Residential Substance Abuse Treatment (RSAT) for State Prisoners Formula Grant: Compendium of Program Implementation and Accomplishments

FINAL REPORT

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Introduction to RSAT Compendium

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As the administrator of the Residential Substance Abuse Treatment (RSAT) for State Prisoners Formula Grant, the Office of Correctional Programs has provided valuable information in the following document. It is commendable that the RSAT grant provides funding to encourage states to develop substance abuse treatment programs for incarcerated offenders. However, it is as equally significant and beneficial to RSAT program participants, that an objective evaluation of the program was performed and later summarized in this report.

With the advent of performance based budgeting and increased accountability to tax payers, substance abuse professionals are finding it more important than ever to be able to clearly articulate and demonstrate, with data, both the success and cost-effectiveness of programs. A program that can be proven to be both beneficial to the offender population and cost-effective to the government can be promoted for future existence and expansion. It is responsible business to fund programs that work.

Beyond the more obvious concern of funding maintenance and acquisition, lies the real benefit of the type of objective program evaluation modeled in this report. An unbiased critique offers program administrators an opportunity to modify, improve, or discontinue a program based on the results it has produced. An evaluation report may reveal that a program can achieve the goal it was designed to achieve with just a few modifications. It may also reveal that the program simply isn't producing enough results to justify funding the program any longer. Pilot programs can be set up so that the success or failure of that pilot program is measured by an objective evaluation. Program administrators know which programs are producing the best results for the best price. Furthermore, program administrators no longer have to convince the general population and government that treatment works. The programs prove themselves through data.

It is also important that program data is collected carefully so that it truly represents what is actually occurring in reality at the program. Program administrators not only have to continually improve the programs, but also data collection and management procedures. Data is only an effective tool in program evaluation if it represents program reality. When data accurately reflects program reality, it is invaluable assessment tool that will provide important evaluation reports.

A report such as this RSAT evaluation report also allows the sharing of ideas within the substance abuse profession. One state can learn from another state's successes and/or failures in program development, implementation, and evaluation. Substance abuse professionals' awareness of the presence of similar programs around the country opens new channels of communication. If we endeavor to continue to look objectively at our programs and to enter into an open dialogue with the treatment community, we need to present what we have learned in our process and discovered about our programs. The publication of the Compendium presents an opportunity for RSAT participants to make new contacts, gather new ideas, and offer suggestions.

All in all, this Compendium represents a significant accomplishment, both for the programs reviewed herein and for the RSAT program creators. This charge goes to the recipient of this report. Do not simply toss this document into a pile, but use it as the practical tool it has the potential to become. A tool is only valuable in the hands of one who chooses to use it skillfully.

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RSAT Compendium

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1. Executive Summary

The Residential Substance Abuse Treatment (RSAT) for State Prisoners Formula Grant Program was created by the Violent Crime Control and Law Enforcement Act of 1994. RSAT has encouraged States to develop substance abuse treatment programs for incarcerated offenders by providing funds for their development and implementation. With the prison population at a record high and substance abuse problems present for the majority of inmates, the RSAT program has the potential to help break the drug-crime nexus for many offenders, greatly reducing relapse and recidivism. Treatment has been shown to be cost-effective primarily through reductions in costs of crime, criminal justice services and health care services. The funding for the RSAT initiative was $270 million, divided across 5 years (1996-2000), representing the largest sum ever devoted to the development of substance abuse treatment programs in State and local correctional facilities. Each State received a base amount of 0.4 percent of the total funds, and the remaining funds were allocated on the basis of the ratio of the prison population of each State to the total prison population of all participating States. The mean award for implementing the RSAT treatment programs to the States was about $450,000 in FY96, rising to about $495,000 in FY 97, and then a million in FY 98.

The RSAT grant funds may be used to implement (or expand) treatment programs for inmates in residential facilities operated by State and local correctional agencies that provide individual and group treatment activities for inmates and:

- are 6 to 12 month in duration,
- are provided in residential treatment facilities set apart from the general correctional population,
- are directed at the inmate's substance abuse problems,
- are intended to develop the inmate's cognitive, behavioral, social, vocational and other skills so as to solve the substance abuse and related problems,
- continue to require urinalysis or other drug and alcohol testing during and after release.

States are required to give preference to programs that provide aftercare services coordinated between the correctional treatment program and other human service and rehabilitation programs.

The funds for the RSAT programs at the State level are administered by the Corrections Program Office (CPO). The National Institute of Justice (NIJ), in partnership with CPO, provided funds and oversight for an evaluation of the RSAT program. This report reviews findings from 12 local site evaluations funded for 15 months and a national evaluation that documented the RSAT program through its midpoint. Although it is not clear how representative these evaluations are of all the RSAT programs, they meet NIJ's goal of evaluating a variety of programs including programs for adults and juveniles, males and females, and prison and jails.

National evaluation. The national evaluation was funded for $500,000 over two years, although the expectation was that it would be renewed for up to three additional years. Initially, the national evaluation had an ambitious process and outcome agenda examining: the types of RSAT treatment programs and client characteristics, the impact of the RSAT program on treatment capacity and the

costs of treatment, and the key elements of successful programs. The National Development and Research Institutes, Inc. (NDRI) undertook the National Evaluation of RSAT, referred to as NERSAT. NDRI collected data from all the States and programs using a series of three questionnaires. Through the surveys and outreach efforts with local evaluators, NDRI identified 77 operating RSAT programs by August, 1998.

NERSAT found three primary treatment modalities in the RSAT programs: therapeutic communities or TCs, cognitive behavioral approaches, and 12 Step programs (AA/NA). About 60% of RSAT programs reported using some elements of the TC approach. Some cognitive behavioral approaches were reported by most programs, and 12 Step programs were also nearly universal. Based on the surveys, NERSAT categorized 58% of the programs as combined or mixed modalities, 24% as primarily TCs, 13% as cognitive behavioral approaches, and 5% as primarily 12 Step programs.

Unanimously, State officials reported that RSAT increased their State's treatment capacity for substance abusing prison inmates. Although the information provided by the States was often not comparable, NERSAT concluded:

- prison treatment slots increased from an average of 330 slots to an average of 400 per year per State over the 2-year evaluation period;
- non-residential treatment slots increased from an average of 842 in FY95 to 910 in FY98;
- the numbers of State treatment staff increased from 17 full-time equivalent staff (FTEs) prior to the implementation of RSAT to 26 by the end of 1998;
- 9,600 treatment beds or slots that were created as a result of the RSAT initiativ;

- although many programs had not yet opened, over 13,000 inmates had been admitted to RSAT treatment programs, 3,600 inmates had graduated, and 7,700 inmates were still in RSAT programs;
- over 860 FTEs staff were providing treatment in 97 programs that were either open or about to get underway by March, 1999.

The majority of RSAT programs were in State prisons, although 17 were in jails. About 70% of operational programs at midpoint were aimed at adult offenders, with the remainder targeting juveniles. About 70% of RSAT treatment programs were for males, 12% for women, and the remaining 18% included both genders.

NERSAT produced only a partial and preliminary picture of the scope and early accomplishments of the large national RSAT program. Nevertheless, there were important lessons from the national evaluation. The major problems reported by State officials were locating or constructing appropriate facilities and recruiting appropriate staff. Over half did not have one or more treatment components operational, and about half indicated the program was still in the "shake down" phase. The national evaluation expressed concern over the lack of aftercare. Concern was also expressed about the mixing of treatment components in the RSAT treatment programs, that may be incompatible and have no proven track record.

Local site evaluations. Like the national evaluation, many of the local site evaluations were actually partial evaluations usually encompassing 15 months near the beginning of a 3-4 year RSAT program. Considering the short duration of the grants, the funding available, and timing of the evaluation studies which often coincided with program start-up, many of the evaluations were modeled after process evaluations. However, responsiveness to NIJ dictated that the evaluation also

include elements typically found in outcome evaluations. Therefore, the evaluation studies were not standardized and tended to blend process and outcome elements. Nevertheless, many of the themes found in the national evaluation were echoed in the local site evaluations.

All the RSAT programs established treatment programs that attempted to be responsive to the RSAT initiative's multi-modal treatment approach. Only one of the 12 programs evaluated did not indicate it was a TC or incorporated major elements of TCs. However, several that labeled themselves as TCs or modified TCs contained few of the elements typically found in TCs. At least one RSAT program was not isolated from the remainder of the general incarcerated population, which is in contradiction to the requirements of the RSAT formula grants. All 12 included cognitive behavioral elements and AA/NA meetings and/or 12-step philosophies.

Virtually all the programs experienced moderate to severe start-up problems. The exceptions were those pre-existing programs expanded with RSAT funds. [These programs also had start-up problems, but they occurred before the RSAT initiative and evaluation.] The evaluation reports documented that administrative expedience and demands often took precedence over program operations. This included having to accommodate the following kinds of problems:

- initially filling a program to capacity even if there weren't sufficient staff;
- inexperienced staff;
- inappropriate inmates;
- not isolating the treatment program clients due to overcrowding and the need to fill all beds;
- graduates returned to the general prison population at treatment completion;
- too great or too little demand for treatment from inmates.

The evaluations documented the many and varied demands and obstacles placed on the RSAT treatment programs that were beyond their control. Several States had little to no aftercare, or aftercare was 'planned' and not implemented. Few programs delivered all the services they planned, even programs that had a full staff complement. Many of the RSAT programs experienced inordinate staff turnover. However, other contributing factors appear to be endemic to all prison employment -- the isolated location of many prisons, the poor pay, and the lack of appeal of the correctional institution's environment. Several of the correctional institutions had policies discouraging, if not denying, employment to those with a criminal background or persons in recovery. TCs are often staffed with a mixture of recovering TC graduates and degreed professionals. It was very difficult to locate qualified treatment staff, so imposing these types of limits placed further constraints on the programs. There remains a paucity of training for treatment staff, and, with their high turnover rate, there needs to be more attention nationally to providing training for correctional treatment staff.

Nearly all programs experienced difficulties with inappropriate referrals. These generally took the form of inmates with too little or too much time remaining on their sentences. Some programs were successful in matching sentence to treatment. South Carolina created a novel RSAT program in that the sentence length of offenders sentenced to the RSAT program under the Youthful Offenders Act was based on treatment completion. Similarly, in Pennsylvania, technical parole violators were sentenced for 12 months to correspond to the RSAT programs' 6 months in-prison and 6 months aftercare components. Tying sentence length to treatment completion also serves as a motivator for inmates to complete the programs in a timely manner.

With the litany of identified problems, one might conclude the RSATprograms had few achievements. However, most of the identified problems were those of start-up programs trying to be responsive to the multiple and conflicting demands placed upon them. Their major achievements were implementation of treatment programs in correctional environments, and progress towards stabilizing the programs. The evaluation reports emphasized the difficulty of establishing and maintaining a treatment program within a correctional setting. Even with adequate resources and excellent administrative support from the correctional system, program implementation was a tortuous process, and program stability was not reached for two to three years at a minimum. It is not surprising that many of the RSAT programs had slow and problematic start-up periods. It is perhaps more surprising that so many of them were doing as well as they were during early program phases, and it is most unfortunate that the local site evaluations were not able to encompass a program's entire history.

Summary. The programs that fared the best were those that were established programs that used RSAT funds to expand operations, and those that had higher level administrative support and cooperation. The support of higher level administrators was essential to weather many of the implementation obstacles. Even when programs faced major problems in program implementation, if the State administration and prison officials had a commitment to treatment, there were good prospects that the program will develop, stabilize, mature, and become a regular part of the correctional system. Also, those programs that had experienced and well trained staff had fewer implementation difficulties. However, due to the low pay, isolation, and the correctional environment, there will likely be problems with finding experienced staff.

The RSAT program has had significant national implications for treating drug involved offenders. Prior to the RSAT program, there was no national mandate or directive positing the value of treatment with criminal justice populations. With the RSAT program in operation, every State has been exposed to and offered a "carrot" to expand its residential treatment capacity. Every State has applied for and is using the RSAT funding to expand their treatment capacity. It remains to be seen if the gains in capacity will be retained once RSAT block funding to the States ends after 2000.

Another important observation from the RSAT evaluations, both national and local, is the need for treatment options in jail settings. Jail-based offenders with substance abuse problems are a significant group, as the DUF/ADAM studies have made clear. However, the transient nature of jail-based populations is not conducive to a lengthy, structured treatment program. Corrections, as well, has less time and resources for jail-based programs. Still, the attraction remains of treating those in jail. The lessons from the jail-based program evaluations are that treatment modality should fit correctional mandates, and jails should incorporate short term education and intervention rather than long-term phased treatment.

There are two other areas of major theoretical and practical interest that emerged from the local evaluations that should be examined. First is the appropriateness of TC treatment or some other modality for the client. TCs are generally cheaper than other residential treatment modalities since they are less reliant on paid professional staff. AA/NA approaches have also been favored in prisons primarily because they are "staffed" by volunteers. Support also continues in the community with the availability of 12-Step meetings. It is important to determine the mix of elements that contribute to inmates success, and which treatment modalities are most appropriate for what type of inmates. The second area that needs to be considered is the compulsory versus voluntary nature of treatment.

Compulsory treatment may be the "stick" that increases the length of time in treatment, the most consistent program characteristic associated with long term client success. Conversely, a sentence reduction or tying sentence length to successful program completion can serve as the "carrot" that gets more offenders to volunteer for treatment.

There are three recommendations with respect to future plans of OJP, CPO and NIJ.

● First, the local evaluations demonstrated that, with a functioning program, good internal data collection and management, good working relationships between program staff and outside evaluations, and with resources for evaluation, it is possible to do a very successful evaluation. However, any process evaluation requires several years of data to be really informative, and any meaningful outcome evaluation will require sufficient sample sizes, appropriate comparison groups, and sufficient time to conduct a prospective analysis to see if successes are maintained over a reasonable follow-up time after release from prison. Longitudinal evaluations are necessary to really evaluate programs, and they should last for a minimum of three years for a process evaluation and five years for an initial outcome evaluation.

● Second, a strong recommendation for future funding of offender treatment programs is to offer funding for aftercare programs for existing State residential programs. One of the most consistent findings across the RSAT evaluations, both national and local, was the lack of effective aftercare programming. As noted by Pearson and Lipton, 1999; Wexler et al., 1999; Knight et al., 1999; and Martin et al., 1999, clients who receive aftercare do significantly better than clients who do not. These recent outcome evaluations suggest that treatment programs for offenders need a strong aftercare component, and, probably, the aftercare should be tied to probation or parole stipulations. The Office of Justice Programs should consider introducing a new program to fund aftercare

programs for existing and ongoing residential treatment programs that have been sponsored by RSAT. A good aftercare program is not cost-free by any means, but the cost per client will be much less than a residential treatment slot. Such a new initiative would be cost-effective and would build on the residential treatment program funded by RSAT.

● Third, there is a need for more Federal cooperation in the area of providing treatment and in evaluating its effectiveness. One of the lessons from the local site evaluations was the necessity of pre planning and cooperation and coordination between criminal justice and public health administrators and agencies. Such a model of collaboration needs to be replicated at the Federal level among agencies interested in treatment for drug involved offenders. In the early 1990s, NIJ, NIDA and CSAT had several meetings where the Federal agencies and their grantees shared information, findings, and strategies. It would be tactical if these agencies and others interested in treatment for criminal offenders would renew these efforts and move a step further to real collaboration. The RSAT initiative and the programs it spawned are a potential laboratory for research in treatment efficacy.

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2. Overview of RSAT Program

The Residential Substance Abuse Treatment for State Prisoners Formula Grant Program was created by the Violent Crime Control and Law Enforcement Act of 1994. The Act authorizes programs to support both the treatment and punishment of drug-using and violent offenders. The Residential Substance Abuse Treatment (RSAT) for State Prisoners Formula Grant was established to address the treatment goal of the Act. RSAT encourages States to develop substance abuse treatment programs for incarcerated offenders by providing funds for the development or enhancement of existing substance abuse treatment programs. The RSAT funds are administered by the Corrections Program Office (CPO) of the Office of Justice Programs (OJP) within the U.S. Justice Department.

The RSAT program was designed to be responsive to the increasing number of incarcerated individuals in the U.S. and their identified substance abuse problems. At the end of 1998, there were 1,302,019 State and Federal prison inmates and 592,462 adult inmates in local jails, totaling more than 1.8 million incarcerated men and women (Beck and Mumola, 1999). This record high represents a near doubling in the numbers incarcerated since 1985 when 744,200 inmates were incarcerated (Gillard, 1999). Since 1990, the State prison population has grown by 65% and the Federal prison population by 106%. During the 1998 calendar year, the prison population grew 4.8%, or an average of 1,151 new inmates each week (Beck and Mumola, 1999).

A significant portion of the increase in the prison population may be attributed to drug offenses. In 1986, drug law violators comprised 9% of the population in State prisons. By 1991, this figure had increased to 21% (BJS, 1994) and by 1995, drug offenders made up 23% of the State prison population (ONDCP, 1998). They constituted about 21% of State prison inmates in 1997. Local

jails show the same general trend, with the percentage of drug offenders rising from 9% in 1983 to 23% in 1989, and 22% in 1996 (BJS, 1995; Harlow, 1998). Drug offenders constitute an even greater share of the Federal prison population. They totaled 25% of the population in Federal prisons in 1980. By 1986, their percentage was 38% and by 1993, it had risen to an astronomical 61% (BJS, 1995). It remained at about 60% on October 31, 1997 (ONDCP, 1998). Estimates by statisticians at the Bureau of Justice Statistics are that 72% of the growth in the Federal prison system in the period 1990-1996 was due to drug violations (The Washington Post, March 15, 1999). Many incarcerated drug offenders report fairly extensive criminal histories, having been on probation, parole, or on escape at the time of their arrest. Many have had a prior sentence (Mumola, 1999).

The 1997 Survey of Inmates in State and Federal Correctional Facilities found half (52%) of State prison inmates and a third (34%) of Federal prison inmates reported they were under the influence of alcohol or drugs while committing the offense leading to their imprisonment. This representative survey of inmates found that alcohol use at the time of offense was reported by 37% of State and 20% of Federal inmates, and illicit drug use at the time of the offense was reported by 33% of State and 22% of Federal inmates (Mumola, 1999). Similar proportions committing property crimes and violent crimes reported being under the influence of alcohol or illicit drugs as among those charged with drug related offenses . Even more direct connections between drug use and criminal offending is evident from the 1991 Survey of State Prison Inmates in which 17% of prisoners reported committing their offense in order to purchase drugs. Data from the Bureau of Prisons shows that 10% of Federal prisoners in 1991 admitted committing their offense in order to purchase drugs. And a representative survey of jail inmates in 1989 found 13% reported committing their offense to buy drugs (BJS, 1995).

The connections between drug abuse and criminal activity have long been recognized. But the efficacy of treatment has only recently been acknowledged with policymakers mandating treatment in the criminal justice system. The last decade has seen some reversal of policies and practices. In fact, many who currently work in the criminal justice system (police, judges, probation/parole officers, correctional personnel, and others) now serve as major sources of referral to, and payment for, drug abuse treatment (McLellan et al., 1996). The criminal justice system has become the largest source of mandated, or coerced, drug treatment in the U.S. (NIDA, 1992).

One of the classic questions in drug abuse research is whether or not the benefits of treatment outweigh the economic cost. Although different treatment modalities are associated with different costs, the answer appears to be that drug abuse treatment is cost beneficial regardless of which treatment modality is considered. Perhaps the classic study in this arena was published by the California Department of Alcohol and Drug Programs in 1994 (Gerstein et al., 1994). Known as the California Drug and Alcohol Treatment Assessment (CALDATA) study, this 2-year study included a rigorous probability sample protocol of the almost 150,000 individuals who received alcohol and/or drug treatment in 1992 in California. All treatment modalities were incorporated including methadone treatment. The estimated cost of treating the 150,000 treatment receivers was $209 million. Weighed against this were the estimated benefits amassed during treatment and in the first year thereafter; this figure was estimated at about $1.5 billion. Simple division shows that for every dollar spent on treatment, approximately $7 in future savings costs could be gained. Generally these gains took the form of reduced criminality and a reduction in hospital episodes for health problems. Criminality, from before to after treatment was received, was reduced by two-thirds and hospital episodes by one third. Nearly a 40% reduction was also realized in the before-after model in the use

of alcohol and other drugs. Also of note was the finding that no differences were found in treatment efficacy by gender, age, or ethnic group (Gerstein et al., 1994). Recent economic research suggests the quickest and most cost effective way to reduce the cost of drug abuse to the nation as a whole, is to treat chronic hard drug users (Reuter, 1997; Caulkins and Reuter, 1998).

The RSAT program represents the largest sum ever devoted to the development and enhancement of substance abuse treatment programs in State and local correctional facilities. The funding for the 5 year effort was $270 million, divided across 5 years. The sums for each of the years from 1996 to 1998 were $27 million, $30 million, and $63 million, respectively. In 1999 and 2000, $63 million and $72 million respectively were available each year for the program. Each State receives a base amount of 0.4 percent of the total funds, and the remaining funds are allocated on the basis of the ratio of the prison population of each State to the total prison population of all participating States. A match of 25% in cash funds for the RSAT program must be contributed by the States. The grants are for three years and cannot be used to supplant non-Federal funds that would otherwise be available.

The RSAT grant funds may be used to implement (or expand) treatment programs for inmates in residential facilities operated by State and local correctional agencies that provide individual and group treatment activities for inmates and:

- are 6 to 12 month in duration,
- are provided in residential treatment facilities set apart from the general correctional population,
- are directed at the inmate's substance abuse problems,
- are intended to develop the inmate's cognitive, behavioral, social, vocational and other skills so as to solve the substance abuse and related problems,

- continue to require urinalysis or other drug and alcohol testing during and after release.

States are required to give preference to programs which provide aftercare services that are coordinated between the correctional treatment program and other human service and rehabilitation programs.

Another important requirement of the RSAT initiative to States was to "ensure coordination between correctional representatives and alcohol and drug abuse agencies at the State and, if appropriate, local levels. This should include coordination between activities initiated under the Program and the Substance Abuse Prevention and Treatment Block Grant provided by the Department of Health and Human Services Substance Abuse and Mental Health Services Administration."

The National Institute of Justice (NIJ), in partnership with CPO, provided funds and oversight for an evaluation of the RSAT program. The first Request for Proposals (RFPs) evaluating RSAT programs by NIJ provided funds for 18 awards of $50,000- $60,000 each for local evaluations, and one national evaluation using data provided by the States for up to $500,000. The local evaluations were intended to last about 15 months, while the national evaluation was funded for two years (although the expectation was that the national evaluation would be continued over the life of the RSAT program, for 5 years). The second RFP in FY98 provided for 7 more local site evaluations (6 process and 1 outcome). NIJ also issued subsequent solicitations requesting both local process and outcome evaluations resulting in 12 new process evaluations (funded up to $60,000 and 15 months), and 17 new outcome evaluations (funded up to $100,000 and 24 months). This report includes information gleaned from 12 local evaluations and the national evaluation funded under the first and second RFPs that have submitted final reports to NIJ.

The language in NIJ's first and second RFP was nearly identical, although the national evaluation was only requested in the first RFP. The type of local site evaluation was not specified in the RFP. The mandate was to provide measurement of program characteristics, and:

- allow and prepare for subsequent impact evaluations.
- incorporate some meaningful comparison group.
- use valid and reliable measurement.

Evaluation were also "to the extent possible, [to] be conducted in collaboration and cooperation with the national evaluation." NIJ hoped to create standardized data elements across local evaluations. NIJ also wanted to fund local evaluations that "reflect a spectrum of programs, including programs for adults and juveniles (males or females), State correctional facilities and local jails, programs based on different theoretical approaches, and programs in different regions of the United States." Local evaluators could focus on all participating programs in a State, or a subset.

The local evaluations were given "some discretion" in the choice of evaluation topics. The lack of specific instructions resulted in non-standardized local evaluations. Based on the relatively small amount of funding available for the evaluations, the timing of evaluations that often coincided with program start-up, and the 15-month evaluation period mandated in the RFP, most of the evaluations were process evaluation. Process evaluations focus on documenting and assessing program implementation. However, in attempting to be responsive to the RFP, some evaluations primarily focused on preparing for outcome evaluations rather than assessing implementation difficulties. NIJ's third RFP is much more specific in requesting process and outcome evaluation studies. Therefore, in the first and second round of local site evaluation reports, there is a mix of elements that may be found in process and outcome evaluations.

The instructions in the RFP for the national evaluation are somewhat more specific. The national evaluation was designed to include both process and outcome components examining the types of programs and client characteristics. The natioanl evaluation also included a technical assistance component to enhance State correctional residential substance abuse programs. The grantee was also expected to identify promising programs for intensive impact evaluations, appraise the evaluation capacity of the "State residential substance abuse programs," and enhance those capacities through feedback and technical assistance.

The National Development and Research Institutes, Inc. (NDRI) entered into a cooperative agreement with NIJ and CPO to perform the national RSAT evaluation. NDRI planned to evaluate the accomplishments of the RSAT program during its first two years through a series of surveys. Rather than using a sample of programs, however, they proposed to collect data on the census of States and programs using RSAT funds. This was an ambitious undertaking as all fifty States, the 5 U.S. territories, and the District of Columbia developed plans for RSAT programs. The national evaluation report covers RSAT through the midpoint of its existence on December 31, 1998. (Information was updated through March 30, 1999 for the final report.) By that time, they had identified 97 programs that were operational or about to become operational.

There were inherent difficulties in conducting the national evaluation (either a process or outcome evaluation) as programs were continuing coming on-line. The number and types of programs and the characteristics of the clients they served were constantly in flux. Since the RSAT initiative was rapidly expanding, new issues became apparent as it matured. Therefore, the focus of the national evaluation was also somewhat in flux over its history. The national evaluation ended at the midpoint of RSAT's existence without even fully keeping abreast of the activities in all the

States and territories, and in all the RSAT treatment programs up to that point. The next section provides more detail from the findings of the national evaluation.

3. Review of National Evaluation Report from NDRI (1997-1998)

The national evaluation was funded for $500,000 over two years, although the expectation was that it might be renewed for up to three additional years. The key function of the national evaluation was to track implementation nationally, using data provided by the States and programs. The evaluation was to include process and outcome elements examining the types of programs and client characteristics that RSAT was funding, the impact of the RSAT program on treatment capacity and the costs of treatment, and the key elements of successful programs. The grantee was also expected to identify promising programs for intensive impact evaluations, appraise the evaluation capacity of the "State residential substance abuse programs," and enhance those capacities through feedback and technical assistance. NIJ hoped to develop a coordinated data set from the data gathered from the RSAT programs. Each State was required to submit an annual report and to cooperate with the data gathering requests of the national evaluators. Additionally, the local evaluations were to provide more specific and detailed program data.

The National Development and Research Institutes, Inc. (NDRI) entered into a cooperative agreement with NIJ to undertake the National Evaluation of RSAT, referred to as NERSAT. Rather than study a sample of the funded States and programs, NDRI proposed to collect data from all the States and programs to document the accomplishments of RSAT during its first two years. Much of the data NDRI wanted to gather was to be accomplished through three surveys mailed to each State: a Survey of the key Official in each State responsible for the RSAT program, a Survey of RSAT-funded Program Directors, and a Follow-Up Survey of key State Officials (referred to hereafter as the Initial State Survey, Program Survey, and Final State Survey, respectively).

NERSAT Evaluation Methodology

The original design of the national research evaluation was modified over its existence so that little priority was placed on finding model programs for outcome evaluations. The technical assistance component was also phased out (CPO has a technical assistance contractor that provides training at national and regional workshops, as well as onsite). The primary goal became that of collecting data from a census of the States and programs using RSAT funds. The Corrections Program Office (CPO) provided contact information on State officials serving as the RSAT contact person to whom the Initial State Survey was mailed. These surveys asked for contact information on the RSAT program(s) and director(s).

The Program Survey was aimed at actual RSAT programs, but some States' programs were still in the planning or development stage. Since new programs were continually coming "on line" and CPO had no national directory of programs, NDRI had difficulties identifying the programs and the appropriate person to complete the survey. The complexity of conducting a process evaluation of a "moving target is readily apparent.

Process evaluations are normally based on observational data and interaction with program and facility staff. Information is generally gathered first hand, but such a procedure was not possible with up to 97 programs in 50 States, 5 territories, and DC. The national evaluation made no site visits, but tried to satisfy the goals of the initiative by conducting surveys on the census of RSAT funded States and programs. The use of extensive and persistent follow-up methods to gather information on the RSAT programs resulted in high response rates on their 3 surveys. The first mailing of the State survey netted a response rate of about one third, and the first mailing of the program surveys netted a response rate of about 25%. Through subsequent efforts, including

multiple follow-ups with State officials, 77% of the States completed the Initial State Survey and 82% completed the Final State Survey.

Between the first mailing in November, 1997 and August, 1988, through the surveys and outreach efforts with local evaluators, NDRI identified 77 apparently operational RSAT programs. Six more were being planned. Of these 77 programs, 70 (91%) returned the Program Survey. Again, this was a commendable response rate for a mail survey. Information from questionnaires through March, 1999 was included in the national evaluation. Despite the high response rates, however, there were difficulties with the survey data. The questionnaires were put together by a committee, and questions are sometimes awkward, ambiguous, and arcane. Many questions were skipped by respondents. It is obvious that different respondents interpreted questions differently. Often, they provided information in the way it was readily available to them rather than restructuring it to directly respond to the questions. So the information is often not comparable across the States.

The Final Report of the National Evaluation consists of a review of the main treatment approaches used in residential treatment programs. The Report provides a summary page for each State with correctional and treatment statistics for the State, a map identifying RSAT program locations, and a summary table of RSAT implemented programs in the State. The report summarizes the RSAT implementations at midpoint, and highlights key findings and problems.

Treatment Modalities and Their Use in the RSAT Programs

There are three primary treatment modalities identified by the NDRI evaluators: therapeutic communities or TCs, cognitive behavioral approaches, and 12-Step Programs. The National Evaluation spends about a fifth of the Final Report Narrative reviewing Treatment Approaches in

general. In practice, none of these approaches exists in a pure form. Even the strictest TC has cognitive behavioral group work and includes 12-Step meetings. And many of the TC techniques such as group encounters, rewards and punishments, and phased programming are used in other programs. The RSAT enabling legislation encouraged mixed modality approaches, and many RSAT programs have implemented very mixed programs. There are potential strengths and weaknesses to mixing modalities, as reviewed below. In any case, it is safe to say that the RSAT programs did not rely on a single modality.

Therapeutic Community. The primary treatment modality implemented in the RSAT treatment programs was a TC, modified in various ways to fit the structure of the institution, or to balance other cognitive-behavioral approaches. The national evaluation report at midpoint indicated about 60% of RSAT programs were using at least some self-identified elements of the TC approach. The typical community-based TC is a residence with a few professional staff, and with recovered addicts serving a mentoring and staffing role. The typical TC is 6-12 months in duration, and residents progress through a phase system, gaining increased responsibility. Residents are involved in all aspects of governing the TC and its operations. The TC is organized hierarchically, with a clear chain of command. New residents are assigned to the lowest level of jobs in the hierarchy and earn better work positions and privileges as they move up the chain of command. They take responsibility for their own and others' treatment. This may be one of the most distinguishing features of a TC; the use of the community as the primary method for facilitating an individual's social and psychological change. Another distinguishing feature is the isolation of the TC. The requirement of the RSAT RFP was that programs be set apart from the general correctional population, which is a hallmark of correctional TCs.

The TC views drug abuse as a disorder of the whole person with drug abuse as a symptom, so treatment is designed to address the whole person. Drug abuse and other behavioral problems are seen as symptoms of immaturity and low self esteem. Groups and meetings provide positive persuasion to change attitudes and behaviors, and confrontation by peers when values or rules are violated. The TC socializes individuals and helps them develop a sense of personal identity and the values, attitudes and conduct consistent with "Right Living." This means adopting both positive "social values such as the work ethic, social productivity, and communal responsibility, and positive personal values such as honesty, self-reliance, and responsibility to oneself and significant others" (p. 14). Change is viewed as a lifelong process. Most TCs today include additional services such as family treatment, and educational, vocational, medical and mental health services. TCs are generally staffed by mixtures of recovering addicts and professionals from the treatment and mental health fields. Many of these elements were encouraged in the RSAT RFP and were incorporated into many of the RSAT prison TCs.

Cognitive Behavioral. Cognitive behavioral treatment approaches are based on the social learning theory, which assumes people are shaped by their environment. Some do not acquire certain cognitive skills or have learned inappropriate ways of behaving. Cognitive-behavioral approaches help offenders to understand their motives, recognize the consequences of their actions, and develop new ways of controlling their behavior. Problem-solving training, social skills training, and pro-social modeling with positive reinforcement are frequently used to augment cognitive-behavioral programs. Although most research evaluations of cognitive behavioral therapy have been conducted with juveniles and young offenders, they consistently show substantial reductions in recidivism.

Relapse prevention techniques are generally part of cognitive behavioral therapy and have been incorporated into all RSAT treatment programs.

12-Step Programs. It appears AA and/or NA 12-step programs have become universal components of virtually all residential treatment programs. The 12-step approach views substance abuse as a spiritual and medical disease. The approach began with AA for persons with alcohol dependence, but has been adopted for people with other drug problems such as Narcotics Anonymous (NA), Cocaine Anonymous (CA), Marijuana Anonymous (MA), and Nicotine Anonymous. There are also extensions to other behavioral problems such as Overeaters Anonymous (OA) and Sexaholics Anonymous. All these are guided by 12 steps which consist of specific graduated practices, beliefs and traditions that progress from dealing with denial to sustaining a healthy and responsible, abstinent lifestyle. The 12-step approach is spiritual in nature, and is usually used as an adjunct to other treatment. There are virtually no research studies evaluating the effectiveness of 12-step approaches with offender populations. But, it is probably the most widespread treatment within the correctional system, which is at least in part due to the low costs, as it typically depends on volunteers from outside the prison. The national evaluation report indicated 12-step programs were evident in about a third of RSAT treatment programs, but our review found it employed nearly universally in the RSAT treatment programs examined in the local evaluations, always in conjunction with other therapeutic approaches.

The NERSAT Summary of the RSAT Programs at the End of 1998

The national evaluation report covers RSAT through the midpoint of its existence on December 31, 1998 (with some information updated through March 30, 1999 for the final report). At midpoint,

all fifty States, the 5 U.S. territories, and the District of Columbia developed plans and received funds for RSAT programs. At least 70 programs in 47 States were operational, admitting clients. About a third (35%) were located in medium security prisons, 29% in minimum security prisons, and 16% in maximum security prisons.

The mean award for implementing the RSAT treatment programs to the States was about $450,000 in FY96, rising to about $495,000 in FY 97, and then a million in FY 98. Of note, the funding could be carried over to subsequent years. States reported spending 40% of their annual budget within the first year, generally before programs became operational. One intent of the national evaluation was to assess the growth in numbers of treatment slots and staff over the 5-year RSAT initiative. Although the information provided by the States was not always comparable, the national evaluation concluded prison treatment slots increased from an average of 330 slots to an average of 400 per year per State over the 2-year evaluation period. Non-residential treatment slots increased as well (although RSAT did not fund them), from an average of 842 in FY95 to 910 in FY98. The numbers of State fulltime equivalency (FTE) treatment staff increased from 17 prior to the implementation of RSAT to 26 by the end of 1998. The non-residential staff mean rose from 16 to 22.

Most RSAT programs sought to combine several treatment approaches, a strategy which was encouraged in the enabling legislation for the RSAT program to the States. NDRI attempted to classify primary treatment modality (or modalities) by asking Program Directors to self-identify their program type. Based on the reports from the Program Directors, the national evaluation categorized 58% of the programs as combined or mixed modalities, 24% as primarily TCs, 13% as cognitive behavioral approaches, and 5% as primarily 12 step programs. Most programs indicated they

incorporated cognitive behavioral approaches. The vast majority reported they were either based on the TC model of treatment, or incorporated major elements of the TC model. It appears that national and regional training conferences have encouraged programs to adopt more and more of the elements found in typical TCs.

State officials responding to the national evaluation surveys were unanimous in agreeing that the RSAT initiative helped their State increase treatment capacity for substance abusing prison inmates. At midpoint, the national evaluation counted about 9,600 treatment beds or slots that were created as a result of the RSAT initiative. Not all programs had opened, yet over 13,000 inmates had been admitted to RSAT treatment programs. About 3,600 inmates had graduated from in-prison treatment programs, and 7,700 inmates were still in RSAT programs. Over 860 FTEs were providing treatment. The national evaluation determined that three-quarters of the RSAT programs were new. The remaining quarter were existing programs whose capacity was expanded using RSAT funds.

Before completing the final report, the national evaluation identified 97 programs that were either open or about to get underway by March, 1999. The majority were in State prisons, although 17 were in jails. About 70% of operational programs at midpoint were aimed at adult offenders, with the remainder targeting juveniles. Of those States that target juveniles, a quarter also have adult programs. About 70% of RSAT treatment programs were for males, and 12% were designed for women. The remaining 18% included both genders.

Achievements and Shortcomings of the National Evaluation

The NERSAT evaluation did accomplish many things. It presented a breakdown on the number, focus, and increased treatment capacity provided nationwide by the RSAT program. It also provides a useful description of treatment modalities. In its recommendations, the NERSAT report provides some useful and important suggestions for future treatment and evaluation.

The initial tasks proposed by the National Evaluators were probably too ambitious given the budget and time period available. As they relate it, much of the early planning work was revamped more than once in consultation with NIJ and CPO. Time and resources were spent on areas that were not developed and probably should not have been attempted. In the end, too few resources were devoted to the process implementation data collection that was most appropriate and feasible within the time and budget constraints and that would have been the most valuable product of an interim process evaluation.

In hindsight, it is easy to note problems with the NERSAT strategy of relying solely on mail surveys to gather program data. Reality dictated that some reliance on mail or phone surveys would be required, but the study would have benefitted from using other data sources such as States' block grant reports and State statistical analysis reports. Once reliance on the mail surveys was determined, it appears that diverse research and evaluation interests led to very long and complex questionnaires for both the State surveys and the program survey. For example, the Program Survey asked Program Directors to record the duration, number of sessions and importance of each of 54 treatment components – and all of that amounted to only <u>one</u> of 117 questions on the program questionnaire! It is not surprising that the completeness and accuracy of program data was questionable. The long and complex questionnaire also effectively prevented a phone survey with

Program Directors. A shorter, more focussed survey instrument would have produced better data to begin with, and it could have been completed by phone for mail survey non respondents.

The NERSAT program initially had what they referred to as "evaluability" assignments. This meant providing technical assistance to the States and the local NIJ grantees in conducting evaluations and collecting "evaluatable" data from clients and appropriate comparison groups. The NDRI evaluators had the major role at the first RSAT "cluster meeting," but this role quickly diminished, though it did result in a useful generic document of "standards of evaluability." that could be helpful to many States.

One unrealized goal of the national survey was to determine the costs of treatment, and whether services were being delivered in a cost-effective way. The evaluation was to examine the contributions of States to correctional treatment over and beyond the RSAT grant. However, much of the reporting of costs was missing from the individual State reports. And, when reported, the inconsistences in how States estimated costs was even greater than the inconsistencies in program size and composition. Consequently, the cost data were not reliable. NDRI was not able to use the data to determine the costs of treatment, nor State's contributions to correctional treatment beyond RSAT funding.

Lessons Learned from NERSAT

The National Evaluation attempted to do many things, but, in the end, produced only a partial and preliminary picture of the scope and early accomplishments of the large national RSAT program. Any assessment of impact would have been premature. It is unfortunate that no evaluation data exist

for the second half of the RSAT funding period. Nevertheless, the NERSAT report does end with some useful, if general recommendations, for States' treatment programming.

Lessons Learned and Recommendations of the NERSAT Evaluators. The most severe problems reported by State officials on the surveys were locating or constructing appropriate facilities and difficulties in recruiting appropriate staff. Over half (53%) had moderate or severe delays due to the difficulty of locating facilities to implement the residential treatment program, and 37% reported delays due to the need to construct or physically alter existing structures. About a quarter of States (28%) reported encountering difficulties due to State regulations and another fifth (21%) reported delays due to State bidding or competitive processes. Nearly two-thirds (62%) of the States reported difficulties in getting training for treatment staffs.

The national evaluation expressed concern over the lack of aftercare, in particular because the RSAT RFP for States emphasized that in-prison programs with aftercare services should be given preference. However, aftercare was an unfunded mandate, and RSAT funds could only be used for the residential treatment component. The national evaluation found Work Release (23%) or Half Way Houses (20%) were incorporated as aftercare programs in less than half the RSAT treatment programs. A few others had parole supervised treatment as part of aftercare, but these numbers were not reported in the national evaluation. The national evaluation determined 86% of RSAT in-prison treatment programs have either specified how graduates may continue treatment in the community, or indicated their intention to do so. The continuity of care is an important element in treatment for offenders strongly linked to reductions in recidivism and drug use.

The national evaluation expressed concern over the merging of treatment components that is so much in evidence in the RSAT treatment programs. The RSAT programs are "intended to develop

the inmate's cognitive, behavioral, social, vocational, and other skills," which lends itself to a multi-faceted approach. Yet, the national evaluation pointed out that TCs and 12-step programs in particular, are based on different theories and practice. 12-step programs are spiritually based, which is radically different from professional therapy. Nevertheless, 12-step programs have worked in conjunction with TCs for many years. The national evaluation accurately points out that combination treatments have not been fully evaluated, and that many combinations may result in "watered down" components leading to less effective treatment.

NDRI's evaluation showed that 55% of the RSAT programs did not have one or more treatment components operational, and 53% of program directors still considered their programs to be in the "shake down" phase rather than stabilized at the RSAT midpoint. Programs had difficulty recruiting staff. There are too few counselors trained in TC and/or Cognitive Behavioral methods – the methods suggested in the RSAT RFP to States. It appears many States encountered difficulties in employing ex-offenders and recovering addicts as counselors in prison TCs. Often those with a criminal record were not allowed in the institution to work or visit. Evidence regarding the effectiveness of TC staff show they should consist of a mixture of persons emergent from TC (recovered graduates) and other counseling (social work, educational, or mental health) professionals (Wexler 1997).

The national evaluation also pointed out the unmet need of treatment programs for jail inmates. About one in five jails reported a drug treatment program supported by paid staff, but even in these, only 13% of inmates were involved in treatment (BJS 1995). Only 2% of the programs provided more than 10 hours per week of treatment activities. One major impediment to providing treatment in jails is the relatively short stay of most inmates. Only 32% of jail inmates nationwide were

incarcerated for over 3 months. However, the national evaluation points out that even relatively short-term interventions of 6 to 8 weeks can provide inmates with important coping skills and skills crucial to recovery. These require further investigation, but the absence of in-jail treatment services represents a neglected opportunity to reduce drug use and recidivism among offenders.

4. Review of RSAT Program Evaluations

As noted previously, the National Institute of Justice funded small evaluation studies mostly focussed on the implementation of the RSAT programs. This section of the report is based on findings from the first 12 such evaluations to submit final reports. These State/local evaluations were awarded between March 5, 1997 and September 30, 1998. Not only were the start dates for these local evaluations spread over 18 months, some also delayed their inception to allow their State's RSAT program to get started. Others began their evaluation right away even if their particular RSAT program was not operational. And, the awards were scheduled to be for a maximum of 15 months each, while the RSAT programs themselves were funded for three full years. Consequently, each evaluation represents a specific, varying, and only partial time period in the life course of the RSAT program being studied. And when one looks across evaluations, it is apparent that the time of study is often not coterminous from one evaluation to another. These differences make structured comparisons difficult, though a number of cross-site observations can be made.

Local evaluations could be designed to look at a single program or, if a State funded more than one program with RSAT funds, to examine all or a subset of sites. The RFP requested information on program characteristics (i.e., number of participants, number of graduates, demographic, and other information about the participants), and "in-prison performance of participants on pertinent dimensions." The applicants were asked to propose additional topics. The short duration of the grants and the small amount of funds available precluded impact evaluations, but NIJ wanted to lay the groundwork for possible future impact evaluations. Therefore, the RFP requested the evaluation incorporate some meaningful comparison group, use valid and reliable measures, and, in general, prepare for future outcome evaluations. However, most of these "requests" were not requirements,

and many of the requests could not be accommodated given the limited funds and limited time available. So, many of the local evaluations are neither process nor outcome evaluations. Some are not responsive to the intent of the RFP, but all probably meet the requirements of the RFP. All seemed to make a good faith effort to do what they proposed, even if what they proposed is not what NIJ intended.

NIJ awarded 18 site evaluations and a national evaluation from the first Request for Proposals (RFP) in FY97. Half of these site evaluations and the national evaluation are reviewed in this first compendium. These first cycle evaluations were funded for $50,000 - $60,000 each. Three of the seven site evaluations funded in FY98 under a second RFP are reviewed in this report as well. These three second cycle evaluations were all funded at about $60,000. In FY99 and FY00, another 30 site evaluations were funded: 12 new process evaluations and 18 outcome evaluations. These later evaluations will be presented in future compendia. Here we review findings from the 12 completed RSAT program evaluations. A brief summary paragraph as well as more comprehensive descriptions and critical reviews of each these programs and their evaluations are contained in the Appendix.

It is difficult to establish how representative the 12 RSAT evaluations currently available for review are of the total 36 funded evaluations. It is even more difficult to determine how well the 12 represent the total array of RSAT programs funded nationally. As the national evaluation points out, the States could carry over RSAT funds to later years, and programs were still coming "on line" even as the national evaluation concluded in early 1999. However, it is possible to say that the evaluation reports reviewed here do represent a diverse group of programs. There are programs in male and female based correctional institutions, as well as in coed jails. Most of the evaluations are of prison-

based programs, but two evaluate jail programs (of which one evaluates 6 different jail-based programs in Virginia). One includes programs in both prison and work release settings. One is for dual diagnosed clients. One RSAT treatment program that was evaluated was specifically aimed at technical parole violators, and in South Carolina, one targeting males sentenced under the Youthful Offenders Act was evaluated. There are programs located in juvenile correctional centers. Most of the programs used a combination therapeutic community milieu, and cognitive behavioral techniques. Virtually all included AA/NA. NIJ's goal of awarding evaluations to reflect the spectrum of programs in different regions and using different theoretical approaches is reflected in the first 12 State and local evaluations.

Commonalities and Differences in Evaluation Methodologies

The funding available from NIJ for the evaluations, and the conduct of evaluations early in the RSAT programs history, lent themselves to Process Evaluations. The goals of a process evaluation are to record and assess the implementation and development of the treatment initiative, as well as provide a thorough examination of the experiences of the clients and staff throughout the treatment process. In undertaking a process evaluation, researchers not only investigate the underlying theoretical principles of treatment, but the manner in which these principles are incorporated into the program, the institutional context within which the program operates, and the program's relationship with other agencies. In this way, process evaluations provide important information that is rarely included in outcome evaluations, which are generally based on statistical analyses of drop-out, relapse, and recidivism rates, without examining program fidelity. Process evaluations are intended to complement and inform outcome evaluations by providing: 1) a detailed description of

the program, including its planning, implementation, and modifications; and 2) an analysis of variables that explain program changes (Scarpitti et al., 1993).

The central data collection strategy for process evaluations is qualitative, although quantitative measures often play an important role. The dominant methods that constitute the qualitative component of the process evaluation include both participant observation and qualitative interviewing. Evaluators engage in participant observation in order to develop a deeper understanding of the treatment initiative, as well as the interpersonal relations that occur among residents, between staff and residents, and between program staff and correctional personnel. Qualitative interviews supplement data gathered from participant observation techniques. Open-ended interviews may be undertaken with program staff, residents, and program drop-outs, institutional staff, and higher level administrators, in order to gather information on the program's development, strengths and weaknesses, and impact. All information garnered from interviews, participation in staff and institutional meetings, and observations, are recorded in field note form. Quantitative data, including intake and discharge statistics are also collected. These data are gathered in order to more completely inform certain areas of observational analysis. Some process evaluations include quantitative outcome measures. In this case, structured interviews are administered to clients throughout the evaluation period. At the conclusion of the process component of the evaluation, outcome statistics are compiled which may include measures of recidivism and relapse. Data collected from structured interviews is then used to investigate the capacity of certain variables (e.g., length of time in treatment, educational background, frequency of former drug use, etc.) to predict treatment success (Scarpitti et al., 1993).

It appears that many of the local site evaluation reports, while containing elements of a process evaluation, are not really process evaluations. Although the mix varies, the evaluation reports tend to blend process and outcome elements, perhaps in their attempt to fulfill the spirit of the RFP and prepare for outcome evaluations. A few of the evaluation reports appear to minimize implementation problems, not recognizing these type of problems are to be expected, nor that good process evaluations are designed to document such problems and the progress towards resolution. A process evaluation can be especially useful in feeding information back to program officials and providing recommendations to address problems (although is it sometimes the case the information is not what program officials want to hear).

Most of the evaluation reports are actually partial reports, examining the program up to the time the evaluation cooperative agreement expired. It appears this is due to the slow start-up of programs due to a myriad of reasons. For some programs, this amounts to the evaluation ending before the program has cut its proverbial teeth. For these evaluations, (i.e., Wisconsin, New Mexico, the Virginia Jail Programs), it is difficult to determine whether the problems identified are simply start-up problems that will stabilize over time or are chronic problems.

Commonalities and Differences in: Modalities, Startup, Problems

All the RSAT programs established treatment programs that attempted to be responsive to the RSAT initiatives multi-modal treatment approach. Of the 12 local evaluations included in this report, only the juvenile program in Michigan does not indicate it is a TC or incorporates major elements of TCs. However, several that label themselves as TCs or modified TCs contain too few of the elements typically found in TCs to merit that label. This includes the in-prison RSAT

treatment programs in Wisconsin, New Mexico, South Carolina, Texas' Harris County jail program, and the 6 Virginia jail programs. The programs in Delaware and Missouri are mature TCs, and those listed above may yet develop into TCs. The women's TC in Washington State is to be commended for its approach to adapting a TC model responsive to issues pertinent to women.

The RSAT funding to States was for the creation or expansion of treatment programs in which inmates were isolated from those not in the treatment program. However, the RSAT prison treatment programs in Wisconsin, New Mexico, and the 6 Virginaia jails were not isolated from the rest of the prison.

Virtually all the programs experienced moderate to severe start-up problems. The exceptions are those pre-existing programs that were expanded with RSAT funds, rather than programs that were being implemented from scratch. This includes the Delaware and Missouri programs, and to a lesser extent, the Virginia and Michigan juvenile programs. The Delaware and Missouri programs experienced many implementation problems at start-up, but they were in a more mature stage of development by the time of RSAT funding. The Virginia juvenile treatment program was also an established program that was expanded using RSAT funds so that the entire institution was converted. The Virginia evaluation report paid more attention to outcome measures than the program expansion, and did not focus on implementation problems – either in the past or as the program was expanded. The juvenile Michigan program reported few implementation problems probably because there was excellent staff training before the program was implemented, and because they utilized current staff; it helped that the RSAT treatment services were in addition to the 'regular' array of services provided at the institution. The juvenile Michigan program was also

relatively small in comparison to many of the RSAT funded programs, and there were still problems – just not necessarily implementation problems.

Initiating a program with a full complement of clients, but not sufficient staff, has obvious problems. However, since nature abhors a vacuum and correctional systems abhor an empty bed, this situation occurs with some frequency. Several of the in-prison RSAT treatment programs were initally filled to capacity, including Texas' Harris County Jail RSAT Treatment Program, South Carolina, and Michigan's adult program. These and other programs such as New Mexico's and the Michigan adult program began without a full complement of staff. Better pre planning and a full staff complement would have helped minimize attendant problems. Few programs delivered all the services they planned. There were fewer group counseling sessions and other types of scheduled services delivered than planned, even in programs that had a full staff complement. There were few individual counseling sessions in any of the RSAT treatment programs.

Many RSAT treatment programs experienced an inordinate amount of staff turnover. This was probably due to the unstable nature of the program resulting in many obstacles for staff. However, other contributing factors appear to be the isolated location of many prisons, the poor pay, and the lack of appeal of the correctional institution's environment. As the national evaluators pointed out as well, several of the correctional institutions had policies discouraging, if not denying, employment to those with a criminal background or persons in recovery. TCs are often staffed with a mixture of recovering TC graduates and degreed professionals. It is very difficult to locate qualified treatment staff, so imposing these types of limits places further constraints on the programs. In fact, there are limited numbers of professionals trained in TC treatment service delivery, so most receive in-service training from more senior counselors. The programs were oftentimes initiated with inexperienced

staff. This problem was identified by the evaluators of the Michigan adult RSAT treatment programs, as well as others. Overall, there appears to be a paucity of training for treatment staff, and, with their high turnover rate, there needs to be more attention nationally to providing training for correctional treatment staff.

Several of the programs that were not immediately filled upon opening their doors, are still not filled to capacity. This includes the programs in Wisconsin and Washington. New Mexico's RSAT program was close to full initially but, due to drop-out, slipped below capacity fairly quickly and has stabilized at about 25-30 inmates in the 45 bed treatment program. These States and/or programs also have policies of only accepting volunteers. That is, there is no coerced treatment. Since the treatment programs were new and not well understood, there were few inmates willing to voluntarily enter treatment. Further, drug and alcohol addiction are characterized by denial, so it is not surprising that many inmates do not recognize their addiction or volunteer for treatment.

Several of the programs have few graduates. At the time of reporting, the Wisconsin program had not yet graduated anyone. The New Mexico and Michigan juvenile RSAT program had graduated only a few inmates. Graduates are often returned to the general population, as in the Michigan adult program. This is not advisable since it will be difficult for inmates to maintain the gains made in treatment in an environment that mitigates against such. The Washington State TC for women had a novel idea in that program graduates remain in the program to serve as mentors until release. This innovation is probably facilitated by the lack of a waiting list.

Nearly all programs experienced difficulties with inappropriate referrals. These generally took the form of inmates with too little or too much time remaining on their sentences. If there was too little time, they were released before completing the RSAT treatment program. If there was too

much time remaining on their sentence, they were often returned to the general prison population. Two states managed to avoid the problem by tying sentence to treatment. South Carolina created a novel RSAT program in that the sentence length of offenders sentenced to the RSAT program under the Youthful Offenders Act was based on treatment completion. Similarly, in Pennsylvania, technical parole violators were sentenced for 12 months to correspond to the RSAT programs' total of 6 months in-prison and 6 months aftercare components.

The local evaluations generally coincided with program start-up and only lasted 15 months, so there was a structural reason for less attention to aftercare. For many programs, aftercare was only in the planning stages; for others, aftercare was not much more than an afterthought. Yet recent research demonstrates the importance of aftercare to assist inmates in maintaining the gains they have made as they transition back to the community. The more established Delaware and Missouri programs had aftercare components in place. There were also aftercare programs for the 2 Pennsylvania RSAT program for technical parole violators. Several States had little to no aftercare, or aftercare was 'planned' and not implemented. Noting the residential programs implementation problems, it is reasonable to anticipate implementation problems will also exist with aftercare that will need to be addressed.

Achievements

With the litany of problems noted in the previous section, one might be tempted to conclude the RSAT initiative and the programs have few achievements. However, most of the identified problems are those of start-up programs trying to be responsive to the multiple and conflicting demands placed upon them. Their major achievements are implementation of treatment programs

in correctional environments, and progress towards stabilizing the programs. The evaluation reports emphasize the difficulty of establishing and maintaining a treatment program within a correctional setting. Administrative expedience and demands often took precedence over program operations. This includes having to accomodate the following kinds of problems: initially filling a program to capacity even if there weren't sufficient staff; including inappropriate inmates; not isolating the treatment program participants due to overcrowding and the need to fill all available beds; graduates being returned to the general prison population because their sentence is not completed and there is a need for the bed in the treatment program. The many and varied demands and obstacles placed on the RSAT treatment programs that are beyond their direct control is a principal finding from the evaluations. The fact that they survived and adapted in the face of such obstacles is more than praiseworthy. Only a few of the RSAT programs that were evaluated appear to be in serious trouble. The programs for dually-diagnosed inmates are perhaps the hardest to implement because they are also dealing with the most difficult clients -- mentally-ill substance abusing criminals. The programs that fared the best were those that were already established programs that used RSAT funds to expand operations.

Both established and new programs benefitted greatly when they had higher level administrative support and cooperation. The support of higher level administrators was essential to weather many of the implementation obstacles. Those programs that had experienced and well trained staff also had fewer implementation difficulties.

South Carolina and the Pennsylvania RSAT program for parole violators are to be commended for their advance planning and coordination in sentencing inmates to treatment program completion. They reduced sentences somewhat to the length of the treatment programs, thus matching treatment

and sentence while also saving the States some correctional costs. Tying sentence length to treament completion also serves as a motivator for inmates to complete the programs in a timely manner. This precluded a major problem evident in several programs where graduates were returned to the general population.

Several States had good aftercare programs in place. This includes the more established programs in Delaware and Missouri. One of the two Pennsylvania RSAT treatment programs for parole violators had established the foundation for a good aftercare program with inmates flowing into halfway houses, and their treatment plans being overseen by the in-prison program director. Good planning for aftercare was also evident in Washington State, and promising plans were being developed in a few other States.

Another achievement noted in many States was the cooperation between the evaluators and those involved with the program. The evaluators were able to feed information back to program officials and higher level administrators who were able to be responsive to the identified problems. Many evaluations adapted or created instruments and/or data management systems that they shared with program staff.

Problems

Programs had to overcome a myriad of start-up problems, many that will diminish over time. For example, a slow process of gradually breaking in new staff and filling client slots is preferrable for start-up. However, it was often not an option due to institutional overcrowding and the need to keep beds filled. Although these type of problems have to be anticipated and accepted as "status quo," this points to the necessity of good pre planning. It is especially important in light of the

anticipated problems with starting a correctional residential treatment program, that there is a full complement of experienced, well-trained staff. The required pre planning will have to be supported and implemented by the administrators developing and overseeing the program. Major program transitions, where necessary, should also be well planned before implementation is attempted.

An appropriate staff to client ratio is necessary to ensure the optimal functioning of the treatment program at all times. There is no established norm in the research literature, but residential TCs in Texas, California, Washington, and Delaware have shown good success with staff to client ratios between 1 to 15 and 1 to 20. Staff will generally require additional training to function effectively as counselors in a correctional environment and extensive training in the TC model to work in correctional TCs. There is a paucity of such training available. Due to the low pay, isolation, and the correctional environment, there may always be problems with finding and retaining experienced staff.

Continuity of staff and effective staff are essential to program success. Changes that lead to major staff turnover will generally be very disruptive to the treatment program. Therefore, there needs to be greater attention to recruiting and maintaining appropriate staff. There is also a critical need for extensive training involving administrative and correctional staff to create the kind of cooperation necessary for an effective corrections-based treatment program. Little such training is available.

Even with adequate resources and excellent administrative support from the correctional system, program implementation is a tortuous process, and program stability is not reached for two to three years at a minimum. A program needs to be strong enough to survive unintended consequences of bureaucratic changes. Even a mature treatment program or TC can be threatened by external

program changes such as funding levels, key administrators, and the actions of judges. For example, State bidding processes may mean a new treatment contractor is selected for an established program (as happened at one site). This example illustrates the need for strong institutional leadership to oversee and assist in the transition of treatment providers. Therefore, it is critical that correctional treatment programs have outstanding support from higher level administrators who are committed to the program's success.

The outcome research from the treatment programs in Texas, California, and Delaware (see the 1999 articles by Knight et al., Wexler et al., and Martin et al. in *The Prison Journal*) correctional settings demonstrate the importance of aftercare. The lasting effects from in-prison residential treatment alone are not large. Aftercare is not being implemented in meaningul ways in many of the RSAT programs. Therefore, more attention to developing viable aftercare programs is necessary.

Jails represent another opportunity to break the drug-crime nexus by providing treatment for drug abuse. However, transient populations create additional problems for treatment programs with too few inmates with sufficient sentences to complete TC-like programs that generally last 6 to 12 months. Premature release was a characteristic of the 6 jail programs evaluated in Virginia. Therefore, there is a need to develop (and evaluate) shorter programs that can be delivered in a jail setting.

Process evaluations can be very useful tools for programs. Outside researchers, as neutral observers, are in a key position to feedback issues and problems to administrators in a position to help create necessary changes. Process evaluation will be for a limited time frame, and are not necesssarily costly, especially in light of what they can bring to a program. However, as the local evaluations reviewed in this report demonstrate, some reports did a good job of process evaluation,

some did not seem to understand or be able to successfully implement process evaluation, and some (since they were not required to do so) did not even attempt a process evaluation. In its later RFPs, NIJ has made an effort to require process evaluation and standardize its components.

5. Implications and Conclusions: Lessons Learned and Implications for Practitioners, Policymakers, and the Research Community

Criminal justice systems nationwide have observed a growing problem of offenders with significant and lengthy drug using careers. Solutions relying on strict sentencing and incapacitation are putting an increasingly onerous burden on U.S. correctional systems and U.S. taxpayers. Any prospect of changing this scenario requires that substance abuse treatment also be intensive and extensive. Until the pharmacological researchers and brain chemists find their "silver bullet," the only proven means of counteracting an offender's longstanding substance abuse problem is a lengthy and intensive behavioral intervention.

The Department of Justice, through the Bureau of Justice Assistance's support of Project Reform and Project Recovery in the late 1980s, was at the forefront of introducing and evaluating innovative and intensive treatment programs. In the early 1990s, for political reasons, BJA ceded the field to NIDA and CSAT. These U.S. Public Health Service organizations proceeded to fund a variety of new treatment approaches in correctional settings. They supported evaluation of these programs. And, most importantly, they disseminated and promoted successful treatment programs. It was the publicized success of TC programs in New York, Texas, Delaware, and California that was instrumental in turning legislative and OJP/CPO attention to funding new offender treatment programs through RSAT and supporting evaluation efforts through NIJ.

The RSAT program is a major Federal initiative which has had significant national implications for treating drug involved offenders. There have been some notable and well publicized residential treatment programs for offenders that emerged in the late 1980s and early 1990s (e.g., Stay'n Out, CREST, Amity, Kyle) dotted around the country. However, until the RSAT program, there was no

national mandate or directive positing the value of treatment with criminal justice populations. With the RSAT program in operation, every State has been exposed to and offered a "carrot" to expand its residential treatment capacity. Every State has applied for and is using the RSAT funding to expand their treatment capacity. TC treatment programs that had seemed unworkable or esoteric are now present nationwide from Windham, Maine to Honolulu, Hawaii due to RSAT. Cognitive Behavioral modules on criminal thinking, stages of change, and other areas are now regular parts of correctional programming from Ventress, Alabama to Medical Lake, Washington. RSAT is helping to make intensive treatment programs normative in correctional settings rather than the exception.

Regardless of the limitations of the National Evaluation's program data, it demonstrated that treatment capacity has been noticeably increased nationwide. The fact that RSAT funding was disbursed as a block grant allotment to States based on formula calculations did not create any inducement to States to make extensive plans for treatment programs ahead of time. It remains to be seen if the gains in capacity will be retained once RSAT block funding to the States ends after 2000. There are perhaps more important lessons to be learned from examining the small group of 12 local evaluations. A number of important observations from the local evaluations were made in the previous section of this report, and they are expanded in the more lengthy program reports in the Appendix. Here, we focus upon a few of those points and add some additional observations.

One observation from the individual program evaluation reports is that the most successful programs – successful at least in the limited time frame of these evaluations – are ones that were not starting a program from scratch but were expanding existing and relatively stable programs. It would be an easy mistake to infer that these are the better programs. That may not be the case; rather these programs experienced similar start-up problems, but before RSAT funding. In the case of the

Delaware programs, the start-up issues were enormous, as detailed in the published process evaluations, and the programs might not have survived except for administrative commitment to programs, good oversight management, and, most definitely, very well-funded implementation budgets. It is not surprising that many of the RSAT programs have had slow and problematic start-up periods. It is perhaps more surprising that so many of them were doing as well as they were during early program phases, and it is most unfortunate that the process evaluations were not able to encompass a program's entire history. Oftentimes, either an existing program that was expanded was already well established when the evaluation started, or a new program was not well established by the time the evaluation ended.

Several of the local evaluations were particularly instructive on the program strengths needed to survive changes in treatment providers and institutional policies and leadership – the kinds of mid stream changes (one would not want to call them corrections) that many correctional treatment programs face. State mandates on bidding contracts affect correctional system food services, health providers, and, of immediate note, treatment providers. Treatment programs have to be strong enough and well-enough documented to survive changes in key personnel. Old-fashioned TCs with charismatic leaders rather than institutional leadership cannot survive long in a bureaucratic State system.

Conversely, a supportive system can be a real strength to a treatment program, particularly in its start-up phase. Even when programs face major problems in program implementation, if the State administration and prison officials have a commitment to treatment, there are good prospects that the program will develop, stabilize, mature, and become a regular part of the correctional system.

Another important observation from the RSAT evaluations, both national and local, is the need for treatment options in jail settings. Jail-based offenders with substance abuse problems are a significant group, as the DUF/ADAM studies have made clear. This is a group that has been identified in the past in both NIDA and CSAT treatment demonstration initiatives. At the same time, the jail programs that have been evaluated by NIDA, CSAT, and now NIJ provide some understanding of the limitations of jail-based treatment. It becomes apparent that the transient nature of jail-based populations is not conducive to a lengthy, structured treatment program based on community continuity and phased progression. There are other reasons why this group is under served – they are less likely to want treatment than prison-based substance abusers; and they are less likely to perceive that they have time for treatment. Corrections, as well, has less time and resources for jail-based programs. Still, the attraction remains of treating those in jail. However, jail programs will do best to avoid resource-intensive, long-term programs. A lesson from the jail-based program evaluations is that treatment modality should fit correctional mandates, and jails should think more about short term education and intervention rather than long-term phased treatment.

There are two other areas of major theoretical and practical interest that emerged from the local evaluations and should be examined. First is the appropriateness of TC treatment or some other modality for the client. Several local evaluations questioned whether appropriate clients were being recruited into the programs. There is a growing literature on examining whether clients are assigned to the appropriate treatment and the implications of appropriate assignment to treatment success (De Leon et al., 1994). A second area that should be considered in future research is the compulsory or voluntary nature of the treatment (Leukefeld and Tims, 1988; De Leon et al., 1995). Compulsory treatment may work better than voluntary treatment for offenders. They are under compulsion

anyway by virtue of their sentence. Compulsory treatment may be the "stick" that increases the length of time in treatment, the most consistent program characteristic associated with long term success. Conversely, a sentence reduction or tying sentence length to successful program completion can serve as the "carrot" that gets more offenders to volunteer for treatment. Therefore, examining the issues of 1) appropriateness of a particular treatment modality for clients, and 2) the degree of self-selection versus involuntary selection into treatment, will be important additions to further process analyses of treatment effects that may be important covariates to subsequent outcome analyses of relapse and recidivism.

Beyond the observations and recommendations made relating to the existing evaluations that have been done of the RSAT program, we want to make three larger recommendations that relate to future plans of NIJ, CPO, and their parent organization – OJP. One observation relates to future evaluation support, one to future treatment support, and one to both evaluation and treatment program support.

First, the local evaluations of RSAT demonstrate that, with a functioning program, with good internal data collection and management, with good working relations between program staff and outside evaluators, and with resources for evaluation, it is possible to do a very successful evaluation that can have national implications for research and treatment agendas. However, any process evaluation requires several years of data to be really informative, and any meaningful outcome evaluation will require sufficient sample sizes, appropriate comparison groups, and sufficient time to conduct a prospective analysis to see if successes are maintained over a reasonable follow up time after release from prison.

If NIJ, CPO, and OJP wish to have anything more than rudimentary information on services delivered and clients completing, they need to fund truly longitudinal evaluations. It is a relatively large program where 75 clients complete each year. To have a marginal group of 200 completers for whom you wish to see how they are doing one year after completing treatment and leaving prison would require 4 years after you had completed a year or two of process evaluation about program start-up and delivery. Such evaluations do not have to be extremely costly per year, but they should last for a minimum of three years for a process evaluation and five years for a preliminary outcome evaluation.

Second, a strong recommendation for future funding of offender treatment programs is to offer funding for aftercare programs for existing State residential programs. It was probably a mistake, as General McCaffrey, Director of ONDCP, stated during a visit to the Delaware programs in 1997, that the RSAT program was not allowed to fund non-residential treatment. One of the most consistent findings across the RSAT evaluations, both national and local, is the lack of effective aftercare programming. The fact that the RSAT legislation explicitly precluded funding of aftercare undoubtedly contributed to the problem.

Recent research, much of it sponsored by NIJ, has demonstrated marked increased in long term positive outcome for offenders who receive both residential TC treatment and an aftercare program. As noted by Lipton et al 1999; Wexler et al. 1999; Knight et al 1999; and Martin et al. 1999, clients who receive aftercare do significantly better than clients who do not. These recent outcome evaluations suggest that treatment programs for offenders need a strong aftercare component, and probably, the aftercare should be tied to probation or parole stipulations. A brilliant next step for CPO/OJP would be to introduce a new program to fund aftercare programs for existing and ongoing

residential treatment programs that had been sponsored by RSAT. A good aftercare program is not cost-free by any means, but the cost per client will be much less than a residential treatment slot. Such a new initiative would be cost-effective and would build on the residential treatment program funded by RSAT.

Third, we see the need for more Federal cooperation in the area of providing treatment and in evaluating its effectiveness. The Delaware TC continuum received much national attention, and it is continuing to be followed with multi year support from NIDA and NIJ. Delaware was both industrious and lucky to pursue and receive funding to gradually establish its TC programs over several years through support from BJA, NIDA, CSAT and NIJ/RSAT for both its offender treatment and evaluation. One can hope that such a model of collaboration among Federal agencies interested in treatment for drug-involved offenders can become more of a planned model rather than one pieced together by entrepreneurs in one State. As has been seen throughout these evaluation reports, pre planning produces a much more successful implementation. It is a lesson that the various Federal agencies interested in offender treatment might consider. In the early 1990s, NIJ, NIDA and CSAT had several meetings where the Federal agencies and their grantees shared information, findings, and strategies. It would be tactical if these agencies and others interested in treatment for criminal justice populations would renew these efforts and move a step further to real collaboration. The RSAT initiative and the programs it spawned are a potential laboratory for research in treatment efficacy.

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APPENDIX

Synopses and Summaries of Individual Program Evaluation Reports

Page

Table of Contents for Synopses and Summaries

PROGRAM SYNOPSES

o Wisconsin used their RSAT funds to establish a 25 bed mental illness-chemical abuse program for dual diagnosed clients. The program was located in a medium security prison and shared space with another specialized program that focused on mentally ill inmates. Clients in both special programs regularly interacted and shared facilities with regular inmates. At the end of the evaluation period in summer 1998, the program was about three-quarters full. No clients had yet finished the 8-month program. Program planning took longer than anticipated, and client recruitment was slow. Client assessment and referral procedures had been established statewide. The evaluation report described the program as a mixed modality with some TC elements, but the TC elements were minimal. Although planning and cooperation was excellent at the administrative level, staff appeared to be still developing the workings of the program, agreeing on a program philosophy, and dealing with the realities of dually diagnosed clients not easily treated in an 8-month program. Lack of program segregation also was very detrimental to program development and work with dually diagnosed clients. (97-RT-VX-K001)

o New Mexico used their RSAT funds to establish a modified TC for male inmates in the minimum security wing of a medium security prison. The program and inmates were housed in a pod with 45 beds, but the inmates frequently interacted with inmates in the other 3 pods on the wing. Between July 31, 1997 and July 1, 1998, the program admitted 48 inmates – 8 of whom were fairly quickly terminated. All were volunteers. The evaluation report described the program as a TC, but it appeared to be a modified TC. The program had not been able to become fully operational and was only fully staffed at the closure of the evaluation period. The prison was located in a rural area near a major city, but several hours by car from most of the State's population. Due to prison crowding, the DOC kept the beds full, so inmates not in treatment were housed in the same pod as those in the RSAT treatment program. The plan for aftercare called for the Probation and Parole Division's Community Correction Program to case manage treatment services. No graduates had entered aftercare yet. The evaluation report did not describe the program implementation in detail, but it appeared this program was suffering from more than start-up problems. Failure to isolate the program was not in accord with the RSAT initiative. (97-RT-VX-K002)

o Delaware used their RSAT funds to expand the residential components of an existing continuum of therapeutic community treatment in "primary" (prison), "secondary" transitional (work release), and "tertiary" aftercare (parole) settings. The continuum of treatment had been gradually put into place since 1989. Less than 20% of the 1400 prison and work release TC beds were RSAT funded. Treatment was provided by an outside contractor involved with the program since 1989. The Delaware programs expanded from demonstration programs funded and extensively evaluated with BJA, NIDA, CSAT, and then RSAT/CPO/NIJ support. This report was not a process evaluation but rather a summary of a series of outcome studies. The Delaware programs have been some of the most developed, studied, and publicized TC offender treatment programs in the country. The TC treatment was geared to and timed with the offender's level of progress toward release. The programs operated in 7 facilities and are truly statewide. Each program was isolated from the rest of the facility. Staffing was reasonably stable, programs licensed, staff met State certification requirements, and the program was highly functional. The Delaware programs, developed with Federal start-up funding have become institutionalized parts of State correctional budgets. (97-RT-VX-K004)

o Michigan used some of its RSAT funding to expand services at the State's most secure facility for adjudicated male delinquents. A wing with 18 beds was converted in both medium and maximum security centers, and initially filled with 30 youth. The program was developed by the subcontractor, and staff problems led to some delays in program implementation. The program was psycho-educational and included relapse prevention, delivered in group meetings. These services were in addition to the regular cognitive and behavioral treatment services provided by the institution. Staff received pre-service training in substance abuse treatment, and there were certified substance abuse counselors in each wing. The youth identified problems with the mixing of correctional and treatment roles in the same staff. Despite the advance planning, less services than intended were delivered. Just over a third of the initial cohort completed the program in a year, and over half of the original cohort remained in the program at the one year anniversary. Aftercare services were not described, although several youth who completed the program went to stepdown type programs in the institution. The report alluded to good interagency cooperation to facilitate aftercare services outside the institution. It was not clear why the program was taking longer to complete than designed. The evaluation report suggested few implementation difficulties, so the failure to graduate many youth was not explained. (97-RT-VX-K008)

o Harris County, Texas used their RSAT funds to establish a treatment program in a jail – the 4th largest in the nation. The RSAT program was to have a capacity of 200 located on a dedicated floor of this maximum security jail. The program was a modified TC, although inmate governance or participation in peer treatment was not permitted by the jail. The program was coed, with most treatment services delivered in large gender segregated counselor-led groups. At time of evaluation, there were 120 beds for males and 40 for females. By July, 1999, 531 inmates had been assessed and 426 admitted to the program. The program was opened in June, 1997, but changes to the physical structure were required, and the program was not fully staffed and operational until November, 1998. There was no aftercare in place, but the evaluation report indicated new discharge procedures had been developed and contractual agreements were being made for aftercare client placement. The program was one of the relatively few RSAT programs focused on an underserved population – jail inmates. Progress was evident towards solving many of the start-up problems. The need for continued communication between the treatment and correctional staffs, as well as outreach to the courts was evident. (97-RT-VX-K010)

o Missouri used their RSAT funds to expand an adult male in-prison TC which had been started in 1993 with support from CSAT. The Ozark program had 650 beds, an increase from 500 under CSAT. It encompassed the entire institution in the south central part of the State. At the time of evaluation, the program appeared to operate well as a TC, was in a mature state of development, and was well established in the institution. Specific detail on program content and implementation were not provided but the program scored well on the major national instrument for evaluating TCs. The evaluation report provided a process evaluation of 3 changes in the institution since the RSAT phase began that "tested" the program: change in treatment provider; institution of work release into the program; and instituting, then rescinding, a no smoking policy. The thorough report on these 3 areas used a variety of data sources and methods to show how the program was affected – negatively in the short term. However, the program seemed to recover well. Rather than revealing much about the Ozark TC, the report was very informative on how a program dealt with "mid-life crises." The evaluation also made a promising start at conducting an outcome evaluation, which is possible with an already existing program. (97-RT-VX-K013)

o Washington used their RSAT funds to establish a 72-bed TC for women in a minimum security institution. The program was established in March, 1996, and had not reached capacity 3 years later in March, 1999, when 63 inmates were enrolled. Treatment was provided under contract to a private firm and based on a modified TC with attention to women's issues. The prison was on the other side of the State from many of the women's homes, and they were not volunteers. The evaluation report documented many problems, but most were consistent with a start-up program. The therapeutic model appeared well developed and evolving over time in response to needs. There were no graduates released at time of evaluation. An innovation involved the use of graduates as mentors in the TC, rather than returning them to the general population, until they were released by DOC. The evaluation report documented the need for all the program stakeholder to coordinate and communicate their efforts so that the program was receiving consistent expectations. The aftercare component had not been operationalized, but the plan seemed generally sound. Women were to participate in a work release program strictly for women, be case-managed to continue treatment, participate in AA/NA, and receive other services available to all the women residents of the halfway house. (97-RT-VX-K014)

o South Carolina used their RSAT funds to establish a modified TC, utilizing a cognitive behavior approach and 12-step principles. The program was housed in a medium security prison and targeted male offenders sentenced under the Youth Offender Act (YOA). The program's capacity doubled to 272 beds 13 months after opening in August, 1997. YOAs 17-20 years of age were separated from the program for 21-27 year-olds. Treatment was provided under subcontract. Treatment was not fully operational when the YOAs first entered the program, and the institution refused to restrict the privileges of the incoming cohort in line with the TC regimen. During the first year, there was a shortage of job and educational opportunities for RSAT program participants, but this improved over time. There was also staff turnover. Through September, 1999, the program enrolled 633 inmates, 266 were still enrolled. Of those no longer in the program, 67% had graduated. An innovative aspect provided for program graduation to coincide with community release. Aftercare did not operate initially, and youth entered regular parole. A one year grant to develop specific aftercare services began to provide 2 hours of group counseling, but this was only temporary. This program experienced many start-up difficulties, but also made great strides. Although more attention to aftercare was needed, the coordination of releases dates with program graduation was exemplary. (97-RT-VX-K015)

o Virginia used some of its RSAT funds to establish a juvenile male TC program at Barrett, 25 miles North of Richmond. This was an expansion of a program started with CSAT support, increasing to encompass the entire facility of 145 beds distributed over 6 cottages. Each cottage functioned as its own smaller community within the larger community. There were over 100 staff members but this included all correctional officers, administrators, food service workers, etc. The major program elements were firmly grounded in a TC philosophy. Program elements were clearly explained and implementation issues addressed. One concern was that youth assigned to Barrett may not be correctly assessed and appropriate for the program. One major program element, the family education component, proved to be not effective. Also the report noted the absence of an viable aftercare component. Overall, the report was very informative about the implementation of a juvenile TC program. The report also attempted some retrospective outcome evaluation from program data; however, the inability to separate those in the program from those not made the outcome analysis not very helpful. (97-RT-VX-K020)

o Virginia also used RSAT funds to establish 6 jail-based treatment programs in 6 separate facilities in the eastern and central parts of the State. The units ranged from an 8-bed coeducational dual diagnosed unit to a 60 bed coed facility in a large jail. Each program was run by a local Community Service Board, a quasi-government unit responsible for local community drug treatment services. Programs differed from one another and there was no overall jail program. Although some programs claimed they were a TC, no program would strictly be characterized as such, even as a modified TC. No program was totally segregated from other jail inmates. Staffing at each program was small (about 2) and staff often did not seem to be involved or able to deliver all the planned services. A major disappointment was the failure of the Community Service Boards to provide case management or referrals to aftercare – services that should have been their strength. The evaluation report did a fine job of describing and distinguishing each of the 6 programs using systematic social observation and systematic data recording. The evaluation pointed out problems of delivering intensive or extensive treatment in a jail setting. Most clients did not complete the program, many because of early release. (98-RT-VX-K001)

o Pennsylvania used their RSAT funds to establish 2 male in-prison treatment programs for technical parole violators returned to prison: one in a maximum security and the other in a medium security prison. The in-prison program was 6 months in a modified TC run by contractors, followed by 6-months in a halfway house with specialized treatment programming. A multi-agency working group made all RSAT commitments 12 months to coincide with treatment. The RSAT program at the maximum prison had greater implementation problems. Both programs opened in February, 1998, and each site expanded from 50 to 60 beds 3 months later. Both programs filled quickly, which led to early problems with the TC model since there were no senior residents to mentor junior residents. The treatment staff at the maximum program had no experience providing treatment in a correctional setting, but the program director at the medium program had many years of experience working with the DOC. The contractor at the maximum program also had staff problems and difficulties communicating with prison officials. Aftercare was also more of a problem for the maximum program. Medium program graduates went to several smaller halfway houses, and the program director supervised their aftercare. Through December, 1998, 237 clients entered the 2 programs. By the end of December, 1998, 38% of the graduates of the maximum program had failed at the halfway house, as compared to 22% of the graduates from the medium program. Problems with program implementation and aftercare, especially at the maximum security prison, were detriments to program success. More attention needed to be paid to aftercare. (98-RT-VX-K002)

o Michigan also used RSAT funds to establish a treatment program based on cognitive behavioral approaches for males in a minimum security prison. There were 272 in-prison beds. It was designed to include a 6 month in-prison component followed by a mandatory 12-month aftercare. Aftercare services were coordinated by a case manager. The program was voluntary and opened on January 1, 1999. By August 30, 1999, 834 inmates had applied, of which 700 had been accepted, 323 admitted, and the rest on the waiting list. Parts of the program were not implemented during the evaluation, such as individual counseling sessions and AA/NA meetings. Inmates, at least during this initial period, received less structured programming than designed. The program was filled to capacity when it opened, but it was not fully staffed. Staff were not well trained or supervised. Problems also existed with program space. By August, 1999, there had been 128 graduates, though only 15% had been discharged to the community. Others were returned to the general population, which may have worked against the gains made in the treatment program. There were significant communication problems with the aftercare provider, who was subsequently terminated. Due to the short length of the program and the evaluation period, many problems had not been effectively resolved. Most are those of a start-up program that could be expected to diminish over time. The program should be fully implemented before conducting an outcome evaluation. (98-RT-VX-K007)

Process Evaluation of the Wisconsin Residential Substance Abuse Treatment Program: The Mental Illness-Chemical Abuse (MICA) Program at Oshkosh Correctional Institution 1997/1998 (97-RT-VX-K001)

(Report by Kit R. Van Stelle and D. Paul Moberg,
University of Wisconsin, Madison Medical School)

Program Modality

This RSAT program is an adult male mental illness-chemical abuse program (MICA) for offenders dually diagnosed with a substance abuse and a mental illness problem. The program is located at the medium security Oshkosh Correctional Institution in Oshkosh, Wisconsin, in the south central part of the state. The MICA program is a 25 bed section of the facility but not segregated from the rest of the institution. Oshkosh was chosen as the location for the MICA program because of its central location and its existing Transitional Treatment Center for mentally ill inmates. Two other MICA units are planned in the state but have yet to be implemented. The MICA is physically located within the existing Transitional Treatment Center. TTC and MICA clients share cells in a 62 bed wing of a building which also houses another 150 inmates. So MICA and TTC clients are directly connected, and both groups share many common facilities with 150 non program inmates.

The treatment philosophy and approach is something of a mixed modality, incorporating some elements of a therapeutic community (e.g., community meetings, common meals, common (but not exclusive) residential quarters, community work assignments, group recreational activities), but the program also makes significant modifications so that it does not really fit a TC model. Based on the process evaluation information, the Oshkosh MICA model has 4 2-month phases lasting a total of about 8 months:

- Phase 1 is engagement and persuasion
- Phase 2 is active treatment
- Phase 3 is a second phase of active treatment
- Phase 4 is relapse prevention

The Oshkosh MICA appears to be well planned and staffed and to be reasonably well integrated into the larger correctional system. The data collection instruments and procedures -- many developed by the evaluators -- are superb. However, the program has not completely found its identity. Staff have mixed views on program content and an appropriate system of rewards and punishments to habilitate community living have not been agreed upon by staff and administrators.

The Oshkosh MICA report, like the report from most other states, is a partial report of program implementation -- up to the time that the evaluation cooperative agreement expired. In Wisconsin this included a planning period but only 6 to 9 months when the program was functional. As such, there is little information available on the program's success in actually working with MICA clients.

Client Population and Program Staffing

The Oshkosh MICA has a capacity of 25 adult male clients. The process report provides essentially no data on client characteristics for the program, probably because there are so few clients for which to report. The reader is told that for the first 6 months of operation, the MICA program admitted 3 cohorts with a total of 28 participants, eighteen still enrolled and ten who were terminated (reasons not specified). The 28 clients were about evenly divided between white and African-American.

Client selection criteria call for male inmates who are diagnosed with schizophrenia, schizoaffective disorder, or bi-polar disorder. Of note, primary diagnoses of depression or anti-social personality disorder are excluded. Subjects also need to have a diagnosed substance abuse disorder. Prospective clients also must be minimum or medium security, medically stable, volunteer, be parole eligible, and have 18 months or more sentences remaining to their mandatory release date.

At the time of the evaluation, the Oshkosh MICA program had 9 primary staff members, including one dedicated corrections officer. The other staff are program director, treatment specialist, outcome specialist, social worker, nurse clinician, psychologist, psychiatrist, and program assistant -- a total of 7.2 FTE. The program began with director and psychologist roles filled from the existing Transitional Treatment Center at Oshkosh; however, other staff proved difficult to recruit, and the program was not staffed until August 1997.

Program Implementation

Program implementation was systematic, well planned, well documented and very slow. Recruitment and assessment procedures took time to establish, but they are comprehensive and thorough. Other correctional institutions statewide are aware of the program and the selection criteria and how to make referrals to it. However, there is some indication that potential clients are unwilling to try a new program where they would have to change their behavior, share a room, transfer to a new institution, and have to deal with the confrontation reputed to be part of TC substance abuse treatment.

The Oshkosh MICA start-up provided an extensive array of trainings on topics ranging from group facilitation, to criminal thinking, to cultural sensitivity, to understanding the dually diagnosed. However, ironically, one training area neglected, as pointed out by the evaluators, was in the implementation of the particular program Wisconsin had decided to implement -- the New Hampshire Treatment Model for a MICA program. In fact, the only explicit training in the model was a one day workshop, and only the program director and program psychologist attended.

It is obvious that the content and the treatment schedule for clients was still in flux at the end of the evaluation period. The program schedule included for April 1998 shows a number of changes from schedules reviewed in earlier site visit reports, and the evaluators report on more planned changes to come. One difficulty for the MICA program was that it was not able to isolate itself from the regular prison routine -- counts, canteen time, meals, medication times. Not controlling medical dispensing in a highly medicated client grouping has been a problem, though again the institution has tried, within its institutional mentality, to accommodate the program allowing the MICA nurse to sometimes give medication outside of scheduled times. This example is indicative of the institution's willingness to work with the program, a key factor for any treatment program and particularly for a MICA program.

Evaluation Type

The "final" report is a detailed process report emphasizing the planning for the MICA program. Early on, the evaluators realized that they would not be able to accomplish evaluation of aftercare or of intermediate outcomes in their funded time frame. Even making that realization, few clients were available to study during the entire evaluation. Despite the 18 months covered

by the evaluation there is really little to be said about the program delivery beyond the extensive discussion of intake and assessment. It is a revealing omission that Table 1, a very fine summary of the study's goals, research questions and measures, has no column indicating progress toward each goal.

The process report makes use of data from program and client records, site visits, and monthly meetings with program personnel. The site visit reports produced by one of the evaluators are extremely comprehensive and indicate an attention to detail and a real integrated role for the evaluator with the program staff. The Oshkosh program evaluators maintained an excellent working relationship with the program and with correctional and other state administrators. A real strength was the evaluators creation and training of program staff in a data management system and capability that could be used by and useful to the program itself.

This evaluation report is helpful in revealing the start up problems and solutions introduced in implementing one of the most difficult kinds of programs -- one for the dual diagnosed offender. The literature review, however, does not fully inform the reader about much of the dual diagnosis literature from the last five years. The biggest problem with the evaluation is the report's tendency to gloss over the difficulty of getting clients through the program. It is true that, as with most of the RSAT evaluations, the evaluation was premature and the funding ran out before much of what a process evaluation should reveal had happened. However, in this case the evaluators seem to be too uncritical of a process that, during the evaluation, was slow to recruit and even slower to graduate clients. It is likely that the Oshkosh MICA will need to either reevaluate the required time in treatment for its clients or face the possibility of "socially promoting" clients not

ready to face the challenges of out of prison learning. Neither case will be a promising scenario for later outcome evaluation.

The evaluators' main contribution to the Oshkosh MICA Program has been the creation and implementation of data management systems that can be used by the programs as well as by the evaluators. The evaluators also developed a detailed and viable plan for at least intermediate outcome evaluation, including means and procedures for collecting adequate data on: program participation, institutional outcomes, substance abuse outcomes, mental health outcomes, recidivism outcomes, utilization of social support, and community services. A comparison group of those eligible but not entering the program will also be followed. Assuming client flow in the program can be established to be sufficient, such an evaluation would be a useful addition to the literature.

Achievements

The Oshkosh MICA has the potential to be a good specialized program but its limited size precludes great value of an in-depth outcome evaluation. It is particularly instructive on the program strengths and organizational circumstances, particularly the need for higher level administrative "buy-in" to the program, that are needed to get a dual diagnosed program implemented in a correctional setting. Treatment programs have to be strong enough and well-enough documented and appropriate client intake processes assured before clients are admitted, and the Oshkosh program did mange to do this. Some strengths of the Oshkosh MICA program are:

- Created an effective and viable referral and admission process for MICA clients;

- State and prison administrators seem to have a real commitment to the program and a willingness to cooperate in dealing with problems of implementation;
- More than other Wisconsin correctional treatment programs, the MICA program has managed to acquire and maintain a dedicated and solely dedicated staff that is both qualified for dually diagnosed treatment and not shared with other programs. The presence of a designated correctional officer for the program is another plus;
- The program provided extensive staff training opportunities, though not always on the most directly relevant program aspects;
- There remains a deep commitment to the needs of the dual diagnosed, with commendable and labor intensive attention to the development and following of individual client treatment plans.

The process evaluation report of the Oshkosh MICA program leads one to believe that, if the program had sufficient clients to be a functioning program, the excellent program description and data gathering instruments, the good internal data collection and management, and the good working relations between program staff and outside evaluators, would produce a good process evaluation and set the stage for a potential outcome evaluation effort. Unfortunately, the clients are not present at the time to tell for sure.

Evaluation of Problems

The need for MICA programs is well recognized by both state mental health and criminal justice systems, but most systems do not begin to realize the difficulties in starting one, nor do they take into account the fact that many MICA clients cannot be expected to progress as fast as

substance abuse offenders without mental health co-morbidity. The problems with the Oshkosh MICA program relate mostly to the difficulties of implementing a dual-diagnosed program in a correctional setting. The start-up problems identified by the evaluators included:

- The New Hampshire Treatment Model used for this program is a well developed MICA program, but it is definitely not a TC nor a program designed to simultaneously addresses personality disorders and criminality issues. Adapting the program to include TC elements and locating in a prison proved a challenge that had not been entirely overcome at the end of the evaluation period.
- There appears to be difficulties in selecting MICA clients with a high enough functional capacity to effectively participate in and progress in an 8 month program. Eight months is a marginally viable length for a regular adult TC and probably is too short a period for MICA clients to work through their dual problems. Many of the Oshkosh clients did not have the clinical stability or reading ability to effectively participate in a program that required quite a high functioning level. Much time and effort was devoted to clients referred from other institutions who turned out to not be clinically stable enough to begin treatment.
- Creating an effective staff team is essential to continuity of TC programming and even more necessary in a MICA program. Whereas the Wisconsin program did a good job forming a diverse team with excellent individual qualifications, it was less successful in meshing the personnel into a team that embraced the treatment model. Conflicting strong viewpoints delayed the program development.
- As with most of the Round 1 and 2 NIJ-evaluated programs reviewed where the treatment program was essentially "started from scratch" with RSAT funding, the MICA program suffered

from insufficient training. Here, although training was strong in some areas, it was lacking on the specifics of the MICA model brought from New Hampshire. At the same time, it suffered from insufficient training in the functioning of a TC in a correctional setting.

- As with many RSAT programs, there were difficulties incorporating the supposedly required urine tests into the treatment regimen and random testing policies of the institution.
- Because of the size of the program (25 beds) within a larger institution, the program was unable to isolate clients fully from the general population. Too many services had to be shared.

Process Evaluation of the Genesis Program at the
Southern New Mexico Correctional Facility (97-RT-VX-K002)
(Report by Paul Guerin, Robert Hyde, and
Mitzi Wyatt, University of New Mexico)

Program Modality

This RSAT program is located in the minimum security wing of a medium security correctional institution in the southern part of New Mexico, just outside Las Cruces. The program has 45 beds and is located in one of 4 housing pods, each with 45 beds. Unlike typical TCs, the program is not set apart from the rest of the institution. RSAT program participants have contact with other inmates in the pod(s), sharing showers, the cafeteria, and the gym. Due to overcrowding, vacated beds are filled by non-TC residents.

The evaluation report describes the treatment program as based upon a 'social therapeutic community model.' The treatment philosophy and approach is based on social learning theory. All treatment services are provided on a group basis. The program operates Monday through Friday from 8:00 a.m. to 4:30 p.m. From 8:30 to 9:30 daily, there is a community (family) meeting, run by the inmates. Small group sessions are held from 9:30 to 10:30; they include counseling groups, psycho-educational group, and art/experiential therapy group. There is a weekly 1.5 hour encounter group, as well as recreational activities. The program also includes journaling and AA/NA meetings. A treatment plan is developed for each inmates and they may receive additional services such as education or individual counseling. The TC is considered the inmates work assignment and they are paid just as inmates working in the kitchen or laundry are

paid. The inmates earn points in the treatment program that are used to determine good time to apply towards early release.

The program began on July 31, 1997, and the evaluation describes the program as of July, 1998. The evaluation report indicates one of the larger program changes was the organization of the resident inmates into 5 crews: Education, Information, Expeditor, Service and Creative Energy. The crews are selected by staff, but the crews chose a leader among themselves. A senior coordinator and an assistant oversee the crews. The structure is based on accountability and role modeling, and was implemented following a week-long RSAT training.

Client Population

Between July 31, 1997, and July 1, 1998, the Genesis program admitted 48 male inmates. Several of these inmates were transferred or terminated soon after admittance, so information is only available on 40. Their average age was 34, and the majority (40%) were Hispanic. Forty-four percent were married, and 40% had not completed high school.

All state inmates are processed through a centralized facility while classification and diagnosis are completed. Inmates spend an average of 1.3 months at the centralized facility, which screens for substance abuse dependency. Those diagnosed with substance abuse dependency are provided with a list of substance abuse treatment options and encouraged to participate. All participants volunteer for the program because state laws prohibits forcing inmates into treatment. The TC staff postulate most current referrals are from other inmates.

To be eligible for the program, inmates must have 9-18 months to serve on their sentence with good time left. Only inmates classified to minimum security are eligible for the program. They

must agree to accept urinalysis. Inmates with serious mental health or cognitive problems that would limit participation in the program are excluded. Those with a current sexual offense or violence toward children are excluded, as are others that represent a security risk. The program also excludes those taking prescription psychotropic medications.

Program Implementation

The evaluation report indicates there have been changes in the program since it was initiated. A complete description of the program at onset is not included in the evaluation report, making it difficult to describe the changes in the program structure or what prompted the changes.

The evaluation report explains the program has not been able to become fully operational and has never reached its projected capacity of 45. Of the 40 inmates admitted, 37 were still in the program on July 31, 1998, when the evaluation concluded. The treatment program is divided into three phases, but none of the inmates completed them within the scheduled time.

The program was not fully staffed until the end of the one year evaluation period. The evaluators conclude this is due to the remote location of the prison and the limited pool of individuals willing to work in a prison. Also, the evaluators explain that the New Mexico DOC has historically been punitive, and has been unwilling to relax some rules that would create more a favorable treatment environment within the prison.

The program director is the Director of Mental Health at the prison. He does not have day-to-day responsibilities in the program. He recently appointed one of the senior counselors to the position of Program Coordinator. There are 2 additional full-time counselors and 2 part-time counselors. Only one staff member has resigned since the program was implemented. The

evaluation report states the RSAT program hoped to hire additional staff as the program grew, but the program stabilized at about 25-30 inmates, with new entrants replacing those exiting the program.

The report provides little information on actual program implementation. The evaluation report states the program was slow starting due to delays in hiring and acquiring program participants. No one graduated from the program during the evaluation period, so there was no utilization of aftercare. The plan for aftercare is to have the Probation and Parole Division's Community Corrections Program provide aftercare. This is one of four specialized programs that is designed for probationers and parolees with special treatment needs. They have 15 sites throughout the state, concentrated in areas with the biggest population concentrations. It appears the stakeholders were all convinced of the necessity of aftercare, but without additional funding to support such, they have had to choose among available alternatives.

Evaluation Type

The review consisted of program observations, meetings with RSAT treatment staff, and client and program level data. The evaluators were located 3 hours by car away from the facility, which interfered with their ability to conduct observations and interact with program staff. During the evaluation, a graduate student who lived closer to the prison was hired and "trained to conduct all aspects of the evaluation." The evaluation report explains they made 5 trips to the facility, but does not indicate how often the graduate student visited the program.

The evaluation report is lacking important information and details one might expect. This evaluation was funded under NIJ's first RFP, which was not specific about the type of evaluation

requested. However, the title of the report suggests that the researchers were conducting a process evaluation. Yet, much of the richness about program implementation one would expect in a process evaluation is absent in the report. Information is not provided on how many inmates were initially transferred to the program. Information is not provided on actual services, both those as planned and those as implemented. We are told the inmates were not segregated from the rest of the inmates; information on this should have been developed in the evaluation. As a process evaluation, the methodology should have documented the slow start-up and all the attendant problems in more detail. The observational data is therefore weak.

On a more positive note, the evaluators created a data collection instrument in Microsoft Access which facilitated access to baseline information in the form of an ASI. They developed and implemented a revised ASI to be completed at program intake, graduation, and at follow-up in the community. The intake included other scores from standardized assessment tests, demographic information, and criminal history that was included in the data collection instrument. It also included information on services rendered and their content, urinalysis results, and disciplinary information.

The evaluators hoped to establish a framework for an outcome evaluation, but found it difficult. They indicate they were not able to develop a comparison group because of the slow program startup. However, the evaluation report states that some of these problems have been resolved so they could develop a comparison group. They have developed pre and post test instruments for a comparison group, but these are not described.

The evaluation report indicates the evaluators had some difficulties establishing a relationship with the RSAT program staff, primarily due to the geographical distance. This was resolved by

hiring a graduate student who lived nearer the institution and was presumably, able to maintain more regular contact.

Achievements

The lack of depth of the information provided and the difficulties in establishing the RSAT treatment program, makes it difficult to determine the accomplishments. The fact that 40 inmates have entered treatment is positive however, and that the program was fully staffed by the end of the evaluation period. There has been some planning for aftercare, although the evaluation period ended before any graduates were sent to aftercare. The evaluation report indicates the aftercare plan is to utilize the services of the Probation and Parole Division's Community Correction Program which focuses on drug abusers treatment needs, however, without implementation, it's not clear how well developed the plans are nor how easily implementation can be accomplished.

The creation of computerized case files with information on assessment tests and treatment services was a considerable achievement. It appears the RSAT treatment staff found this system useful to them, as they maintain the system. This suggests good collegiality between the evaluators and treatment team, although the evaluation report indicates some difficulty in establishing good working relationships due to the distance between the facility and the research investigators.

Evaluation of Problems

The physical distance between the evaluators and the prison program was problematic. It appears they arrived at a plausible solution, however, there are no details about when the graduate

student was hired, and the frequency of their contact with the facility. As such, the process evaluation, which is generally based on program observations, provides little information about program implementation and how obstacles were overcome.

It is unclear why the program has achieved difficulties in reaching capacity. We learn in the evaluation report that all commitments to treatment are voluntary. Based on the amount of substance dependence among inmates, it is reasonable to expect that there would be 40 inmates in the state at any one time who would volunteer for treatment. The problem may be that the prison is physically located in a rural area far from the more densely northern portion of the state, making it difficult for family and friends to visit. Inmates may not volunteer for the program based on the physical location of the prison. There are other in-prison treatment programs in the state. It would be interesting to know more about the inmate flow into and out of these programs.

The failure to separate the RSAT program inmates from other inmates is an issue that needs to be addressed. The RSAT funds are designed to be used in environments that separate the treatment program from the rest of the prison.

Factors Affecting Client Motivation in Therapeutic
Community Treatment for Offenders in Delaware (Delaware, 97-RT-VX-K004)
(Report by Steven S. Martin and Christine A. Saum, University of Delaware)

Program Modality

This RSAT program partially funds the expansion of the Therapeutic Community Continuum of Treatment in Delaware. The continuum is a series of TC programs for both male and female adult drug-involved offenders in the Delaware correctional system. The programs are located statewide with in-prison "KEY" TCs in 4 of the 5 prisons in the state, "CREST" work release TCs associated with each of the state's 3 residential work release centers, and aftercare programs operated out of each of the work release TCs. The continuum began with one in-prison TC, the original KEY Program, established with a BJA Project Reform Grant in 1988. It was followed by the original CREST Program at the Plummer Work Release Center established by a National Institute of Drug Abuse Treatment Demonstration Grant in 1991 and a women's KEY program funded by a Center for Substance Abuse Treatment Residential Treatment grant in 1993. State funding continued these programs after the initial Federal demonstration periods, and since 1996 they have been expanded with a combination of state and RSAT funding.

The continuum is based on a combination of "primary" treatment in prison, "secondary" treatment in residential work release, and "tertiary" treatment or aftercare when on parole. Treatment is tied to the correctional mandate at each stage. The Delaware TC Continuum, particularly the transitional residential treatment program in a work release setting, was highlighted in the enabling language of the RSAT Program (OJP 1996). Treatment services are provided by an outside contractor. The program has approximately 700 beds operating at each

of its primary, secondary residential treatment levels for a total of 1400 residential beds. As opposed to what was reported in the National RSAT evaluation summary charts, less than 20% of this residential treatment was RSAT funded, rather than 50%. This may be indicative of unreliability in individual state reports on RSAT funded beds.

The Delaware programs treatment philosophy and programmatic components are firmly grounded in the TC model. In fact, the Delaware program has been one of the more often cited programs in other RSAT evaluation reports, though, it does not appear that any of the other subset of "evaluated" RSAT programs have incorporated the actual Delaware program elements or tools. The major program elements of the Delaware continuum are not reviewed in the "Final" report; however, the reader is referred to earlier published process evaluation reviews that were funded by NIDA, some of which were included in the appendix material, but most seemed to predate the RSAT period.

The Delaware continuum report, like the report from a few other states, is not a report of program implementation -- in Delaware the treatment program was well in place and a model for the whole RSAT project. Initially, Delaware had wanted to use the RSAT money to fund an extensive aftercare program. The NIDA and CSAT funds had supported the first two elements of the TC continuum, now supported by the state, and Delaware wanted to use new funds to implement the "tertiary" or aftercare stage. However, the "Residential" restriction in RSAT precluded this. So, Delaware used money from the RSAT funding to expand services and treatment slots, and, although the report does not say it explicitly, it used RSAT money to support some planned but not yet implemented residential treatment beds, and diverted other state funds to expand aftercare. Although not reviewed in this report, the published material on the Delaware

continuum appears to show a program with high fidelity to the TC model. The residential programs operates 24 hours a day, and the living quarters are truly isolated from other parts of the prisons or work release facilities. Except for two years when the University of Delaware actually operated the CREST program at its inception, all TC treatment services in Delaware have been provided by the same outside contractor. Of note, the contractor has been very involved in the development and evaluation of the expanding TC program in Delaware and has participated in some of the research reporting.

Client Population and Program Staffing

The following description of Delaware TC offenders is based on data recorded for the one-year period ending July, 1999. There was a grand total of 1,111 clients participating in any of the 7 statewide residential TC programs. This number includes participants in both the in-prison based programs (KEYs) and the community-based work release centers (CRESTs). The number of clients who participated in any of the three statewide aftercare programs was about 600.

KEY Programs – 455 offenders or 41% of the total correctional TC population were enrolled in one of the 4 KEY programs. Males made up most of the client population (90%). The low percentage of female participants is related to the limited availability of TC beds in the women's prison. The race/ethnicity breakdown for KEY participants was as follows: White (25%), Black (71%) and Hispanic/Other (4%).

CREST Programs – 656 or 59% of the total correctional TC population were enrolled in one of the 3 CREST programs. Males were the primary participants at these work-release TCs

(87%). The race/ethnicity breakdown was White (38%), Black (58%) and Hispanic/Other (4%).

Aftercare Programs - (600) clients attended one of 3 Aftercare programs which are located at each of the 3 CREST programs. The Aftercare programs are equipped to handle unlimited numbers of graduates from the KEY and CREST programs as well as some clients who enter from other programs. Ninety percent of the Aftercare clients were male. The racial/ethnic breakdown was White (30%), Black (63%) and Hispanic/Other (7%).

Because the report is not an evaluation of implementation, it does not provide much information of client selection criteria or referral processes. It would have helped to include copies of all the process evaluations referred to in the report's references in order to provide important background information. Some of the papers that were included, however, do indicate that clients who enter the continuum come from a combination of volunteers, institutionally mandated treatment (as a condition of release) and court mandated commitments. Depending on the source and the sentence to be served, some clients enter or are assigned to in-prison KEY programs, while others enter the continuum at the work release CREST stage. One of the foci of the ongoing research project being conducted by the University of Delaware is the difference in outcomes depending upon whether the client enters the continuum at the primary or secondary stage, and the source of referral to the program.

For the same time period, staffing fluctuated somewhat but was generally quite consistent. Contracts called for staff to client ratios of 1 to 16 or 1 to 18, depending on the specific institution. Actual ratios ranged from 1 to 15 to 1 to 20. Staff consisted of a mixture of degreed and recovering counselors, with a number who are both. The treatment programs are licensed by the

state's Division of Alcoholism, Drug Abuse, and Mental Health and meet state guidelines for number of certified addictions counselors. Staff roles seem well delineated and ongoing staff education is a priority and necessary to retain certification.

Program Implementation

Implementation was not a focus of this evaluation report. The Delaware residential programs were well established and following regular procedures by the end of 1995. The residential programs were in a mature TC stage by 1995. The evaluation report did indicate an intention to process evaluate the expansion of CREST and the issues involved in the increase in client referrals directly to KEY and CREST by judges (rather than be assessed and classified within the correctional system). The evaluators report on updated client flow information and new program openings during the RSAT evaluation period, and these are reported in some of the presentation material and in a summary chart in the report.

The issues that are most interesting from a process evaluation standpoint on CREST expansion all occurred after the RSAT evaluation period, but some of the information is reported in the final report. Now aftercare is explicitly tied to each of the 3 CREST centers: North, Central, and South, which helps with the delivery of the complete continuum of treatment. CREST clients now come theoretically from three sources: Level V flowdowns from the in-prison TCs, Level V flowdowns from regular population inmates with an assessed substance abuse problem, and Level IV direct commitments from the Courts for less than a year sentences and for probation violations. In practice, judges (including Drug Court judges) make many direct commitments to CREST, so there are not enough beds for regular drug-involved inmates and not even sufficient space for those

graduating from the in-prison TCs. An examination of the "appropriateness" and success of the direct court versus Level V TC flowdown cases is just beginning under a Merit renewal to a NIDA grant (Inciardi, PI; Martin, Co-PI).

Evaluation Type

As seen in the state's reports, it is not possible to show results for a discrete RSAT funded program, and in any case, the Delaware programs have an extensive published process evaluation record. That record, if nothing else, forcefully demonstrates that, even with adequate resources and excellent administrative support from the correctional system, program implementation is a tortuous process, and program stability is not reached for two to three years at a minimum. The Delaware evaluation had three specific aims:

1) To evaluate the new program expansion of the CREST TC program.

2) To use grant support to access official correctional and criminal justice records to improve the recidivism outcome criteria.

3) To make retrospective use of existing client treatment files to improve the control variables and ability to model program engagement for inclusion in multivariate outcome models.

Progress on the first of these Aims is reviewed above. In regard to Aims 2 and 3, by using existing outcome data from the ongoing NIDA-sponsored study and extracting individual level information from existing treatment and criminal justice records with RSAT support, the evaluators were able to, retrospectively, improve both our predictor variables as well as our outcome measures, which has led to several national presentations and a major 3 year outcome *Prison Journal* article in Fall 1999. The most notable finding from this work (and ironic from the

point of view of the RSAT program) is that it calls into question reliance on only "residential" treatment for criminal justice offenders. It appears that long-term (3 year) effects are most apparent when residential treatment is followed by aftercare. Lasting effects of "residential" TC treatment alone are not large. Work by RSAT contractors Simpson, and Wexler and their colleagues in the same *Prison Journal* issue support this conclusion.

This evaluation report is different than others in providing a useful outcome evaluation rather than a process evaluation. Funding it under the "process evaluation" category was a misnomer, but it does provide some provocative findings as well as the first long-term outcome evaluation results from an RSAT funded program.

Achievements

The Delaware continuum is a national model program, and it continues to be followed with multi year support from NIDA. The results of the NIJ/RSAT expansions of the Delaware program evaluations have been incorporated in several presentations and recent publications that credited the NIJ support. Delaware has been fortunate in being able to have support over the past decade from NIDA, CSAT and the Department of Justice for both its offender treatment and evaluation. One can hope that such a model of collaboration among federal agencies interested in treatment for drug-involved offenders can become more of a planned model rather than one cobbled together by entrepreneurs in one state. As has been seen throughout these evaluation reports, pre planning produces a much more successful implementation. It is an example that the interested federal funders should take to heart themselves. Some key findings are:

- Ironically (and perhaps erroneously -- as General McCaffrey told the Delaware evaluators during a visit to the Delaware programs in 1997), the RSAT program was not allowed to fund non-residential treatment. This outcome evaluation suggests that treatment programs for offenders needs a strong aftercare component, and probably, the aftercare should be tied to probation or parole stipulations.
- Program delivery remained faithful to the TC model.
- Those who complete a continuum of treatment have the best outcomes. The benefit of the full continuum of treatment becomes more evident as one moves from 1-year to 3-year outcome data.
- The most consistent program characteristic associated with long term success is the length of time in treatment. Compulsory treatment may work better than voluntary treatment for offenders, because compulsion increases the length of time in treatment.
- There remains a deep commitment to the implementation of the TC model in Delaware among state administrators.

The evaluation report and its accompanying research reports demonstrate that, with a large functioning program, good internal data collection and management, good working relations between program staff and outside evaluators, and large resources for evaluation, it is possible to do a very successful evaluation that can have national implications for research and treatment agendas. However, any process evaluation requires several years of data to be really informative. Any outcome evaluations require relatively large samples, appropriate comparison groups and sufficient time to see if successes last.

Evaluation of Problems

Problems with the Delaware continuum implementation were myriad and varied, but most had been resolved before the beginning of the RSAT program. Two problem areas were noted by the evaluators:

- Even a mature TC program can be threatened by external program changes such as funding levels, key administrators, and the actions of judges. A program needs to be strong enough to survive unintended consequences of bureaucratic changes. The Delaware TC continuum was somewhat a victim of its own success and notoriety. State judges were well aware of it and took it upon themselves to become clinical assessment agents. In many cases they sentence an inmate directly to CREST or KEY, and that assignment takes precedence over clients referred from within the prison after clinical assessments. As the state has moved more to the use of a Drug Court, with more substantial and appropriate client assessment, this problem has begun to subside. However, many non Drug Court judges do continue to make direct commitments.
- Even a rigorous and well-funded evaluation like that conducted in Delaware can have its detractors. Results from the Delaware study had a greater impact nationally than they did in Delaware until the state's statistical analysis center confirmed the findings. It never hurts to get confirmation.

Process Evaluation of a Residential Substance Abuse
Treatment Program for State Prisoners (Michigan Juvenile, 97-RT-VX-K008)
(Report by William C. Birdsall and Maureen Okasinski, University of Michigan)

Program Modality

This RSAT program was implemented in the most secure facility for adjudicated male delinquents in the state of Michigan--Maxey Boys Training School. Maxey houses over 500 youth in five centers; 2 maximum and 3 medium security centers. Each center has several wings housing about 20 males. One of the RSAT programs was housed in the wing of a maximum security center, Green Oaks, and the other in the wing of a medium security center, Sequoyah. Initially, Green Oaks had 18 residents and Sequoyah had 12. The evaluation report does not indicate the number of youth served over time, but provides information on program completion on 31 youth admitted to the program(s) between May, 1997, when the program(s) opened, and May, 1998, when the evaluation ended.

The basis of the RSAT program was psycho-education and relapse prevention. It was developed by consultants and synthesized into a unified program by March, 1998. The program was delivered in 90 minute group meetings scheduled to occur four times per week. Individual and family sessions were also part of the program design. The program is delivered in addition to the services provided at Maxey, which include group, individual and family session facilitated by a group leader and/or social worker. The Maxey Model is a hybrid of cognitive behavioral treatment, behavioral modification and trauma resolution. It includes a level system, but it was structured differently in the two wings, and was revised during the evaluation period.

Client Population

RSAT program clients were selected from the general population of Maxey. Selection was based on a history of substance abuse, and a release date close within a year. Sex offenders were not permitted in the program. The youth in the two centers did not differ on several important demographic and background variables, although the evaluation report is somewhat inconsistent in positing this. It appears the youth in the maximum security center, Green Oaks, were more likely to have unmarried parents and more than 3 prior placements. They were also more likely to be minorities.

There were differences in risk and protective factors between the two groups, but not between the groups and their respective comparison groups. The maximum security residents reported that someone in their family listened to them more often than the medium security residents. Surprisingly, more of the medium security residents reported someone in their family was drunk or violent 'a lot of the time' than the maximum security residents.

Program Implementation

The RSAT program began in May, 1997, following a period of staff training. Program staff received over 100 hours of substance abuse and relapse prevention training in three separate weeks. The original participants were assessed and screened for substance abuse problems, length of time remaining on their sentence, and any history of sexual abuse. The selected residents were transferred to the programs. It appears the two programs were implemented simultaneously. Since the RSAT treatment services are provided in addition to the general treatment services

provided to all Maxey residents, implementation was facilitated by advance staff training and beginning the programs with small groups of 12 and 18 male youths.

Three substance abuse consultants were contracted to provide three group sessions per week. The evaluation report states they spent 'considerable time developing the details of the program and support materials.' On average, the consultants spent 8 hours per week providing direct services, but the amount varied across the three consultants. The consultants also had responsibilities for training the staff, but the report explains that there were personnel problems caused when the union initially protested the hiring of consultants rather than regular staff to fill the 3 positions. This delayed program start-up, although there is little detail about this in the evaluation report.

There was not a standardized curriculum. The evaluation report states consultants shared the same tools, worksheets, and resources, but it appears each had a great deal of control over what they implemented. Observations also revealed variation in the structure of the groups. Some facilitators ensured that everyone participated, set a clear group focus, and balanced participant needs and provided closure. In others, disruptive and disrespectful behavior was not addressed by the leader, a few people monopolized the group, and sessions lacked focus and/or closure. The program curriculum was standardized in March, 1998, but the evaluation ended 2 months later, so it is not clear how this impacted on service delivery.

Neither of the RSAT programs met expectations for the number of group sessions. The number of family and individual sessions were also low. Sequoyah, the medium security program, had twice as many family sessions, and more group sessions than Green Oaks, but still fell short of initially established standards.

Three Maxey staff had experience working in substance abuse treatment in addition to the consultants. There was a nearly even mix of staff with Bachelors Degrees, some college, and no college training, and about the same number of staff were in recovery in both wings. Also, 3 staff in each wing were Certified Addiction Counselors by the State Board of Addiction Professionals via RSAT program training. There was some staff turnover in both program, with 3 staff leaving Green Oaks and 4 leaving Sequoyah in the first year.

The program was designed to be completed in 6 to 12 months, but only 38.7% (n=12) of the residents finished the program in that length of time. Over half (52%) had not completed the program in 12 months. Three of the 31 residents admitted in the one year evaluation period left the program prematurely. According to the evaluation report, this was in part due to the fact that Maxey does not have absolute control over release dates. Other than the 3 released prior to program completion, none of the program completers left Maxey. Although specifics are lacking, it appears several of the youth who completed the program went to stepdown type programs in Maxey. The evaluation report includes little information on other stepdown or aftercare programs or services outside Maxey, although the report suggests many of the graduates will be sent to such.

Evaluation Type

The evaluation of service delivery began when the program was implemented in May, 1997, and ended a year later. The methodology included a review of records indicating the frequency and type of clinical services, program observations, focus groups with residents, and a client survey evaluation about satisfaction with services. Several program managers and staff, both the substance abuse consultants and regular Maxey staff, were interviewed regarding their experience

in substance abuse treatment, their education, and whether they were in recovery. The treatment groups were also compared with the control groups of youth from another wing in the same center. Although the methodology sounds comprehensive, the evaluation report was sketchy on many details regarding the program and problems encountered.

Although the youth did not receive as many services as designed, there were no significant differences in the number of group session between the RSAT and the comparison group. This suggests that RSAT services were substituted rather than added to regular Maxey services, although it appears the RSAT services were to be delivered in addition to regular services. There were differences between the groups, and the Sequoyah residents had more individual sessions than the Green Oaks residents; 7 to 2 average sessions per week respectively. This is due to the fact that in Green Oaks, psychologists and psychiatrists are the main facilitator of individual counseling. Youth advocates are more likely to deliver individual counseling sessions in Sequoyah.

There is a level system at Maxey, but it was structured differently in the two wings, and the evaluation report states it was revised during the evaluation period. Level promotions or demotions were not recorded in case files and the evaluation does not describe the level system in a meaningful way.

Focus groups revealed the youth had a number of criticisms of the Maxey services in general rather than the RSAT program alone. The clients desired increased individual and family counseling, as well as a more challenging educational program. They expressed their desire for connection to the outside community. They criticized the Maxey behavioral control method and

its effect on insincerity in treatment. They suggested it created mistrust and negatively affected their relationship with staff.

Sixty-five youth completed the client survey of satisfaction with services. The RSAT groups rated the quality of their group sessions more highly than the comparison groups. The youth reported staff, peers, and teachers treated them fairly most or all of the time; however, in the focus groups, they had reported much less perceived fairness. The Sequoyah youth rated the school significantly more highly than the Green Oaks youth, but the Green Oak youth did not attend the main school building with other Maxey residents. They had more learning disabilities and educational challenges. The Sequoyah youth also rated the hall staff more favorably than the Green Oaks youth. Overall, less than half viewed Maxey positively.

Achievements

One of the program achievements is the planning and overall relatively smooth implementation. The Maxey staff received over 100 hours of training in week long session before the program was implemented. It is not clear who selected the youth for inclusion in the program, but presumably these staff were involved. Since these staff were already working at Maxey, they were aware of other program rules and regulations making for a smooth transition.

The youth received an average of at least 3 additional group sessions per week geared specifically to substance abuse problems, in addition to the regular Maxey curriculum. The substance abuse program is now standardized.

The evaluation report states that agencies and individuals from the community have been included in the RSAT program, which create an important link to the community for the

recovering youth to access that can provide support once they are released from Maxey (p. 9). The Sequoyah program included attendance at 12-step meetings in the community and some community outings. Unfortunately, the report does not detail the community agencies or interagency linkages in detail.

The high ratings the youth gave to group sessions is encouraging. They rated the quality of their groups more highly than the comparison groups. They also reported feeling treated fairly by peers, staff, and teachers. The evaluation report indicates the University of Michigan (UM) is conducting follow-up in the community 6 and 12 months after release.

Evaluation of Problems

It is difficult to evaluate the problems in the program and proposed solutions, since the evaluation report is meager on many details. Perhaps one of the biggest problems however, is that treatment and correctional roles may be overly concentrated in the same individuals. The youth indicated in focus groups that the 'behavioral control method of the Maxey Model' created mistrust and insincerity in treatment, as it negatively affected their relationships with peers and staff. One must remember that in youth correctional facilities, the staff perform custodial, treatment, and correctional roles. This may work well much of the time, but it needs further investigation when drug treatment is the focus of the program. The client satisfaction survey conducted by the evaluators indicates the young men felt that the staff and teachers treated them fairly, and they were satisfied with the group counseling services. These are encouraging signs portending success, as will be measured in the impact study conducted by UM.

The evaluation study left details unfilled about how the RSAT program dovetails and complements the Maxey treatment model. The Maxey model is not fully described, but the evaluation suggests that program services are being substituted rather than added to the Maxey model. Whether in addition to or as a substitute, there are appealing aspects to this model which includes adding or substituting to focus more upon substance abuse and relapse prevention. But it is difficult to evaluate without more information. The program staff received 100 hours of training, but as pointed out above, these same staff have both treatment and correctional roles. It appears the consultants led most of the treatment groups, but there may have been other staff led treatment groups. There was a fair amount of staff turnover in the one year evaluation period, and substitute staff training or qualifications are not described.

It would be useful to know more about the level system and how it is tied to release from Maxey. Importantly, details about aftercare services are missing, although the report suggests there are strong interagency ties with the RSAT treatment program (or perhaps with the Maxey program more generally). The evaluation report points out the need to connect the young men with support services in the community, including jobs or school programs

The number of youth enrolled in the RSAT programs was relatively small. The evaluation report indicates the programs opened with 30 youth between them, but what happened to the size of the client population over the year is not discussed. The failure to graduate youth in a timely manner (the program was designed to be completed in 6 to 12 months) also needs further investigation.

The evaluators do not provide enough information on critical aspects of the program in their description to allow for a replication. It would have been useful to describe more of the problems

encountered, such as the union problems with hiring the substance abuse consultants and the high rate of staff turnover. It would have been useful to know more about the process that led to the curriculum being standardized. Nevertheless, there is much useful information provided, especially in the form of client satisfaction.

An Evaluation of the "New Choices" Substance Abuse Program in
the Harris County Jail, Houston, TX (97-RT-VX-K010)
(Report by Kirk von Sternberg and Joseph P. Carbonari, University of Houston)

Program Modality

Providing substance abuse treatment in a jail setting is a fairly recent undertaking. Jails typically serve offenders with sentences of one year of less, as well as individuals awaiting trial or sentencing, and individuals awaiting transfer. Those serving sentences are a prime target for substance abuse services as there is a demonstrated need. This program was implemented in response to those recognized needs at the Harris County Central Jail in Texas. The Harris County Central Jail is a maximum security jail, and the 4th largest jail in the nation, with an inmate capacity of about 8,500. The RSAT treatment program is on a dedicated floor of the jail, with a capacity of about 200. Separation is maintained with the exception of medical visits, law library weekly privileges, and recreation. In addition, those with jobs and those taking GED classes interact with other offenders. Jobs are available based on positive behavior and treatment progress.

The program is an amalgamation of several approaches, although it is promoted as a quasi TC of 6-12 months duration. While the model includes some characteristics of a TC, major aspects of the TC model have not been fully implemented. There is a morning motivational group that all clients attend, and AA/NA groups. The Harris County Jail policy will not allow inmate government, a job structure hierarchy, or peer confrontation. Since these are critical aspects of a TC, and the evaluators posit that establishing a sense of community has been difficult at best, it seems inappropriate to characterize the program as a TC.

The core program is based on the Hazelden substance abuse treatment module for the criminal offender, which is heavily based on AA and the 12 steps and traditions. The treatment delivered has been primarily an education and skills based program designed for delivery through didactic instruction and written exercise. The actual content of the program is not reviewed in detail. Most treatment is delivered in large counselor-led groups; one for the males and one for the females. Treatment and correctional staff provide the feedback that addresses client behaviors, rather than peers as is typical in a TC.

Virtually no information is provided on aftercare services. The evaluation report indicates a contract has been awarded for aftercare client placement, but there is little information on how aftercare is coordinated with the residential treatment provided in the jail, the length of the aftercare program, or its components.

Client Population

The program targets sentenced inmates with at least 6 months of their sentence remaining. Clients are self-referred (65%), referred from the jail's medical unit (21%), and from court mandates (14%). There are both male and female units. The male unit includes 120 beds and the female unit, 40 beds, for a total population program size of 160 beds.

Between June of 1998 and July of 1999, when participant recruitment ended for the evaluation, the evaluation report states that 531 inmates had been assessed, and 426 had been admitted to the RSAT treatment program. Since the capacity of the program is 160, these numbers suggest several cohorts have moved through the program in the 13 month period. The evaluation report

provides no information on removals, dropouts, or other program failures, except those that did not have enough time remaining on their sentence to complete the program.

Program Implementation

Due to jail overcrowding, and the necessity of efficiently utilizing all available bed space, the RSAT treatment program was initially filled with some participants that did not have enough time remaining on their sentence to complete the program. The RSAT program was funded on March 1, 1997, and began admitting clients the following June. Renovations were being made to the floor, so when the evaluation began (the following November), there were approximately 80 males and 30 female clients. In January, 1998, there were 2 counselors, one for the males and one for the females. A second counselor for the female side was hired in the summer of 1998. Renovations were completed in September, 1998, creating the capacity for 120 males and 40 females. The evaluation states that by November, 1998, after 18 months of diligent recruitment efforts, the treatment staff was up to full capacity. Staff-client ratios were approximately 1:16 for males and 1:13 for females.

There were obvious start-up problems revolving around insufficient treatment staff to provide services. The Harris County Jail prohibits the employment of ex-offenders or anyone with a previous conviction that involves drugs. This limits those eligible for counseling positions, particularly in comparison to a TC, which typically includes some recovered addicts and ex-offenders in counseling positions. These requirements, and the correctional environmental which is lacking in appeal to many treatment professionals, (and perhaps salary levels as well), combined

to created problems with staff recruitment. The delays in hiring affected all aspects of the treatment program including recruitment and treatment delivery.

Evaluation Type

This evaluation was funded under the second NIJ RFP on November 1, 1997. The second solicitation indicated evaluations would be cooperative agreements between the evaluators, NIJ, and CPO, with discretion as to the specific topics associated with the evaluation. The evaluations were encouraged to allow and prepare for subsequent impact evaluations, use valid and reliable measurement tools, and incorporate some meaningful comparison group.

The evaluation methodology addresses the requirements of the RFP. The RSAT evaluation of the Harris County Jail was conducted by the Change Assessment Research Project at the University of Houston. Data collection began in January, 1998, and was completed by February, 1999. The final report was submitted in March of 2000. The evaluation includes a description of the overall treatment efforts, an evaluation of treatment efficacy among clients at 45 days and 3 months using standardized tests, and a plan for securing a cohort of program clients and an appropriate comparison group for a future impact evaluation. The evaluation utilized record reviews consisting of a review of program and treatment materials and schedules. Fifteen staff members were interviewed and/or completed paper and pencil questionnaires. Included among this number were treatment and corrections staff, and administrators. The report also includes information on participant and staff measures of satisfaction with the program. The evaluators report they conducted weekly program observations during the evaluation period, including observing assessment interviews, treatment components, support services operations, and

discharge procedures. Much of the evaluation report describing the program services appears to be derived from program materials on how the program was intended to be delivered, with somewhat less attention to how it was actually operationalized. Therefore, it may be that the observations did not as heavily influence the evaluation as limited data is presented from observations.

The "Evaluation of Treatment," based on the DATAR form developed by Texas Christian University, was adapted to measure client satisfaction with treatment staff and program services. Inmates generally rated the group counseling sessions as the most valuable treatment component. The 'Working Alliance Inventory' measured the inmate's perception of their relationship with their counselor. It was administered at 45 days. The inmates generally rated the counseling staff highly. The 'Community Oriented Program Environmental Scale (COPES)' was administered at 45 days, showing that inmates strongly endorse a number of major program dimensions. The staff was also administered the COPES, and found most measures to be at the norm mean or above.

Several other tests were administered to clients including a client intake interview modelled on the ASI, the University of Rhode Island Change Assessment Scale (URICA), and The Transtheoretical Model (TTM) of change. The TTM was administered at intake, 45 days, and 3 months to measure motivational aspect of the change process. The results showed the treatment group was advancing through the change process as they progress in the treatment program. The TTM was also administered to a comparison group from the general population showing they also made some changes, but those in the RSAT treatment program showed greater indication of change and motivation to change.

Achievements

Perhaps the most notable achievement of this RSAT program is the success toward operationalizing a treatment program in a jail setting. Sentenced jail inmates have a high prevalence of drug abuse and dependence, as the DUF/ADAM study and several national surveys of jail inmates have demonstrated. However, services to this underserved population which address their substance abuse treatment needs could be extremely cost effective. There are special circumstances in a jail environment relative to a prison environment that can hamper treatment efforts, including the relatively short confinement period. Therefore, the successes of this program are to be lauded.

Despite the implementation problems, the treatment program provided services to a number of inmates. And although the client to staff ratio was initially quite large, and the groups quite large, the inmates gave favorable rating to both the counseling staff and the group services. The evaluation included several tests demonstrating the change in inmates as they progressed through the treatment program. These assessments among the RSAT treatment group are indicative of the potential success of the program in effecting change in the inmates substance abuse patterns.

Another notable strength of the program was the dedicated Director and Program Supervisors. There was also documentation of difficulties between the treatment and correctional staffs, which was improving as evidenced by their cooperation on developing joint rules for handling inmate violations and infractions. The evaluation report also indicates there is ongoing cross training with the correctional and treatment staffs.

Evaluation of Problems

Many of the problems reported were those related to start-up, and have all diminished. The delay in hiring and recruitment of staff affected all aspects of the treatment program including recruiting inmates and treatment delivery. Some of the planned aspects of the program were not fully implemented until later such as individual and small group counseling. With the unit now fully staffed with an acceptable staff to client ratio, these problems have been effectively handled. Additionally, the increased staff size has permitted more time and energy to be devoted to the continued development of relationship with the courts.

More problematic is the lack of aftercare services to help inmates sustain the changes they make during treatment as they transition to the community. The evaluation report indicates new discharge procedures have been developed and contractual arrangements have been made for aftercare client placement. However, these have not been fully implemented and will undoubtedly require some attention to improve as well.

A substantial proportion of the initial cohorts did not have enough time remaining on their sentences to complete the program. However, the evaluators report the number of clients that have 6 months remaining on their sentence has increased 5-fold since July 1998. This is due to more efficient screening methods. This issue needs continued monitoring, as well as increased coordination with the courts.

The process of educating the courts about the program took longer than anticipated, resulting in fewer court mandated participants than anticipated. While this has improved for males, there is less improvement for females. Most of the women sentenced to the Harris County Jail are

sentenced for 3 months or less, and courts appear to be reluctant to sentence women for much longer periods. Continuing to improve linkages with the courts will be necessary.

The disparate approach to confronting inmates' behaviors between the treatment and correctional staff proved problematic, as it has in virtually all correctional treatment programs. However, by December, 1998, the staffs jointly created rules and infraction policies. This has contributed to a more consistent and unified approach.

This RSAT program was still evolving. Policies and procedures have been developed to address the myriad of problems encountered at start-up. These have set the stage for increased effectiveness and future success.

Final Report of a Process Evaluation of the Ozark Correctional Center
Drug Treatment Program (Missouri, 97-RT-VX-K013)
(Report by Donald M. Linhorst, St. Louis University)
Final Report of Outcomes for Ozark Correctional Center
Drug Treatment Program (Missouri, 97-RT-VX-K013)
(Report by Jeffrey E. Nash, Southwest Missouri State University)

Program Modality

This RSAT program is an adult male TC. The program is located in Ozark Correctional Center, a male minimum security facility in Fordland, Missouri, in the south central part of the state. The facility has housed a TC since 1993 when one was started under sponsorship of a CSAT grant, and, in 1997, under RSAT support, the entire facility became a substance abuse treatment facility run on the TC model. Treatment services are provided by an outside contractor. In May 1997 the contractor changed from the vendor who had provided service under the CSAT grant, the result of state competitive bidding. The program has 650 beds; the entire institution. This is an increase of 150 beds from the 500 bed CSAT TC program.

The treatment philosophy and approach is that of a therapeutic community environment grounded in behavioral and social learning concepts. Based on the process evaluation information, Ozark benefitted greatly from the training resources included with the CSAT grant, and used the resources to adequately staff and thoroughly train them in the TC model. Consequently, more than many self-styled, Ozark seems to truly operate as a TC, and the training allowed this to continue despite the strains put on the program when the state assumed full control of the program in fall 1996. The major program elements at Ozark are not reviewed in either of these process or outcome evaluations, but the reader is referred to the final report for the CSAT-funded project.

Evidence is provided, however, that the program truly is a TC, and a viable one, comes from the data reported from administering George De Leon's and George Melnick's 139 question, 6 domain TC Scale of Essential Elements Questionnaire to 20 staff members. Ozark's scoring in each of the 6 programmatic domains and overall exceed Melnick and De Leon's criteria for a modified TC.

The Ozark report, like the report from a few other states, is not a report of program implementation -- in Missouri the treatment program was well in place. And, although the report does not say it explicitly, it appears, from comparing information in the state report and the NERSAT report, that Missouri used RSAT funding to replace the CSAT funding that was just ending and to increase program capacity from 500 to 650. The evaluation report emphasizes Ozark's fidelity to the TC model in its manuals. The program operates 24 hours a day. As noted below, however, the evaluators also observed some modest deterioration in key TC elements with the transfer to the new treatment provider in May 1997. In fact, the Process Evaluation report is really an account of 3 major changes that impacted the TC early in the RSAT-funded period: 1) the change in private sector treatment provider, 2) the integration of work release into the treatment program; and 3) the imposition of a smoke-free policy in this TC institution (at a time when other prisons allowed smoking).

Client Population and Program Staffing

Ozark has a capacity of 650, and, at the time of the evaluation, the program census was 650 (the state's switch to a capitation payment rather than a monthly flat fee has given the provider a major incentive to keep the program full). The Process report provides extensive data on client

characteristics for the program for two time periods: what is referred to as Cohort 1 (program admission between February 1, 1995 and June 30, 1995, n=642) and Cohort 2 (admitted between July 1, 1995 and September 30, 1996, n=626). There is little difference in demographics between the cohorts: the program is about 53% white, 46% African-American, and 1% other with median age in the 20s. Cohort 1 is somewhat more alcohol involved and somewhat less other drug involved than Cohort 2. About 55% of clients admitted completed the program (693/1268). Program dropouts were more likely to have earlier release dates and a history of disruptive behavior. The process evaluation report provides extensive tables on client characteristics for both cohorts and for program completers and dropouts.

Because the report is not an evaluation of implementation, it does not provide much information of client selection criteria or referral processes; it would have helped to include copies of the CSAT reports as appendices to provide important background information. By inference, to be eligible for the program, males should: 1) have a one year sentence or more; 2) have an assessed need for substance abuse treatment; and 3) be eligible to serve their sentence at a minimum security facility.

At the time of the evaluation completion, there were 20 counselors and 3 supervisors. This was a decline from 24 counselors and 4 supervisors at the time of the change of treatment contractor on May 1, 1997, but an improvement from the lowpoint of 17 counselors at the end of May 1997. Because of staff turnover, group sizes increased 50 to 100%, many staff were undertrained and less qualified than before, and working relationships with assigned correctional officers were disrupted. Still, staff roles were fairly well delineated, and staff education was better than many programs.

Program Implementation

Though not a focus of this evaluation report, by all accounts from staff and clients, the Ozark program had become a mature TC by the time of the end of the CSAT project in Fall 1996. The evaluation report indicates there were 3 major changes in the program since the end of CSAT funding in Fall 1996. First, the change in private sector treatment provider in May 1997 was a major disruptive influence. Whereas the CSAT program had been grant funded and the program budget grant determined, the RSAT program became a target for state auditors or administrators. The competitive, cost-based bidding process produced a new contractor who immediately cut staffing modestly but cut salaries appreciably, leading to a number of long-term staff resignations. This left fewer staff available to 1) maintain the program, 2) train new staff, and deal with a 30% increase in clients as the 150 new cases were absorbed into the program. Staff focus group results detailed the harm from the program changes and client surveys drive home the point -- almost two-thirds of clients said the change in provider hurt the program and virtually none thought the change improved the program.

Second, Ozark clients began to be included in the work release program. This is not transitional or half-way status in Missouri but a program for prison inmates to work in the community and get paid. The 150 non TC clients had traditionally been allowed to leave prison grounds to work in the community, but TC clients were not allowed to participate. With the change to all TC institution, TC clients were not allowed to go out until they had finished Phases 1 and 2 of the treatment program (phases not described in the RSAT report). This created some disruptions because community work was expected from the institution and for awhile, not enough

clients were eligible. Gradually, though, work release became more integrated as an incentive in the TC program and efforts were made to integrate it into the treatment phases.

Third, and perhaps most disruptive to the program was the initiation of a no-smoking policy for all Ozark clients. Ozark was one of several state institutions that "piloted" a no smoking policy. The policy was changed in April 1998 to allow smoking outdoors. In the interim, however, cigarettes became the illegal drug of choice, trafficking was rampant, and inmates accumulated smoking violations and sought to get other program violations so that they would be transferred to another institution where smoking was allowed. Staff and CO roles were compromised by having to be "smoking cops." The policy produced noticeable effects on the program completion statistics during the period of the smoking ban. Clients described the effect on the program as a return to a "street mentality." Focus groups conducted just a few weeks after smoking was again allowed outdoors indicated a great improvement in both staff and client morale.

Evaluation Type

The "final" report includes separate process and outcome reports, with the process report emphasizing the effects of the 3 major program changes noted earlier, and the outcome report doing a commendable job of comparing outcome differences between Cohort 1 and Cohort 2 on drug use , recidivism, employment education, work release, HIV risk and violations. The process report makes use of data from program and client records; focus groups of staff, supervisors, administrators, and clients; and interviews with clients and staff. The emphasis on including staff who had worked under both treatment providers was helpful. As noted earlier, the evaluators did a commendable application of the Melnick and De Leon SEEQ scales to indicate how closely the

Ozark program met the "standards" of a TC model, and the Ozark program ratings indicated a viable TC program was being delivered.

The process and outcome evaluation both made use of a 12-month follow-up survey of released clients conducted by Southwest Missouri State University (the CSAT grand had supported 3, 6 and 9 month follow-ups). The process report used the survey information to provide data on client involvement in aftercare. Although the data are limited, they do provide support for the growing evidence of the pivotal role of aftercare in increasing the potential of success for any residential offender treatment program. Clients rated the value of their aftercare services highly.

The outcome report made more extensive use of the 12-month survey as well as the earlier CSAT-sponsored surveys and surveys of dropout and comparison cases as well. Intake assessments, parole reports, and state criminal justice records were also used. The evaluators attempted to compare Cohort 2 completers, drop outs, and those having no treatment at all. It was an ambitious effort but a number of problems resulting from sample attrition, and reliance on incomplete and inaccurate data sources from program and state records made it difficult to draw conclusions. Intake data about degree of substance abuse also cast some doubt on whether appropriate clients were going to the TC -- some appear to not have a serious substance abuse problem at assessment. Finally, the problems related to the change in treatment provider and the no smoking policy may also have affected composition of treatment completer and drop out groups. Still, there are some indications of modest results in the direction of improved outcomes for treatment completers, particularly related to employment. A more complete analysis with larger samples and the ability to measure more accurately and impartially baseline and intervening

variables would have more possibilities of success, but the effort at a retrospective outcome evaluation and the model are commendable.

This evaluation report is exceptional in providing a useful outcome evaluation as well as the informative process evaluation -- both accomplished with a 15 month process evaluation cooperative agreement from NIJ. Another plus is that the evaluators attempted to make changes suggested by the NIJ review of the preliminary "final" report. Responding to earlier reviewers' comments both process and outcome reports have included a short but relevant and up to date literature review. The evaluators end with a reasonable consideration of a framework for a subsequent outcome evaluation with appropriate comparison; and this is a program where an adequately funded outcome evaluation would be warranted.

Achievements

Ozark is a good program worthy of more in-depth evaluation. It is particularly instructive on the program strengths needed to survive changes in treatment providers and institutional policies and leadership -- the kinds of mid stream changes (one would not want to call them corrections) that many correctional treatment programs face. State mandates on bidding contracts affect correctional system food services, health providers, and, of immediate note, treatment providers, and treatment programs have to be strong enough and well-enough documented to survive changes in key personnel. Old-fashioned TCs with charismatic leaders rather than institutional leadership cannot survive long in a bureaucratic state system. Despite some cost-cutting program changes in number of staff and pay rates initiated by the new contractor and despite the loss of state

accreditation for the new contractor, the SEEQ score evaluations suggest that the Ozark program continued to:

- Provide a consistent range of TC group treatment activities;
- Program delivery remained faithful to the TC model;
- More than in many programs, clients expressed satisfaction with key program elements and staff;
- The RSAT grant began to provide additional staff training toward the end of the evaluation period;
- There remains a deep commitment to the implementation of the TC model at Ozark and this commitment is strong among staff but even stronger among administrators.

One advantage did accrue from the switch in May 1997 to the new TC contractor and capitation funding: the institution made a rapid switch (a matter of days) to an institution-wide TC, ending the mixing of treatment/non treatment clients that had existed throughout the CSAT period. This meant that the TC is isolated from outside influences as called for in the RSAT initiative. On the down side, the rapid infusion of 150 new (and not appropriately screened) TC clients disrupted regular treatment schedules for a time.

The evaluation reports themselves demonstrate that, with a functioning program, with good internal data collection and management, and with good working relations between program staff and outside evaluators, it is possible to do a very successful evaluation with limited resources. However, any process evaluation will be for a limited time frame, and any outcome evaluations done in this time frame must necessarily involve less reliable and valid retrospective techniques.

For a relatively stable program like Ozark, evaluation does not have to be too costly, but it should be a multi-year (3+ years) funding commitment to provide real value.

Evaluation of Problems

Problems with the Ozark program relate mostly to responding to the unanticipated consequences of change. In practice, the program did so by slowly correcting problems with the new contractor, rescinding a counter-productive no-smoking policy, and incorporating the new concept of work release into the treatment program. Some "lessons learned" were identified by the evaluators:

- One key point identified by the evaluators is the need for extensive training involving administrative, correctional and treatment staff in the new roles and cooperations necessary in an effective TC. The CSAT grant gave Ozark the resources to do this, but they would not probably have existed in sufficient scope or intensity if the training had been part of a RSAT funded initial start program.
- Even a mature TC program will be attenuated by external program changes such as smoking policies or treatment providers. A program needs to be strong enough to survive unintended consequences of bureaucratic changes.
- Continuity of staff is essential to continuity of TC programming. Effective counselors trained in the TC model are not easy to find, and even good counseling staff require extensive training before they can function as effective TC counselors. Therefore, changes that lead to major staff turnover will in most cases be very disruptive to treatment programs, and transitions to new

providers, where necessary, should be well planned and slowly implemented -- making sure to maintain the strengths of the program and staff in the transition process.

- Administrative support is necessary during the 2 to 3 years it takes a TC to mature, and that support must be present through external changes.

A Collaborative, Intermediate Evaluation of the Pine Lodge
Pre-Release Therapeutic Community for Women Offenders
in Washington State (97-RT-VX-K014)
(Report by Clayton Mosher and Dretha Phillips, Washington State University)

Program Modality

The RSAT program, a TC designed for women with 12 months or less remaining on their sentences, is located at a minimum security coed correctional institution in Washington. The TC is isolated from the general population in a separate dormitory of the facility. The inmates have only occasional contact with other inmates at meals. The program includes peer encounter groups; behavioral modification and therapy; social and problem solving skills training; rational emotive, cognitive, and assertiveness training; anger and aggression management; and educational training. Inmates progress through a 5 phase program linked to the 12 steps of AA/NA, and the 16 steps to freedom identified in Moral Reconation Therapy programs.

The program is designed to take 270 days to complete. The theoretical model on which the program is based approaches addiction as a biopsychological disease. The treatment emphasizes a mental health component to chemical dependency treatment. There is a focus on women-specific issues including codependency, victimization, intimacy, and family of origin problems.

The final phase of the program is aftercare. The women are placed in a work release program, where they continue participation in AA/NA, 24 weeks of structured treatment, job-finding assistance, and a structured parenting program. The aftercare program is provided through two 'Work Training Release Programs' for women, with a focus on women's issues.

Client Population

The program capacity is 72 beds, but as of the end of the evaluation report, the program had not reached capacity. As of March 31, 1999, 221 women inmates have been referred to the TC of which about 72% (n=158) have been admitted; 63 inmates were enrolled in the program (including those in the Orientation phase). About 43% of admitted inmates completed the program by March 31, 1999, in an average of 247 days. About 70% of the inmates are white. Their average age is 37. About 70% have been incarcerated in the past for drug related crimes, and 60% are serving time for their third (or more) convictions. One in five is classified as a violent offender.

Treatment is provided by a private firm, the Pierce County Alliance, under subcontract. The treatment staff includes a treatment supervisor, two chemical therapists, and two mental health specialists. The DOC prison staff includes one vocational counselor, and one community corrections officer. Other prison staff include corrections officers, recreational programmers, educators, and medical personnel. The program was designed and is overseen directly by DOC professionals. The evaluation report found treatment staff were well trained, committed to helping the inmates, and knowledgeable about the program participants.

The evaluation report indicates there is another treatment program in the prison, and staff are rotated between the programs. It is not clear if this includes the contract staff, or only the prison staff. In any case, the evaluation is neutral about the impact of this practice on treatment, noting both that this reduces inmates dependence on individual staff, and that it presents problems with program continuity.

Program Implementation

The program was initiated in November, 1996. The original design called for 12 women inmates to be admitted to the program bi-monthly and proceed through treatment as a group. Twenty-four women were referred between November and December of 1996, and 12 were admitted. An additional 58 had been referred 6 months later, of which 29 had been admitted. By June 30, 1997, 48 inmates were in the program and 4 had completed the program. (The evaluation report had some inconsistencies in the numbers referred, admitted, dropped out, and completed.)

The TC staff have no control over who, or how many, inmates are sent to the program nor when they enter the program. The evaluation report notes that a 1997 report from the treatment supervisor stated "to intimate that our participants are less than enthusiastic about being in treatment upon their arrival would be an understatement" (p. 39). The inmates referred to the program were initially incarcerated in the west side of the state, where most of the inmates resided. That correctional facility refers virtually all the RSAT program inmates, which is in a prison on the other side of the state. The inmates are rarely voluntary treatment referrals, and many were not aware they were being sent to a TC. That, coupled with the distance from their previous homes and from family and friends who might visit, combined to create an unhappy group of program initiates.

The treatment staff became concerned that some of the inmates referred to the program had not been assessed appropriately. Some of referrals were inappropriate because they had too much time remaining on their sentence. This resulted in some discharges, but most of the discharges

were due to rule violations. Due to the relatively large amount of discharge in the Orientation Phase, it was decided to make program admission coincide with graduation from the Orientation Phase. Discharged inmates are returned to the prison that 'feeds' the prison in which the RSAT treatment program is based. They propagate misinformation about the program which affects potential referrals.

An early implementation review by the DOC expressed concerns about unfilled beds. Concerns were also expressed about the high attrition rates from the program. However, as stated above, the TC staff has no control over who is sent to the program. Some of the inmates referred had too much time remaining on their sentence, some did not wish to be in treatment, while others were violent. Their disruptive behavior led to being dropped from the program, which resulted in the relatively high attrition and the accompanying increase in unfilled beds.

There are tensions between the treatment and correction staffs. There are misunderstandings about the goals of the community, and disagreements about how to deal with infractions as well as how inmates should be treated more generally. Some correctional staff thought the RSAT inmates were 'coddled,' and some treatment staff thought the correctional staff too willing to "infract TC members out of treatment" (p. 46).

Major problems were lack of clear program guidance and inconsistent expectations or understandings of the program among program sponsors. The program was accountable to many agencies including the correctional facility, various State agencies, and the subcontractal treatment provider. This resulted in conflicting performance expectations, which appears to have been operationalized at the program level with some inconsistencies in treatment. For example, an early DOC implementation review recommended that the Mental Health Program Manger "is

counter productive to the evolving ...treatment program." The report suggested while the Mental Health Program Manager was important initially, their role in the program should be discontinued. The same report suggests the treatment staff were "overly invested in a 'helper/nurturer' role" (p. 27).

Ideally, program graduation should coincide with release from prison to aftercare. This ideal is rarely realized due to the many factors that determine release, and the difficulty of predicting such. As inmates graduated, they would therefore be returned to the general population to serve the balance of their sentence. One very useful adaptation of the program was the use of program graduates as mentors in the program before they were released.

Evaluation Type

The evaluation methodology consisted of observations of the program, interviews with inmates, interviews and telephone conversations with treatment and correctional staff and the prison superintendent, and reviews of program materials, records and reports. The evaluators stated they logged over 120 hours on-site during the 15 month evaluation--equivalent to about an eight-hour day per month. The evaluators reported that much of the individual level data was not available to them until the end of the evaluation period.

This evaluation was funded under the first RPF which included limited instructions on expectations. The evaluation contains process information on implementation as well as quantitative descriptive information on program inmates. While the overall evaluation report is excellent, there is insufficient detail on implementation issues and how they were resolved. The evaluators state that "changes were constantly occurring in treatment staff, specific program

components, and individuals involved in oversight as well as their philosophy regrading program methods and goals" (p. 51). Although the report documented many of the most important changes, there was scant attention to changes in program components. The evaluation report presents the program as designed, but does not mention how it was implemented or modified over time. There is little discussion of aftercare. The report includes conflicting information on whether anyone has gone to aftercare.

Achievements

Perhaps the most notable achievement is that 221 inmates have been referred, and 158 (72%) have been admitted to treatment in just under 3 years. The evaluation report indicates of the 865 women incarcerated in Washington in 1996, 70% were assessed as having substance abuse dependence. Obviously the program is addressing unmet needs.

There is no blueprint for adapting a TC for women. Women have special needs and issues that are different than men, and the programs attention to women's needs is commendable. The program, as described, appears to be addressing relevant issues.

The evaluation report found staff were well trained, committed, and knowledgeable about the program inmates. The full time staff of 5 professionals with supplemental staff providing services available to all prison inmates, seemed to be appropriate for a TC serving between 50 and 60 female inmates. Instructors from the education programs, in which only TC inmates participate, reported that the women work well as a group and are generally more respectful than other prison inmates.

Another notable strength and adaptation of the program is the function of graduates within the program to mentor other program participants. This was a great solution to a problem so often encountered in correctional treatment programs, where program graduation often does not coincide with leaving prison. Rather than return these inmates to the general population, they remain in the TC practicing their new skills and mentoring others.

Evaluation of Problems

The most significant problem identified by the evaluation was the extent to which the prison TC answers to and accommodates multiple levels of oversight. These oversight agencies oftentimes place competing and inconsistent demands on the treatment program. The agencies the TC is responsible to include the prison, state agencies with responsibilities for corrections (DOC) and/or substance abuse treatment programs, private agencies that contract to deliver treatment, state organizations that administer the RSAT grant, and to a lesser extent, the Federal agencies that award the RSAT grant. As reported earlier, the DOC designed the program, and they monitor the program content through their Chemical Dependency Program Administrator, Correctional Unit Supervisor, and less directly, the Research Unit. The Washington State Division of Alcohol and Substance Abuse certifies treatment staff and establishes data reporting standards and conventions. The multiple levels of oversight led to confusion surrounding lines of authority, as well as conflicting demands being placed on the program. The evaluation report points to the need for more coordination among the agencies and a resolution of some of the conflicting messages and demands made on the program. Similarly, the tension between treatment and custody staff

dissipated some over the course of the evaluation, but will require continual monitoring and attention.

The evaluators commented on problems of documenting information in participants case files. They recommended that clear lines of responsibility for recording and reporting needed to be developed as well as shared commitment to accurate information.

Most of the problems reported are those of a start-up program, and will dissipate as staff become more experienced and as all stakeholders improve coordination. It appears the problem with inappropriate referrals with too much time remaining on their sentence was being effectively addressed. The attention to women's issues in the treatment program was commendable. This continues into the aftercare programs, but there was little information on the aftercare programs and how treatment is continued. The treatment staff appear to be outstanding and committed to the program. The evaluators expressed some good ideas about how to deal with the problem of discharged inmates spreading negative information about the program upon their return to the prison from which the treatment program participants are drawn. Again, this is a problem frequently experienced in in-prison TCs. In the overview, it appears this is an outstanding program that will only improve over time in addressing the needs of their inmate population.

Evaluation of South Carolina Residential Substance
Abuse Treatment Program for State Prisoners (97-RT-VX-K015)
(Report by William Ruefle and J. Mitchell Miller, University of South Carolina)

Program Modality

The South Carolina RSAT program is a modified TC, utilizing a cognitive behavioral approach, and encompassing 12-step programs. The program targets male offenders aged 17 to 27 sentenced under the Youth Offender Act (YOA) to an indeterminant sentence. Program eligibility is based upon a reasonable opportunity for parole eligibility upon program completion, and drug dependency as measured by standardized assessment tests. The program is housed at Turbeville Correctional Institute, a medium security level program.

The treatment program is subcontracted to CiviGenics, a private, for-profit company that operates corrections programs in several states. The program is an adaptation of a TC, although the evaluation report does not include a good description of the program services. Another evaluation report of an RSAT treatment program that also contracted with CiviGenics as the treatment provider indicated that confrontation was not part of the treatment program. The other evaluation report indicated the curriculum was highly structured, and that counselors read the curriculum verbatim in group sessions. The other evaluation suggested that the CiviGenics program was not really a TC, but it is difficult to determine how much of the structure of a TC is incorporated into this RSAT treatment program, based on the evaluation report. The program materials are included, but we are told there was no group counseling in the program initially. The program as designed and the program as implemented may vastly differ.

Client Population

When the program was opened on August 25, 1997, there were 136 beds. Through September 30, 1998, 307 YOAs had entered the program, and 149 had graduated. The first cohort included those aged 21 to 27. On October 1, 1998, the RSAT program was expanded to twice its original size--to 272 beds. The expanded RSAT treatment program was designed for YOAs ages 17 to 20. It moved into the space the original program occupied, and the original program was moved into the wing of the building that had previously housed disciplinary YOAs. Therefore, the expansion involved taking over the entire building that housed the original program. It occurred while transforming the Turbeville Correctional Institution into primarily a YOA facility. The capacity in each program is 136 beds.

During the 2 year evaluation period--August 25, 1997 through September 30, 1999, 633 YOAs entered the RSAT programs. 266 were enrolled in the programs when the evaluation ended. The average age was 21.8 years, and 71% were African-American and 28% were white. Of the 367 who were no longer in the RSAT programs, 67% had graduated, 10% were removed for cause, and 23% were removed for administrative reasons. The administrative reasons were primarily due to an inappropriate placement as the YOAs did not have sufficient time remaining on their sentence to complete the program. The average length of time to complete the RSAT program was 6.6 months.

In the first year of the RSAT program for YOAs, there was no aftercare program. Graduates entered the regular parole system. The South Carolina Department of Pardon, Probation and Parole Services (PPPS) received a one year Bryne Grant to develop specific aftercare programming, and a referral and tracking system for RSAT graduates. The evaluation report

indicates this grant will be able to provide 2 hours of group counseling per week for three months, and for some graduates, for 6 months. The grant will also be used to train community-based treatment providers. A Program Director will provide reports on aftercare treatment services and provide updates to PPPS and the County Commissions. This was all in the planning stages, so there is no information provided on implementation successes or difficulties. Also, it is not clear if the aftercare program will continue past the one year of funding.

Program Implementation

The RSAT program was initially filled with 125 YOAs who entered the program in three groups. The first group numbered 42, a week later the second group of 50 entered the program, and a week later, a group of 33 entered the program. The original cohort was selected from the general population of YOAs by DOC staff. The selection criteria was changed after the initial cohort of 125 entered the program. All YOAs complete an initial assessment period at another Correctional Institution which graduates YOAs weekly. The staff at the other Institution maintains weekly contact with the Turbeville Institution, and refers appropriate YOAs to the RSAT program. If they refer less YOAs to the program than available bed space, the DOC fills those remaining openings. If the other institution refers more YOAs than there is bed space, the evaluators randomly select the RSAT program entrants. An RSAT staff member visits the other institutions and briefs YOAs on what to expect in the RSAT treatment program. The staff person is also briefed on the YOAs and reviews their case files. The staff person presents the history of the incoming YOAs at a case management meeting to the rest of the RSAT treatment staff.

The initial cohort was all assessed within 24 hours of entering the RSAT program. This placed a burden on counselors. The RSAT program rules would have limited or eliminated some existing privileges as part of establishing a TC environment that the transferred inmates had, so the DOC ruled the RSAT could not impose these rules on the first cohort. This obviously impacted on establishing a TC.

The expansion of the RSAT program created some implementation difficulties. The plan for the expansion was to place all the 17 to 20 year old residents in the new program, and retain the 21 to 27 year olds in the other program. The two programs would gradually be filled with appropriate YOAs as they were selected for substance abuse treatment. Unfortunately, the need to fill bed space was paramount, as the conversion of Turbeville to primarily a YOA facility resulted in youth being transferred from other institutions. Therefore, 55 YOAs were assigned to the RSAT program on a one-time basis. These 55 YOAs were parole violators who had been brought back into custody. None of them had sufficient time remaining on their sentence to complete the treatment program, and were consequently 'administratively removed' from the program at the end of their sentence. The evaluation report indicates they "proved to be troublesome in terms of both behavior and program performance. They were more like hardened convicts than the freshly minted YOAs the program was designed for."

The evaluation report states that the first year of the program, not all YOAs were able to work in a prison job or attend classes. However, over time, the Turbeville Correctional Institution was able to expand the number of prison jobs and the size of the school, so by the middle of 1998, all YOAs were either working in prison or attending school. There is no mention of when or where they work, nor of how these 'programs' dovetail with the RSAT treatment program.

The program staff received 4 weeks of pre-service training. They were trained at the South Carolina Criminal Justice Academy for all new (non-guard) employees in the first week. The second week consisted of training by CiviGenics on their treatment model. The third week was the Turbeville new employees training and in the final week, the staff was trained on operations of the RSAT treatment program.

The original staff numbered 15 including 11 counselors and 4 administrative staff. Nine counseling positions were added when the program doubled in size. Of the original 15 employees, 5 remain with the program, including 3 of the original cohort of 11 counselors. A large number of the initial staff were hired after another residential substance abuse treatment program was closed when the contract ended. This experienced cohort of staff was appealing, but none remained with the program. They were loyal to the treatment philosophy of their prior program and were unable to commit themselves to CiviGenics approaches and administrative leadership.

Five of the current staff have previously worked as correctional officers at the Turbeville Correctional Institution. This could create some problems in terms of their changing focus from correctional to treatment. On a positive note, all had prior counseling experience. The starting salaries for the counselors at $23,000 was $5,000 more than that for correctional officers. The low pay, the rural location of many prisons, and the restrictions of working in a prison environment made it difficult to hire and maintain staff. There has been a fair amount of staff turnover.

Evaluation Type

The evaluation was funded under the second NIJ RFP on November 1, 1997. The evaluation report included information on the characteristics of the YOAs who entered the RSAT programs between August 25, 1997 and April 30, 1999--a 20 month period. The evaluation included observations of program activities on 17 occasions, and interviews with staff including the DOC administrator when the program was opened, the associate warden at Turbeville, treatment director, counselors, security staff, and administrators 'responsible for the aftercare portion of the program ' (p. 12). This evaluation did not include preparing for an impact evaluation, and establishing meaningful comparison groups.

The evaluation report does not include much detail in many critical areas. The CiviGenics treatment program is not well described, although the evaluation report indicates it is a TC. The report indicated there was no group counseling initially, so it is not clear what constituted the initial curriculum. Also, the fact that there was no group counseling is notable and it would have been useful if the rationale behind this had been included in the evaluation report. The program materials are included, but the program was not implemented as designed. Therefore, it would have been helpful if the major focus of the evaluation had been an examination of how the program was implemented compared to how it was designed.

The aftercare program was not initiated until after the first year of the program, but precisely when it was implemented is not clear. The evaluation report only briefly describes plans for aftercare services. Since this was a '20 month' evaluation, it would appear some information on the implementation of aftercare services could have been included in the evaluation report.

Achievements

The fact that the program was able to open and provide services although it was filled to capacity in three weeks, is quite an achievement. In the first year, the program size was doubled--also a notable accomplishment and evidence of the state of South Carolina's commitment to the RSAT treatment program. During the course of the evaluation, a number of problems were identified and addressed, such as creating more space for small group and individual counseling sessions or meetings.

The referral system and the good working relationship with another institution that assessed YOAs, helped to create a smooth transition for the YOAs to the RSAT program. There appears to have been good communication as the RSAT staff person visited the referral institution and was briefed on each incoming YOA. The staff person then briefed the rest of the RSAT treatment staff.

CiviGenics has a computerized database that includes information on all inmates, including their test scores on intake and exit tests. At program admission and completion, inmates are administered a battery of tests including the TCU Drug Dependency Screen, the Criminal Sentiments Scale, and the Coping Behavior Inventory. The evaluators were thus able to compare pre- and post- intervention outcomes. There was a significant increase in coping skills needed to prevent relapse and shifts towards prosocial norms. Records also show that 89% of the 88 graduates who successfully completed the YOA program by April 30, 1998, were not reincarcerated during the first year after their graduation and release from the RSAT program.

The evaluation report indicates the treatment management team was able to establish good communication and a cooperative relationship with the staff and administrators of the Turbeville

Correctional Institution (p. 15). This communication and cooperation is even more exemplary when we take into account another evaluation of a program operated by CiviGenics where their policy was that their headquarters and regional headquarters conducted virtually all of the communication with the prison officials.

Evaluation of Problems

Staff turnover was a big issue that remains a concern. Considering the low rate of pay, the rural locations of the correctional institutions, and the prison environment, it will be difficult to attract and retain qualified staff. The evaluation report indicates that when the program size doubled, there were enough resumes of counselors on file to fill the 9 positions. This may be indicative of improvements, but we suspect staff turnover will continue to plague the program. On a positive note, the attention to staff training with 2 of the 4 pre-service training weeks devoted to the treatment program is commendable.

Many of the problems indicated are those typical of start-up. Most of them should be resolved with attention and the good cooperative working relationships between the RSAT staff and the Correctional staff and Administration, as well as with the referral institutions and the aftercare programs. The cooperation and coordination between the correctional and treatment staffs needs to be formalized with regular meetings and cross-trainings. It is important to monitor the implementation of the aftercare services to ensure the same thing as occurred in the RSAT program does not occur there, i.e., no group counseling sessions for the first year.

The evaluation report did not reveal a sophisticated approach to program evaluation. Many details were omitted with respect to the treatment program design and implementation that would

have strengthened the report. It appears the report overly relied on program descriptive material without examining how the program was actually implemented. For example, the evaluators indicate the program followed the schedule without deviations during their observations, but report that there were no group counseling sessions the first year.

A Quantitative Examination of the Program Implementation Process
at Barrett Juvenile Correctional Center (Virginia, 97-RT-VX-K020)
(Report by Jill A. Gordon, Virginia Commonwealth University)

Program Modality

This RSAT program is a juvenile male TC. The program is located in a male juvenile correctional center in Hanover, Virginia, 25 miles north of Richmond. The facility has an interesting history in that it started as a facility for black female juvenile delinquents in 1915 (apparently there was not seen to be a need for a facility for white female juvenile delinquents in Virginia at the time), became a "diverse" juvenile female facility in 1965, went co-ed in 1972 and became all male in 1978. In 1993, two cottages were converted to TCs under sponsorship of a CSAT grant, and, in 1997, under RSAT support, the entire facility became a substance abuse treatment facility run on the TC model. Treatment services are provided by Gateway Foundation, an outside treatment contractor. The program has 100 beds, distributed over 6 cottages.

The treatment philosophy and approach is a therapeutic community environment grounded in behavioral and social learning concepts. More so than many self-styled TCs, Barrett seems to truly operate as a TC, particularly so on paper but also to a reasonable extent in practice. The major program elements are:

- The Therapeutic Community environment. Barrett's motto is that each youth should serve as "his brother's keeper." The program description and description of client manuals points indicates a true commitment to the TC philosophy at Barrett. Of particular note is the use and reliance on peer leaders. The cottages at Barrett operate as separate villages with reliance on a youth leader in each cottage. The evaluators note significant variation in the "potency of the

community" among cottages based on staff and youth leaders, and they also note that "potency" varies over time depending on the leaders present.

o The Structure Board. This is Barrett's name for the hierarchical job/position structure that organizes TCs and allows them to operate. Hierarchy ranges from senior coordinator to crew member. One major difference from traditional TCs is that youth in higher positions do not have authority over youth in lower positions, but higher levels have more privileges and serve as role models.

o Group Counseling. Most treatment work occurs in group, and the content of the group sessions follows the phases of treatment. There are 4 phases to the program: Phase 1 is orientation (4 weeks) where TC goals, expectations, and argot are introduced and a position on the lower end of the structure Board is assigned; Phase 2 is primary treatment (4 weeks) with an emphasis on education about abuse and addiction; Phase 3 is intensive treatment (10 weeks) with more in depth education,12-step programs, and work on emotional and personal issues; and Phase 4 is pre-release (8 weeks) which focuses on vocational preparation and developing relapse prevention skills. Group work also deals with sessions on life skills development, therapeutic recreation, and community enhancement activities which occur during all phases of the client's tenure at Barrett.

o The Behavioral Management System is the traditional TC system of rewards and punishments designed to inculcate appropriate behavior. The system has allowances for positive and negative consequences for even small behaviors. "Pull-ups" and "learning experiences" are regularly used, with verbal pull-ups used for minor infractions, followed by written pull-ups, and then a learning experience assignment. Maladaptive behaviors can also

be sanctioned ranging from a Take-Five to isolation. The behavioral management system uses detailed and daily scoring to determine privileges and phase standing.

o Family Education occurs in conjunction with family visits on Sunday and seeks to integrate the youth's family into the therapeutic process with education, and family counseling.

The evaluation report describes Barrett as a TC and emphasizes its fidelity to the TC model in its manuals. The program operates 24 hours a day. As noted below, however, the evaluators also observed some problems in delivering all the program elements and in doing so consistently over time.

Client Population and Program Staffing

Barrett has a capacity of 145 and at the time of the evaluation, the program census was 122 juvenile males. The report does not provide additional data on client characteristics for the program in 1998 at the time of the process evaluation. Data for an outcome study done on 586 program releasees from 1995 to 1997 suggest about a 50/50 white and African-American racial split.

To be eligible for the program, males must: 1) be between the ages of 13 and 18; 2) have a "mandatory" or "recommended" need for substance abuse treatment, as decreed by courts or Juvenile Justice; 3) a sentence of at least 6 months to serve; 4) no major mental health problems; and 5) not have been convicted of murder, rape, or arson.

At the time of the evaluation, there were 106 full time and 10 part-time staff at Barrett. This includes administrators, correctional officers, psychologists, teachers, chemical dependency counselors, and rehabilitation counselors. Staff were 73% male and 73% African-American.

Group work involves one counselor and CO for a group of 12 youth. Staff roles appear well delineated, treatment staff education is high (90% BA or above), and ongoing training is provided and appears exceptionally thorough.

Program Implementation

The Barrett Center program is notable for beginning from an apparent comprehensive statewide assessment process for juveniles. Operated centrally, all adjudicated juveniles are assessed at a central location, which apart from the juvenile courts determines need for treatment, appropriateness of TC treatment, and the required length of stay. Based on the assessment which includes interviews, SASSI, DSM3R, and other measures, a youth is assigned to Barrett or one of the 5 other juvenile facilities statewide.

The evaluation report indicates there has been changes in the program since it was initiated. First, the program moved from a 2-cottage CSAT-sponsored program, to an all-institution (6-cottage) RSAT-sponsored program. Then there were subsequent changes since 1997. The Gordon report describes the program up to July 1998 -- the end of the evaluation period, and effectively before all of the corrections to program implementation were implemented

The report provides a very good "snapshot" of program implementation in the first 6-9 months of the RSAT expansion. Overall, the program got off to a strong start and seems to have avoided many of the start-up issues in other sites where programs were beginning from square one. Still, because of the timing one does not have a good sense of client completion or client flow.

The program superintendent is very experienced with a bachelor's degree and over 30 years of work with offender treatment centers. She was at Barrett before the transition to substance

abuse programming, and she was very involved in the design and implementation of the changes. She is directly involved in staff hiring, training, and supervision, and has a commitment to the program model.

A notable change made at Barrett came from the recognition by supervisors that some cottages operated more as TCs than others. This was due in part, of course, to different youth leaders, but also and more importantly due to different staff behaviors and particularly different attitudes by the Correctional Officers attached to each cottage. The solution was general staff and CO training followed by regular meetings. Also, staff and COs both were temporarily rotated among cottages to see how the TC operated in the other "villages." These changes occurred after the evaluators on site observational period, but subsequent reports from supervisors indicate that differences between cottage "therapeutic environments" had lessened.

Evaluation Type

The title of the revised "final" report emphasizes that this is a qualitative evaluation, and, as such, the evaluation does a good job of describing program implementation and development right up to the point of judging program viability. Then it is as if the tape ran out just as the narrative was getting to the climax. Nevertheless, the process evaluation does provide a thorough and at times exemplary detail about program implementation that one would hope to find in a process evaluation. Of particular note is the thoroughness of describing services, both those planned and those implemented. Another plus is that the evaluators attempted to make changes suggested by the NIJ review of the preliminary "final" report. Some of the changes were more helpful than others.

The review consisted of program observations, meetings with treatment and correctional staff, and reviews of client and program level data. The evaluators conducted intensive observational studies for 3 months in 1998. The evaluators also did a commendable application of the Gendreau and Andrews Correctional Program Assessment Inventory (CPAI) to indicate how closely the Barrett program met the "standards" of correctional program treatment. This is a structured and copyrighted program which produces a narrative report and ratings in areas of program implementation (very satisfactory), pre-service assessment (very satisfactory), program characteristics (satisfactory but needs improvement), staff characteristics (satisfactory), evaluation (satisfactory but needs improvement), and "other" (very satisfactory) -- for an overall score of 66 (satisfactory). Despite the "canned" nature of the CPAI evaluation, it provides a useful accounting of program strengths and weaknesses. The CPAI evaluation was done as a separate report in July 1998, and material from it was used in the "final report."

This evaluation report is hurt by its attempt to provide outcome information. This evaluation was funded under NIJ's first RFP, which was a small award and not specific about the type of evaluation requested. In the initial "final" report on Barrett that was received and reviewed by NIJ, the evaluators emphasized a preliminary outcome assessment. The evaluators tried to create a retrospective outcome report from earlier Barrett data. The NIJ reviewer correctly pointed out that the outcome assessment was for clients at Barrett before RSAT funding. This would not be a major problem if it was the same program; however, the existing data could not separate findings for TC vs non TC Barrett clients at the time. When the logistic regression findings suggested unexpected results that could not be explained (e.g., SASSI scores inversely related to relapse and recidivism), overall results for Barrett similar to results for all juvenile males, and no ability to

relate the findings to the TC treatment program, the study should have been dropped. Bowing to the earlier reviewer, they did move the section to the end of the report; still more than a quarter of the final report, the section on outcome, is irrelevant. The evaluators end with a reasonable consideration of a framework for a subsequent outcome evaluation with appropriate comparison; and this is one program where an adequately funded outcome evaluation would be warranted. The program has real possibilities as a national model.

Achievements

Barrett has the potential to be a model program worthy of more in-depth evaluation. If nothing else (and it is a notable achievement) the process evaluation demonstrates that an adequately funded evaluation could monitor the treatment progress of youth. A particular advantage was the switch in 1997 to an institution-wide TC so that there is no mixing of treatment/non treatment clients or those with a different modality of treatment. Barrett is a secure facility meaning that the TC is isolated from outside influences

The Program model is an effective implementation of the TC model and the ties with the assessment process are commendable, particularly in insuring that youth will be there for the 6 months of the program. The program is well grounded in behavioral and social learning theories and offers a highly structured approach.

Evaluation of Problems

Some problems with the Barrett model relate mostly to the inability to fully implement the program model. Because of the premature termination of the evaluation, some of these problems may no longer exist.

- One problem identified by the evaluators is the lack of appropriate risk and responsivity assessment in assigning youth to Barrett. To this reviewer, although not perfect, the Virginia assessment and assignment process and criteria is far better than available in most states.
- The program appears to be well staffed, but not all staff were thoroughly versed in the TC model at the time of the observations (March - June 1998), though subsequent training and meetings may have alleviated this concern.
- There seems to be some deficiency in the actual number of hours of group work received compared to what is called for in the program manual. Given the adequate staff and time available, this should not be the case.
- The family education component is not effective. This is one of the most difficult aspects of treatment to accomplish -- getting real family involvement -- yet even so, the staff do not seem to be working on this component. There needs to be more incentives for family to attend and participate.
- There appears to be a "social promotion" policy at Barrett without any consistent means of assuring that the material in each program Phase has been mastered.
- A related point not made by the evaluators is that it appears that the program does not distinguish releasees (who do their time) from graduates (who complete all four phases of the treatment model). This may be a necessity of the correctional process, but it should be a focus for

evaluation of the program for it has major implications for judging program completion as well as subsequent reductions in relapse and recidivism.

- Finally, the evaluators make a major point (which this reviewer wishes to underscore) that an aftercare component lasting at least a year needs to be developed. Recent research is pointing to the critical role of aftercare in creating any hope of achieving long-term positive results from treatment, and this need is likely even more critical for juveniles than for adults.

Residential Substance Abuse Treatment (RSAT) in Jail:
Comparison of Six Sites in Virginia (98-RT-VX-K001)
(Report by Faye S. Taxeman, Jeffrey A. Bouffard, Bruce Kubu, and Danielle Polizzi, University of Maryland)

Program Modality

This RSAT program is actually six programs located in six jails in Virginia, mostly in the Eastern part of the state. The six programs are:

1. Changing Times, a 10 bed male facility in the Northern Neck Regional jail in Warsaw, Virginia;

2. The Fork in the Road includes 60 beds (three 15-bed male units and one 15-bed female unit) in the Riverside Regional jail in Petersburg (it is possible that only the female and one male unit are RSAT-funded);

3. "Sapphire" ("substance abuse program promotes health incarceration recovery environment" -- one of the more convoluted program acronyms) is a 30 bed facility for male and female clients (since the program does not have separate housing, the gender distribution can vary) in the Salem Jail Facility;

4. True Freedom, an 8 bed facility (4 male and 4 female) for the dual diagnosed at the Adult Detention Center in Fairfax;

5. Jail Treatment Services, a 12 bed female facility in the Virginia Beach Correctional Jail; and

6. Bridges to Freedom is a 24 bed facility (12 male and 12 female) in the Norfolk City Jail.

Each program is run by a quasi-government agency called a Community Service Board who provide both community drug treatment and jail based services throughout the state. Oversight

for the programs is provided by the state Department of Mental Health, Mental Retardation and Substance Abuse Services. All site directors meet quarterly with the state representatives. All of the programs purport to be modified TCs, though none should truly be called a TC, and some programs offered little that would be recognized in a TC. Although there are some commonalities, each program operated independently and has a distinct program philosophy and emphasis. Because of jail logistics and limited staffing at each program, no unit was totally segregated from other jail inmates, and no unit operated 24 hours a day.

The treatment philosophy and approach is really six approaches, and each is something of a mixed modality, incorporating a few elements of a therapeutic community (not the same in each program) as well as cognitive behavioral and 12 step components. Based on the process evaluation information, each of the six jail programs was supposed to involve 6-12 months of participation in a living area set apart from the general population, use a multi modality approach in a modified TC environment, drug tests of 5% of clients, and provide a plan of aftercare treatment. Such a regimen would be a task for a single prison-based program; it is likely unobtainable in any jail setting. Nevertheless, the attempt detailed in this comprehensive process evaluation is instructive and potentially very informative to treatment providers who have any desire to implement a jail-based TC.

The Virginia jail report, like the report from most other states, is a partial report of program implementation -- up to the time that the evaluation cooperative agreement expired. In this case, however, it is a second round report and had the opportunity over the 14 month period of evaluation up through mid 1999 to observe more mature programs than were examined in most

other RSAT evaluation reports. As such, there is actually little information available on the programs' ability to actually work with clients.

Client Population and Program Staffing

As noted above, program capacity varied from 8 to 60 across the 6 programs. The process report provides data on client characteristics for 313 clients served in the RSAT programs ranging from a low of 32 to a high of 64 across sites. Demographic characteristics vary by program and region, but it appears that clients were highly criminally involved (average 6-11 previous convictions) and, with the exception of the small dual diagnosed program, their primary drug of abuse is crack cocaine.

Staffing at each site was small, usually amounting to the program manager and one other. Most staff had Bachelor's degrees and counseling experience, and about one-third were recovering. Original plans had called for each site to have a case manager/discharge planner, but in most cases this role was not filled (which is probably related to the programs' poor aftercare referrals). Staff were mostly contractual employees from the local Community Service Board and working part-time. Reliance on part-time contractual staff was done to contain costs but resulted in high staff turnover and lack of involvement in program development or referral.

Program Implementation

Program implementation varied significantly across sites as each program accommodated itself to the environment of the jail where it was located. In some cases the program was entirely new and in other cases RSAT funds expanded existing programs or services. There was great variation

in average length of stay across the six sites ranging from 49 to 188 days. No program began to approach the target of 180 to 360 days. Inmates simply did not stay in jail that long.

During the treatment meetings, several topics predominated: discussing emotional skills and other cognitive behavioral training techniques; community relatedness; and psychological development. On the other hand, no program seemed to focus on criminal thinking or past street experiences or use of the community itself as an agent of change (as outlined in a TC model). The evaluators note that the programs should pay more attention to those treatment topics related to the State of Virginia mandate that programs focus on clients' multiple social, economic, familial and personal problems, beyond substance abuse.

Evaluation Type

The report is a detailed process report emphasizing the actual functioning of six discrete jail-based treatment programs. This is a prodigious task, and the evaluators used a novel and structured methodology to accomplish six process evaluations that each have more detail than often found in other single site process evaluations.

The report does a good job of synthesizing the extensive observations and limited client data presented in separate chapters on each of the six programs (they are not six sites of the same program). The potential success of these six programs in any subsequent outcome analysis is unlikely, but the techniques used in this process evaluation to describe various program characteristics and aspects of the therapeutic intervention at each site is instructive and a useful contribution to corrections-based treatment literature.

The process report makes use of data from program and client records, site visits, and structured interviews with program personnel. The site visit reports to each program are extremely comprehensive and follow a similar format including both descriptive and tabular information. Of particular value are several tables that summarize results across all 6 programs. The evaluators seem to have maintained a good relationship with the state administrators and with the staff at each site. A real strength was the evaluators' use of systematic social observation and the creation of a structured observation instrument with validated reliability for use in coding observations and material from each site. This up front planning produced information that was quite comparable across sites and would be a useful tool in other process evaluations. Tying sections of the instrument to the planned phases of treatment and aftercare planning was particularly helpful -- and particularly revealing in the lack of program implementation of aftercare.

After a thorough consideration of process results from the structured observations, the evaluators make a commendable attempt to compare across sites such areas as average length of treatment stay, degree of urine testing, use of graduated sanctions, graduation rates, and transfer rates to aftercare in the community. Again the comparative tables were informative.

The evaluators made changes suggested by the NIJ review of the preliminary "final" report. Responding to an earlier reviewer's comments, the process report added information on program characteristics and therapeutic integrity of programs. They also added a fairly extensive literature review on TCs; however, it does not seem too relevant to the programs that were actually implemented. One can note that the process evaluation is perhaps a little too uncritical of the apparent minor impact of the jail based programs. The one omission in the process evaluation

report is in the area of staff training. It is not well covered and it appears that there may be a lack of training.

The evaluators' main contribution to the Virginia jail treatment programs is a thorough understanding of the limitations of jail-based treatment. This is not to suggest that the Virginia jail-based programs are bad; they are probably better than most nationally. However, it becomes apparent that the transient nature of jail-based populations is not conducive to a lengthy structure treatment program based on community continuity and phased progression. The evaluators also developed a good model and application of structured observation that can be of real value to the treatment field.

Achievements

The Virginia jail-based treatment programs are important in that they address an underserved group: jail-based offenders with substance abuse problems. This is a group that has been identified in the past in both NIDA and CSAT treatment demonstration initiatives. There are probably reasons why this group is underserved - they are less likely to want treatment than prison-based substance abusers; and they are less likely to perceive that they have time for treatment. Corrections as well has less time and resources for jail-based programs. Still, the attraction remains of treating those in jail. However, jail programs may do best to avoid resource-intensive long-term programs like those employed in therapeutic communities. A lesson from this study is that treatment modality should fit correctional mandates, and jails should think more about short term education and intervention rather than long-term phased treatment. Although the

evaluators are not overly critical of the jail based programs, they really only identify a couple of strengths:

- On the plus side, all six sites had operational programs, which resembled their original intentions and, in general, conformed to the minimal guidelines for RSAT programs. This in itself is a significant accomplishment in jail settings;
- State and jail administrators and the local Community Service Boards seem to have a real commitment to providing treatment and a willingness to cooperate in dealing with problems of implementation.

The process evaluation report of the Virginia jail-based TCs is perhaps the most convincing document yet about the limits of the TC treatment model in jail settings. If one fact is present across sites it is the lack of circumstances conducive to establishing the "community as method" in jails.

Evaluation of Problems

The evaluators note that a major problem with jail programs like the ones they observed is the danger that, "if clients do not consistently engage in therapeutic activities, outside of their scheduled, counselor-run treatment sessions, the program may likely come to more closely resemble outpatient treatment, rather than a residential TC-style treatment program." This appears to have been the case in the Virginia jail programs. The problems with the Virginia jail "TC-like" programs relate mostly to the difficulties of attempting to implement a long-term treatment program into a short-term sentencing mandate. Problems identified by the evaluators included:

- As has been observed in almost every instance where an intensive treatment and relatively long treatment program has been tried in a jail setting, it proves almost impossible to retain clients to finish their treatment. Either their sentences are not long enough, they are transferred to other institutions, or an overcrowded system lead to release before completing treatment. Premature release characterized each of the six programs. On average across the 6 sites, only 16% of clients successfully completed their program.
- The evaluators found that program staff often did not have background information or assessments on their clients. Information was not systematically made available by the jails. This made it difficult to do client planning.
- One of the major program goals had been to have a "seamless system" of care between the jail and community treatment, and the failure to get clients into community treatment was a very disappointing finding. Only 1 to 10 percent of released offenders entered community treatment. One would have hoped for a higher percentage, particularly since the jail-program providers were the actual agencies responsible for community based services in their region.
- Even with the best of data gathering techniques, it is difficult to get comparable information from different programs, particularly when the jails themselves as well as the treatment programs they house, do not have the resources to collect and manage it. Consequently, some of the conclusions about client services received are suspect.
- Despite some successes in basic program implementation, the structured observation methodology revealed that the majority of these programs were not guided by a single program emphasis (i.e., a treatment philosophy and set of specific program goals) regarding the provision of services to offenders. In fact, only Programs 2 and 6 were rated as using more than one

program emphasis. And no program seemed to focus heavily on issues related to the TC philosophy. Spirituality and disease model approaches seemed most prevalent. Overall, the steps to program completion were not clear to staff, let alone to clients.

- Because of overcrowding, the jail-based programs were not able to maintain closed groups, which would have helped the development of trust and a sense of community central to the workings of a milieu-based TC model. This also made phased progress through the program more difficult.

A Collaborative Evaluation of Pennsylvania's Program
for Drug-Involved Parole Violators (98-RT-VX-K002)
(Report by Douglas Young and Rachel Porter, Vera Institute of Justice)

Program Modality

The Pennsylvania RSAT programs are unique in their focus on technical probation violators. In Pennsylvania, about one-fifth of prison inmates are incarcerated for parole violations. Half are committed for technical violations such as missing meetings with parole officers or positive urinalyses. Instead of incarcerating these individuals for the typical 12 to 36 month sentence, the RSAT program provides an alternative 12 month treatment program. The first six months of treatment is delivered in prison, with the balance delivered in halfway house type environments called Community Corrections Centers (CCC). All RSAT commitments carry a mandatory time limit of 12 months. This feature was a very useful part of the advance planning for the programs which required cooperation at various levels in the criminal justice system. The evaluation report states 'in the spring of 1999, the RSAT working group agreed to restructure the "12 month clock" to start it upon admission to RSAT treatment.' (p. 5) The programs are cost effective for the state due to the decreased length of confinement, especially if reoffending and substance abuse are reduced or eliminated.

Programs for technical parole violators were created with RSAT funds in two Pennsylvania prisons, one near Philadelphia (Graterford) and the other in the central part of the state (Huntingdon). The programs have a number of similarities, although there are different contractors for the treatment services. The in-prison portion is a TC. The aftercare treatment portion is administered by the same agency that provides in-prison treatment at Huntingdon, but

the treatment is subcontracted to a different treatment provider in the Philadelphia area. The CCCs are operated by the DOC (or its subcontrators) and are not secure facilities. The RSAT population is not segregated in the CCCs, although in the Philadelphia site, they occupy a single floor of a six-story building. A parole officer is assigned to each RSAT treatment site, both in prison and in the CCC, to assist transitions.

Graterford is a maximum security prison, while Huntington is a minimum security prison. This creates some differences in structure, as well as the inmate population. The treatment program was administered in both programs from 8 a.m. - 4 p.m. Monday through Thursday. Both programs employed highly structured curriculums, combining a cognitive-behavior approach with AA/NA steps and traditions. Homework assignments were an integral part of the curriculums. Both programs were designed to include individual counseling sessions, but neither provided many such sessions to inmates (i.e., inmates reported engaging in an average of 9 individual counseling sessions of about 40 minutes at Graterford and 11 at Huntingdon).

The program at Graterford is operated by CiviGenics, a private, for-profit company that operates correctional treatment programs in several states. The program is an adaptation of a TC, incorporating many of the components of a TC. The are daily morning meetings. AA/NA meetings are held three time a week, and there are weekly 'academy' meetings to discuss group issues. However, confrontation is not part of the treatment program. The curriculum is written word for word, and during the evaluation period, counselors read the manuals in group sessions. This type of delivery does not lend itself to peer involvement that is a cornerstone of TC treatment. Staff monitor progress through a review system. Inmates take tests to demonstrate mastery of the material as they progress through the program's 3-phase system, but inmates are

rarely held back. Progress is operationally defined by time in the program. The Graterford program does not have air conditioning and large fans circulating all the time lend a large amount of background noise that was complained about by staff and inmates.

The program at Huntingdon was operated by a for-profit treatment provider that operates various treatment facilities in western Pennsylvania. It is based on a modified TC, and it also incorporates a cognitive behavior approach and 12-step principles. There are daily morning meetings and daily evening 12-step groups. The program includes homework assignments as well. Inmates progress through the 3-phase program based more upon time in treatment, although their treatment progress is monitored by staff using a rating system. All inmates are required to work for 3 hours per day in the Huntingdon program, although the evaluation states this varies. The jobs are generally in the unit; however, some are in the kitchen and laundry.

Client Population

Both RSAT in-prison programs opened in February, 1998. Each site expanded from 50 to 60 beds in May, 1998. Through December 31, 1998, 237 clients had entered the two in-prison treatment programs. There was little dropout in the in-prison treatment phase, with fewer than 10% terminations.

The average age of both RSAT programs was 37 and 70% were African American and 80% were unmarried. About half (46%) of the Graterford inmates had previously been in treatment, but fully 82% of Huntingdon inmates had been in treatment. Huntingdon men also had twice the number of prior convictions, but half the total amount of time incarcerated. The inmates at Huntingdon were a little more likely to say they needed drug treatment (about three-quarters),

compared to Graterford (about two-third). The intake process takes longer at Huntingdon, as inmates are transferred there from other institutions. Identified inmates are held at local correctional facilities while they await transfer. They join the general population at Huntingdon for an average of 20 days until they are classified to enter the low-security modules. While the inmates are undergoing classification, the RSAT staff complete the intake and assessment interviews.

As of December 31, 1998, 38% of the Graterford graduates attending the CCC in Philadelphia had failed, and 22% of Huntington graduates attending the CCCs had failed. Nearly half of the failures were drug-related, but 40% were related to infractions such as fighting or curfew violations. These are preliminary findings however, based on small sample sizes. They may reflect the less sophisticated nature of the program as it was developing. However, these early numbers could inflate over time, especially since they indicate failure at the CCC, and there is likely to be more failures once treatment has ended. It is important for the programs to continue to collect this critical information.

Program Implementation

The Graterford program was filled to capacity within the first month of opening. The Huntingdon program was just 2-3 inmates below capacity for most the year, reaching capacity in December, 1998. The staff was in place in both programs, and the highly structured curriculums were ready for implementation. At Graterford, problems were created by counseling staff inexperience. None of the staff had any experience providing treatment in a correctional setting, although most of them had an extensive treatment background, and three of the 3.5 staff members

had worked together previously. Their unfamiliarity with the curriculum resulted in them reading the materials, rather than creating an atmosphere for discussion. There was tremendous staff turnover at Graterford during the evaluation period. The project director and other staff resigned, such that only one of the original treatment staff members remains. The treatment provider at Graterford had a management hierarchy in which primary communication with prison officials was maintained by their central office in Massachusetts. This arrangement impeded the on-site treatment staff's ability to establish good working relationships with DOC administrators. This situation may have contributed to staff's feelings of impotence with correctional officers, as well as staff turnover. Increased communication with prison officials was delegated to a regional office, with some improvement noted in the treatment environment.

The Huntingdon program had fewer implementation problems. There was little staff turnover, and the counseling staff was very competent. Some had experience working in corrections-based treatment programs. Importantly, the project director had worked in the Pennsylvania DOC for many years, which was a great asset to the program. The staff experience undoubtedly allowed for a more fluid implementation.

The Huntingdon program was organized around two phase groups, one for those with less than 3 months in the program, and one for those with more than 3 months. This structure was implemented in limited ways in the first year of operations due to the irregular flow of new admissions. Also, there were some delays in transferring inmates to the Huntingdon program. The evaluation indicates this was one of several issues that officials in the interagency working group identified early and were addressing in coordinated efforts.

Although the Huntingdon treatment curriculum was primarily delivered in a didactic manner, inmates were expected to engage in the group process, and express themselves and respond to fellow inmates concerns. There was little lecturing from treatment staff, and group discussions were reportedly lively. Unlike Graterford, the staff had much greater command of the curriculum and were able to facilitate the groups to create good discussion and interaction among the participants.

There were conflicts between treatment and correctional staffs, especially at Graterford. The treatment staff expressed an attitude of impotence in dealing with DOC regulations, and rarely contradicted or intervened in DOC protocol. This led to inmates feelings of resentment and confusion and some inmates disengaged from treatment for periods of time. Similar concerns surfaced at Huntingdon, although perhaps not as intense. In both programs, inmates expressed frustration over correction officers feeling they were treated better than other inmates. DOC staff at Huntingdon expressed concerns about tensions, and the issues were addressed with an agreement to increase interagency meetings to resolve concerns. The Huntingdon administrative, treatment and correctional staffs have developed standard procedures for addressing inmate misconduct and implemented a model to increase communication and cooperation.

Much less information was available about the CCCs. The Graterford graduates attended a large CCC serving about 120 parolees. This six-story facility was in an economically depressed area. The original agency contracted to provide aftercare severed the contract before the first graduates entered the CCC, pushing CiviGenics to react quickly to find another provider. The major treatment service provided in aftercare appears to have been one weekly out-patient group

counseling session. This was later doubled, when it was discovered the agency was not providing the services agreed to in their subcontractual agreement.

Sparse information is provided about the CCCs that Huntingdon graduates attend, but there were several as opposed to the one large one available to the Graterford graduates. The graduates are not segregated from the rest of the residents at these facilities. The CCCs are located in relatively stable commercial areas. The project director at Huntingdon supervises the treatment at the sites, meets with staff at each site at least monthly, and maintains weekly telephone contact. This appears to create needed coordination and cooperation in ensuring the fidelity of the treatment plan.

Evaluation Type

The process evaluation began in December, 1997, (before the programs were implemented) and ended in February, 1999. It was funded under the second NIJ RFP on November 1, 1997. Methods included reviews of intake interviews, exit interviews conducted by the evaluation staff, observation of program operations, and informal interviews with residents. Interviews were also conducted with staff members from each program. Regular contact was maintained by telephone with program directors and the evaluators also attended a number of statewide meetings of the RSAT interagency groups.

Just about two-thirds of the inmates completed intake and exit interviews in the in-prison component. The intake interview consisted of the ASI supplemented with additional questions. The exit interview included the COPES, program rating and satisfaction measures developed by

researchers at Texas Christian University, and an adaptation of the Treatment Services Review developed by researchers at Pennsylvania University.

Counselors received high ratings in both programs. The correctional officers were understandably, not rated as highly. There were relatively high levels of satisfaction reported by the inmates in both programs, although the Huntingdon program was rated more highly by its participants.

The evaluation included some information on the implementation of the aftercare treatment programs and services, and provides valuable information on program failures at this stage in the treatment process. More information on the aftercare services and the difficulties in implementing them, including the replacement of contracted treatment providers in Philadelphia, would have been useful (although the evaluation was designed to focus on the in-prison portion of treatment, and not aftercare).

Achievements

There are several achievements notable from the Pennsylvania RSAT program. The focus on technical parole violators in unique, and represents a cost-savings program as designed. The 6-months in-prison portion followed by 6-months in a CCC saves the DOC money relative to the typical in-prison sentences of 12 to 36 months for technical parole violators. The DOC is especially to be commended for their advance planning and interagency coordination. Commuting the parole violators sentence to successful program completion is a tremendous asset, and a tool not available to many other RSAT programs. The programs served a relatively large number of clients (n=237) through December, 1998.

The positive ratings of the counselors and the overall program by the inmates in both RSAT treatment programs, indicates both these programs are doing a good job in clients eyes. Inmates rated the counseling competence and rapport very highly in both programs, although they gave higher rankings on spontaneity and preparedness to the Huntingdon counselors. The Huntingdon program appears to have had fewer implementation difficulties probably due to the experienced staff and prior work history with the DOC. It also appears there is also more continuity in providing aftercare services as the Program Director supervises the treatment in both programs. There were very few terminations in either in-prison treatment program, which may also be a testament to the program quality.

Evaluation of Problems

Staff stability was a tremendous problem in the start-up phase of the Graterford program, with much turnover. This continued throughout the evaluation period with another resignation expected as the evaluation was ending. There was much greater stability in the staff in Huntingdon, and they had greater experience and appeared more competent in delivering the program. The group sessions at Huntingdon were primarily discussion, compared to the treatment lectures (or actually reading of material) evident in the Graterford program. There may also be some effects introduced by the maximum in comparison to minimum security environments between the prisons that needs to be factored in. It is also important to examine the CiviGenics management structure to ensure that the treatment staff work in a coordinated manner with the DOC. There needs to be more communication between the treatment and correctional staff.

Staff stability will lead to a more experienced staff, which should lend itself to increased competence. It is important that staff are comfortable with the curriculum, so that treatment delivery is more fluid. Progress through the program should be defined by attaining treatment goals and mastery of the program, and not moving inmates through based on their time in the program.

Issues surrounding the conflicting priorities of treatment and control surfaced in both programs, especially at Graterford. This led some inmates to disengage from the program at times. Efforts to improve cooperation, such as cross-training, would help to ease tensions. The evaluation report indicated that state administrators and treatment staff have identified these issues and are addressing these problems.

Due to the relatively high rates of failure in the CCCs, more attention needs to be devoted to this aspect of the program. The Philadelphia CCC is located in a poor area of town with thriving drug markets. An attempt to place inmates in settings of smaller groups, and preferably isolated from the larger community in the CCC, would be logical. Process evaluations of the implementation and functioning of the aftercare programs would be useful as a means to identify problems.

Process Evaluation of the Michigan Department of Corrections' RSAT Program (98-RT-VX-K007)
(Report by James Austin, Kelly Dedel Johnson, and Wendy Naro, George Washington University and National Council on Crime & Delinquency)

Program Modality

This RSAT program was based on a cognitive behavioral intervention, guided by a standardized curriculum created by Ken Wanberg and Harvey Milkman (Strategies for Self-Improvement and Change). The 50 session curriculum was designed for correctional settings. It is supplemented with other program components including education and employment services, and recreation. There was a 6 month in-custody component followed by a mandatory 12-month aftercare phase. The evaluation report focused almost entirely on the in-custody component, providing little information on the aftercare phase and the services provided. Residents averaged 23.6 weeks in the in-custody treatment program.

The program was promoted as a modified TC, but did not feature enough components of a typical TC to label it as such. There was no resident hierarchy, nor does it appear residents assumed responsibility for their own and others treatment as operationalized in TCs. Intensive treatment, another hallmark of TCs, was also absent. The program was delivered a few hours a week primarily using didactic lectures. The program incorporated 4 phases, but the evaluators opined that the residents moved through the curriculum at a standard pace, rather than through demonstrating mastery of each phase of the program.

The program as designed included the following activities: a 15-minute opening meeting to initiate daily treatment activities through devotional readings and a 15-minute closing meeting to

organize the group for the next day and clarify expectations and responsibilities. Psychoactive Substance Education Groups were designed to assist residents in understanding the impact of drug abuse on their life. There were Thinking Skills Groups and Interactive Therapy Groups based on the curriculum, which required inmates to complete homework assignments. Relaxation Sessions were also part of the curriculum. The program was designed to include bi-monthly individual sessions, as well as family counseling, but these rarely occurred due to staff shortages. AA/NA meetings were also supposed to be available to residents who were expected to attend 3 a week. The fourth and final phase of treatment was the aftercare component, coordinated by the Aftercare Treatment Monitor (ATM) upon release from the RSAT program. Clients were expected to attend group sessions led by their ATM and meet individually with their ATM at least monthly. The ATM is supposed to schedule appointments with treatment providers for the aftercare phase.

Client Population

The program was conducted in a minimum security prison for males. At the end of the evaluation period, there were 272 in-custody beds, divided between two housing units; one with 120 beds and one with 152 beds. Inmates were transferred en masse to the units within the first few days of operations bringing them up to near capacity. The treatment program was voluntary, and as of August 30, 1999, the program had received 834 applications, of which 84% (n=700) were accepted. By July 1, 1999, 323 inmates had been admitted with the remainder on the waiting list. Of the 323 admitted inmates, 17% (n=55) dropped out or were terminated. This is a fairly low level of dropout compared to most in-prison treatment programs. There were low levels of misconduct, averaging only about 5 incidents per month.

The program targets individuals within 12 to 18 months of their earliest release date. However, due to overcrowding inherent in virtually all custody institutions today, nearly one-third of those who entered the RSAT treatment program did not meet these criteria. Another criteria for admission was that inmates were non-violent. However, 42% of RSAT clients were incarcerated for violent offenses. Nevertheless, the evaluators reported this did not compromise the program as there were only 3 incidents of physical violence reported in the first 6 months of program operation.

There were 128 graduates from the first cohort in late July, 1999. Nevertheless, only 15% were actually discharged to the community within 4 weeks of graduation. The report did not include information on the number of graduates throughout the remainder of 1999.

Program Implementation

As previously reported, the program(s) were filled within a few days of opening on January 1, 1999. However, the treatment staff was not up to capacity, and there were significant space issues. As a result, services were not begun for four to six weeks, creating frustration and resentment by the RSAT program participants. This also led to significant obstacles in developing clinical rapport with treatment staff, and many inmates lost some of their original motivation for joining the program. The evaluation report states that treatment staff were able to provide bi-weekly group sessions in the second treatment unit, that opened only a few days after the first, and effect the transfer of some inmates so that treatment start dates were a bit more staggered.

Western Michigan University (WMU) received the contract to operate the RSAT program. WMU initially subcontracted with one agency to provide the in-custody treatment, and another to

provide the aftercare treatment. The aftercare contract was terminated after the first cohort completed treatment, although it appears that most of the staff was rehired by the in-prison treatment provider, who then assumed responsibility for providing aftercare. The contract was terminated in order to deal with issues of interagency cooperation and communication. The decision to employ a single agency to provide both in-prison and aftercare services was done in an attempt to improve communication and quell animosities between the staffs of the two agencies.

There were several modifications to the program as designed. There were significant adjustments in the use of the structured curriculum. Due to problems with ample space and staff shortages, the time frames for each of the phases of treatment did not conform to the prescribed duration. It was not clear to the evaluators how the program was modified, especially for Phases II and III, which constitute the bulk of the treatment. But inmates spent less time in these phases on average than designed. The program was intended to include a minimum of 4 hours of structured programming per day for six days a week. The evaluation concluded inmates spent an average of 3 hours a day in structured programming on 3 days a week. For the most part, the reductions were a consequence of staff shortages and space limitations. The space did not permit multiple group meetings, nor individual counseling or assessment sessions. There was some improvement in space over time as a large group room was divided in half, modular office furniture was installed to provide space for counselors to complete paperwork, and a trailer was added to provide group and office space. There were also difficulties in locating group facilitators for some activities. Consequently, there were no AA or NA meetings, nor relaxation sessions. Opening and closing meetings became weekly rather than daily occurrences.

There were concerns about the treatment staff and their qualifications, and the frequency of staff supervision. There was difficultly in recruiting qualified staff. In July, there was some reorganization of staff so that less experienced counselors were now supervised by more senior counselors.

The RSAT program accepted many inmates initially that did not meet the criteria established for admission, in order to fill bed space. This obviously created problems in that inappropriate inmates occupied the RSAT treatment slots, particularly those with too much time remaining before eligibility for parole. Of the 323 inmates admitted, 100 had more than 12 months before their earliest parole date. Upon program completion, they were returned to the general population, without continuing treatment services. Also, they were not eligible for the aftercare component when they were eventually granted parole. Another problem was created in that after the beds were filled, due to the demand for services, most inmate applicants were placed on a waiting list and waited significant periods of time. There were few additional program admissions during the first six months of program operations. Some inmates on the waiting list no longer had enough time before parole when a treatment bed became available.

As many programs have found, there are multiple influences on inmate release dates. Staff were not able to influence the release dates so that program graduation coincided with parole. Consequently, many of those discharged to aftercare were still in custody and returned to the general population after completing the in-custody phases of treatment.

Evaluation Type

This RSAT evaluation was funded under the second NIJ solicitation. The RFP requested a process evaluation designed to prepare for a subsequent outcome evaluation. NIJ awarded a contract to the National Council on Crime and Delinquency to conduct the RSAT evaluation in a minimum security prison in Michigan in 1998. On January 1, 1999, the Council subcontracted the balance of the original contract to The Institute on Crime, Justice and Corrections at The George Washington University. The final report was completed just over a year later. The rationale for the change in contractors is not explicated.

The evaluation used information from a variety of sources. The DOC made its Correctional Management Information System available to the evaluators, which included demographic, criminal history, programming, and institutional misconduct information for the inmate population. These data were useful in determining the universe from which eligible participants could be drawn, as well as comparing the RSAT applicants with the overall inmate population. During the period of the process evaluation, the state contracted with the University of Michigan (UM) to conduct an outcome evaluation Those researchers made a data file available to the evaluators with demographic information, but more importantly, inmates earliest release date, and the degree to which they satisfied the 5 key eligibility criteria.

Recall that the original evaluator subcontracted the balance of the evaluation to George Washington University. The awarding of the new subcontract coincided with the start-up of program operations--January 1, 1999, so this should not have impacted overly on the evaluation. Nevertheless, George Washington University is a long ways from Jackson, Michigan. The George Washington University made four site visits, which appears to be a fundamental problem since process evaluations are meant to document implementation procedures and problems. This

requires regular program contact. Therefore, much of the evaluation is based on written documentation. Although the evaluators document the program implementation, particularly pointing out the number of difficulties in operationalizing the program as planned, much more insight would have been available from increased observation of the program. It is notable that the evaluation did not discuss any apparent problems between the corrections and treatment staffs, although the problems among the treatment staff members themselves may have been more apparent.

The evaluators were concerned about errors found in data files and client files, and mention they spent considerable time reconciling incorrect information. The client/inmate tracking system was improved over the course of the evaluation, but the evaluators recommend adding information on amount and type of services. It appears the bulk of the evaluation focused on about the first 6-9 months of program operations.

Achievements

Despite the many problems with implementation, the treatment program provided services to a number of inmates. And although the curriculum was not delivered as planned, inmates and staff viewed the curriculum as one of the program's strengths. The low level of dropouts, positive drug tests, and misconduct violations are indicative of the appealing environment for the inmates, and demonstrate the safety and security of the program.

The significant support for the goals and objectives from the warden was one of the RSAT programs greatest assets. She contributed resources to resolve key structural and operational issues, including paying for staff overtime and drug testing.

The Michigan DOC has made a commitment to treating drug abusing offenders. In 1998, the inmate population in Michigan was 44,000; 4,500 completed substance abuse education programs, 1,300 participated in drug treatment in any given month, the average weekly attendance at AA and NA meetings totaled 1,100. When this report was completed in February, 2000, the Michigan DOC was preparing to open two additional RSAT programs with an additional capacity of 100 each--one for males and one for females. The Michigan DOC has conducted drug testing for inmates and parolees for over 10 years for cause, randomly, for placement in prison industries and community-release programs, and as a condition of a parole. The RSAT clients are drug tested twice monthly, and only 5 inmates tested positive over an eight month period.

The evaluation included a cost component. Excluding drug testing, program space rental, the costs were $19.44 per day, which is in addition to the normal costs associated with incarceration of $85.32 per day. This is a relatively low outlay of funds in the face of the potential benefits.

The RSAT program administrators did considerable outreach to the state's minimum security facilities to encourage qualified offenders to apply. Therefore, many more applied to the program than it could serve. However, the large number of applicants is clearly indicative of an unmet need.

Although the program encountered many difficulties, it appears progress was made toward resolution in the program's brief history. Staffing and spacing issues have improved. The termination of the aftercare treatment provider's contract, and the awarding of the contract to the in-prison treatment provider, should help to alleviate some of the interagency coordination problems.

Evaluation of Problems

Many of the problems inherent in the start-up of any prison treatment program were experienced in this program. Prison overcrowding and the need to keep beds occupied meant that the program was up to its full operating capacity within a few days of opening their doors-- with approximately 250 inmates. Nearly one-third of those who entered the RSAT treatment program did not meet the eligibility criteria in terms of their earliest release date. It is possible better planning could have avoided some of this, but gradually filling the program was not an option and will rarely be an option for in-prison treatment programs. Therefore, these type of problems have to be anticipated and accepted as 'status quo.' However, better planning would have allowed for a full staff complement, which was not in place when the first cohorts entered treatment. Many inmates waited several weeks until the program was operational for treatment to begin. Even then, the amount of structured treatment time was greatly reduced, and some important program components were not implemented during the evaluation--such as AA and NA meetings. Likewise, the mass transfer of inmates into the program implied that this first cohort also graduated and were ready for aftercare in mass. However, these are start-up problems which have or should be easily remedied with time.

One significant problem related to start-up and the need to fill beds was that only 15% of the first cohort of 128 graduates were actually discharged to the community within 4 weeks of graduation. A significant number will remain in DOC custody for at least 6 months. There is no continuation in services for the 85% who remain in custody. The evaluation report explains that DOC is now engaged in efforts to fund and implement an 'interim care unit' for program graduates

to receive 'step-down' services until release on parole. This will facilitate the continuity in services. Problems with treatment aftercare providers did not surface until graduation approached.

The treatment program was essentially asked by the Parole Board to prove their effectiveness before it would consider connecting parole with program completion. However, recently the Parole Board worked with the DOC to develop a revised eligibility screening instrument to ensure the program admits 'parole-able' offenders. These are necessary improvements.

The evaluation was also somewhat problematic in that it ended before many inmates were admitted to the aftercare program, so little of the evaluator's attention was devoted to this important component of the program. The aftercare treatment program has already experienced some major changes since the subcontract with the provider was terminated and awarded to the same provider responsible for the in-prison treatment. This was probably a valuable alteration, but due to the brevity of the evaluation period, we do not know to what extent the alteration facilitated the increased communication it was designed to address. The aftercare treatment program is not well described in the evaluation, and even if it were, it would be of the design, and not of the actual implementation. Further, it was problematic to switch evaluators in mid-course as well, and they were physically so far removed from the program that observing the program was limited to 4 site visits.

Overall, the program experienced typical start-up problems that have or will be resolved. The strong support of the warden was invaluable during this period, and involving the Parole Board and other stakeholders will continue to be critical issues that need attention.