekly);

Feelings (twice weekly); Family Issues (twice weekly); Recovery (twice weekly); Anger Management (once weekly); Social Skills (twice weekly); Decisions (once weekly); and Drug and Alcohol Education (once weekly).

Written goals, topics, and procedures were not completed for the majority of these types of classes, even though the program had been running for approximately two years by the start of the observation period. Four written descriptions of these types of classes (Social Skills, Decisions, Drugs and Alcohol, and in Phase II, Relapse Prevention) were provided to the observer (These are discussed in Chapter 3 - Curriculum Section.). The remaining six class types did not have written descriptions completed as of the end of the observation period.

Because of the staff shortage, the coordinators decided to temporarily limit the number of classes to two a day. As of March 29, 1999, Phase IA attended the following classes at 10:30 a.m. and 1:30 p.m. on Monday, Tuesday, Thursday, and Friday along with two community meetings: Crime and Drugs (twice weekly); Recovery (twice weekly); Anger Management (once weekly); Decisions (once weekly); Feelings (once weekly); and Social Skills (once weekly). Phase IB attended: Family Issues (twice weekly); Drug and Alcohol Education (twice weekly); Recovery (twice weekly); Decisions (once weekly); and Feelings (once weekly).

**B. Phase II**

In Phase II, the participants attended classes once a day, three times a week. As of March 29, 1999, clients in Phase II level C attended the following classes once a week: Stress/Time Management; Employment Readiness; and Relapse Prevention, while those in level D attended once a week: Community and Family Support; Relapse Prevention; and Feelings. Treatment classes in Phase II are conducted during the evening hours

because clients in this phase are also required to participate in either a work program or GED classes during the day.

## II. Client Characteristics and Program Processes

### A. Demographic Information

The MD RSAT program reported information on a total of 324 clients served over the 30-month observation period (see Table 4). The majority of clients served by this program were African American (74%). The average age of clients was approximately 28 years, but ranged from 20 to 57. A very small proportion of clients had been employed prior to participating in the RSAT program, primarily because they were incarcerated during that time period.

Table 4

Client Demographic Characteristics

| | |
|---|---|
| Number of Clients | 324 |
| Average Age | 27.9 years |
| Minimum-Maximum Age | 19.75 - 57.33 years |
| African American | 74% |
| White | 19.4% |
| Other | 1.5% |
| Missing Race Info | 5% |
| Employed 30 days prior to TC | 4% |

### B. Client Criminal History

Clients in the Maryland RSAT program had extensive criminal histories, with an average of eight adult arrests and five adult convictions. While one-third of the instant offense data was missing for this group of clients, it appears that among those for whom data was reported, the most common instant offenses were property crimes (14.5%),

distribution, smuggling, or manufacture of drugs (13%), and robbery (9.9%). Other common instant offenses are listed in Table 5. Overall, the relatively large amount of missing information on the clients' criminal histories is problematic, in that it suggests that the counselors at this program may not have all the information they need to effectively work with their clients available to them.

Table 5

Client Criminal History Characteristics

| | |
|---|---|
| **Mean Number Of Adult Arrests** | 8.5 |
| Arrest Data Missing | 2.7% |
| **Mean Number Of Convictions** | 5.4 |
| Conviction Data Missing | 1.5% |
| **Instant Arrest Offense** | |
| Property Crime | 14.5% |
| CDS Possession | 7.4% |
| CDS Distribution, Smuggling, Manufacture | 13% |
| VOP | 7.4% |
| Assault/Aggravated Assault | 3.4% |
| Robbery | 9.9% |
| Other | 11.4% |
| Missing | 33% |

### C. Substance Abuse Characteristics

Among those clients for whom "drug of choice" data was submitted (n=228), the most common drug of choice was cocaine (crack or powder, 38.5%), followed by Heroin (28.9%) and Poly-Drug use (12.2%). While more than one-third of clients did not have "frequency of drug use" data reported, most clients did not appear to have been using drugs in the past month (as expected while they were incarcerated). Many of the clients (66.7%) in the Maryland RSAT program had prior experience with drug treatment services.

Table 6

Substance Abuse Characteristics

| | |
|---|---|
| Total Number of Clients Reported | 228 |
| **Drugs Of Choice** (% of 228) | |
| Crack/Cocaine | 38.5% |
| Heroin | 28.9% |
| Poly-Drug Use | 12.2% |
| Alcohol | 9.6% |
| Marijuana | 7.0% |
| Missing (of 324 clients) | 29.7% |
| **Frequency Of Use** (% of 228) | |
| No past month use | 66.2% |
| 1-3 times in past month | 0.4% |
| 1-2 times per week | 0.4% |
| 3-6 times per week | 2.2% |
| Daily | 17.5% |
| Missing (of 324 clients) | 35.8% |
| **Any Prior Treatment Experience** (% of 228, including self-help groups and education) | 66.7% |

### D. Graduated Sanctions

Of the 324 clients served in this program, 41 had committed an infraction that was reported by program staff. These 41 clients committed a total of 61 infractions during the observation period. In response to these infractions, staff levied a total of 74 graduated sanction responses (more than one per infraction). The most common infractions were failing to appear at a treatment session (one time, n = 13) and violation of prison rules (n = 11). The most commonly reported responses to these infractions were verbal warnings (25) and written warnings (10).

Table 7

Graduated Sanction Use

| | |
|---|---|
| Number of Infractions Reported | 61 |
| Number of Clients with an Infraction | 41 |
| Average Number of Infractions per Client | .19 |
| Number of Recorded Responses to Infractions | 74 |
| **Most Common Infractions** | |
| Failure to Appear at Treatment Session #1 | 13 |
| Violation of Prison Rules | 11 |
| Negative Community Behavior | 7 |
| Failure to Appear at Treatment Session #2 | 5 |
| **Most Common Graduated Sanctions** | |
| Verbal Warning-Phone Call | 25 |
| Written Warning-Letter | 10 |
| Admin. Removed/Therapeutic Discharge | 8 |
| Individual Session | 8 |
| Jail for 30+ Days | 5 |

### E. Drug Testing

The MD RSAT program staff submitted data forms on 291 of the entire population of 324 clients. Of these 291 clients for whom drug-testing data forms were submitted, 260 were drug tested at some point during the 30-month observation period. The average client (among those for whom data was reported) was tested over 6 times during the observation period, with the program conducting nearly 2 tests per day. Overall, there were relatively few positive drug tests (only 36, out of nearly 1800 total tests), the majority of which were for heroin or other opiates (16) or amphetamines (8).

Table 8

Drug Testing

| | |
|---|---|
| Total Number of Clients (With Data Forms Submitted) | 291 |
| Number of Clients Tested | 260 |
| Mean Number of Drug Tests Per Client | 6.7 |
| Rate of Drug Testing | 1.9 drug test /day |
| **Total Positive Drug Tests** | 36 |
| # Amphetamines | 8 |
| # Heroin, Other Opiates | 16 |
| # Hallucinogens | 7 |
| # Marijuana | 1 |
| # Sedatives/Barbiturates | 2 |
| # Cocaine | 1 |
| # Other | 1 |

### F. Length of Time in Treatment

Table 9 shows that the average offender stayed in the MD RSAT program for 161 days in both 1997 and 1998,with a range of 4 days to 474 days. Thus, the program was successful in maintaining clients. Although the minimum number of days increased from 1997 to 1998, the maximum number of days decreased over time.

Table 9

Length of Time in Treatment

| | **1997** | **1998** |
|---|---|---|
| Average Length of Time in First Treatment (TC) | 161 days | 161 days |
| Maximum Length of Stay | 474 days | 293 days |
| Minimum Length of Stay | 4 days | 23 days |
| Median | 172 days | 171 days |
| Standard Deviation | 77 days | 39 days |

### G. Continuum of Care

The RSAT program provided data on 192 of the 324 total clients, regarding their progression through the continuum of treatment. Of these 192 clients for whom data was submitted, 117, or 60.9%, were reported as completing the program within the appropriate time frame (i.e., graduated). Another 19 of these clients were discharged from the program for failing to meet various program criteria or for negative behaviors. Nine clients were transferred to less intensive drug treatment services and 4 were sent to another treatment program of similar intensity. Thirteen of the reported clients were released outright and five were transferred to other facilities, all before completing the program. Data was submitted to indicate that three clients continued on to a second type of treatment after the work release. None of these three clients were reported to have continued to a third treatment placement.

Table 10

Continuum of Care Information

| **Number of Clients with Reported Data** | 192 | *(of 324 total)* |
|---|---|---|
| Completed in Time Frame (of 192) | 60.9% | |
| Released before Completion of RSAT | 6.8% | |
| Negative Discharge from RSAT | 9.9% | |
| **After RSAT** | | |
| Sent to Less Intense Treatment | 4.7% | |
| Sent to Similar Treatment | 2.1% | |
| Transferred to Other Facility | 2.6% | |
| Continued to 2nd Treatment | 1.6% | |
| Continued to 3rd Treatment | 0% | |

## Chapter 5 - Observation Results

### I. Structured Observation Results

#### A. Program Emphasis

Items in the Program Emphasis category assess the program's overall philosophy of addiction and treatment. Results from observations of items in this category reveal that the program relies heavily on a self-help model of addiction, and to a lesser extent relies on the contemplation of change, in both Levels IA and IB. In addition, in Level IA the program focused somewhat on the acceptance of disease, however by Level IB the program focused significantly less on this model of addiction. Other program emphases were used less intensively in both Levels of Phase I. The program's reliance on the self-help model of addiction and treatment seems to support the findings reviewed in Chapter 4 regarding the lack of a structured treatment curriculum. The self-help model typically places less emphasis on professional counselors helping clients to build specific cognitive, emotional or behavioral skills. However, the program also appeared to place significantly less emphasis on the self-help model, as clients moved from Level IA to Level IB. This change might suggest that the program began to emphasize a more specific skill-building model, but in fact the program tended to decrease the use of all program emphasis categories.

In addition, it appears that the program did not vary the emphasis placed on the contemplation of change during either level of Phase I. The program appeared to focus on building awareness that a problem existed, but it did not appear to focus as thoroughly on making the decision to change (motivation) or developing strategies to implement that change (action planning). In fact, the program appeared to involve little action planning,

maintenance, relapse prevention or aftercare. It did however, place emphasis on motivation readiness, but coupled with acceptance of disease and contemplation of change, this emphasis may have been too much for the first level. These three emphases are three different stages of change and should be presented sequentially instead of all together. Based on these results, the current RSAT program may need to shift its emphasis to approaches involving more specific skill development in order to help its clients attain measurable changes in behavior and to prepare them for release.

Table 11

Mean Program Emphasis Ratings for Each Program Level (Phase I)

| Variable Name | Mean | | Significant Difference[1] |
|---|---|---|---|
| | Level IA (n= 55) | Level IB (n=22) | |
| Acceptance of Disease | 1.45 | .01 | Yes |
| Action Planning | .03 | 0 | No |
| Aftercare | .30 | 0 | Yes |
| Contemplation of Change | 2.44 | 2.27 | No |
| Maintenance | 0 | 0 | No |
| Motivation | .33 | .23 | No |
| Motivation Readiness | 1.53 | 1.86 | No |
| Redefining Action | 0 | 0 | No |
| Relapse Prevention | .03 | 0 | No |
| Self-Help | 3.69 | 2.59 | Yes |
| Spirituality | .36 | 0 | Yes |

[1] $p < .05$

### B. Treatment Topics

The treatment topics section of the instrument assesses the type and extent of use of various possible treatment topics. By examining Table 12, it is apparent that the clients impose their own values (which were typically not prosocial) onto their learning

based on the relatively high use of subjective learning in both levels. It is during this level that structured learning should be used, where the counselor has more control over the direction of the session. For both discussions of past experiences (street and personal), there was a significant decrease in their use. Overall, issues related to aftercare were not discussed at great length, but in Level IB, where aftercare should have been more of an important focus, it was not used at all. Overall, this program was not frequently rated as highly using any of the treatment topic items, such as cognitive skills, emotional skills, socialization, and psychological development, which would be consistent with the counselors' reporting that the program does not follow a set curriculum. Nurturing, physical safety, review of diaries, and review of unit issues were all not used in Phase I (A or B). Similarly, healing experiences and review of letters were not used in IB.

Table 12

Treatment Topics

| Variable Name | Mean | | Significant Difference[2] |
|---|---|---|---|
| | Level IA (n=55) | Level IB (n=22) | |
| Aftercare | .28 | 0 | Yes |
| Cognitive Skills | .67 | .18 | Yes |
| Diaries | 0 | 0 | No |
| Emotional Skills | 1.33 | 1.18 | No |
| Healing Experiences | .03 | 0 | No |
| Review Recent Incidents | .58 | .41 | No |
| Letters | .09 | 0 | No |
| Nurturing | 0 | 0 | No |
| Past Personal Experiences | 1.35 | .59 | Yes |
| Physical safety | 0 | 0 | No |
| Psychological Safety | .71 | .45 | No |
| Psychological Development | .73 | .01 | Yes |
| Socialization | .73 | .27 | No |
| Social Relatedness | 1.66 | 1.27 | No |
| Past Street Experiences | 1.09 | .23 | Yes |
| Subjective Learning | 2.78 | 2.14 | No |
| TC Issues | .36 | .50 | No |
| Unit Issues | 0 | 0 | No |

[2] $p < .05$

### C. Treatment Activities

The third section of the instrument regards the type and extent of use of various treatment activities commonly associated with a TC model of drug abuse treatment. Table 13 shows that this program had high use of peer encounters in Level IA but these peer encounters were significantly less widely used in Level IB. This pattern could be expected because Level IA is the level at which group members should help each other become aware of the attitudes, behaviors, and values related to their drug use. By Level

IB, ideally, clients should be aware of these issues as a result of working in the peer encounter groups. On the other hand, one would expect that in this level, peer encounter groups would increase because here the clients know each other better and would be more comfortable pointing out and accepting constructive criticism from the group. It is also important to notice that this program did not increase the use of other activities in Level IB, such as emotional growth training, relapse prevention, trigger analysis, and education, which might have addressed issues identified in the earlier peer encounter groups. In Level IB, one would expect clients to have more insight into their own behavior, which is shown in emotional growth training. The program also did not appear to prepare the clients for discharge and adaptation to civilian life in Level IB. For example, discussion of discharge, awareness training, parenting, vocational training, and pre-release were not widely used. These are all topics relevant to a successful discharge. One would expect pre-release planning to increase as the clients got closer to release, but in fact, in Level IB, pre-release planning was not used at all.

Additionally, some important structural components of a therapeutic community were frequently not used in this program in either Level IA or Level IB. For example, community and clinical management, pull-ups, and check-in were all infrequently used. These activities would contribute to community building (an important aspect of the TC model) which was under-utilized in this program.

**D. Treatment Style**

The next series of observation items focus on the treatment style used in treatment sessions and describes the manner in which services are delivered in this program. As can be seen in Table 14, the clients in this program were active in their treatment

activities. Most of these activities took the form of formal (scheduled) and interactive interventions, delivered to the entire treatment community. Many activities also attempted to help clients become more introspective. Informal (impromptu) interventions were apparently never used, though observation of the clients on their living units was not possible. It would be helpful to house all of the RSAT inmates in the same dormitory so that informal meetings could be encouraged and would be more feasible. Punishment and reward meetings were also under-utilized. In fact, reward-type meetings were never used in Phase I (A or B) and the rate of nonuse for punishment-style meetings was 94.5% and 95.7% for each phase, respectively. The use of punishments and rewards might have allowed the staff to have more control of the group. As it was, the inmates had few incentives for good behavior or active treatment participation.

Table 13

Treatment Activities

| Variable Name | Mean | | Significant Difference[3] |
|---|---|---|---|
| | Level IA (n= 55) | Level IB (n=22) | |
| Discharge Discussion | .15 | .50 | No |
| Education Groups | 0 | 0 | No |
| Emotional Growth Training | 1.86 | .91 | Yes |
| Community Enhancements | .09 | .05 | No |
| Goals of Phase | .09 | 0 | No |
| Peer Encounter Group | 2.64 | .86 | Yes |
| Pre-Release Planning | .20 | 0 | Yes |
| Parenting | .03 | 0 | No |
| Pull-ups | 0 | .59 | No |
| Relapse Prevention | .07 | .18 | No |
| Sharing Experiences | 1.95 | 1.36 | No |
| Trigger Analysis | .27 | .41 | No |
| Therapy/Education | 1.04 | 1.09 | No |
| Vocabulary | .35 | .18 | No |
| Vocational Training | 0 | 0 | No |
| Awareness Training | .60 | .36 | No |
| Check-In | .15 | 0 | No |
| Community Management | .13 | 0 | No |

[3] $p<.05$

On the other hand, in the few sessions in which "listening post" type activities were used, the technique seemed very effective. Participants seemed to enjoy the meetings and the facilitator was generally able to keep the activity focused. However, this type of activity, as well as check-in meetings, was infrequently used. In fact, check-in meetings were not used at all in Level IB. Check-ins should have been used throughout

the length of the program in order to gauge the changing attitudes of the group in each session. Finally, staged presentations (e.g., clients presenting homework assignments to the group) were never used in this program.

By Phase IB, the meetings had become significantly less formal and interactive. Though not significant, the meetings in Phase IB were also less introspective than those in Phase IA. This may suggest that in later stages of the program the curriculum shifted to focus on less structured (less formal) activities. It may also suggest that in the later stages the clients focused less on introspection. This shift would appear to be appropriate, provided that the clients had been successful at self-exploration and were then moving on to build specific new skills, as needed.

This shift away from formal, introspective, and interactive styles might also suggest that clients became less interested in self-exploration or that the program's topics shifted focus. Examination of the pattern of results for Treatment Topics does not however suggest that the curriculum itself shifted focus toward more skill building activities or topics. In fact, most topics that changed significantly in their use from Phase IA to IB, showed declines in their use. In other words, no treatment topics significantly increased, as would be expected if the program made a planned shift in curriculum. This general decline in the discussion of various treatment-related topics is more consistent with a change in client interest or motivation than a planned shift in curriculum used by the program.

Finally, the lesser emphasis placed on interactive treatment styles also suggests either a curriculum shift or a lessening of interest/motivation. Again, there is little evidence from the treatment topics data to suggest a specific shift in program curriculum

to accompany this decline in interaction as a treatment style. Therefore, the researchers must conclude that the declining emphasis on interactive treatment styles in Level IB is due to a lessening interest in the program.

Table 14

Treatment Style

| Variable Name | Mean | | Significant Difference[4] |
|---|---|---|---|
| | Level IA (n=55) | Level IB (n=22) | |
| Check-In | .11 | 0 | No |
| Community | 2.55 | 2.45 | No |
| Formal | 4.56 | 3.23 | Yes |
| Informal | 0 | 0 | No |
| Interactive | 4.18 | 2.77 | Yes |
| Introspective | 1.98 | 1.18 | No |
| Listening Post | .07 | .45 | No |
| Punitive | .13 | .09 | No |
| Reward | 0 | 0 | No |
| Staged Presentation | 0 | 0 | No |

[4] $p < .05$

### E. View of the Residential Community

The final section of the observation instrument contained items that measured how the treatment program made use of the clients and the overall community as agents of therapeutic change. Table 15 provides the results for variables included in the view of the residential community section. The clients in this program were often active participants in the sessions and these treatment activities involved a high degree of collective interventions (i.e., delivery of services to the group). However, where high use of collective formats and participants would be expected to be increasing (or at least to remain constant) in Level IB, the use of these aspects of the community decreased

significantly over the course of the program (consistent with the decline of interaction as a treatment style). In fact, the program used participants in less than half of the meetings in Level IB and the use of collective formats also decreased over this time period. This program also used a high degree of open communication and membership feedback, especially in Level IA. These aspects of the community intervention also declined from Level IA to IB (open communication declined significantly).

Overall, the use of confrontation was generally low in this program, as was the use of members as role models. These two aspects of the community are cornerstones of the traditional TC model. A stronger focus on the use of these two treatment aspects (in both Level IA and IB), might have improved the level of interest and motivation among this group of clients. Specifically, these types of community action might be expected to increase clients' interest in participating in the program. In 95 percent of the sessions in Level IB, members were not used as role models and no meetings were rated as using a high degree of this characteristic. It would seem that towards the end of the program, more role models would develop for the inmates to follow because some members of the group would develop faster than others by following the intentions of the program. The number of meetings that were rated as using a high degree of confrontation increased in IB; however, in 82% of the meetings confrontation was not used at all.

Additionally, shared norms and values were not used in 91% of the meetings (in Level IB). Also, the under-utilization of structured systems increased over time (as clients progressed from IA to IB). In fact, the lack of clear rules and regulations also seemed to be problematic throughout the observations of this program. Finally, the program decreased its use of individual relationships from Level IA to IB.

Table 15

View of the Residential Community

| Variable Name | Mean | | Significant Difference[5] |
|---|---|---|---|
| | Level IA (n=55) | Level IB (n=22) | |
| Confrontation | .44 | .68 | No |
| Collective Formats | 4.42 | 3.14 | Yes |
| Membership Feedback | 2.13 | 1.55 | No |
| Shared Norms | 1.49 | .32 | Yes |
| Open Communication | 3.47 | 2.41 | Yes |
| Use of Participants | 4.44 | 2.36 | Yes |
| Individual Relationships | 1.69 | 1.18 | No |
| Role Models | .66 | .09 | Yes |
| Structured Systems | 1.46 | .64 | Yes |

[5] $p<.05$

**II. Discussion of Structured and Anecdotal Observations**

The present program is missing many of the intended components described in Chapter 3. According to the stipulations of the Maryland RSAT grant the program is intended to include the following six components. First, the program is designed to include a designated living and treatment space in a separate minimum-security facility and should provide a minimum of 20 hours of treatment a week, using a cognitive-behavioral and social skills approach. The program should also include discharge planning by the parole agent and placement in community treatment, with specialized supervision through the Division of Parole and Probation. Community supervision should also involve drug testing in the community.

Although the clinical director reports plans to develop CLF into an RSAT-only facility (Spingarn, Personal Communication, April 13, 1999), presently the treatment facility is not separate from the correctional facility, nor is a separate living space

assigned to the RSAT participants. In addition, treatment participants do not attend 20 hours of treatment, as intended. Instead, clients receive a maximum of fourteen hours of treatment per week in the first phase and a maximum of four and one-half hours in the second phase.

Furthermore, according to the clinical director, participants are not placed in any specialized parole services. The Traffic Office, which is part of the Clinical Services Program, is responsible for placing offenders in treatment in the community after release from prison.

In addition to these difficulties in achieving the program implementation goals, many discrepancies between policy and daily practice were noted. For example, the inmates are not reprimanded for poor behavior by being sent back to their dormitory and they are not kicked out of the program for missed classes, reportedly in order to "keep their numbers high." Additionally, in contrast to the report of the counselors, they do not meet with their clients individually for an hour a week. More often these meetings last for less than a half-hour. In fact, the individual sessions are only scheduled to last for half an hour. Furthermore, missing more than three classes (which the observer was told would result in dismissal from the program) and/or missing all of the individual counseling sessions did not result in any sanctions and no inmates were observed to be removed from the program for these infractions.

Although the three classrooms are divided, groups in these rooms can usually hear each other during group discussions. Frequently, one cycle would become rowdy and disrupt the other cycles' meetings. For example, from Week 2 Field Notes, the observer noted, "one could hear the cycle in the next classroom singing." In light of the small

treatment facility space, these disruptions are inevitable. Available space is one of many hurdles that the RSAT staff face in the attempt to provide a successful modified therapeutic community.

### A. Correctional Culture Conflict

The clinical director views the RSAT treatment facility as a way "to provide those inmates with an opportunity through treatment to resist the temptation of drugs and crime upon release from prison" (Spingarn, Personal Communication, April 13, 1999). The issue for therapeutic communities and their researchers is whether an inmate can change his behavior in an environment that is meant to punish him. Fortunately for this RSAT program, many of the participants separate the treatment facility from the correctional facility. They do not see their treatment counselors as part of the correctional facility and feel open to express their dislikes and problems regarding the correctional officers and the correctional facility. The treatment providers respect their role and the role of the officers completely and are often heard repeating the motto, "This is their house."

The correctional officers, however, are not respectful of the treatment facility and many voiced to the observer that the RSAT program was a waste of time and money because these participants will never change. The clinical director believes that the facility staff's understanding of the treatment facility should be emphasized more (Spingarn, Personal Communication, April 13, 1999). It is difficult to have an environment that successfully encourages change when the inmates are preoccupied with repercussions of behavior from the correctional staff in or outside of the treatment facility. More respect for the treatment facility on the part of the correctional staff could result in more positive outcomes for treatment participants.

The counselors are required to wear body alarms in the classrooms so that a correctional officer does not have to be present during group or individual sessions. This tactic is used in an attempt to have open sessions where the participants feel comfortable openly talking about anything. There is one officer posted at the door and all officers who hold this position have different levels of respect for the treatment program. For example, on one occasion in Week 1:

> a correctional officer needed to speak with a member of the group during a group session. He knocked on the door and waited until he was asked in the room. He stuck his head in the door and asked the group if a certain inmate was present. He then quietly left with the inmate, disrupting the class as little as possible (Silverman, 1999a).

However, some of the officers just open the door without knocking and disrupt the class. The latter is much more common than the former. Although the inpatient coordinator believes that the treatment staff has "a good working relationship" with the correctional staff (Sato, Personal Communication, April 27, 1999), the following excerpt from Week 2 field notes describes the relationship between the treatment facility and the correctional facility most accurately:

> During this session, the officer interrupted three times. First, he knocked on the door and entered the room without being invited in order to take two inmates with him. Then, he came into the room without knocking, asking for an inmate who was in the next room. Finally, the officer knocked on and opened the door when class time was over. This interruption was not necessary or appropriate (Silverman, 1999b).

Unfortunately, the behavior of the officers did not improve over the three months of observations. In Week 9, "in the middle of class, the officer came in the room to tell an inmate that he was needed after class but he did not knock before entering" (Silverman, 1999d). This officer could have waited until the end of class to give his

request. The following is also an example of the disrespect the officers show to the RSAT program from Week 11:

> First, the correctional officer came to get an inmate who needed a bandage. She did not knock and loudly called the inmate's name. Later, the group got a little loud (not as loud as they have been) and the officer opened the door and told them to be quiet. She came back a third time and told them that they had to be quiet. Then, she immediately came back to the room a fourth time and told the inmates that they should go back to their dormitory if they could not be quiet. Two inmates left the group and the officer came back to the room and yelled at the group to be quiet. She left and then the two inmates came back in the room. The important aspect to recognize in this situation is that the officer (similar to many officers here) has no respect for the RSAT program and the inmates are aware of this. In similar situations, if the officer knocks on the door and asks the group to quiet down, they oblige with only a small amount of complaining. The officer never knocked and the group felt disrespected and intruded upon. The officer also disrespected Counselor D by not addressing her any of the times that she barged into the room (Silverman, 1999f).

As shown above, the relationship between these two groups could benefit from cross training.

**B. Therapeutic Intervention/Curriculum Issues**

Since the program made use of several different counselors, (and had at least some staff turnover, during the observation period) the nature of the daily therapeutic interventions varied considerably. To the observer's knowledge, there are no inmate run groups scheduled as part of the program's curriculum. Even when run by the counselors, group discussions tended to dominate each treatment activity. Despite this widespread use of member discussion, specific treatment issues were not commonly processed thoroughly. Instead the counselors and members tended to follow a relatively unstructured curriculum within the meetings, without stopping long to discuss any one issue at great length.

In terms of specific therapeutic intervention techniques, the observer saw no rewards or punishments implemented in these program activities. Handouts were often used and homework was given in a few instances, however, even in these few instances assigned homework was never observed being checked, collected, or reviewed. Movies were also used in some sessions, however the general response to these from members was not favorable. For example, one movie appeared to bore the clients, another they had already seen in the program, and in still another the importance to their recovery was apparently too subtle for them to thoroughly understand.

For the most part, all classes would start with a reading of a handout and then an unstructured discussion. The overall talkativeness of the group seemed to depend on a variety of factors, including the time of day (they were less talkative in the morning), the temperature of the room (the heat often made them sluggish) and the subject of the session (they did not like the feelings group and thus, were not talkative). In addition, clients seemed to interact more effectively with some counselors rather than others. For instance, at different times throughout the treatment cycle clients reported that they did not like either Counselor C or Counselor D and were openly difficult during these counselors' sessions. Despite being relatively obvious, these difficulties (or the disruptions they caused) were never discussed as part of the treatment activities.

Overall, the daily activities of the program seemed to lack specific focus, largely due to the program's lack of a formalized curriculum and the inexperience of the staff. In addition, there appeared to be some conflict between trying to deliver treatment using a TC model and also using cognitive behavioral interventions. While the TC model inherently relies on the use of peers and the development of prosocial values, the CBT

model emphasizes the more extensive use of skilled counselors and the teaching of specific, cognitive and emotional skills. Balancing these two approaches is difficult enough, in light of their somewhat conflicting underlying assumptions and techniques, when their integration is carefully planned. When the two models are hurriedly forced together, as they often appear to have been in this program, it seems extremely difficult to make either work effectively.

### C. The Community of Offenders

In this program, there was little emphasis on a community. It seemed that the group was just in a classroom. For example, Week 2 observer field notes state, "when addressing the group, the inmates were not talking to each other, but to the counselor" (Silverman, 1999b). Friendships within the cohort as a whole did not seem to be established although "they did talk to each other in private groups when others were addressing the group" (Silverman, 1999b). Instead of forming peer groups, many participants appeared to be on their own. Most of the inmates would share with the group but none of them seemed to be friends. Because the inmates are not in their own unit, the lack of community is not surprising. This group does not see themselves as a community, partly due to the fact that the counselors are not emphasizing it and do not seem to have even addressed this issue. Week 2 shows during one session, an inmate pointed out that:

> he disliked Counselor C as well as disliking some of the members in the group. Although Counselor E addressed the dislike of Counselor C, she did not address the lack of community that was reinforced by this participant's comments about disliking his group (Silverman, 1999b).

The declaration of dislike by a participant was surprising to the observer because open hostility toward other members of the group was extremely rare. Unfortunately, this

feeling did not change over time because, as of Week 12, "the inmates still say that there are people in the group that they do not like" (Silverman, 1999g).

Additionally, the absence of designated roles of participants in the program (e.g., facilitator, expediter) allowed the participants to distance themselves from the program and thus, not invest much time and energy into it. If the participants had roles within their cycle that they felt a responsibility towards, then they might be less likely to sleep through a session or just not participate. Although the inpatient coordinator believes that "they are all participants in the program" (Sato, Personal Communication, April 27, 1999) this is not the case. Roles could increase participation.

The RSAT participants have little respect for their counselors, other participants, and the program. Many times, the observer noted in the Field Notes that participants were "interrupting each other," "carrying on side conversations" (Silverman, 1999e), "talk[ing] to each other in private groups when others were addressing the group," and "passing a paper" (Silverman, 1999b). Also, there was "a lot of talking at once," and "they frequently [got] too rowdy and talkative" (Silverman, 1999b). These above patterns of lack of community were consistent throughout the six months of observations.

According to DeLeon (1994), one of the two distinguishing characteristics of a TC is that "the primary therapist and teacher in the TC is the *community* itself" (p. 18). The previously mentioned characteristics are not conducive to a healthy treatment environment and the participants were not learning from each other because they did not have respect for other members of the group. DeLeon (1994) also points out that "the main messages of recovery, personal growth, and right living are mediated by peers . . . as supportive friends in daily interactions" (p.21-2). When group members constantly

interrupt each other they are not creating a supportive environment and thus, not becoming a community. A community treatment environment could result in more positive outcomes.

Additionally, the participants frequently did not pay attention in class and those who chose not to participate were not reprimanded. The following excerpt from Week 9 emphasizes these happenings:

> There was some inmate participation but one inmate was reading a book, one inmate was asleep, and five inmates were doing another activity. Also, some inmates were playing paper football during the session (Silverman, 1999d).

A similar example occurred in Week 10:

> The inmates are continually disrespectful to this counselor and most were not participating: three were reading a magazine; two were talking about one's financial situation; one was reading the comics; and one was drawing. There were a lot of side conversations and no one seemed to be listening (Silverman, 1999e).

The lack of respect for the program and all of its components as well as no repercussions for poor behavior are not conducive to a therapeutic environment. It seems that the only knowledge that participants gained from each other are the effects of drugs that one participant might have used and they had not. Therefore, the peer groups that are unique to the TC did not form over the course of the six-month program and made the attempt at a successful modified TC extremely difficult.

**D. Staffing Issues**

The program employs two treatment supervisors (who also provide treatment services) to monitor the treatment staff. These supervisors report to the inpatient coordinator. The inpatient coordinator is a liaison between the warden and the RSAT program. She is in charge of most of the day-to-day operation of the RSAT program and

the RSAT staff but still reports to the clinical services director. The clinical services director is in charge of all addiction treatment in probation, parole, pre-trial, and prison (e.g., RSAT, Correctional Options Program (COP), Regimented Offender Treatment Center (ROTC)). The director does not handle most of the daily operations at the facility (Spingarn, Personal Communication, April 13, 1999).

**1. Staff Experience and Credentials**

Many of the counselors in this program were new to both the RSAT model and substance abuse counseling in general. At the start of the observation period, the observer conducted informal interviews with the seven current counselors. As of January 11, 1999, five of the counselors had been working for RSAT less than six months. Five of the counselors had earned Bachelor's degrees in a field related to counseling, although two held degrees in unrelated fields (Health and Fitness, and Nursing). None of the supervisors or counselors held advanced degrees. Additionally, three of the counselors had no previous counseling experience of any kind. One of these previously inexperienced counselors was appointed to a supervisory position after only six months as a counselor at the RSAT program. This counselor had also had no previous supervisory experience. Two of the counselors with no previous experience received less than one month of training before being allowed to conduct their own treatment groups. Over the six-month period of observations, three counselors left permanently, one left temporarily, and two new counselors joined the staff in May and June. The inexperience of at least four of the counselors is apparent from the content of their classes and in their handling of the group. Although the counselor styles differ, none were confrontational in their approach to treatment.

Although an Addictions Counselor II requires at least one year of counseling in drug and alcohol treatment, not all of the RSAT counselors (who are all at least Addictions Counselor II) fulfill this requirement. As of January 11, 1999, three of the counselors did not have any counseling experience, much less drug and alcohol counseling. It is apparent that it is difficult not only to fill the contractual counselor positions with qualified staff but also to retain them. The pool of applicants is not as strong as it could be if the job's compensation (e.g., benefits, etc.) was more desirable.

**2. Staff Continuity/Attendance**

Classes are routinely late for a variety of reasons: the inmates could be slow getting together; the counselors could be running late; or the officer who escorts the counselors to the trailer could be finishing up some other assignment. This last reason is an example of the conflict between treatment and corrections and is explained in detail below. The reason for late classes is usually not apparent. The habit of late classes seemed to get better as the cycle progressed through the program but was still a problem. The following is an excerpt from Week 2 field notes:

> Day 7 began a half hour late because of a late counselor. Everyone had to wait for her at Operations so that the officer could escort everyone to the trailer together (Silverman, 1999b).

During the twelve weeks of observations, eight of eighty-six sessions observed (9.3%) were cancelled. Five cancellations were due to poor weather, one was due to a counselor running late, and two were due to counselor absence. Out of 88 sessions, 59 were started late (67%). The lack of punctuality and mediocre work attendance showed that the commitment of the staff to their job was poor and this feeling was reflected in their sessions. The staff spent a lot of the time between classes talking and doing non-work

related activities. If more time was invested in planning, the sessions could be more productive and the treatment outcomes could be more positive. Additionally, if the staff was monitored more closely they might tend to spend more of their out of class time on work activities.

Although the counselors are supposed to be teaching the same sessions for each cycle, they are routinely unprepared for class and not infrequently decide right before class what they will do in that next session. There is no curriculum and no module that they have to follow. Because there is no set structure, the counselors do not know the goals and objectives of the classes they are teaching. If the schedule changes and counselors are given a new class, they must develop the curriculum. Many times counselors have to substitute for other counselors but the absent counselor almost never leaves plans. Thus, the counselor who is substituting does not know where the regular counselor has left off or what lesson to do. More often than not, counselors do not know that they are substituting for a class until ten minutes before class. The staff has a lot of free time and should have no difficulties developing a strong curriculum for their classes. The following excerpt provides an example of the problems that arise when a counselor substitutes:

> Counselor E was absent so Counselor C (who was leading Recovery for Cycle 16) combined the two cycles to watch a movie, "Circle of Recovery." [It] had terrible tracking for the whole session. Cycle 15 told Counselor C that they had already watched this movie but she showed it anyway . . . They did not seem interested in the movie, understandably because they had already seen it in RSAT (Silverman, 1999c).

The counselors are not always knowledgeable about the sessions for which they are substituting. Currently, the RSAT program is set up so that six counselors teach each

cycle but counselors only teach specific subjects. The following is an excerpt from Week 2 field notes regarding this issue:

> In discussing the issue of six different counselors teaching each cycle, the supervisor expressed that it is the view of her supervisor that each counselor should have a module specialty. Therefore, each counselor is not trained in every module but specializes in four to five modules. When counselors are absent, it is harder to find a substitute than if everyone was cross-trained for every module. Additionally, the counselors do not get to know the participants as well as if they followed one cycle and taught every module. Likewise, the inmates do not get to know the counselors well because, as mentioned previously, they have six different counselors for their first six classes. It would be advantageous to have all counselors able to teach all classes because of the high frequency of staff absences and to establish closer relationships between counselors and participants (Silverman, 1999b).

### 3. Counselor Style Ratings

Table 16 shows the average rating that the MD RSAT counselors received for counselor style, which is a large obstacle to the RSAT program.

Table 16

Ratings for Counselor Style Variables by Counselor (7-point Likert scales)

| Counselor | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Variable** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **Weighted Average[1]** |
| Authority | 4.00 | 5.67 | 3.78 | 2.08 | 5.39 | 1.80 | 6.00 | 2.00 | 3.50 |
| Confrontational | 1.29 | 1.67 | 1.56 | .923 | 2.77 | .667 | 2.00 | 1.00 | 1.44 |
| Directive/Goal | 3.43 | 6.33 | 4.00 | 3.08 | 5.00 | 2.87 | 4.00 | 3.00 | 3.77 |
| Experience Level | 3.36 | 6.00 | 2.56 | 2.39 | 5.85 | 1.40 | 6.00 | 2.00 | 3.17 |
| Guidance | 3.07 | 6.00 | 2.67 | 1.85 | 5.54 | 1.47 | 6.00 | 3.00 | 3.03 |
| In Charge | 4.14 | 6.00 | 4.00 | 2.31 | 5.54 | 1.93 | 6.00 | 2.00 | 3.68 |
| Informative | 2.93 | 5.67 | 2.89 | 1.77 | 5.39 | 1.60 | 5.00 | 2.00 | 3.00 |
| Lax | 4.14 | 2.00 | 3.67 | 5.46 | 3.31 | 3.27 | 1.00 | 7.00 | 3.86 |
| Parental | 1.36 | 4.00 | 1.28 | 1.92 | 5.00 | 1.13 | 2.00 | 1.00 | 2.10 |
| Process Oriented | 3.29 | 5.67 | 3.33 | 2.85 | 5.92 | 1.73 | 4.00 | 3.00 | 3.46 |
| Total Number of Sessions Observed | 14 | 3 | 18 | 13 | 13 | 15 | 1 | 1 | |

[1] The weighted average was calculated by multiplying the counselor's rating score for each variable by the number of sessions observed for that counselor, then averaging the counselors' scores across the total number of sessions observed.

By examining Table 16, one can see that the RSAT counselors rate low on all of the variables, especially for confrontation (1.44), which was infrequently observed. Table 16 shows that counselors seven and eight were only observed once and counselor two was observed only three times. Overall, these counselors tended to score relatively low on all categories, however, it is interesting to note that the highest absolute score was for the lax variable (3.86). These results and the informal observations suggest that the counselors need to take charge of their groups more often and have explicit curriculum for each session. More control and organization would likely create a more productive treatment program. Comparing the inter-rater reliability for the counselor style variables

showed that the two observers consistently agreed on the ten counselor-style variables (100% of the items were rated within 1.5 scale points of each other by both observers).

### E. Aftercare and Community Reentry Planning

As mentioned in the previous chapter, the RSAT staff is not involved in the reentry process. However, the clinical director believes that if a paroled RSAT graduate performs poorly in his outpatient program, he should be brought back to inpatient treatment.

As of April 1999, a member of Cycle 15 was currently waiting to return to RSAT. He missed thirty days of the RSAT program as a correctional sanction for returning to CLF late from his father's funeral. According to the inpatient coordinator (Sato, Personal Communication, April 27, 1999), he should be entered in the next cycle of RSAT. He was not allowed to start the program from where he left off by joining another cycle. Because the RSAT staff is not involved in the reentry process, it is unclear what occurs before a person reappears in the program. As of June 23, 1999, the inmate was still waiting for reentry into RSAT.

A large part of improving the Maryland RSAT program would be to improve the staff by increased training, evaluation, and supervision. There was tremendous variation within the staff and the curriculum in the six-month period of observations. The program was constantly changing even though the observations were conducted two and a half years into the program.

## Chapter 6 – Discussion & Conclusion

Implementing correctional treatment programs in prison often encounters a number of challenges and obstacles. The RSAT program in Maryland is no different than other locations where many adjustments are needed before the program is operating at a level to achieve the success noted by Key/Crest, Stay 'n Out, and Amity—the prison therapeutic community programs that have been evaluated and found to effectively reduce recidivism. This process evaluation was designed to examine the implementation of the program according to the key components of effective interventions. The observations and data collection are designed to understand program observations for the purpose of examining the strengths and weaknesses of the program. This last chapter provides an overview of the program with a focus on next steps to improve program operations.

### I. Status of the Program

#### A. Accomplishments of RSAT

The Department of Public Safety and Correctional Services was able to develop and implement a six month residential substance abuse treatment program, despite several obstacles presented by the facility itself and the specific stipulations of the funding grant. In order to achieve even this level of success, however, the correctional treatment staff often had to remain flexible and willing to deal with the needs and restrictions of the wider correctional facility. The difficulties are described in the next section, but it is important to highlight the areas where the program was largely successful because they provide a solid foundation for further development of the TC and RSAT concepts.

First and foremost, is the commitment by the DPSCS to treatment behind the walls. Many correctional systems have a difficult time identifying a location and facility for treatment programs. Providing separate living space and a facility are usually desired and seldom realized. In this case, DPSCS made a commitment and used the Central Laundry Facility (CLF) for the treatment program. Although not all of the living space was designated for offenders in treatment, the living space was designated for offenders in special services. The trailers and special housing areas are important components of the treatment program and provide a foundation for programs.

A key component of correctional treatment programs, particularly TC, is forming and maintaining closed groups. Closed groups are usually difficult to achieve but the MD RSAT program established a process whereby clients entered and completed the treatment cycle together. The closed groups provides the potential for establishing a community to allow the addict-inmates to work on recovery issues. Many institutions do not establish communities, which dilutes the effectiveness of the intervention.

Another advantage of this particular program was the low drop-out rate and transfers from the program. This is particularly difficult to achieve in many correctional institutions—transfers are often daily events. The MD RSAT program, however, developed a process to ensure that offenders selected for the treatment programs were not transferred out. The program succeeded in creating a low level of dropouts and conversely, a high level of program completion among its clients—a major step towards advancing the recovery process.

Drug testing was used as a tool of the intervention. The facility itself was highly successful at implementing its random drug testing policy, as evidenced by the large

number and high rate of drug tests performed on the clients in the RSAT program. The drug testing policy resulted in a low level of positive drug tests reported. However, the observations noted that offenders were aware of the drug testing sequence that may have allowed them to change their behavior accordingly. But the frequency of drug testing illustrates how a proper tool was installed and resulted in low drug test positive rates.

**B. Major Drawbacks to Implementation**

The most critical components of a substance abuse treatment program are the components of the intervention and the processes to continue treatment services (transition). This is the area where the MD RSAT program faltered the most and the areas where more attention is needed to ensure that the foundation of the program can be extended. That is, the separate facility, closed groups, high completion rates (and corresponding operational practice to minimize transfers), and drug testing practice provide a solid foundation for the program. More attention is needed to the delivery of services, use of behavioral management (graduated responses), and the continuation in other treatment programs after release from prison.

The MD RSAT program is one of several treatment programs offered by DPSCS. The system already has a four-week program (ROTC) that is behind the walls. The goals and objectives of a six-month program need to be clearly defined with more attention on using this program for hard-core offenders who are more likely to need interventions. This distinction is needed because it assists in developing a system of care suited to the needs of individual offenders.

The observations and interviews revealed that the substance abuse program varies depending on the counselor. Given the staffing issues raised in this evaluation, the

program should be guided by a well-defined, formal curriculum. As was discussed in Chapter 4, the clinical supervisor and administrator for the program identified that 4 of 10 treatment classes had formal written descriptions, even two years into the program's operation. Even then, the focus was modeled after the 4-week program. More attention is needed on developing a solid curriculum to guide the intervention that can be used by staff. This would reduce some of the variation in the treatment services provided and improve the purpose of each treatment component. A formal curriculum has been found to be an effective component of interventions to improve the integrity of the treatment services—it assists with providing consistency and direction within the therapeutic milieu. Most importantly, it ensures that the treatment assists the offenders in moving through different stages of recovery.

A formal curriculum has been shown to address some of the issues involved in delivering effective interventions. These staffing issues include low levels of prior clinical experience, inadequate academic qualifications, lack of systematic clinical review of staff treatment-related activities by the supervisors, and a generally inefficient use of staff time between treatment activities. A curriculum benefits programs by providing the staff with direction as the next steps of the treatment process. Several public domain curriculums are available which could be adopted by DPSCS including *Thinking About Change* (National Institute of Corrections) and *Motivational Enhancement* (National Institute on Drug Abuse).

The MD RSAT program made very few attempts to utilize either punishments or rewards as a means of ensuring compliance with treatment activities and goals. This lack of consistent discipline frequently resulted in the staff's inability to adequately control

clients' behavior during treatment sessions, which in turn negatively impacted the effectiveness of those activities. In many instances, clients openly disrespected the counselors (specific staff members in particular). Treatment clients were also frequently "off-task" during treatment meetings, holding side-conversations, sleeping, or even playing "paper football", with little, if any, consequences from the staff.

All of the data from the project confirms that little attention was given to transitional planning or developing treatment continuum of care. Parole agents were not part of the intervention to begin the transition to the community; nor did the program itself have a curriculum to develop transitional or discharge plans. It is thus not surprising that the few clients (only 3 that were reported) were placed in treatment services after release from the CLF. Several indicators are that the program staff did not have sufficient training and access to substance abuse and criminal history information, and the mechanisms for working with the parole system were not well-developed. The data reveals that staff did not always have the necessary client information to them to offer treatment suited to the offender or to provide guidance to the next steps of the treatment process.

Finally, as usually occurs, the interaction of the treatment staff and the wider correctional facility culture was tenuous. Several instances observed during the period of this evaluation suggest that the working relationship between the correctional staff, treatment staff, and facility administration could be greatly improved.

## II. Recommendations

The MD RSAT program has a foundation to build on. The evaluation revealed, as discussed above, some major areas where more attention is needed to improve the efficacy of the program.

### A. Designated Facility

To further develop the sense of community among treatment clients, all RSAT members should be housed together in the same dormitory; non-RSAT inmates should not be included in the housing area. The housing of all inmates in one single residential unit would enable the clients to incorporate informal interventions into their program. Additionally, RSAT members should not be put back in the general population of the facility after their graduation from RSAT if they have time left to serve. One way to eliminate this problem would be to improve client selection by placing inmates in the RSAT program only when they are six months from their release, not between ten and twenty-four, as reported.

### B. Staffing

More emphasis should be placed on the hiring of qualified staff. Several of the counselors lacked experience in providing clinical services and were not trained by the supervisors. For example, one of the counselors had only seven-months of counseling experience (all within this RSAT program) when she was appointed to be the program's supervisor. Prior to working in this RSAT program she had had no previous counseling experience, which was apparent in her counseling style. In addition, many of the counselors were either uncomfortable in front of the group or had insufficient training in running groups. This group of counselors was not appropriately supervised or evaluated,

nor did there appear to be much peer supervision or consultation. As such, the success or failure of the counselors within the classroom was not monitored. Periodic clinical supervision of each counselor's sessions, along with regular individual and team-wide clinical supervision, may help improve both the counselors' skills and the eventual effectiveness of the treatment delivered.

In terms of the use of six different counselors to teach each cycle, the supervisor expressed that it is the view of the inpatient coordinator that each counselor should have a module specialty. Therefore, each counselor is not trained in every module but specializes in four to five of the treatment modules. This practice leads to difficulties when a counselor is absent. Additionally, the counselors do not get to know the participants as well as if they followed one cycle and taught every module. Likewise, the inmates do not get to know the counselors well because, as mentioned previously, they have six different counselors for their first six classes. The use of different counselors throughout the daily activities makes it difficult to follow up on issues initially developed in a given meeting. Finally, this practice results in the provision of treatment services that vary widely from one meeting to the next, as the counselors have vastly different styles, skill levels, and experience. Training each counselor to teach each treatment module would likely improve many of the problems presented by the current program structure, especially given the high frequency of staff absences. This practice also results in an inconsistent approach to the provision of treatment since the treatment is not guided by any underlying theoretical component that all counselors subscribe to.

### C. Develop the Therapeutic Community

Currently, community meetings occur at the beginning and the middle of the week. These meetings might be made more effective if they were offered in the middle and end of the week so that issues raised over the week can be addressed in a more timely manner. For example, if an issue occurs on a Thursday, it could be brought up in the Friday community meeting rather than waiting until the Monday meeting when it could be forgotten over the weekend. Additionally, Cycle 15 seemed lost at their first community meeting because it was also their first day in the program. Holding the meetings later in the week would benefit the new cycle by giving them a chance to become familiar with the program.

A more important change to these community meetings would be to provide some structure to them, in terms of what they try to accomplish and how they attempt to do so. Typically these meetings were observed to last less than 15 minutes and relatively little seemed to be accomplished in them. Due to difficulties presented by moving clients between the residential area and the classroom trailer, these meetings were held immediately after the groups completed their individual-cycle classes. Most of the meetings were also conducted immediately before the clients were to be brought back to the living unit to be served their meals. The combination of fatigue after having just been in a treatment meeting for an hour and looking forward to lunch seems to work against clients bringing up any important community issues, or working on them in a productive manner. Therefore, rescheduling and restructuring these meetings appears crucial to their becoming effective treatment tools. The community meetings need to be run by the offenders in their free time, in-between treatment sessions.

### D. Managing the Treatment Environment

In terms of the management of their treatment meetings, more structure and direction in the group setting would serve to reinforce the treatment message. As mentioned, clients are often "off-task" in treatment meetings. Improvements might include, for example, the counselor formally concluding all sessions and dismissing all inmates, rather than clients "deciding" when the meeting is over by announcing that the outside trailer door is open. During observations, all of the sessions ended when the inmates felt that class was over because it was around the dismissal time. Most of the time, inmates would leave class when another inmate was talking. To eliminate this problem, sessions should be opened and closed with a ritual to enforce the idea of a therapeutic community and the need for structure. During two instances when a ritual was used to open and close sessions the practice seemed effective in uniting the inmates as a community. If sessions were closed with a ritual, not only would the clients know that the class was actually over, but the counselors, rather than the inmates, would be able to exercise more control of the treatment session. The adoption of behavioral management techniques (graduated responses) would help immensely in the provision of treatment services.

Another way to enforce the idea of a community is to remove clients who disrupt treatment sessions. Counselors reported that the program's policy was to excuse disruptive inmates from treatment meetings. Despite this reported policy, during the 12 weeks of observations, not one inmate was dismissed from class, while at least once a day, an inmate would be disruptive enough to warrant early dismissal from the session. This inaction reinforced the counselors' lack of control in the classroom and the lack of

respect that the inmates exhibited toward the counselors. Specifically, sanctions for disrupting, missing, or being dismissed from a session should be made known to the clients and consistently enforced. The current inconsistency between reported policy and actual practice, as well as what the reported policies are, is evidenced by the fact that the observer was first told that inmates were sanctioned for missing more than three classes, but was later told that this was not the case. Without clear rules and sanctions, the clients have little reason to attend group or individual sessions, especially if other aspects of the program have not been effective in building their motivation for genuine treatment participation.

### E. Creating a Treatment Milieu in Prison

Finally, the relationship between the correctional staff and the treatment staff did not appear to be respectful and productive. It does not seem that the majority of the correctional staff has an understanding of, or respect for, the treatment program. There has been no cross training provided to the treatment and correctional staffs. Several instances were observed that would suggest the relationship between the staffs is less than congenial and productive. Many correctional officers voiced that they thought the RSAT program was a waste of time and money. Cross training should be mandatory for all treatment counselors and correctional staff to facilitate a greater understanding and respect of the RSAT program and the facility itself.

## III. Recommendations for Future Evaluation Research

The purpose of a process evaluation is to measure the implementation of the program. The issues that affect program implementation are often glossed over or given little attention. This program is representative of many unevaluated programs; important

integrity issues were often ignored. Without this evaluation, many of the issues would not be addressed. Had program evaluation efforts been included in the original development of this program, valuable correctional and treatment resources might have been better spent during the initial two-year period.

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# Appendix A
## Observation Instrument
Observation Forms To Describe the Treatment Milieu and Goals/Objectives of Treatment

Date:_____ Observer:_____

Session:_____
Number in Group:_____ Type of Group: ___ Male __ Female __ Other
CO present: __No __Yes

| Activity Observed: | Planned | Actual |
|---|---|---|
| Group | | |
| Indv | | |
| Pull-up | | |
| Between Therapy | | |
| Case Management | | |
| Intake | | |
| Orientation | | |
| Other_____ | | |

Phase of the Program: __ Education __Recovery
__ Therapeutic __ Aftercare
__ Other: _____

Style: ___ Lecture ___ Presentation with videos
___ Group Discussion
___ Client presentation
___ Other_____

Techniques Used: ___ Movies/Tapes _____
___ Brochures
___ Life Stories
___ Other, specify_____
____ None

Time: begin _____end_____ Type of Therapist: 1) Professional 3) Inmate
2) Volunteer 4) Paraprofessional

Describe the purpose of the Session: _____

EACH SESSION

| View of Residential Community in a session | Used 1-5 | Purpose consistent with TC *Prosocial Values *Community | Effectiveness | Not Used/ Applicable |
|---|---|---|---|---|
| Use of Participants | | | | |
| Use of Membership Feedback | | | | |
| Use of Confrontation | | | | |
| Use of Members as Role Models | | | | |
| Use of Collective Formats to Guide Indv Changes | | | | |
| Use of Shared Norms/Values | | | | |
| Use of Structured Systems | | | | |
| Use of Open Communication | | | | |
| Use of Relationships/Friendships | | | | |
| | | | | |
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| | | | | |
| | | | | |

Each Session

| | Used 1-5 | Purpose consistent with TC | Effectiveness | Not Used/ Applicable |
|---|---|---|---|---|
| **Treatment Activities** | | | | |
| Use of Discussion of Discharge | | | | |
| Use of Therapy/Education | | | | |
| Use of Peer Encounter Groups | | | | |
| Use of Awareness Training | | | | |
| Use of Emotional Growth training | | | | |
| Discussion of goals of phase | | | | |
| Community and Clinical Management | | | | |
| Community Enhancements | | | | |
| Relapse Prevention Training | | | | |
| Trigger Analysis | | | | |
| Parenting | | | | |
| Educational Groups | | | | |
| Vocational Training | | | | |
| Use of Sharing Experiences | | | | |
| Vocabulary, teach words and meanings | | | | |
| Pull-Ups | | | | |
| Pre-Release Planning | | | | |
| Check-In | | | | |
| Other : _____ | | | | |

Each Session

| Topics | Groundwork Laid (y/n) | Used 1-5 | Purpose consistent with TC | Effective nesseness | Not Used/ App |
|---|---|---|---|---|---|
| TC Community Issues | | | | | |
| Aftercare in the Community | | | | | |
| Socialization Issues | | | | | |
| Psychological Development | | | | | |
| Cognitive Skill Development (awareness, judgment, etc.) | | | | | |
| Emotional Skill Development (e.g. feelings, etc.) | | | | | |
| Healing Experiences | | | | | |
| Nurturance-Sustenance | | | | | |
| Physical Safety | | | | | |
| Psychological Safety | | | | | |
| Social Relatedness | | | | | |
| Subjective Learning | | | | | |
| Review Past Experiences, Personal | | | | | |
| Review diary | | | | | |
| Review Unit Issues | | | | | |
| Review Recent Incidents | | | | | |
| Review Past Experiences (street) | | | | | |
| Review Letters | | | | | |
| Other | | | | | |

Each Session

| Orientation | Used 1-5 | Purpose consistent with TC | Effectiveness | Not Used/ Applicable |
|---|---|---|---|---|
| Self-Help Model | | | | |
| Acceptance of Disease | | | | |
| Contemplation of Change | | | | |
| Motivation Readiness | | | | |
| Motivation | | | | |
| Action Planning | | | | |
| Maintenance | | | | |
| Relapse Prevention | | | | |
| Redefining Action | | | | |
| Aftercare | | | | |
| Spirituality | | | | |
| Other, Comments: | | | | |

Each Session

| | Used 1-5 | Purpose consistent with TC | Effectiveness | Not Used/ Applicable |
|---|---|---|---|---|
| **Style of Treatment** | | | | |
| Interactive | | | | |
| Introspective | | | | |
| Formal Interventions | | | | |
| Informal Interventions | | | | |
| Community Interventions | | | | |
| Punitive (e.g. House Bans, Sit Outs, etc.) | | | | |
| Reward (e.g. special events) | | | | |
| Listening Post | | | | |
| Staged Presentation | | | | |
| Check In | | | | |
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Describe the clinical intervention:

_____

_____

_____

_____

Give examples of the different clinical tools that were used: (e.g. diaries, stress management, leisure time activities, confrontations, etc.)

_____

_____

_____

What should they have done to achieve these goals of the session?

Strengths

Weaknesses

Each Session

## Counselor Style

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|---|
| Confrontation | | | | | | | |
| Directive/Goal | | | | | | | |
| Guidance | | | | | | | |
| Informative | | | | | | | |
| In charge | | | | | | | |
| Parental | | | | | | | |
| Authority | | | | | | | |
| Lax | | | | | | | |
| Experience Levels | | | | | | | |
| Process Orientation | | | | | | | |
| Others: | | | | | | | |
| | | | | | | | |
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| | | | | | | | |

Appeared to be professional? Yes/no

Recovering Yes/No

Other characteristics: _____

Each Session

**Jail:**_____ **Date:** _____

**Describe the Setting** (posters on the wall, type, influence)

**Describe the climate:**

Offenders

Staff

Materials Distributed

**Describe Distractions** (noise, radios, loudspeakers, motion, etc.)

**Describe Groups** (Talkative, Distractive, etc.)

## Case Management / Discharge Planning for Offenders

Date:_____ Observer:_____

Time: _____

1. Describe the main focus of the interaction with the offender (e.g. discharge planning, develop job, find treatment placement in the community, meeting the case manager, etc.)

_____

_____

2. What was the focus of the discussions?

_____

_____

3. Did the parole agent/counselor/other provide the client with information? If so, what type?

_____

_____

4. Did the parole agent/counselor/other require the offender to develop any materials (e.g. a plan, contacts, etc.)

_____

_____

5. Did the offender have any issues they wanted to discuss with the parole agent?

_____

_____

6. What was the main goal of the meeting?

_____

_____

7. Was another meeting scheduled? When and how?

_____

_____

Sessions_____
Site:_____

**OVERALL PROGRAM—Each Day**

| Programmatic Features | Used 1-5 | Purpose consistent with TC | Not Used/ Applicable |
|---|---|---|---|
| Community Separation | | | |
| Community Environment | | | |
| Community Activities | | | |
| Peers as Role Models | | | |
| Structured Day | | | |
| Phase Format | | | |
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Sessions_____
Site:_____

**OVERALL PROGRAM—Each Day**

| | Used 1-5 | Purpose consistent with TC | Effectiveness | Not Used/ Applicable |
|---|---|---|---|---|
| **Philosophy of Substance Abuse** | | | | |
| Disease | | | | |
| Self-inflicted | | | | |
| Subcultural | | | | |
| Labeling | | | | |
| Social Learning | | | | |
| Control Theory | | | | |
| Conflict Theory | | | | |
| Social Disorganization | | | | |
| Criminal Career | | | | |
| Environmental | | | | |

Sessions_____

Site:_____

**OVERALL PROGRAM –Each Day**

| | Used 1-5 | Purpose consistent with TC | Effectiveness | Not Used/ Applicable |
|---|---|---|---|---|
| **View of Recovery** | | | | |
| Change Negative Behavior | | | | |
| Change Negative Thinking | | | | |
| Developmental Process | | | | |
| Self Help | | | | |
| Motivation to change | | | | |
| Focus on Self view of Daily Work | | | | |
| Denial Issues | | | | |
| Abstinence | | | | |
| Moderation | | | | |
| Other | | | | |

| ROLES/DEFINITION OF UNIT | Used 1-5 | Consistent with across situations |
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Sessions_____
Site:_____

| Situation components (e.g. fights, violation of rules, personal dislikes, etc. ) | Used 1-5 | Consistent across situations | Progress over the week |
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Site:_____

**OVERALL PROGRAM—End of Week**

| Programmatic Features | Used 1-5 | Purpose consistent with TC | Effectiveness | Not Used/ Applicable |
|---|---|---|---|---|
| Community Separation | | | | |
| Community Environment | | | | |
| Community Activities | | | | |
| Peers as Role Models | | | | |
| Structured Day | | | | |
| Phase Format | | | | |
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Site:_____

**OVERALL PROGRAM—End of Week**

| | Used 1-5 | Purpose consistent with TC | effectiveness | Not Used/ Applicable |
|---|---|---|---|---|
| | | | | |
| **Philosophy of Substance Abuse** | | | | |
| Disease | | | | |
| Self-inflicted | | | | |
| Subcultural | | | | |
| Labeling | | | | |
| Control Theory | | | | |
| Conflict Theory | | | | |
| Social Learning | | | | |
| Social Disorganization | | | | |
| Criminal Career | | | | |
| Environmental | | | | |

Site:_____

**OVERALL PROGRAM –End of Week**

| | Used 1-5 | Purpose consistent with TC | Effectiveness | Not Used/ Applicable |
|---|---|---|---|---|
| **View of Recovery** | | | | |
| Change Negative Behavior | | | | |
| Change Negative Thinking | | | | |
| Developmental Process | | | | |
| Self Help | | | | |
| Motivation to change | | | | |
| Focus on Self view of Daily Work | | | | |
| Denial Issues | | | | |
| Abstinence | | | | |
| Moderation | | | | |
| Other | | | | |

| ROLES/DEFINITION OF UNIT | Used 1-5 | Consistent across situations |
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Site:_____

End of Week

| **Situation components (e.g. fights, violation of rules, personal dislikes, etc. )** | **Used 1-5** | **Consistent across situations** | **Progress over the week** |
|---|---|---|---|
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## Appendix B
## Operational Definitions for Structured Observation Items

VIEW OF RESIDENTIAL COMMUNITY - How the program uses the group as an agent of change.

Use of Participants- Individuals contribute directly to all activities of the daily life in the TC. This provides learning opportunities through engaging in a variety of social roles (e.g. peer, friend, coordinator, tutor).

Use of Membership Feedback- Social structure relies upon constructive criticism and other's opinions to aid in recovery. Peer membership is the primary source of instruction and support for individual change.

Use of Confrontation- Confrontation opens up the client to see where their problems lie. Therapist may play "devil's advocate" to increase comprehension of problems.

Use of Members as Role Models- Other members of the group make themselves available to share experiences and examples of how they can change.

Use of Collective Formats to Guide Individual Changes- The individual engages in the process of change primarily with peers. Education, training, and therapeutic activities occur in groups.

Use of Shared Norms/Values- Rules, regulations and social norms protect the physical and psychological safety of the community.

Use of Structured Systems- The organization of work used to maintain the daily operations of the facility. Learning occurs not only through specific skills training, but in adhering to the orderliness of procedures and systems.

Use of Open Communication- Clients feel open to express feelings, experiences and discomforts.

Use of Relationships/Friendships- Individual friendships with peers and staff are downplayed, while feelings of community and involvement with the whole group promote adherence to the change process.

TREATMENT ACTIVITIES - The type treatment activities carried out in the program.

Use of Discussion of Discharge- Therapist describes the criteria for both a positive and negative discharge from the treatment program.

Use of Therapy/Education- Focus on strategies for maintaining recovery on the outside.

Use of Peer Encounter Groups- The interaction with the community or therapeutic group is used to heighten individual awareness of specific attitudes or behavioral patterns to be modified.
Use of Awareness Training- Teach the client how to be aware of situations that might lead back to drug use. (Early stage of Relapse Prevention)

Use of Emotional Growth Training- Teach the client to express feelings and concerns more openly.

Discussion of goals of phase- Therapist discusses the goals for each phase of treatment.

Community and Clinical Management- Activities that maintain the physical and psychological safety of the environment. These include privileges, disciplinary sanctions, house surveillance and urine testing.

Community Enhancement- Activities that help the individual feel comfortable in the community. These include facility-wide meetings and ceremonies or rituals for deaths, birthdays, progress landmarks and graduations.

Relapse Prevention Training- Therapist discusses the keys to avoiding relapse.
Used in conjunction with trigger analysis.

Trigger Analysis- Discussion of what type of things cause a person to relapse into the use of controlled substances.

Parenting- Teach good parenting skills to those that may not have had these experiences growing up.

Educational Groups- Activities that increase client's awareness to the advantages of attaining an adequate education, or those that provide education.

Vocational Training- Teach vocational skills and their utility for the client post-release.

Use of Sharing Experiences- Clients share their drug experiences (i.e., relapse triggers, etc.) with the group in attempts to help other clients examine their substance abuse patterns.

Vocabulary- Teach therapeutic terms and their meanings.

Pull-ups- Used to confront inappropriate behaviors monitored by group members or staff.

Pre-release Planning - The group discussion focuses on the needs of the client after-release, use with Aftercare. Also deals with the relation between client's behavior in the TC and his/her behavior in the community.

TREATMENT TOPICS – Topics discussed during the treatment process.

Community Issues- Issues related to anticipated problems in the community.
Socialization Issues- Client is taught improved social skills (how to live with other people), especially as he/she returns to the community. The evolution of the client into a member of the larger society.

Psychological Development- Client is taught how to think more positively and develop clear, rational thinking. Development of maturity and responsibility.

Cognitive Skill Development- Teach skills that deal with self-awareness and using good judgment.

Emotional Skill Development- Helping the client learn to address their emotional issues.

Healing Experiences- Teach clients how to find experiences that are not harmful to their bodies, but that make them feel good about themselves.

Nurturance/Sustenance- Client is taught how to find what makes them feel happy, alive, and healthy.

Physical Safety- Issues related to the physical safety of clients in the community, used to facilitate self-examination and disclosure.

Psychological Safety- Issues related to the psychological safety of clients in the community, used to facilitate self-examination and disclosure.

Social Relatedness-The essential social experiences that directly reflects clients' relationships with others include identification and bonding.

Subjective Learning- Learning through examination of issues in terms of the client's own personal values.

Review Past Experiences - Clients talk about their past drug and street experiences to the group or therapist.

Review Diary- Client talks about any journal or diary entries that are pertinent to the discussion or the group session.

PROGRAM EMPHASIS - The program's philosophy of drug addiction and treatment.

Self-Help Model – Focus on the idea that the client is the only one who can change his/her behavior.

Acceptance of Disease- Focus on the idea that the client accepts his addiction as a disease (something beyond his/her ability to control).

Contemplation of Change- Focus on building client's awareness that a problem exists and that they must seriously think about overcoming it, though they have yet to make a commitment to take action.

Motivation Readiness- Preparation of the client to take action within the next month, and the client has unsuccessfully taken action in the past year.

Motivation- Focus on helping the client make the decision to change

Action Planning- The individual plans how to modify negative behaviors in order to overcome their problems (Action).

Maintenance- Focus on the client working to prevent relapse and consolidate the gains attained during the Action stage.

Relapse Prevention- Client learns which situations put him in danger of returning to substance abuse/criminality.

Redefining Action- Modification of the target behavior to an acceptable criterion and client makes significant overt efforts to change.

TREATMENT STYLE - Style of treatment delivery.

Interactive- Clients are active in treatment activities, which may include open group discussion or role-playing.

Introspective- Activities are delivered in such as way as to promote self-exploration and awareness.

Formal Interventions- Planned/scheduled activities such as meetings, groups and one-to-one counseling sessions.

Informal Interventions- Unplanned sessions that are informally initiated by group members.

Community Interventions- Activities are delivered to the entire group of participants, most treatment is delivered in a group format.

Punitive- Meetings designed to deliver punishments to clients for negative behavior.

Reward- Meetings designed to provide benefits to clients for positive behavior.

Listening-post Activities- Activities in which a client or a group of clients are singled-out and confronted about their behaviors in the TC. The confronted clients are made to listen to their peers and not respond.

Stage Presentation - A client presents some set of information, for example about his/her life story to the group.

## Appendix C
## Interview Guide-Clinical Director

1. What is your role in the RSAT program?
2. In your opinion, what is the main purpose of the correctional facility?
   What is the main purpose of the treatment facility?
3. What were some of the challenges to developing and implementing this program?
   Who were the advocates of the program?
   What types of issues must be addressed to implement the program?
4. What training was undertaken to prepare the RSAT staff to work with the correctional staff?
   Why or why not?
5. What programmatic changes do you feel should be made to improve client outcomes?
   Why?
6. What are the goals and objectives of each of the RSAT levels (A, B, C, and D)?
7. What institutional changes do you feel are necessary in order to enhance the functioning of your modified therapeutic community?
   Why?
8. What program components do you feel need to be added to or deleted from your program in order to improve its functioning and effectiveness?
   Why?
9. What types of clients are suitable for this RSAT program?
10. How does RSAT relate to RAC?
    How are clients different in the two different programs?
11. What do you hope that the client accomplishes in his six months in the RSAT program?
12. How does the correctional facility respond to positive drug tests?
    How does the program respond?
    Do the offenders know when they are going to be drug tested?
13. What processes have you attempted to put in place in order to transition clients into aftercare in the community?
    What aftercare services are being provided to clients?
    How will you track these clients upon release?
    How will you exchange information on these clients between yourself and their community-based treatment providers?
    Supervision agents?
14. What criteria are used to decide what types of aftercare each RSAT client receives?
15. If a client fails the RSAT program, can he reenter?
    What are the conditions of reentry?
16. If you could be given additional funds to improve the RSAT program, where would you funnel the money?

*****

1. Is there anyone you can recommend to give me additional information regarding the MD RSAT program?
2. Where can I find names of parole officers and treatment providers who will be handling the RSAT clients once they have graduated from the program and are in the community?

## Appendix D
## Interview Guide-Inpatient Coordinator

1. What is your role in the RSAT program?
2. In your opinion, what is the main purpose of the correctional facility?
   What is the main purpose of the treatment facility?
3. What were some of the challenges to developing and implementing this program?
   Who were the advocates of the program?
   What types of issues must be addressed to implement the program?
4. What staffing issues affect the program in terms of day-to-day operation? Why?
5. What training was undertaken to prepare the RSAT staff to work with the correctional staff?
   Why or why not?
6. What programmatic changes do you feel should be made to improve client outcomes?
7. What do you hope to accomplish in each of the following sessions?
   Crime and Drugs
   Feelings
   Community Group
   Denial
   Recovery
   Anger Management
   Social Skills
   Decisions
   Abuse
   Family Issues
   Drug and Alcohol Education
   Community and Family Support
   Stress and Time Management
   Employment Readiness
   Relapse Prevention
8. Do the clients have assigned roles in their therapeutic community?
   Why or why not?
9. What institutional changes do you feel are necessary in order to enhance the functioning of your modified therapeutic community?
   Why?
10. What program components do you feel need to be added to or deleted from your program in order to improve its functioning and effectiveness?
    Why?
11. Do you feel it is necessary to improve the relationship between the correctional and the treatment staff at your facility?
    Why or why not?
    What changes would you make?
12. Do you feel cross-training could be undertaken to foster a more positive working relationship between the correctional and treatment staff?
    Why?

13. Does the RSAT staff enjoy working with the correctional staff?
    Why or why not?
14. Do you feel that treatment is given a priority within this correctional setting?
15. What types of clients are suitable for this RSAT program?
    How do offenders find their way into the RSAT program?
16. How does RSAT relate to RAC?
    How are clients different in the two different programs?
17. What do you hope that the client accomplishes in his six months in the RSAT program?
18. How does the correctional facility respond to positive drug tests?
    How does the program respond?
    Do the offenders know when they are going to be drug tested?
19. What processes have you attempted to put in place in order to transition clients into aftercare in the community?
    What aftercare services are being provided to clients?
    How will you track these clients upon release?
    How will you exchange information on these clients between yourself and their community-based treatment providers?
    Supervision agents?
20. If you could be given additional funds to improve the RSAT program, where would you funnel the money?