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A Process Evaluation of the Forever Free Substance Abuse Treatment Program

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A Process Evaluation of the Forever Free Substance Abuse Treatment Program

Executive Summary

Introduction

The Forever Free Substance Abuse Treatment Program is an intensive residential treatment program lasting four to six months for women inmates with substance abuse problems, followed by up to six months of community residential treatment during parole supervision. The evaluation research is funded by the National Institute of Justice (NIJ) under its Residential Substance Abuse Treatment (RSAT) Evaluation Program.

The process evaluation of Forever Free reported here focused on characteristics and behaviors of the women while in treatment. The study was also intended to establish the foundation for an outcome evaluation of the program. The future outcome evaluation will assess the effectiveness of the Forever Free Program in addressing the problems of substance-abusing women in criminal justice populations.

Background

The number and proportion of women inmates have grown dramatically in the last decades, with drug crimes accounting for most of the increase. Because most jurisdictions do not have appropriate treatment programs for women, alternatives to incarceration do not adequately deal with the underlying problems (e.g., drug dependence) driving their criminal activities. Furthermore, the propensity for relapse to drug use after release leads to recidivism (American Correctional Association, 1990; Bureau of Justice Statistics, 1998; Mumola & Beck, 1997; Snell, 1994; Wellisch, Anglin, & Prendergast, 1993a). Drug-dependent women, therefore, pose an increasingly serious problem for criminal justice authorities.

Women Inmates and Their Children

At the end of 1997, 79,624 women were in state or federal prisons, constituting 6.4% of all prison inmates, up from 4% in 1986 (Snell, 1994; Gilliard & Beck, 1996). Gilliard & Beck (1998) estimated that in 1996, 23,700 women were sentenced under state jurisdiction for drug offenses as compared to 11,800 in 1990; during the same period, income-associated offenses for women showed similar increases. More than half of incarcerated women used drugs in the month before their current offense (U.S. Bureau of Justice Statistics, 1994). At least 74% had a history of alcohol abuse, and almost half had a history of some drug abuse (American Correctional Association, 1990).

Most substance-abusing women have children, many are single parents, and most women in prison have children (Snell, 1994). More than two-thirds of women inmates had children under 18 years of age (U.S. Bureau of Justice Statistics, 1994).

Recidivism may be attributed, in part, to the characteristics of women offenders (Bureau of Justice Statistics, 1991); they have usually been imprisoned for non-violent economic crimes, are predominantly undereducated, poor, young, and, if employed at all prior to incarceration, usually work in unskilled, low-paying jobs.

Substance-Abusing Women Offenders in California

In California as of October 1, 1998, there were 159,820 inmates in the state's prison system, 7.2% of whom were women (California Department of Corrections, 1998d). In 1996, 26.2% of inmates were committed for an offense involving drugs; women were more likely than men to be committed for a drug offense (38.3% versus 25.3%).
A recent overview of women offenders in California (Blakeley, 1998) indicated that among the total felon population of women, 42.4% were imprisoned for drug offenses and 30.5% for property crimes. New admissions in 1997 showed 33.6% crimes against property and 48.4% for drug offenses. Most of the women had used drugs immediately prior to their commitment offense, and their initial drug use dated to their early teens; 78% of the substance-involved women inmates had children.

Parole Violators and Recidivists in California

Of the controlling offenses for the 9,640 women under parole supervision in California in 1997, 45% were for drug offenses and 37.1% were for property offenses. During that same year, 7,457 women parolees had been returned to prison, 1,412 with a new term, and 6,045 pending a revocation hearing or to serve parole revocation time (CDC, 1998a; 1998b; 1998c; 1998d).

Treatment of Substance Abuse among Women Offenders in California

Fifty-seven percent of the women in California prisons interviewed by Owen and Bloom (1995) reported that they had participated in drug and alcohol treatment. Self-help programs (e.g., 12-step, AA, NA, peer counseling) were the most frequently reported, split evenly between community-based and custodial programs.
During 1998, there were 129,931 unique admissions into the community-based treatment programs and women comprised 45,497 (35.0%) of these unique admissions (California Alcohol and Drug Data System, 1999). Of the women admitted to treatment, 14,450 (31.2%) were involved with the criminal justice system: 65.8% were on probation, 17.3% were on parole, 13.2% were under diversion, and 3.6% were incarcerated.

Description of the Forever Free Program

The Forever Free Substance Abuse Treatment Program began in 1991. It was developed and is currently being operated by Mental Health Systems, Inc., under contract to the Office of Substance Abuse Programs of the California Department of Corrections. Between May 1991, when Forever Free began, and December 31, 1998, 2,017 women graduated and were released to parole. The original Forever Free program was designed to provide four months of in-prison treatment, but was extended to a six-month program under RSAT funding.
At the time of the study, the women attended treatment for four hours per day in addition to their eight-hour work assignment in a prison job or education program. A new cohort of about 30 women joined the program every six weeks.
As a modified TC with a cognitive-behavioral curriculum stressing relapse prevention (Gorski & Miller, 1979; Marlatt, 1985), Forever Free's approach presents addiction as a disease. The Gorski curriculum is designed to assist clients in identifying symptoms and teach skills and

strategies for dealing with post-acute withdrawal. Stated objectives of the Forever Free Program are to:

- Provide in-prison treatment with individualized case planning and linkages to community-based aftercare;
- Provide an in-prison program that includes a range of services to meet the psychosocial needs of participants, including counseling, group interaction, 12-step programs, educational workshops, relapse prevention training, and transition plans to refer clients to appropriate community aftercare;
- Reduce the number of in-prison disciplinary actions;
- Reduce substance abuse among participants;
- Reduce recidivism.

In order to achieve these objectives, the Forever Free program offers an array of services and programs, among them assessment, treatment planning, individual and group substance abuse counseling, parole planning, 12-step groups, and urine testing. In addition, the 26-week schedule contains a curriculum that emphasizes relapse prevention, cognitive-behavioral skill building, and women's issues. Sessions devoted to women's issues cover a number of subjects important to women's recovery, including self-esteem and addiction, anger management, assertiveness training, healthy versus disordered relationships, abuse, post-traumatic stress disorder, co-dependency, parenting, and sex and health.

Design and Methodology

This section describes study objectives, measurement domains, instruments, subject selection, and data collection procedures at the program and individual level.

Objectives

The objectives of this process evaluation study were to:

1. Document the history and the current status (under Formula Grant funding) of the Forever Free Program in regard to philosophy and objectives, operation, institutional relationships, staff profile, client characteristics, and linkages with community programs that provide continuity of care following release to parole.
2. In preparation for the outcome evaluation, select a treatment and a comparison group and collect background data and locator information on the subjects.
3. Determine the psychosocial status of the treatment group, including psychological functioning, level of motivation for treatment, drug-related locus of control, and client-counselor therapeutic alliance.
4. Determine the relationship that mothers in the treatment group have with their children with regard to custody, placement, visitation, and reunification plans following release.
5. Disseminate findings of the project to policy makers, researchers, and practitioners in criminal justice and drug treatment.

Instruments and Measurement Domains

Instruments. We used four data collection instruments: (1) the study intake form completed by treatment participants approximately one month after program entry, (2) the pre-release form completed by treatment participants just prior to their release from the program (approximately 5 months after completing the intake form), (3) the comparison group form, and (4) the locator form that all subjects in the study were asked to complete.
Domains. We assessed participants in the Forever Free Program in five domains: therapeutic alliance, psychological functioning, treatment motivation, group interaction, and locus of control.

Data Collection Procedures

Treatment clients. All clients entering the Forever Free program between October 1997 and June 1998 were invited to participate in the study. Of the 149 eligible clients, 15 (10%) declined to participate and an additional 15 were unavailable for study intake due to illness, court appearances, family visits, or other reasons, leaving a total of 119. We collected intake data approximately one month after each new cohort began treatment.
Comparison clients. Women attending Life Plan for Recovery, an eight-week (three hour per day) substance abuse education course, were asked to participate as the comparison group for the study. Of the 105 eligible women, 8 declined to participate and one was removed from the sample, leaving a total of 96 comparison subjects.
Prison context information. We obtained information on the prison context from various sources, including CDC documents, interviews with a Correctional Counselor at CIW, interviews with long-term inmates, and CIW documents.
Treatment program information. Treatment program information was obtained from many sources, including: program reports, proposals, and materials produced by Mental Health Systems by CDC; by the Drug Abuse Research Center; interviews with CDC and program staff; and focus group interviews with clients.
Treatment counselor information. We obtained background information on treatment counselors from the program director and from various printed sources, including program reports, proposals, and materials from agencies and researchers.

Findings

This section includes both quantitative and qualitative results from the process evaluation of the Forever Free program.

Program Participation

Of the 119 women in the treatment group, only four did not graduate from the program. All four were removed from the program by the prison administration for disciplinary reasons. The remaining 115 graduated from the program and 47 (40.9%) of those went on to residential treatment in the community.

Characteristics

In many respects, the treatment sample matches the description of women offenders found in the literature, namely that of a poor, ethnically diverse group of undereducated women working in low-paying jobs. The women reported a 1996 household income averaging in the $15,000-19,000 range; 36% were white, 31% African-American, 24% Latina, and 9% other ethnicities. They had low educational achievement, with 37% never graduating from high school, 26% with a GED or high school diploma, and 33% with trade school or some college training. When they last held a job, the women held primarily low-wage jobs: 37% in sales/service, 30% unskilled, 15% semi-skilled, and 10% had never worked. Their average age was 35 years.

Drug Use History and Drug Treatment

The primary drugs of abuse most commonly reported by the women were cocaine/crack (36%), followed by amphetamine/methamphetamine (28%), and then heroin or other opiate use (25%). The mean ages at which respondents first used their primary drug ranged between 11 years for alcohol and 21 years for cocaine/crack. Reflecting the severity of their drug use, two-thirds of the women reported that they had overdosed on drugs in their lifetime, for an average of two times.

Almost two-thirds (64%) of the respondents reported that, prior to entering Forever Free, they had been in treatment for drug or alcohol problems, including self-help groups. Of this subgroup, 50% reported that they had attended 12-Step or other self-help groups and 51% reported prior residential treatment. Additionally, 39% reported receiving prior treatment in prison or in jail, 26% had attended methadone, 24% hospital inpatient, and 23% outpatient drug-free treatment. (Percentages sum to more than 100% because respondents reported on multiple treatment episodes.)

Relationships with Children

The vast majority (78%) of the treatment group had children; two-thirds (66%) had children under 18 years old, and 40% had at least one child under the age of 6 years old. Sixty-two percent had legal custody of at least some of their children, although only 36% of women with children said that participation in Forever Free would affect or might affect the custody of a child. A high percentage of those with children reported some contact with their children while incarcerated through phone calls or letters, but many also rated themselves as "poor" or "fair" parents.

Therapeutic Alliance and Psychological Change

At one month into treatment, clients appeared to have had high motivation for treatment and to have already developed a strong sense of alliance with their counselors and their fellow clients (indicated by group interaction). We found significant improvements in psychological functioning by the end of treatment, with levels of depression and anxiety decreasing, and levels of self-esteem increasing.

Correlations between Measures

There was no significant correlation between therapeutic alliance and psychological functioning at intake. Of the three measures of motivation for treatment, desire for help and treatment readiness were significantly correlated with psychological functioning (positively correlated with depression and anxiety; negatively correlated with self-esteem). Women with higher treatment readiness scores appeared to be more willing to interact with counselors and fellow clients.

Correlations between psychological functioning, locus of control, and the therapeutic alliance measures were run on scores for clients at pre-release; those who feel that they have little control over their drug use have higher levels of anxiety and depression and lower self-esteem. Unlike at intake, where we found no correlations between psychological functioning and therapeutic alliance, we found that at pre-release, clients with higher levels of depression reported a stronger alliance with their counselors.

For the high-depression group, alliance at pre-release was strongly correlated with an improvement in depression. For the low self-esteem group, alliance at intake was correlated with an improvement in self-esteem.

Focus Groups Conducted with Participants

For a separate study, partly funded by the California Department of Corrections, we conducted focus group discussions with four groups of current and former Forever Free participants (40 women in all) in order to elicit participants' opinions about the Forever Free program, especially regarding supports for and barriers to remaining drug free and crime free, motivations for entering or not entering community residential treatment, personal and other factors contributing to success or failure on parole, and the women's perceptions of the community treatment component.

Focus group participants gave two main reasons for entering the Forever Free program: (1) their lives felt out of control and they had been unable to stay clean in the past, and (2) they wished to transfer to CIW from a prison in the north.

Overall, the women overwhelmingly praised the program for educating them about addiction and its relationship to other aspects of their lives. The strong connection of Forever Free participants to their counselors and the program is notable, although some women voiced concerns about staff turnover, lack of fit between counselor and client, and unmet commitments.

Despite the strong urgings of Forever Free counselors to enter residential treatment following release to parole, many women decided not to do so. The most commonly stated reasons for not entering residential treatment involved family and financial obligations, a desire for freedom, and the belief that they had learned their lesson and could remain drug free on their own or with the support of 12-Step meetings. The scarcity of residential programs that accepted children was also mentioned as a barrier.

Focus group participants felt that their inadequate vocational training was or would be a barrier to their long-term success. Some felt that they were handicapped by having to give up vocational classes in order to enter the Forever Free program.

All 12 women interviewed in the group of women with long-term success (greater than three years clean after release) went to residential treatment in a county other than their county of commitment. The women felt strongly that they needed to avoid the old patterns and bad influences that were present in their old neighborhoods.

Discussion

Forever Free had difficulty recruiting women for the six-month program required by RSAT funding. Not only do women generally have shorter sentences than do men, but most of the women sent to the California Institution for Women were (and are) parole violators whose stay is often six months or less. Since the women spend one or two months in the reception center,

many of them lack sufficient time until parole to qualify for the Forever Free program. As a result, the program had difficulty operating at full capacity.

Research studies of prison-based treatment that provided the foundation for the parameters of the RSAT program generally found that successful outcomes required at least six months of treatment in prison, but these studies focused almost exclusively on men. At least from the experience at Forever Free, the RSAT requirements, with respect to program duration, appear to be inappropriate for prison treatment programs for women.

The Forever Free program is enthusiastically supported by CIW's warden, Susan Poole. The focus group revealed, however, that not all of the correctional staff are as supportive and this can undermine the treatment environment.

Forever Free program objectives stress services for psychosocial needs and cognitive functioning of the participants. Assessment of psychosocial status of Forever Free participants indicated that the women did show significant improvement in measures of anxiety, depression, and self-esteem, between the beginning of treatment and the time just before discharge. Thus, the program does have a positive impact on the women's psychosocial needs.

Although the Forever Free program does not explicitly embrace an empowerment approach to treatment for women, some of the program elements provide women with techniques to improve self-esteem, self-assertiveness, and their ability to manage post-acute withdrawal to prevent relapse. As noted above, we found a significant improvement in self-esteem from the beginning of treatment to discharge.

Considering the high percentage of women who rated themselves as "poor" or "fair" parents, treatment programs for these and other substance-abusing women offenders should include services to address mother-child relationships, parenting skills, and opportunities for improving bonding between mother and child. Unfortunately, the institutional environment in which Forever Free operates severely limits opportunities to strengthen bonding between women and their children and their significant others incarceration.

Forever Free women had generally high scores on the treatment motivation measures and one of these measures (treatment readiness) was associated with higher levels of alliance with counselors and with fellow clients. Our results indicating an association between alliance and improvements in depression and self-esteem for those with greater severity may indicate that clients with high severity would achieve even greater benefits if matched with counselors who have more experience or training in these areas.

The Forever Free model of treatment emphasizes entry into residential treatment following release to parole to support recovery and address the women's other needs. If many women either do not volunteer for community treatment or drop out of treatment after a short time, as was the case in Forever Free, the strategy breaks down.

A one-year follow up of the women in this study (currently in progress) will provide information about the effectiveness of the Forever Free Substance Abuse Treatment Program and subsequent community residential treatment. The follow up study will also investigate possible predictors of long-term treatment success (psychosocial functioning, therapeutic alliance, locus of control, CJS history, primary drug of abuse, and other factors). The follow up study will also provide additional information about the role transitional services play in outcome.

A Process Evaluation of the Forever Free Substance Abuse Treatment Program

Introduction

The Forever Free Substance Abuse Treatment Program is an intensive residential treatment program lasting four to six months for women inmates with substance abuse problems, followed by up to six months of community residential treatment in contracted facilities during parole supervision. The Forever Free program is located at the California Institution for Women (CIW) in Frontera. The study reported here is a process evaluation of Forever Free funded by the National Institute of Justice (NIJ), under its Residential Substance Abuse Treatment (RSAT) Evaluation Program. The objectives of this study were:

1. Document the history and the current status (under RSAT funding) of the Forever Free Program in regard to philosophy and objectives, operation, institutional relationships, staff profile, client characteristics, and linkages with community programs that provide continuity of care following release to parole.

2. In preparation for the outcome evaluation, select a treatment and a comparison group and collect background data and locator information on the subjects.

3. Determine the psychosocial status of the treatment group, including psychological functioning, level of motivation for treatment, drug-related locus of control, and client-counselor therapeutic alliance.

4. Determine the relationship that mothers in the treatment group have with their children with regard to custody, placement, visitation, and reunification plans following release.

5. Disseminate findings of the project to policy makers, researchers, and practitioners in criminal justice and drug treatment.

This document reports on one of a series of evaluation studies of the Forever Free Substance Abuse Treatment Program. Prior studies of Forever Free include a process evaluation on program content and operations (Jarman, 1993a), a demographic description of the women in

Forever Free and women in the study's comparison groups (Jarman, 1993b), an ethnographic study of nine program participants (Short, 1992), and an outcome evaluation that used success on parole as the principal measure of program effectiveness (Jarman, 1993c). These studies of Forever Free were conducted by the Office of Substance Abuse Programs (OSAP) of the California Department of Corrections (CDC). A further study (Prendergast, Wellisch, & Wong, 1996) was conducted by the UCLA Drug Abuse Research Center (DARC) under a contract from CDC with funding from the Center for Substance Abuse Treatment (CSAT). That research was intended to provide substantive findings about women released from CIW, some of whom were Forever Free participants, and also to serve as a pilot study for future evaluations, including the current NIJ-funded study.

The following section provides an overview of substance abuse problems among women offenders nationally and in California, and presents information on the prior treatment experience of substance-abusing women offenders in California. The next section discusses the need for treatment and current directions in the treatment of substance-abusing women offenders, followed by a brief summary of findings from previous studies of the program. The subsequent section presents the research design, including domains and instruments, subject selection, and data collection procedures. This is followed by a discussion of the findings of the evaluation, including a description of the program in its institutional context and data on clients. The final section provides study conclusions and recommendations.

Background

Drug-dependent women pose a serious problem for criminal justice authorities for several reasons: (1) because the number and proportion of women inmates has grown dramatically in the last decade and because their number is growing at a faster rate than that of men, there are

increasing demands for new facilities; (2) because female prisoners have some needs that differ from those of male prisoners, different management and programming approaches are required that contribute disproportionately to burdens on the system; (3) because most jurisdictions do not have appropriate treatment programs for women, alternatives to incarceration usually do not deal adequately with the underlying problems driving their criminal activities; and (4) because of relapse to drug use, failure on parole and recidivism in general is high (American Correctional Association, 1990; Bureau of Justice Statistics, 1998; Mumola & Beck, 1997; Snell, 1994; Wellisch, Anglin, & Prendergast, 1993a). Below we provide a summary of statistics on substance-abusing women offenders in the United States and in California by way of background to the current process evaluation of the Forever Free program.

Recent Statistics on Women Inmates and Their Children

According to the Bureau of Justice Statistics (Gilliard & Beck, 1998), the state prison population in the United States increased by 59.7% between 1990 and 1997, from 708,393 to 1,131,580. At the end of 1997, 79,624 women were in state or federal prisons, constituting 6.4% of all prison inmates, up from 4% in 1986 (Snell, 1994; Gilliard & Beck, 1996). Gilliard and Beck (1998) estimate that in 1996, 23,700 women were sentenced under state jurisdiction for drug offenses as compared to 11,800 in 1990; during the same period, income-related offenses for women—larceny, burglary, and fraud—showed similar increases. During the 1990 to 1996 period, the number of women serving sentences for drug offenses doubled while the number of men who were inmates rose 55%; however, the number serving time for violent offenses rose at about the same pace--up 57% for men and 58% for women (Gilliard & Beck, 1998).

According to a survey conducted by the U.S. Bureau of Justice Statistics (1994), more than 43 % of women inmates had suffered physical or sexual abuse prior to entering prison; more than two-

thirds had children under 18 years of age, and in most cases the children were living with the mother before her incarceration. Snell (1994) found that with the mother in prison, the children's grandparents were the most common single category of caregiver (57% of black mothers, 55% of Hispanic mothers, and 41% of white mothers). Nearly 10% of the women said that their children were in a foster home, agency, or institution. Since entering prison, half of the women had been visited by their children, four-fifths had corresponded by mail, and three-quarters had talked with them by telephone (Snell, 1994).

An American Correctional Association survey (1990) reported that 74% of women inmates had a history of alcohol abuse; and almost half had a history of some drug abuse. The percentage of women in prison using cocaine or crack before incarceration rose from 23% in 1986 to 36% in 1990, while use of marijuana decreased from 30% to 20%, and use of the other drugs remained fairly constant. Thirty-six percent reported that they were under the influence of drugs at the time of the offense, and 24% reported that they had committed the offense in order to obtain money for drugs. Women who reported that they used drugs were less likely to be incarcerated for a violent crime than were those who reported no use of drugs.

Recidivism may be attributed, in part, to the underclass status of women offenders. They have usually been imprisoned for non-violent economic crimes, are predominantly undereducated, poor, young, and, if employed at all prior to incarceration, usually work in unskilled, low-paying jobs. Moreover, these women are frequently heads of household with children under 18, have histories of physical and/or sexual abuse, and are substance abusers (Bureau of Justice Statistics, 1991; Wilson, Anderson, & Fletcher, 1993).

Numbers and Characteristics of Substance-Abusing Women Offenders in California

In 1997, more than one-third of all women prisoners in the United States were held in the three largest jurisdictions: California, Texas and the Federal system (Gilliard & Beck, 1998). With regard to California, as of October 1, 1998, there were 159,820 inmates in the state's prison system, 92.8% of whom were men and 7.2% women (California Department of Corrections, 1998d). This represents a doubling in the state prison population since 1988. In 1996, 26.2% of inmates were committed for an offense involving drugs; women were more likely than men to be committed for a drug offense (38.3% versus 25.3%). A recent overview of women offenders in California (Blakeley, 1998) indicated that more than half of those in prison were incarcerated for non-violent crimes related to drugs or crimes against property. Most of the women used drugs immediately prior to their commitment offense, their initial drug use dating to their early teens; and 78% of the substance-involved women inmates had children.

In 1997, 37.4% of incarcerated women were White, 33.5% were Black, 23.7% were Hispanic. As of January 1, 1998, the average age of women inmates was 35.3 years, with over 80% between 25 and 44 years of age (Blakeley, 1998).

Owen and Bloom (1995) conducted face-to-face interviews with 294 women inmates to obtain a profile of women prisoners in the four California prisons that housed women. The background characteristics of the women were as follows: 46% of the sample were Black, 36% were White, and 14% were Hispanic; over two-thirds of the women were between 25 and 44 years of age; most were unmarried; over one-third had not completed high school, although 11.6% had obtained a GED; over 50% had been unemployed prior to arrest; 37.1% worked at legitimate jobs, 21.8% had been on public assistance; and about 80% of the women indicated that they had been victims of abuse at some time in their lives. Regarding criminal involvement, 15.6% had

engaged in drug dealing, and 12.3 % had obtained support through other illegal sources; 60.4 % were imprisoned on new commitments, the remainder were committed for parole or probation violation; and just under 30% were committed for a drug offense. They had extensive drug involvement: only about 13% reported no drug use at any time; for the others, 59% indicated initial drug use at age 18 or younger; and almost half reported that they had injected drugs at some time in their lives.

Based upon a study of substance-abusing women in the Forever Free Program at the California Institution for Women, Prendergast, Wellisch, and Wong (1996) reported that most of the women offenders were of childbearing age, 75% had children under 18 years old, and most were single mothers who received little or no help from the child's father. Prior to incarceration, 37.5% of these women had custody of their children, and most expected to live with their children after release from prison.

Parole Violators and Recidivists

In 1997, the average daily population of felons on parole totaled 115,299, which includes parolees supervised by the California Department of Corrections (CDC) and parolees at large; of this number, 11,101 were women. The five top counties to which released prisoners were paroled for their first parole were Los Angeles (35.6%), San Diego (8.6%), Orange (7.3%), San Bernardino (6.9%), and Riverside (6.0%). Of the controlling offenses for the 9,640 women under parole supervision, 45% were for drug offenses and 37.1% were for property offenses. During that same year, 7,457 women parolees had been returned to prison, 1,412 with a new term, and 6,045 pending a revocation hearing or to serve parole revocation time (California Department of Corrections, 1998a; 1998b; 1998c; 1998d).

Prior Treatment Experience of Women Offenders in California

Fifty-seven percent of the women in California prisons interviewed by Owen and Bloom (1995) reported that they had participated in prior drug and alcohol treatment. Self-help programs (e.g., 12-step, AA, NA, peer counseling) were the most frequently reported, split evenly between community-based and custodial programs. Outside of self-help, the overwhelming majority reported little other treatment experience. Among women inmates who had ever used drugs, 64% reported that they had been in a clinic, therapy, self-help group, class, or some other type of treatment, including a program offered in prison.

During 1998, there were 129,931 unique[1] admissions into the community-based treatment programs that reported to the California Alcohol and Drug Data System (CADDS), maintained by the California Department of Alcohol and Drug Programs (ADP) and available to DARC for analysis. Women comprised 45,497 (35.0%) of these unique admissions. Of the women admitted to treatment, 14,450 (31.2%) were involved with the criminal justice system: 65.8% were on probation, 17.3% were on parole, 13.2% were under diversion, and 3.6% were incarcerated.

Treatment Needs of Substance-Abusing Women Offenders

Identification and treatment of substance-abusing women, particularly those who are parenting and those of childbearing age, is important primarily for three reasons. First, these women are filling our jails and prisons in increasing numbers for drug offenses and other crimes associated with their drug dependency. Second, they are significantly at risk for contracting and spreading HIV and other infectious diseases. Women and children are the fastest growing segment of the population to be infected, largely through the mother's drug use or through sexual contact with

[1] To determine unique admissions, we counted each client only once for the year.

injection drug users. The third reason, which may be most important in terms of continuing societal impact, is that the children of substance-using women offenders are at risk to continue intergenerational patterns of substance abuse, disease, and personal and family dysfunction—the children are at high risk to continue the pattern of alcohol, tobacco, and illicit drug use, criminal and other antisocial behaviors, and neglectful, even abusive, parenting (Sheridan, 1995).

Given the importance of treatment for women substance abusers, the Center for Substance Abuse Treatment (1994, p. 178) listed the following issues pertinent to women's recovery that need to be addressed in a comprehensive treatment program:

- The etiology of addiction, especially gender-specific issues related to addiction (including social, physiological, and psychological consequences of addiction and factors related to the onset of addiction)
- Low self-esteem
- Race, ethnicity, and cultural issues; gender discrimination and harassment
- Disability-related issues
- Relationships with family and significant others
- Attachments to unhealthy interpersonal relationships
- Interpersonal violence, including incest, rape, battering, and other abuse
- Eating disorders
- Sexuality, including sexual functioning and sexual orientation
- Parenting
- Grief related to the loss of children, family members, or partners; and grief related to the loss of the comfort of alcohol or other drugs
- Work
- Appearance and overall health and hygiene
- Isolation related to a lack of support systems (which may or may not include family members and/or partners) and other resources
- Life plan development
- Child care and child custody

These issues can be categorized into two broad, conceptually separate, though interacting, domains. These are issues having to do with *The Self*, and issues having to do with *Relationships*. The former domain would include: standard demographic characteristics; education, work history, employable skills, and life skills; psychosocial characteristics including psychological/psychiatric statuses, physical health, self-esteem, feelings of control or powerlessness; sexual functioning and sexual orientation; trauma and grief; and history including victimization, discrimination, onset and use of substances, criminal career, and treatment history. Issues having to do with *Relationships* would include: bonding with children and other significant persons; knowledge and skills relating to parenting; family cohesion; and support systems including support for expression of spirituality. Only the most comprehensive, intensive, and long-term program could address all of these issues. Most treatment will focus on a subset of these issues, selected on the basis of program philosophy and the specific needs of women treated in the program.

Some researchers point out the requirement for, and attempt to develop, integrated models of treatment that include some or all of these issues. For example, Covington (1998) suggests a model that includes: (1) a holistic theory of addiction, which, according to the author, is analogous to cancer in that it incorporates physical, emotional, environmental, and sociopolitical dimensions; (2) a theory of women's psychological development (based largely upon a relational model, discussed in Covington and Surrey, 1997); and (3) a psychiatric theory of trauma (based largely upon Herman's [1992] three stages of recovery from trauma—safety, remembrance and mourning, and reconnection).

According to Lockwood and colleagues, certain elements are required for successful women's substance abuse treatment: (1) staff members who understand women's treatment needs,

especially in the areas of abuse, health, and street experiences, (2) promotion of a safe environment for women to engage and progress in treatment, (3) promotion of a treatment community with female role models, (4) providing gender-specific programming, and (5) coordination with social welfare agencies such as welfare-to-work programs and child protective services (Lockwood, McCorkel, & Inciardi, 1998).

Few treatment programs for women-substance abusers, particularly for those who are incarcerated and then released to parole, incorporate treatment for all of the issues enumerated above. There is a growing recognition, however, that treatment should provide a comprehensive set of services, and there appears to be increased interest in promoting greater treatment emphasis in three main areas: (1) improving mental health, including displacing low self-esteem and feelings of powerlessness with feelings of competency and control; (2) developing bonding between mothers and their children and developing effective parenting skills; and (3) providing continuity of care through transition into the community and reintegration into family and community life. Because of their importance and saliency in women's recovery and rehabilitation, these three areas were addressed in this process evaluation of Forever Free.

Improving Psychosocial Status

According to a literature review conducted by McQuaide and Ehrenreich (1998), there are few studies on the psychosocial and mental health needs of imprisoned women, although it has been estimated that more than 1 in 10 women in the state prisons receive in-patient psychiatric care prior to their admission to prison, and that 1 in 8 women receive medication for emotional and mental health problems while incarcerated (American Correctional Association, 1990; Bureau of Justice Statistics, 1994). Suicidal ideation, depression, anti-social personality, and post-traumatic stress disorder, which tend to be mental health problems characteristic of substance abusing

women in general, are magnified in women felons. A study measuring psychiatric disorders among women entering the Correctional Institution for Women in Raleigh, North Carolina, found that alcohol and drug-dependence disorders had the highest prevalence, followed by borderline personality disorder, anti-social personality disorder, and depression. There was a trend for prevalence rates for all disorders to be higher for incarcerated women than for community women, except for anxiety rates, which were lower in the inmates, significantly so for African American women inmates (Jordan, et al., 1996). As noted above, the American Correctional Association (1990) survey reported that victimization is pervasive in the lives of incarcerated women—at least 65% of women inmates had a history of extreme physical and/or sexual abuse, primarily as children.

Because the Forever Free treatment program screens for severe psychiatric disorders, the process evaluation was not concerned with treatment for the clinically diagnosed mentally ill. Psychosocial disorders, however—low self-esteem, suicidal ideation and attempted suicide, depression, and long-term residual problems linked to post-traumatic stress—are pervasive among women drug abusers, and are likely to be included in the program participants' treatment needs, and therefore were a concern of the process evaluation.

A number of researchers have looked at the relationship between psychological factors and treatment retention. Several studies have shown that women who stay in treatment longer have higher levels of self-esteem (DeLeon, 1974; Aron & Daily, 1976) and that self-esteem tends to increase with length of treatment. Other psychological factors have been shown to have a relationship with women's length of stay in treatment. For example, women who are more depressed tend to leave treatment early (Williams & Roberts, 1991), and those with high levels of burden, including psychological problems, tend to end treatment prematurely (Brown, Huba,

& Melchior, 1995). A recent study of Turning Point, a women's treatment program in an Oregon prison, found that depression, motivation, and readiness for treatment, and the extent to which clients were satisfied with client-staff relationships and efforts to empower them, differentiated between those who completed the program and those who did not. Demographic characteristics, drug use, and criminal history did not discriminate between program completers and non-completers, except for age, with completers being older (Strauss & Falkin, 1998).

Most studies of the characteristics of substance-abusing women attest to their feelings of low self-esteem and powerlessness. It has been argued that imprisonment itself does little to lessen such feelings and may, indeed, reinforce them. To quote Lord (1995, p. 262), Superintendent of Bedford Hills Correctional Facility:

> The rigidity and authoritarianism of prisons by their very nature can be yet another experience of power and control as belonging to other, not the women. Prison does not allow women to experiment with their own decision making but rather reduces them to an immature state in which most decisions of consequence are made for them.

For many women offenders who grew up in dysfunctional families or who were abused as children, feelings of powerlessness were with them from an early age. Based upon a review of the literature, Heney and Kristiansen (1998) conclude that incarcerated women, many of whom have been severely sexually abused prior to prison, are likely to be re-exposed to traumatic experiences, including sexualization, powerlessness, and stigmatization, while in prison. When they leave prison, they may experience considerable problems and barriers to obtaining needed aid. In many cases, the women will experience difficulty in reestablishing relationships with their children and other family members, having to perform as both the sole breadwinner and parent, and being subjected to negative societal attitudes—problems that their lifelong experiences and recent incarceration have not prepared them to cope with.

According to Wilson and Anderson (1997, p. 349),

> Powerlessness is framed by the continuous interaction between the individual and her environment. The powerless individual assumes the role of an object who is acted on by the environment rather than that of a subject who acts in and on her world. She alienates herself from participation within the social reality of the environment, passively accepting the oppressive cultural mores about her (Freire, 1985). Powerless persons blame themselves for their circumstances, have a sense of distrust and hopelessness in the sociopolitical environment, feel alienated from resources for social influence, and are disenfranchised and economically vulnerable (Kieffer, 1984).

The authors propose an empowerment model to provide for offenders that includes comprehensive, integrated services and that spans the continuum from in-prison, through transition, to reintegration in the community. The model would cover the dimensions of personal, social, educational, economic, and political empowerment.

In-prison substance-abuse treatment programs for women that include follow-on community extensions, such as Forever Free, have components that are directed toward increasing the self-esteem and competencies of program participants. However, such programs, although increasing in number, are still rather few, and in almost no cases can they draw upon comprehensive, integrated delivery of multiple services in the communities to which the women are paroled. Because psychosocial disorders tend to be endemic among substance-abusing women in prison, the process evaluation attempted to assess program components in Forever Free that deal with these problems.

Developing Bonding and Effective Parenting Skills

In addition to the concern about addressing feelings of powerlessness in substance-abusing incarcerated women, many researchers, social workers, drug treatment professionals, and others who are involved with rehabilitating substance-using (and other) women in prison see the need to strengthen familial ties, particularly to children, which may have been severely damaged by

the woman's incarceration. Walker et al. (1991, p. 10), for instance, argue, "If the mother's ties to her child could be preserved and social and familial networks strengthened, there would be a reduction in maternal drug use, an improvement in maternal and child health, and a reduction of the number of children placed in foster care." Several researchers point to the importance of strengthening family ties as part of treatment for substance-abusing women offenders, particularly in the community. The work of Wobie, Davis, Conlon, Clarke, and Behnke (1997) and Finkelstein (1994), among others, suggests that women, to a greater extent than men, have a need to connect with their social environment. This may be their "natural" environment (spouse, children, relatives and friends met through neighborhood, church, and employment) rather than the contrived (drug-related) group formed in-group counseling. From this perspective, the parenting component of treatment programs needs to be broadened to provide multiple opportunities for improved inmate-family relationships during and following incarceration (Sheridan, 1996), although women may need to establish these relationships away from their former drug-using neighborhood and with more prosocial friends and family members.

The matter of preserving maternal ties with children is complicated since drug-abusing women tend to be poor parents. According to Davis (1990), poor parenting practices, parental substance abuse, and high rates of physical and sexual abuse are characteristic of the woman addict's family history. Many, if not most, substance-abusing women are acutely aware of their inadequacy as parents. A study conducted in 1990 (Grief & Drechsler, 1993) reported on common themes raised by heroin-abusing women clients in a parenting group conducted in a treatment program. Four of the six themes related to their problems in parenting: difficulty in being consistent and providing structure, inability to parent because they were poorly parented themselves, guilt because of their past behavior toward the child, and inability to deal effectively

with their own parents who might be blocking their attempt at parenting. In another study (Kolar et al., 1994), 70 men and women in treatment were interviewed regarding the associated effects of their substance use on the life experiences of their children. Sixty-four percent of the mothers reported using drugs during their pregnancy, 80% of the parents reported that they had been arrested during the child's lifetime, and 34% had received treatment for an emotional disorder. In a study of recovering women, Nelson-Zlupko and colleagues (1996) report that issues surrounding sexuality, parenting, and child custody were rated as very important treatment needs.

Women in a Nevada prison, most of whom were incarcerated for a drug offense, were surveyed on the importance of potential educational services on 36 social and personal issues. Out of 203 completed surveys, issues associated with parenting and children were rated as very important (5 on a 5-point scale) by the great majority of the women. The issues were addiction effects on parenthood, parenting skills, child abuse (physical), and child abuse (sexual) (Sanders et al., 1997). Because problems connected with parenting and children are so pervasive in the lives of drug-using women, many community-based and in-prison treatment programs for women offenders have a parenting module in their treatment protocols. Not all prison programs, however, contain a parenting module, and in many programs parenting classes and other services for women in prison relative to their children are limited (Clement, 1993; Owen & Bloom, 1995). In the majority of programs where parenting modules do exist, only the woman is treated, and problems concerned with her interaction with children, mates, and other family members are treated tangentially through the mother. For well-known reasons—costs, licensing, logistical handicaps, philosophic orientation—few programs in the community and fewer still in prisons are able to include combined living arrangements or extended periods of natural face-to-face

interaction between mothers and their children. However, the therapeutic advantages of bringing together mothers and children in supervised parenting is receiving greater recognition, leading to increasing movement in that direction. Most programs for women offenders, such as those described below, attempt to deal with parenting issues through instruction involving only the mother.

One such program, in the Bedford Hills Correctional Facility in New York State's maximum security prison for women, *Parenting from a Distance,* attempted to set up a process whereby women inmates could become more empowered in their relationship with their children (Boudin, 1998). The program was directed toward getting women inmates to become active participants in their own growth, make a difference in the lives of other women in the group, and make a difference in the lives of their children and other significant persons. While not a program for treating substance abuse as such, women in the program tended to have similar histories, including substance use, and shared many of the same characteristics. *Parenting from a Distance* aimed to help incarcerated women deal with their grief in being separated from their children, examine the issues of their relationship with their children, and act upon these issues to positively influence existing relationships with their children and caretakers.

Welle, Falkin, and Jainchill (1998) have reported several models for addressing parenting issues among substance-abusing incarcerated and paroled women. Overall, the programs they examined are directed toward achieving improved parenting, learning how to cope with abusive relationships with partners, and overcoming trauma from past sexual abuse. Some of the programs attempted to get the women to acknowledge their role in perpetuating child neglect and/or abuse as a pre-treatment agenda to encourage women to seek help and take responsibility before trying to regain custody. By contrast, other programs emphasized providing emotional

support for the women, assuming that they were well aware and full of guilt because of neglecting their children. These programs also assisted the women in regaining custody. At the orientation level in some of the community programs, the women offenders discussed the implications and consequences of "not being there" for their children. Recognition of the consequences of "not being there" while incarcerated was very traumatic for some of the women. Later in treatment, women identified the specific needs of their children and the risks that they faced, and were instructed in parenting techniques to deal with problems and reduce stress. The authors state that despite differences in emphasis across the programs they examined, all of the programs, using individual and group methods, attempted to help women overcome self-blame and guilt and the stigma attached to losing custody of a child. Also, the programs attempted to help the women deal with the grief associated with the death of a child, having a child removed from their custody, being rejected by a child, or making the decision not to reunite or raise their child(ren).

Although children raised in families in which one or both parents abuse alcohol or other drugs (AOD) have increased risks for deleterious effects, children who have been prenatally exposed to AOD represent a special category of *high-risk* children (i.e., children with a greater probability of maladaptive development, particularly if, in addition to prenatal exposure, the child's environment is not conducive to healthy growth). A few women's prisons such as CIW, the prison in our study, have the facilities to care for pregnant inmates and the delivery of their children; others refer the women to outside services. An Oregon program for pre-natal and post-partum women offenders and their drug-exposed infants refers the women offenders to hospital-based workshops where they are instructed in the medical as well as social needs of their babies (Welle, Falkin, & Jainchill, 1998). Here they are taught games and other ways to interact so as to

promote psychosocial development. This program also offers grief groups to women who have permanently lost custody of a child.

In general, the programs referred to above attempt to deal with parenting issues through the mother alone, or with very limited interaction between incarcerated women and their children. Until now, few jurisdictions included children in the living arrangements of incarcerated women. Recently, because of mounting evidence of the benefits to both the mothers and their children, as well as for practical considerations of overcrowding and burdens imposed on prisons by women's' special needs, there has been some movement toward using community facilities to house offender women with their young children while they serve their sentences. One such program is the California Prison Mothers Program (CPMP), which currently has six sites and can accommodate 94 women. The CPMP allows eligible inmates to move from their prison setting into a community-based facility for the remainder of their sentence where there is an average stay of 9 months. Such programs may be a model for the future.

In summary, the relationship that women offenders in substance abuse treatment have with their children (and other significant persons), whether in prison or while on parole, is probably an important factor in their rehabilitation and was an important area of focus in the process evaluation of the Forever Free program. Providing services to this population of women addicts and their high-risk children and youth is an important objective of national drug treatment policy. Fortunately, in the last few years, a number of prison programs have been established specifically oriented to the treatment of substance-abusing women offenders, and there appears to be a trend toward developing program components to train women for more effective parenting. However, as indicated above, community-based programs for women and their young children, instead of prison-based ones that separate mothers from their children, are very few and

have room for only a small fraction of incarcerated mothers. Moreover, transitional and aftercare programs that offer a range of services to support women through their reintegration into the community and help to reestablish ties with children and other family members are also few in number; and when such services are available in the community, they may not be sufficiently linked to the custodial program to provide the women immediate and on-going access to needed community services (Falkin, Wellisch, Prendergast, et al., 1994; Wellisch, Anglin, & Prendergast, 1993b).

Providing Transition and Continuing Care

The State of California Senate Concurrent Resolution 33 Commission Report (1994) lists five critical elements that should be included in transitional plans for those released from prison if recidivism is to be reduced. The first involves parole-planning procedures that should be standardized and, for women especially because of their typically short sentence, should begin upon reception at the institution. The second critical element requires that parole planning involve the interaction of correctional counselors, inmates, and parole agents and address critical issues in the lives of the inmates. The third is the need for linkages between the institution and the community to provide a range of programs to address individual concerns, which include long-term, intensive treatment. The fourth element is the need for each inmate's parole plan to be tailored specifically to address individual needs in a comprehensive prerelease program. The final element is the need for linkage between the programs provided in the prison and the services and programs available to inmates when they are paroled. The need for this final element, linkage between in-prison substance abuse treatment programs with community-based substance abuse treatment, has been well established. Based upon the research on in-prison treatment for substance-abusing offenders, it is evident that while several month's participation

in intensive custodial TC-based programs has salutary effects on subsequent drug use and criminal activity, the effects are seldom sustained without integrated transitional and extended aftercare (Anglin & Hser, 1990; Falkin et al., 1994; Graham & Wexler, 1997; Inciardi et al., 1997; Martin, Butzin, & Inciardi, 1995; Prendergast, Wellisch, & Falkin, 1995; Prendergast, Wellisch, & Wong, 1996; Wellisch, Prendergast, & Anglin, 1996).

Well-documented studies of in-prison treatment programs for substance abuse, whether for men or women, such as Stay'n Out in New York (Wexler & Williams, 1986), the KEY-CREST program in Delaware (Inciardi et al., 1997), prison programs in the Oregon correctional system (Field, 1992), the Amity Program at the R. J. Donovan Correctional Facility in California (Wexler, DeLeon, Thomas, Kressel, & Peters, 1999), and the Forever Free program at CIW in California (Prendergast, Wellisch, & Wong, 1996), show substantially similar outcomes. That is, those who participate in a prison treatment program using the TC model do better in terms of recidivism and substance abuse than those who do not engage in treatment; those who continue treatment after release from prison do better than those who do not continue treatment; and length of time in treatment is positively correlated with greater success on parole.

As can be seen, planning for transition, assessing each inmate's needs and preparing for services and programs in the community such as vocational training, linking in-prison programs such as substance abuse treatment to continuation of treatment following release are activities important in the women's success on parole. Because of their importance, the activities conducted by the in-prison component of Forever Free to prepare women for transition to the community, and especially to motivate them to continue their treatment after release, were an important emphasis of the process evaluation.

Previous Studies of Forever Free

As noted above, a number of previous studies, funded by the California Department of Corrections, have examined the Forever Free program. Jarman (1993a) conducted a quasi-experimental study comparing outcomes for 196 treatment subjects (women who participated in Forever Free) and women in two comparison groups (see also Jarman, 1993b,c). All subjects paroled during the period January 1, 1992, to September 30, 1992. All subjects were tracked through state criminal justice databases for a minimum of 4 months to a maximum of 20 months from the time of their release. Data were collected until March 31, 1993, providing a minimum of six months of parole time and a maximum of 14 months of post-release time (including time on parole). The major findings of the study were that:

1. The Forever Free program successfully delivered services to a significant proportion of eligible women at the California Institution for Women.

2. Forever Free participants had more severe problems (type of drug and length of use, social and cognitive deficits, and criminogenic behavior) than women in the comparison groups, even though the groups had been matched for age, ethnicity, and primary offense.

3. Length of time in treatment was related to success on parole—only 38% of program dropouts were successful on parole as compared to 90% of those who completed Forever Free and stayed for five or more months in community-based residential treatment.

More recently, the UCLA Drug Abuse Research Center conducted a small study of Forever Free under contract to the California Department of Corrections (Prendergast, Wellisch, & Wong, 1996a,b). The major emphasis of this research was to obtain an assessment of how particular conditions following release to parole were related to successful outcomes for three groups of substance-abusing women: (1) women who graduated from Forever Free and entered community residential programs (Residential group), (2) women who were in Forever Free only (Non-

Residential group), and (3) women who had volunteered for Forever Free but for administrative reasons did not participate (Comparison group). Funding constraints allowed only about 20 women in each group who had been released to parole in Los Angeles and adjacent counties between December 1993 and June 1994 to be located and interviewed.

For the top-ranked need stated by the women, "help with relapse prevention," women in the Residential group (75.0%) were much more likely to report that they were able to have this need met than were women in the other two groups (33.3% for the Non-Residential group and 11.1% for the Comparison group). Similar results were obtained for the second ranked need, "getting employment." Findings also indicated that even when women offenders entered community treatment, their length of stay tended to be short—most of the women did not complete treatment. As expected, longer tenure in treatment was associated with more positive outcomes. Of those women who stayed in residential treatment for five or more months, 85.7% had a successful outcome (discharged or still on parole with no reincarceration), compared with 58.3% of the women who had less than five months in treatment. The Residential group had the most successful outcomes (discharged or still on parole, with no reincarceration) at 68.4%, compared with 52.2% for the Non-Residential group, and 27.2% for the Comparison group. While drug use during the past year was probably underreported by all three groups, self-reported use in the past year of nearly all drugs was much lower in the Residential group than in the other two groups, particularly so for heroin and cocaine/crack, the preferred drugs among this sample. Also, fewer women in the Residential group than in the other groups reported current dependence on a drug. It is evident from this brief summary of results from prior evaluations that the in-prison and community-based treatment provided by Forever Free was more effective in reducing recidivism than no treatment, and that women who stayed in treatment longer were more likely to have

successful outcomes. Despite these positive findings, however, beneficial results did not extend to all of the in-prison participants. This may have been due to several factors: the relatively short period of in-prison treatment; the fact that most program graduates did not enter residential treatment in the community; of those who did volunteer for community treatment, most did not stay for the full six months; and treatment success was based upon a single criterion. That is, treatment success was restricted to success on parole, which is subject to considerable variability in parole enforcement among jurisdictions and is influenced by the availability of supportive resources in the community.

The study of Forever Free reported on here differed from the prior ones in several important ways:

1. The in-prison component of the treatment program under RSAT funding was six rather than four months.

2. Program graduates had a wider selection of community-based programs to choose from, including one that accepted young children, which might result in higher participation rates than formerly.

3. A number of variables were assessed to determine the during-treatment impact of Forever Free, including therapeutic alliance, psychological status, motivation for treatment, group interaction, and locus of control.[2]

Design and Methods

The main purpose of this study was to conduct a process evaluation of the Forever Free Program; a secondary purpose was to lay the foundation for an outcome evaluation of the program. The focus of the study was on the program itself and on the characteristics and behavior of the clients while in treatment. Although Forever Free includes an aftercare

[2] The NIJ-funded outcome study of Forever Free currently being conducted includes a number of measures of effectiveness in addition to success on parole, including psychological functioning, drug use, parenting, and employment.

component for program graduates, it was not supported with RSAT funds and has received minimal attention in this study. It will, however, be an important element in the outcome evaluation because participation in a community residential program, especially length of participation, will be an important intervening variable for assessing the outcomes of the Forever Free graduates.

This section describes measurement domains, instruments, subject selection, and data collection procedures at the program and individual level.

Domains and Instruments

In the first part of this section, we present the supporting literature on the five major domains addressed in the client survey portion of the study: therapeutic alliance, psychological functioning, treatment motivation, group interaction, and locus of control. The second part describes the instruments used to assess each domain.

Therapeutic Alliance

A large number of studies have concentrated on identifying both the structural and operational characteristics of successful treatment programs for substance abuse and the characteristics of clients that consistently facilitate treatment success. A small number of studies have examined the association between characteristics of the treatment counselor (case manager, therapist) and treatment outcomes (e.g., Luborsky et al., 1985; McLellan, Woody, Luborsky, & Goehl, 1988; Valle, 1981). Another aspect of treatment, the relationship (bond or connection) between client and drug treatment counselor, has received even less attention. Although largely neglected in evaluations of substance abuse treatment, the importance of this relationship is

well recognized in classical psychotherapy where the client receives therapy in a one-on-one interaction with a licensed counselor, clinical psychologist, or psychiatrist.

While the extent, intensity, and exclusivity of client interaction with a particular treatment provider varies across types of substance abuse treatment programs and even within treatment modalities, usually there is some interaction between a client and a particular counselor, and in many treatment programs there is an interaction pattern similar to that found in classical psychotherapy. A few studies have looked at the relationship between client and counselor in treatment for drug abuse (Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985; Bell, Montoya, & Atkinson 1997; and Carroll, Nich, & Rounsaville, 1997). In each of these studies, a relationship was found between therapeutic alliance and treatment outcome measures (termed *connection* in the Bell et al. study).

In the three studies related to substance abuse treatment mentioned above, different measures of the alliance were used, although all used client reports. In addition, there was considerable difference in the subjects of the studies, the goals of the research, the research design, and the outcome measures. Despite these differences, across studies, the relationship between the client and therapist or counselor, as reported by the client, seemed to be an important contributor to the success of treatment. These results encouraged us to investigate this connection in our study of the Forever Free treatment program.

In the psychotherapeutic literature, the relationship between therapist and client typically is referred to as the *therapeutic alliance, working alliance, or helping alliance,* terms that have been used to refer to specific aspects of the relationship as well as to the relationship as a whole. The impact of alliance has been reported for a range of therapies including behavioral,

cognitive, gestalt, and psychodynamic treatment approaches; and alliance measures have been used to predict a variety of outcomes ranging from drug use, through social adjustment, to client and therapist global ratings of improvement (Carroll, Nich, & Rounsaville, 1997; Luborsky et al., 1985; Safran & Wallner, 1991). However, at the time that this study was conducted, we had no accepted model on which to base selection of an instrument to measure alliance—few studies reported using alliance measures in evaluating substance abuse treatment, and there was no agreement upon the alliance measures that had been used.

Horvath and Symonds (1991) identify five relatively more psychometrically sophisticated measures of alliance, measures with good reliability[3] that have been used in the majority of studies published to date: California Psychotherapy Alliance Scales, CALPAS (Gaston, 1991) and Caltras (Marmar, Weiss, & Gaston, 1989); Penn Helping Alliance Scales, Penn, HAQ, Hacs, Har (Alexander & Luborsky, 1987; Luborsky et al., 1983); Therapeutic Alliance Scale, TAS (Marziali, 1984); Vanderbilt Therapeutic Alliance Scale, VPPS, VTAS (Hartley & Strupp, 1983); and Working Alliance Inventory, WAI (Horvath, 1982).

From these, we selected the patient version of the CALPAS for several reasons: (1) a great deal of research has been invested in establishing the validity of the scale (Gaston, 1991; Marmar, Weiss, & Gaston, 1989; Safran & Wallner, 1991) and in investigation using exploratory factor analysis (Hatcher & Barends, 1996); (2) the instrument monitors all of the basic constructs that we felt were important, e.g., common or agreed upon goals (Horvath, Gaston, & Luborsky, 1993); (3) as discussed by Hatcher and Barends (1996), the conceptual focus of the CALPAS is on the individual contributions of the patient and therapist although

[3] The average reliability index for all measures was estimated as .86 (Horvath & Symonds, 1991).

the items reflect the collaborative aspect of the treatment—which both we and they believe is the important aspect for patient improvement; and (4) the scale has been widely used in previous research.

The CALPAS has four subscales: Patient Working Capacity, Patient Commitment, Working Strategy Consensus, and Therapist Understanding and Involvement. CALPAS consists of 24 items rated on a 7-point scale reflecting the extent of subjects' agreement with the item. To these 24 items, we added 3 items from the Working Alliance Inventory (WAI) and 3 items from the Helping Alliance Questionnaires (HAQ). These additions were suggested by Hatcher and Barends (1996) to create a new subscale, *Confident Collaboration.*[4] Based upon factor analysis, they found that with the general factor (total score) removed, *Confident Collaboration* was significantly correlated with patients' estimates of improvement ($rs = .37, p < .001$).[5]

Psychological Functioning

Psychological functioning has been shown to be related to health risk behaviors. Generally, subjects with higher levels of depression and anxiety are more likely to engage in health risk behaviors, while high self-esteem has been shown to be associated with an active behavioral-coping method (Atkinson et al., 1988; Botvin, 1985; Dembo, LaVoie, Schmeidler, & Washburn, 1987; Huang, Watters, & Case, 1988; Malow et al., 1992; Namir, Wolcott, Fawzy, & Alumbaugh, 1987; Nyamathi & Vasquez, 1989; Ostrow et al., 1989; Remafedi, 1988). In addition, psychological functioning is related to substance abuse treatment outcomes

[4] The CALPAS scale consists of the first 24 items, with the Patient Commitment subscale consisting of items 1, 4, 12, 15, 18, and 21; Therapist Understanding and Involvement consisting of items 2, 5, 7, 9, 13, and 24; Patient Working Capacity consisting of items 3, 6, 8, 11, 17, and 22; and Working Strategy Consensus consisting of items 10, 14, 16, 20, and 23. The Alliance scale consists of all 30 alliance items, with the Confident Collaboration subscale consisting of items 4, 12, 21, 24, 25, 26, 27, 28, 29, and 30.

[5] In our analysis, this scale had a reliability coefficient alpha of .88 (N = 115).

(e.g., those with lower self-esteem have shorter treatment stays [Berry & Sipps, 1991]) and to treatment motivation (e.g., those with higher levels of anxiety have higher problem recognition scores, while those with higher depression scores have higher problem recognition and desire for help scores [Simpson et al., 1992]).

We measured three aspects of psychological functioning (self-esteem, depression, and anxiety) using the Psychological Functioning Scales developed by Simpson and his colleagues at Texas Christian University (TCU) (Simpson, 1992a; Simpson, 1992b; Knight, Holcom, & Simpson, 1994). These scales employ a 7-point Likert response set. Using this response set in a study of 122 probationers in a corrections-based residential substance abuse treatment program, TCU researchers obtained Cronbach's reliability coefficient alphas of .66, .71, and .79, for the Self-esteem, Depression, and Anxiety subscales, respectively (K. Knight, personal communication, June 4, 1998).

Treatment Motivation

A client's level of treatment motivation has long been recognized as being associated with both retention in treatment and long-term success (De Leon, Melnick, Kressel, & Jainchill, 1994; Simpson & Joe, 1993; Simpson, Joe, & Rowan-Szal, 1997). Problem recognition, desire for help, and treatment readiness represent important components of treatment motivation. These components were measured one month into treatment using the Motivation for Treatment scales developed at TCU (Simpson, 1992a; Simpson, 1992b; Simpson & Joe, 1993). Simpson and Joe (1993) established the validity and reliability of the earlier version of these scales that employed a 5-point Likert response set. They also showed that higher motivation as measured by the Desire for Help scale significantly predicts treatment retention beyond 60 days. The

most recent version of the Motivation for Treatment scales employs a 7-point Likert response set. For this expanded response set, TCU researchers obtained a Cronbach's reliability coefficient alpha of .70 or above for the three subscales in a study of 122 probationers in a corrections-based residential substance abuse treatment program (K. Knight, personal communication, June 4, 1998).

Group Interaction

Group therapy is an integral part of treatment in most substance abuse treatment programs, and this is especially true in therapeutic community and residential treatment programs. Given that group interaction is essential to many programs, it is surprising that it has not been addressed extensively in drug abuse treatment literature. Like therapeutic alliance, a client's degree of identification with fellow clients could affect both short-term and long-term outcomes. Some attempts to measure group cohesion or group alliance have been undertaken by those studying group psychotherapy (Braaten, 1989; Budman et al., 1987; Budman et al., 1989; Budman et al., 1993; MacKenzie & Tschuchke, 1993; Yalom et al., 1967). Although researchers in this area have operationalized the concept of group cohesion in varying ways (Marziali et al., 1997), those studies aimed at assessing the associations between group cohesion and outcome of group psychotherapy have demonstrated positive relationships (Braaten, 1989; Budman et al., 1989; Budman et al., 1993; MacKenzie & Tschuchke, 1993; Yalom et al., 1967).

One approach to studying group cohesion is to distinguish the member-leader, member-member, and group-as-a whole dimensions. Piper's (1983) work shows that there is relatively little overlap between the member-member dimension and the member-leader discussion, while the group-as-a-whole dimension overlapped with both. Because we were already measuring

clients' degree of identification with their counselors using a modified CALPAS instrument, and because we were focusing on treatment for substance abusers, we decided to measure the member-member dimension of group cohesion using a scale developed by the Drug Abuse Research Center to measure the level of group identification with fellow substance abuse treatment program clients. The scale consists of items like, "When I need someone to tell my feelings to, the other participants in the program are there to help me," and "It is hard to be around the other participants because their conversations make me think about doing drugs." Analyses conducted for the Drug Treatment Process Project at DARC show that the scale has a Cronbach's reliability coefficient alpha of .80 (Y. Hser, personal communication, August 10, 1998).

Locus of Control

An important goal of the Forever Free program is to help clients gain control of their drug and alcohol-related behaviors. Portions of the Forever Free curriculum are aimed specifically at helping participants identify and modify behaviors and modes of thought that contribute to their substance abuse problems. This goal maps onto the locus of control construct.

Locus of control refers to internal states that explain why some people actively deal with difficult circumstances while others do not. It concerns the beliefs that individuals hold regarding the relationships between action and outcome (Rotter, 1990; Lefcourt, 1991). For some individuals, outcomes are experienced as being dependent on the effort expended in their pursuit (internal control). Others experience outcomes as being the result of external or impersonal forces such as luck, prayer, fate, or powerful others (external control) (Lefcourt, 1991). In the literature, an internal locus of control has been associated with a more active

pursuit of goals, more spontaneous engagement in achievement activities, better interpersonal relationships, better emotional adjustment, a sense of well-being, and higher levels of performance, information seeking, alertness, and autonomous decision making. A more external locus of control has been associated with depression, anxiety, and a lesser ability to cope with stressful life experiences (Carton & Nowicki, 1994; Crandall & Crandall, 1983; Lefcourt, 1991).

Although locus of control is one of the most extensively investigated constructs in psychological and social science literature (Carton & Nowicki, 1994; Rotter, 1990), its use by substance abuse researchers has been limited. Much of the substance abuse research on locus of control that does exist is hampered by small sample sizes (under 100 and often under 50) (Canton, et al., 1988; Cohen, et al., 1982; Figurelli et al., 1994; Hunter, 1994; Johnson et al., 1991; Jones, 1985; Nurco et al., 1995; Obitz & Oziel, 1978; O'Leary et al., 1976; Oswald et al., 1992; Walker et al., 1980; Weidman, 1983). Larger studies employing locus of control measures have found: a significant correlation between internal locus of control and greater personal treatment motivation (Murphy & Bentall, 1992); no relationship between 12-step spiritual beliefs and an external locus of control over drug use (Christo & Franey, 1995); a significant correlation between a more internal locus of control and abstinence during the study period (Sadava, 1986); significant shifts toward an internal locus of control during treatment (Abbott, 1984; Walker et al., 1979); and significant differences in six-month outcomes clearly favoring those with internal Drinking-Related Internal-External locus of control scores (Koski-Jannes, 1994).

We used the recently developed Drug-Related Locus of Control scale (Hall et al., 1999) to examine the locus of control of Forever Free participants near the end of treatment. In this measure, mean scores run from 1 to 2 with scores closer to 1 indicating a more internal locus of control. Cronbach's reliability coefficient alpha for the Drug-Related Locus of Control scale was $\alpha = .81$. The split-half reliability coefficient of the scale was .76 after correction with the unequal-length Spearman-Brown prophecy formula (Hall et al., 1999).

Instruments

We used four data collection instruments: (1) the study intake form completed by treatment participants approximately one month after program entry, (2) the pre-release form completed by treatment participants just prior to their release from the program (approximately five months after completing the intake form), (3) the comparison group form, and (4) the locator form that all subjects in the study were asked to complete.[6]

Treatment group study intake form. We used this form to obtain background information on the subjects, including primary substance of abuse, date of birth, previous employment, 1996 income, education, criminal history, relationship status, previous residence type, and zip code. In addition, we collected information on the subjects' relationship with their children (prior to incarceration and during incarceration), drug and alcohol use history, current tobacco use, substance abuse treatment history, therapeutic alliance with their counselors, group identification with fellow clients, treatment motivation, and psychological status.

Treatment group pre-release form. The pre-release form was designed to collect end-of-treatment information on clients' therapeutic alliance with their counselors, psychological

[6] These instruments are available from the authors.

status, drug-related locus of control,[7] release date, and post-release treatment plans (residential treatment, other type of treatment, or none).

Comparison group form. Using the comparison group form, we collected background information on the comparison subjects, including primary substance of abuse, date of birth, previous employment, 1996 income, education, criminal history, relationship status, number of children, and drug and alcohol use history. Owing to limited funds for the evaluation, much less data were collected from the women in the comparison group than from those in the treatment group. Some of the missing information for the comparison group will be collected retrospectively in the follow-up interview.

Locator form. The locator form obtains information needed to locate subjects for follow-up interviews. The form is used to record a subject's driver's license number; Social Security number; California Department of Corrections number; names, addresses, and phone numbers of immediate relatives and of two unrelated friends; date and place of birth; areas of town the subject frequents (particularly if the subject has a history of homelessness); and name and address of the community residential program the subject plans to attend after release (or other location to which the subject is planning to be released). DARC's subject location procedures have been tested and refined over many years and have been described in a detailed manual that is distributed nationwide by the Center for Substance Abuse Treatment (Anglin, Danila, Ryan, & Mantius, 1996).

Subject Selection and Data Collection Procedure

[7] The Drug-Related Locus of Control scale was added to the instrument package after administration of the intake form.

Treatment clients. All clients entering the Forever Free program between October 1997 and June 1998 were invited to participate in the study. Of the 149 eligible clients, 15 (10%) declined to participate and an additional 15 were unavailable for study intake due to illness, court appearances, family visits, or other reasons, leaving a total of 119. We collected intake data approximately one month after each new cohort began treatment. We chose to collect data at this time because Forever Free staff felt strongly that we would get fewer refusals of participation and more honest and accurate information if we waited to collect data until the women had been in the program at least a month. According to staff, it takes about this long for the program participants to develop trust in the program and to see it as separate from the rest of the prison. Also, because we were collecting information on therapeutic alliance, it seemed that by collecting information at one month into treatment, clients would be better able to rate their relationships with their counselors. Approximately one month after each new cohort began treatment, research staff visited the treatment program. After the treatment counselor introduced the researchers, the counselor left the room. Research staff then explained the study to the clients, provided summary sheets describing the study, provided copies of the study's certificate of confidentiality, and read the informed consent form to the clients. After securing consent, clients were asked to complete the intake instrument on their own. Those clients with reading difficulties had the instrument read to them.

Comparison clients. Women attending Life Plan for Recovery, an eight-week (three hour per day) substance abuse education course, were asked to participate as the comparison group for the study. Those enrolled in the course between April and November of 1998 were invited to participate. They were contacted in the drug education program shortly before the time of their

release and asked to be part of the study. Of the 105 eligible women, 8 declined to participate and one was removed from the sample because she subsequently entered the Forever Free program and became part of that sample, leaving a total of 96 comparison subjects. The study was introduced to, and consent obtained from, the comparison group in a manner similar to that described for the treatment group, above.

Prison context information. We obtained information on the prison context from various sources, including California Department of Corrections (CDC) documents, interviews with a Correctional Counselor at CIW, interviews with long-term inmates, and CIW documents.

Treatment program information. Treatment program information was obtained from many sources, including program reports, proposals, and other materials produced by Mental Health Systems; reports and other materials produced by CDC; NDRI's National Evaluation of Residential Substance Abuse Treatment form completed by Ernest Jarman, Project Monitor for Forever Free at the CDC Office of Substance Abuse Programs; previous reports produced by the Drug Abuse Research Center; interviews with CDC and program staff; and focus group interviews with clients and former clients.

Treatment counselor information. We obtained background information on treatment counselors from the program director and from various printed sources, including program reports, proposals, and other materials produced by Mental Health Systems; reports and other materials produced by the CDC; and information on Forever Free contained in the NDRI National Evaluation of Residential Substance Abuse Treatment form.

Findings

The results of the process evaluation of the Forever Free program cover the following main topics: the Forever Free program and its institutional context, the organizational structure of the program and the background and duties of program staff, a description of study participants, findings regarding psychological status and therapeutic alliance, and the results of focus groups with current and former Forever Free clients.

Description of Forever Free and Its Institutional Context

Since its opening in 1991, the Forever Free Substance Abuse Treatment Program at the California Institution for Women has been operated by the same provider (Mental Health Systems) and has thus achieved a degree of maturity and stability that is not characteristic of many other programs that have received RSAT funding. Forever Free has also received attention nationally as a model program for substance-abusing women inmates, including an independent film documentary by Amanda Pope, and visits from treatment and corrections professionals around the country wanting to observe and possibly emulate Forever Free's model. The following section discusses the institutional context of Forever Free, the development of Forever Free, its philosophy and goals, the program elements, and the community aftercare component.

Institutional Context

The California Institution for Women (CIW), which opened in 1952, was designed to provide rehabilitation in a campus-like environment. CIW still retains its campus-like appearance. It has low-slung brick buildings, grass, trees, and flowers. Each housing unit is divided into two wings containing approximately 240 women. The prison was originally designed to house 1,026

women; it currently houses approximately 1,700 women. Until 1987, it was the only California prison for women felons. Throughout its history, CIW has accommodated women inmates at all custody levels and has functioned as a reception/processing center for incoming women inmates. Women currently being admitted to CIW are primarily parole violators, most of whose time to release tends to be less than six months.

Along with its general population, the facility houses women with special needs, such as pregnant women, those needing psychiatric care, and HIV-infected women. It has a prison-based mothers' program and other special programs, such as Arts in Corrections. Based on a prisoner's score on the Test of Adult Basic Education, CIW provides English-as-second-language instruction, academic high school/GED education, and vocational education. Vocational education courses include data processing, electronics, graphic arts, janitorial services, plumbing, upholstery, and word processing. Prison industries are mainly devoted to clothing and textile manufacturing (shirts, shorts, jeans, smocks, aprons, bedspreads, handkerchiefs, bandanas, and Nomex firefighting clothing). Also offered is a child development course, a personal psychology course, and Life Plan for Recovery, a substance abuse education course. While Forever Free clients may enroll in academic or vocational courses, it is not a requirement of the program and the program schedule often conflicts with the courses. (This is especially the case for the morning group, described in more detail below.) Women from the general population who are work-furlough approved or who are within 45 days of their parole date may enroll in a pre-release course that provides instruction in life skills, self-awareness, parole and community resources, and job preparedness. This course is generally not available to Forever Free clients. All prisoners have access to an HIV education course. This is a one-week course, lasting two hours per evening.

Alcoholics Anonymous and Narcotics Anonymous groups are available to CIW inmates, as are Codependency and Narcanon groups. These groups meet one evening a week and are co-sponsored by inmate and staff volunteers. A 12-step group for short termers is also available, meeting one evening per week for seven weeks and covering two steps per night. In addition, a weekly Christian 12-step group is made available by outside volunteers. Other self-help groups include Convicted Women Against Abuse and Breaking Barriers, a self-esteem group.

CIW also offers counseling groups on anger management, abusive bonding, and child molestation. These groups have a maximum of 12 women in them, take place once a week for one hour, and last 12 weeks. Groups for long-termers and lifers are also available. The groups are led by psychologists on staff at CIW.

With the exception of the 12-step groups, inmates participating in the Forever Free program generally do not participate in the courses and groups described above because their work assignment plus program participation takes 12 hours per day.[8] The women selected for the comparison group of this study participated in at least one of these activities, Life Plan for Recovery, and they may have participated in others. (The follow-up interview for the outcome study of forever Free asks about all programs and services received by women in the treatment and comparison groups while at CIW.)

Development of the Forever Free Program

The Forever Free Substance Abuse Treatment Program began in 1991, under funding from the Center for Substance Abuse Treatment (Jarman, 1993b). It was developed and is currently being operated by Mental Health Systems, Inc., under contract to the Office of Substance Abuse

[8] During the study period, the monthly reports produced by the program for CDC showed an average of only nine women in education courses out of a total census of approximately 110. Recently, this number has greatly increased.

Programs of the California Department of Corrections. Between May 1991, when Forever Free began, and December 31, 1998, 2,017 women graduated and were released to parole. The original Forever Free program was designed to provide four months of in-prison treatment, but was extended to a six-month program under RSAT funding. During the period of our study, Forever Free had two components, an intensive in-prison component provided to volunteering women inmates during the final months of their imprisonment, and a six-month community-based residential program for those who graduated from Forever Free and were released to parole. Because participation in community residential treatment was voluntary, Forever Free staff strongly encouraged participants to enter residential treatment.

Forever Free was designed as a modified therapeutic community in which program participants live in a housing unit separate from other residential units. Due to the nature of the institution, participants mix with the general institutional population for work assignments, meals, and other services. To accommodate the work assignment needs of the prison, the program was divided into two sessions, with half of the 120 program participants attending the morning session (scheduled for 8 a.m. to 12 noon) and the other half attending the evening session (scheduled for 5 p.m. to 9 p.m.).

Status of the Forever Free Program During the Study Period

At the time the study was conducted, classes, counseling groups, and program administration staff were housed in a triple-wide trailer located directly behind the housing unit. (The program recently moved into a nine-wide trailer. Forever Free participants continue to live in a separate housing unit located close to the program trailer.)

Because of holds placed on movement during prison count, women typically reached the program at about 8:30 a.m. and in order to get lunch before their work assignment started, they

left at 11:30 a.m. The evening group faced similar logistical problems; after count, they typically reached the program at 5:30 p.m. and left at about 8:30 p.m. in order to be in their rooms in time for final count. A new cohort of about 30 women joined the program every six weeks. About half of the new admissions were assigned to the morning session, with the other half assigned to the evening session.

Philosophy and Goals

Forever Free is a modified therapeutic community with a curriculum stressing relapse prevention (Gorski & Miller, 1979; Marlatt, 1985). This approach assumes that addiction is a disease and that, in order to recover, addicts need to understand the effects of the disease process. The core of the Gorski curriculum is based on the concept of post-acute withdrawal, which occurs in the weeks and months after acute withdrawal has subsided. Gorski and Miller posit a continuing neurological impairment after acute withdrawal has taken place involving higher-level cognitive processes that produce impairment in abstract thinking, conceptualization, concentration, memory storage and retrieval, and increased emotionality or overreaction to stress. Symptoms of post-acute withdrawal include apprehension, denial, defensiveness, isolation, lack of planning, rigid and repetitive social and work involvement, and loss of specific objectives. These actions result in confusion, depression, anger, and breakdown in social relationships, all of which can lead to relapse (Donovan & Chaney, 1985). The curriculum is designed to assist clients in identifying symptoms and teach skills and strategies for dealing with post-acute withdrawal (Gorski & Miller, 1986, 1989; Gorski, 1994). As stated in the Forever Free program proposal and other CDC documents, the primary objectives of the program are:

1. Provide in-prison treatment with individualized case planning and linkages to community-based aftercare.

2. Provide an in-prison program that includes a range of services to meet the psychosocial needs of participants, including counseling, group interaction, 12-step programs, educational workshops, relapse prevention training, and transition plans to refer clients to appropriate community aftercare.

3. Reduce the number of in-prison disciplinary actions.

4. Reduce substance abuse among participants.

5. Reduce recidivism.

Program Elements

The Forever Free program acknowledges the importance of an integrated model of treatment by offering participants an array of services and programs, among them assessment, treatment planning, individual and group substance abuse counseling, parole planning, 12-step groups, and urine testing. In addition, the 26-week schedule contains a curriculum that emphasizes cognitive-behavioral skill building, relapse prevention, and women's issues.

The cognitive skills sessions use the *Reasoning and Rehabilitation* handbook by Ross, Fabiano, and Ross (1986) to teach skills such as problem solving, social skills, negotiation skills, creative thinking, values enhancement, and critical reasoning. The drug/alcohol education class is presented in two parts: (1) understanding the addiction process and (2) post-acute withdrawal, both based on Terence Gorski's biopsychosocial model of the chemically dependent criminal offender (Gorski & Miller, 1989; Gorski, 1994). Basic components of the curriculum include addiction as a disease, managing post-acute withdrawal, understanding the recovery process, and identifying the phases and warning signs of relapse.

The relapse prevention sessions are also based on the Gorski model. These group sessions help women to identify their personal relapse warning signs and learn how to manage them

successfully. The relapse prevention group is not a confrontational group, as might occur in a more typical therapeutic community. Instead, its purpose is to provide each client with the opportunity to apply what she has learned in the education classes to her own situation. Sessions devoted to women's issues cover subjects important to women's recovery, including self-esteem and addiction, anger management, assertiveness training, healthy versus disordered relationships, abuse, post-traumatic stress disorder, co-dependency, parenting, sex and health, and sexual abuse survivors. For example, there are nine sessions devoted to parenting covering the following topics: owning up to a disrupted parent-child relationship, ABCDEs of parenting, age appropriate ways to begin the healing, discipline vs. punishment, esteem building vs. emotional abuse in children, role playing the good parent, appropriate adult and child roles, role playing the appropriate adult, and distorted dependencies in parent-child relationships.
In addition, there is a regular series of workshops on various topics: communication, co-dependency, grief and loss, spirituality, and goal setting. Not every client necessarily attends all of these workshops.

Counselor Training

In addition to their prior professional training, Forever Free counselors received four weeks of training from Richard Jeske, the Program Coordinator at the time of the study. The training covers all aspects of the Forever Free Program including background information on California Department of Corrections populations, program philosophy, physiology of addictive diseases, biopsychosocial aspects of addictive diseases, recovery approaches (cognitive, adapted 12-step, post-acute withdrawal, developmental model of recovery), relapse warning signs, relapse prevention, women's issues, reasoning and rehabilitation, leading 12-step groups, and case

management. Counselors also receive in-service training (approximately two hours every other month).

Program Recruitment, Intake, and Assessment Procedures

Clients are recruited into the program during the time they spend at the reception center. Once a week, a Forever Free Correctional Counselor visits the reception center to describe the program. Those who are interested fill out a short application. Based on these applications, clients are selected for the program. Nearly every applicant with a long enough sentence (nine months left) and a history of substance abuse is admitted to the program, with the exception of those who have a history of assaultive behavior in prison, significant mental health problems, holds or detainers, and certain sexual offenses. At the time the study was conducted, there was no waiting list to enter the program. But, the program did have difficulty recruiting a sufficient number of women to maintain the program at full capacity. This problem was mainly due to the fact that many otherwise eligible women had less than six months to parole. During the study period, clients were grouped in cohorts and went through the program together. Each new cohort was assigned to the counselor whose group had just graduated from the program. Client intake begins with the counselor explaining Forever Free's Principles of Conduct. In order to participate, the client must sign a form agreeing to follow these principles. The intake continues with the counselor interviewing the client in order to complete Forever Free's Psych/Social Form, which contains items on current and past relationships, family and school history, work history, medical history, and diagnostic impression. A drug use history form is also completed. In addition, the counselor and client complete the Addiction Severity Index, an addiction attitude questionnaire, the Test of Nonverbal

Intelligence (2nd Ed.), the Health Problems Checklist for Women, the Trail Making Test (to determine if clients are cognitively impaired), and the client's treatment plan. Counselors were not consistent in how they completed the Addiction Severity Index; some completed it for the past month (during which the client was likely to be incarcerated), while others completed it for the month prior to incarceration. Because of this inconsistency, we were unable to include ASI results in our findings section.

Program Completion

Upon program exit, the counselor completes a discharge summary describing the number of days in treatment, level of attendance, reason for discharge, and the client's response to the program. The counselor determines the client's program completion status (unsatisfactory to greatly exceeded plan goals). The client is asked to complete exit questions on what was learned in various aspects of the program (relapse prevention, education, 12-step, reasoning and rehabilitation, etc.) and to describe her plan for managing relapse warning signs. The client also completes a survey on program satisfaction.

Near the end of a sentence, there is a period of time (approximately two weeks) when prisoners are not assigned to any activities. Called "Short Time" or "S Time" by the CDC, this period allows administrative personnel to complete parole paper work and to definitively calculate release date. Forever Free participants are encouraged to continue attending the program during S Time and most do. Those participating during S Time receive attendance certificates.

Graduation. As each cohort of Forever Free women completes the program, just before they parole, they attend a recognition ceremony attended by the other program participants, the Forever Free staff, the warden or her designee, the CDC OSAP program monitor, and representatives from the community residential treatment programs that many of the women

will be entering. Because of the program's prison location, family members are not able to attend. During the ceremony, there are a series of short speeches by program staff and the CDC program monitor, then each woman is called up for recognition. After hugging staff members, each graduate gives an often tearful speech, thanking her counselor, other staff members, and her fellow cohort members. After the ceremony, the representatives from the community treatment programs are available to meet with the participants remaining in the program to discuss aftercare options.

Annual Reunion. The Forever Free annual reunion is held every year in October. The last reunion (October 1999) was attended by over 150 successful graduates, their families, Forever Free staff members, and community treatment program staff. In addition to a dinner and dance, the reunion includes short ceremonies in which certificates of appreciation are handed out and graduates give testimonials describing the obstacles they have overcome, the goals they have achieved, and how various aspects of the program (including the love and acceptance of staff) helped them through the process.

Transition to Community Residential Treatment

Transition to community residential treatment begins long before Forever Free participants parole. While attending Forever Free, participants are strongly encouraged to enter community residential treatment after release to parole. Representatives of the community programs visit CIW every month in order to describe their programs and register participants. In addition, counselors and the parole agent assigned to Forever Free work extensively with clients in order to encourage them to go to residential treatment following parole. On the day of parole, most community programs transport the women directly from the prison gates to their programs. If the

community residential program cannot provide transportation, the parole agent assigned to Forever Free drives the women to the program. Women not choosing to go to community residential treatment do not receive transportation upon parole and do not receive any additional CDC-funded services once they are in the community, although they may request placement in one of the participating residential treatment programs within six months of paroling.

Community Residential Treatment

An important component of the Forever Free Program, as of many prison treatment programs, is participation in treatment following release to parole, usually in a residential program. During the period of our study, about one-half (up from one-third in earlier years) of Forever Free participants volunteered to continue treatment in one of nine community-based residential programs, which are under contract to provide treatment to Forever Free graduates. Services vary across the community programs, but basic services such as individual counseling and group counseling are common in all programs. Most of the programs offer family counseling, vocational training/rehabilitation, recreational or social activities, and English- and Spanish-speaking staff. Until August 1998, only one of the nine community residential programs was able to take children. Currently, under new state funding, Forever Free graduates are able to attend any residential treatment program licensed by the California Department of Alcohol and Drug Programs, and, as of April 1999, the number of residential programs attended by Forever Free graduates had expanded to 16. This additional availability will give Forever Free graduates more latitude in choosing programs, including the ability to choose programs that take children. This study did not collect descriptive information on the community residential programs or data on participation or retention rates of Forever Free graduates in such programs. In an earlier study, however, Prendergast, Wellisch, and Wong (1996) found that dropout rates were high,

with about one-third of the women leaving the program within 30 days. The outcome study we are currently conducting will include detailed data on the residential programs and on participation rates.

Program Organization and Forever Free Staff (Background and Duties)

Forever Free staff members are employees of Mental Health Systems, a treatment organization based in San Diego with a satellite office in San Bernardino. Forever Free and other programs involving criminal justice participants are supervised by the Criminal Justice Manager. On site, the program is supervised by the Program Coordinator. In addition, the program has a curriculum supervisor and separate counseling supervisors for the morning and evening sessions.

CDC has assigned a parole agent to the program to act as a liaison to the residential treatment programs and a Correctional Counselor to assist in prison-related issues. The program is monitored by a Correctional Program Manager in the Office of Substance Abuse Programs of the California Department of Corrections.

Because each new cohort was assigned to the counselor whose last group just graduated, no attempt was made to match clients and case managers, although, occasionally, clients with special needs were assigned to the counseling supervisor. Counselors carried a caseload of approximately 15 clients, with a range of 9 to 20. Clients kept the same counselor throughout their time in treatment.

Of the ten counselors whose clients were enrolled in the study, one was white, one was Asian/Pacific Islander, three were African American, and five were Latina. All counselors were female. Counselors had varying degrees of education and training: one had an M.A., two

had B.A.s, two had drug and alcohol counseling certificates, and the remaining were non-certified. With one exception, all counselors were in recovery.

Each counselor had weekly one-on-one sessions with her clients. These sessions were usually 30-60 minutes, and a client averaged an hour of one-on-one counseling with her own counselor per week. There were no additional individual counseling sessions scheduled, however, all counselors had an open-door policy with any client (limited to approximately two hours per week). Thus, clients in the study may have had one-on-one sessions with other counselors, but the extent to which this occurred depended largely on the initiative of the client. (Clients had access to a CIW psychologist like any other inmate, but this was not part of the program.) In addition to the individual counseling sessions they conducted, counselors specialized in teaching specific classes (or relapse prevention). It is likely that a client attended a class taught by her own counselor during most of her time in the program.

During the study period, a single counselor led all the relapse prevention groups during the morning sessions and a similar arrangement existed for the evening sessions. We defined group counseling as group therapy (in contrast to drug/alcohol education). As a result, we concluded that the relapse prevention group was the only regular counseling group that clients attended—that was four hours per week. Clients received roughly eight hours per week of drug/alcohol education from other counselors (four hours per counselor). Clients also went to 12-step meetings twice a week for an hour and a half. These meetings were led by counselors and everyone in the program attended these meetings together.

Forever Free Study Participants

Program Participation

Of the 119 women in the treatment group, only four did not graduate from the program. All four were removed from the program by the prison administration for disciplinary reasons. The remaining 115 graduated from the program and 47 (40.9%) of those went on to residential treatment in the community.

Characteristics

In many respects, the treatment sample matches the description of women offenders found in the literature, namely that of a poor, ethnically diverse group of undereducated women working in low paid jobs. Table 1 contains basic demographic information on the Forever Free study treatment participants and the comparison group.[9] Over a third of the treatment group (37%) reported that they had held a sales/service job when last employed, while 15% said that they had held some kind of semi-skilled job. Almost 30% said that they held an unskilled job when last employed and 10% reported that they had never worked. On average, the women reported a 1996 household income in the $15,000 to $19,000 range.

Fifty-eight percent of the treatment sample reported that their present incarceration was for a possession offense and an additional 4% reported other drug offenses. The women had a long history of involvement with the criminal justice system. The women averaged 15 lifetime arrests (range 1 to 150), with a mean of two arrests before the age of 18 and a mean of one arrest before

[9] The comparison group was included in preparation for an outcome study currently in progress. The comparison group showed no significant differences from the treatment group in terms of major demographic characteristics. Although some differences in primary drug and ethnicity are apparent between the treatment and comparison groups, these differences do not reach statistical significance (see Table 1) with the exception of injection history and prior corrections drug treatment. All subsequent tables include data for the treatment group only.

they first began using illegal drugs. They had an average of eight lifetime convictions and had been incarcerated for these convictions a mean of eight times. Women were first incarcerated at a mean age of 21 years.

Over half (56%) of the treatment group currently had a partner or spouse. Of these, over half (53%) had a partner/spouse who used illegal drugs during their relationship. Twenty-one percent of these women had a partner who had been in drug treatment during their relationship.

Regarding their living situation, over half (52%) of the treatment sample lived in a rented house or apartment before their incarceration. Sixteen percent (16%) lived in their parents' home. Somewhat less than half (47%) had lived with someone who used illegal drugs.

Table 1.
Demographic Information on Treatment and Comparison Subjects

	Treatment (N=119)	SD	Comparison (N=95)	SD
Age[1]				
Age in years (mean)	35	7.53	34	7.95
Ethnicity (percent)[3]				
White	36		31	
African American	31		38	
Latina	24		19	
Other	9		12	
Educational Achievement (percent)[2]				
Less than a high school grad	37		43	
High school grad/GED	26		32	
Trade school	21		10	
Some college	12		7	
Other	4		8	
Arrest/Incarceration History (mean)[1]				
Lifetime arrests	15	16.38	17	18.75
Mean age first arrested	19	6.43	18	5.96
Lifetime incarcerations	8	7.06	9	8.00
Controlling Case (percent)[3]				
Drug offenses	62		64	
Robbery, burglary, forgery	27		26	
Assault	4		4	
Other	7		6	
Prior corrections drug treatment				
Received treatment during past incarcerations (% yes)	25*		39	
Primary Drug of Abuse (percent)[3]				
Cocaine/crack	36		54	
Amphetamine/methamphetamine	28		16	
Heroin and other opiates	25		21	
Alcohol	6		6	
Other drugs	4		3	
Injection History (% yes)				
Ever injected in lifetime	64*		50	

1. Independent sample t-test, differences were non-significant at $p = .05$ level.
2. Chi Square, differences were non-significant at $p = .05$ level.
3. Fishers Exact Test (2-Tail), differences were non-significant at $p = 0.5$ level.
* Fishers Exact Test (2-Tail), $p<.05$.

Drug History and Drug Treatment

As reported in Table 1, the most commonly reported primary drugs for the treatment group were cocaine/crack, followed by amphetamine/methamphetamine, and then heroin or other opiate.[10] The mean ages at which our respondents first used their primary drug are reported in Table 2.

Table 2.
Age First Used Primary Drug

	Mean	SD
Cocaine/Crack (N=43)	21.0	7.6
Amphetamine/Methamphetamine (N=21)	18.0	6.5
Heroin and Other Opiates (N=30)	19.8	6.1
Alcohol (any use at all) (N=7)	11.4	6.5

Almost two-thirds of the treatment sample said that they had injected drugs in their lifetime. Of this subgroup, 75% had injected heroin and 56% had injected amphetamines or cocaine, placing this group at risk for HIV infection. Forty-four percent had injected speedballs (cocaine and heroin combined). The vast majority of respondents who reported injecting these drugs regularly at some point in their life were injecting in the 30 days before they were incarcerated. The severity of their drug use is indicated by the fact that two-thirds (66%) of the women reported that they had overdosed on drugs in their lifetime, for an average of two times. In the 30 days before incarceration, the treatment group reported that they had spent an average of $125 on alcohol and $1,976 on illegal drugs.

[10] Compared with earlier years, women recently admitted to Forever Free are more likely to have cocaine/crack or amphetamine/methamphetamine rather than heroin as their primary drug problem and are more likely to be in CIW for a parole violation rather than for a new charge (E. Jarman, Office of Substance Abuse Programs, personal communication).

Almost two-thirds (64%) of the respondents reported that, prior to entering Forever Free, they had been in treatment for drug or alcohol problems, including self-help groups. Of this subgroup, 50% reported that they had attended 12-Step or other self-help groups and 51% reported prior residential treatment. Additionally, 39% reported receiving prior treatment in prison or in jail, 26% had attended methadone, 24% hospital inpatient, and 23% outpatient drug free treatment. (Percentages sum to more than 100% because respondents reported on multiple treatment episodes.)

Relationships with Children

In striking similarity to the Bureau of Justice Statistics' (1994) national sample of women in prison described in the Background, the vast majority of women (78%) in the treatment group had children (see Table 3); two-thirds (66%) had children under 18 years old, and 40% had at least one child under the age of 6 years old. Sixty-two percent had legal custody of at least some of their children, although only 36% of women with children said that participation in Forever Free would affect or might affect the custody of a child. Half of the women (51%) reported that their children were currently living with the children's grandparents and another third (34%) reported that their children were living with the children's father.

A high percentage of those with children reported some contact with their children while incarcerated (at least once a month, 68% called their children, 62% received letters from their children, and 21% received visits from their children). For those not receiving visits from their children, the most common reasons were: the prison is too distant, the caregiver does not want to bring the children, and the female prisoner does not want her children to come to the prison. The women were also asked about typical parenting activities that they may have engaged in

with their children in the year prior to incarceration. Fifty-three percent reported engaging in leisure activities away from home (such as picnics, movies, or sports) with a child at least once a week, 59% reported spending time at home with a child working on a project or playing together at least once a week, 58% reported helping a child with reading or homework at least once a week, and 68% reported eating meals together at least once a week. These percentages presumably include some visits with non-custodial children. Despite the relatively high reported levels of interaction with their children, when asked how well they believed they were doing as a parent prior to incarceration, 68% of the women rated themselves as "poor" or "fair."

Table 3.
Children: Custody Status

	Percent
Have children (% yes)	78.2
Of those with children:	
Number under 18 (mean) (N = 78)	2.4
Custody status of children under 18	
Don't have legal custody	38.2
Have legal custody of some	21.1
Have legal custody of all	40.8
Will your participation in Forever Free affect the custody status of your children?	
No	64.3
Yes	14.3
Somewhat/Maybe	21.4

Therapeutic Alliance and Psychological Change

In regard to therapeutic alliance, the study attempted to answer the following questions:

- To what extent does therapeutic alliance predict change in psychosocial functioning (anxiety, depression, self-esteem) in this population?

- What are the relationships among treatment motivation, locus of control, group interaction, psychological functioning, and therapeutic alliance in this population?

In order to answer these questions, we determined several conditions that could be expected to influence results of the analysis: (1) the extent to which clients' psychosocial status improved from the beginning to the end of treatment; (2) the extent to which clients' scores on psychosocial status were correlated with their therapeutic alliance (ability to bond), treatment motivation, locus of control, and group interaction scores at intake and just prior to release; (3) differences in the initial psychosocial status of clients assigned to each of the case managers; and (4) the extent to which racial/ethnic matching of clients and counselor correlated with bonding and/or psychosocial outcomes.

Table 4.
Means and Standard Deviations for Psychological Functioning, Treatment Motivation, Group Interaction, CALPAS at Intake; and for Psychological Functioning, CALPAS, and Locus of Control at Pre-release

	Intake N = 119		Pre-release N = 95	
	Mean	SD	Mean	SD
Anxiety	3.33	1.54	2.73	1.36
Depression	3.06	1.32	2.24	1.13
Self-esteem	4.75	1.58	5.88	1.11
Problem recognition	5.76	1.17		
Desire for help	6.29	.84		
Treatment readiness	6.28	.78		
Group interaction	5.67	.87		
CALPAS total score	5.79	.85	5.80	.93
Alliance total score	5.90	.82	5.93	.89
Drug-related locus of control[11]			1.20	.18

[11] Drug-Related Locus of Control scores range from 1 to 2, with 1 representing an internal locus of control and 2 representing an external (less desirable) locus of control. The mean score obtained by the Forever Free women compares favorably to that of women in residential treatment programs in Los Angeles County (mean 1.24, SD .24) who were part of the Drug Treatment Process Project (Y. Hser, personal communication, August 10, 1998).

We begin by presenting the intake (at one month into treatment) and pre-release (at six months into treatment) scores on all the psychosocial status scales used in the study. Table 4 shows the means and standard deviations for psychological functioning, treatment motivation, group interaction, CALPAS (24-item scale), and alliance (30-item scale) at intake and for psychological functioning, locus of control, and CALPAS just prior to release. At one month into treatment (indicated as "intake" in the tables), clients appear to have high motivation for treatment and to have developed a strong alliance with their counselors and their fellow clients (indicated by group interaction). To determine clients' improvement in psychosocial functioning, we compared the scores of women who completed the psychological functioning scales at intake and just prior to release using a paired samples t-test (two-tailed).

As seen in Table 5, we found significant improvements in psychological functioning by the end of treatment. Levels of depression and anxiety decreased, while levels of self-esteem increased (t-tests were significant beyond the $p < .01$ level).

Table 5.
Intake and Pre-release Comparisons of Psychological Functioning Scores: Paired T-Tests

	Intake		Pre-release	
Subscale	Mean	SD	Mean	SD
Anxiety (N=92)	3.25	1.48	2.78**	1.36
Depression (N=92)	2.95	1.31	2.26**	1.13
Self-Esteem (N=91)	4.76	1.58	5.87**	1.12

** Significant at $p < 0.01$.

Table 6.
Intake and Pre-release Comparisons of Therapeutic Alliance Scores: Paired T-Tests

	Intake		Pre-release	
	Mean	SD	Mean	SD
CALPAS (24 items) (N=93)	5.79	.87	5.82	.92
Patient Commitment (N=93)	6.01	.92	6.05	.90
Therapist Understanding and Involvement (N=92)	6.25	.95	6.13	1.18
Patient Working Capacity (N=92)	5.19	1.17	5.39	1.01
Working Strategy Consensus (N=91)	5.78	1.18	5.71	1.24
Alliance (30 items) (N=93)	5.90	.85	5.95	.86
Confident Collaboration (N=93)	6.11	.99	6.28	.84

Table 6 shows a comparison of intake to pre-release scores for the therapeutic alliance scales and subscales using the paired samples t-test (two-tailed). There were no statistically significant changes from intake to pre-release in any of the scales or subscales; however, two subscales, Patient Working Capacity and Confident Collaboration, showed intake to pre-release improvements that approached significance ($p = .05$ and $p = .10$, respectively).

As the histogram below makes clear (Chart 1), at intake, clients rated their level of alliance with their counselors very highly and this may account for the lack of a significant difference in intake to pre-release alliance scores.

Correlations between Measures

We ran bivariate correlations among the scores at intake for psychological functioning, treatment motivation, group interaction, and CALPAS scales and found statistically significant correlations between many of the measures (see Table 7).[12] Within the psychological functioning measures, as would be expected, self-esteem was negatively correlated with both anxiety and depression (i.e., those with higher self-esteem had lower levels of anxiety and

[12] Because we have a relatively large number of correlations, we report only on those with p values of less than .01.

depression), and anxiety and depression were positively correlated with one another. There was no significant correlation between therapeutic alliance (CALPAS 24-item scale, Alliance 30-item scale) and psychological functioning at intake. Of the three measures of motivation for treatment, desire for help was significantly correlated with psychological functioning (positively correlated with depression and anxiety; negatively correlated with self-esteem). In addition, all three treatment motivation measures were positively correlated with one another. Treatment readiness was positively correlated with group interaction, and treatment readiness was positively correlated with both measures of therapeutic alliance. In other words, those with higher treatment readiness scores appeared to be more willing or able to interact with their counselors and fellow clients. Not surprisingly, group interaction was positively correlated with both measures of therapeutic alliance. Finally, CALPAS (24-item scale) and alliance (30-item scale) were highly correlated. Again, this is not surprising given that they are nearly the same scale.

Correlations between psychological functioning, locus of control, and the therapeutic alliance measures were run on scores for clients at pre-release (see Table 8). Again, self-esteem was negatively correlated with both anxiety and depression, and anxiety and depression were positively correlated.

Table 7.
Intake Correlations between Psychological Functioning, Treatment Motivation, Group Interaction and CALPAS Scales (N = 119)

	1	2	3	4	5	6	7	8	9
1. Anxiety	1.00								
2. Depression	.72**	1.00							
3. Self-esteem	-.54**	-.64**	1.00						
4. Problem recognition	.50**	.44**	-.46**	1.00					
5. Desire for help	.37**	.38**	-.37**	.68**	1.00				
6. Treatment readiness	-.04	-.07	-.06	.28**	.46**	1.00			
7. Group interaction	-.21	-.23	.13	.01	.05	.39**	1.00		
8. CALPAS total score	-.11	-.17	-.01	.15	.24	.53**	.43**	1.00	
9. Alliance total score	-.12	-.18	.04	.14	.23	.53**	.42**	.99**	1.00

Table 8.
Pre-release Correlations between Psychological Functioning, Locus of Control, and CALPAS Scales (N = 95)

	1	2	3	4	5	6
1. Anxiety	1.00					
2. Depression	.77**	1.00				
3. Self-esteem	-.51**	-.61**	1.00			
4. Locus of control	.41**	.52**	-.53**	1.00		
5. CALPAS total score	-.19	.33**	-.13	-.06	1.00	
6. Alliance total score	-.15	-.31**	.13	-.05	.99**	1.00

** Correlation is significant at the .01 level (2-tailed).

Locus of control was positively correlated with anxiety and depression, meaning that those with a more external locus of control in regard to their drug-use behaviors (i.e., those who feel that they have little control over their drug use) also have higher levels of anxiety and depression. Conversely, locus of control and self-esteem were negatively correlated (i.e., higher self-esteem was associated with a more internal locus of control). Unlike at intake, where we found no correlations between psychological functioning and therapeutic alliance, at pre-release, we found that both therapeutic alliance measures were positively correlated with depression (i.e., clients with higher levels of depression reported a stronger alliance with their counselors).

Recent research (e.g., Bell, Montoya, & Atkinson, 1997) suggests that therapeutic alliance is most useful for predicting outcomes for clients with greater levels of psychological impairment. In order to test this, we divided clients into groups based on their psychological functioning intake scores. For the anxiety measure we divided the clients into low (lowest 33% of scores), medium (middle 33% of scores), and high (highest 33% of scores) scoring groups. We did the same for the depression and self-esteem measures. Then, looking only at the high-anxiety group, we ran a bivariate correlation analysis to see whether these clients' intake to pre-release anxiety change scores were correlated with alliance. We found no correlation between alliance at intake or at pre-release and change in anxiety for this group. However, when we repeated the same procedure for the depression measure, we found that for the high-depression group, alliance at pre-release was strongly correlated with an improvement in depression (Pearson correlation -.579, $p = .002$). For the low self-esteem group, alliance at intake was correlated with an improvement in self-esteem (Pearson correlation .415, $p = .018$).

Focus Groups Conducted with Participants

Funding from the California Department of Corrections allowed us to supplement the NIJ study by conducting focus groups with Forever Free participants (Prendergast, Hall, Baldwin & Wellish, 1999). We conducted focus group discussions with four groups of current and former Forever Free participants in order to better understand women's experiences in the Forever Free program. The four groups consisted of:

- Women who were participating in the Forever Free program and were within one month of graduation and release,
- Former Forever Free participants who had been returned to CIW (and had possibly been readmitted to Forever Free),
- Graduates of Forever Free who had entered community-based residential treatment,
- Graduates who had achieved long-term success (three years or more of abstinence from drugs and alcohol and employed).

The purpose of the discussions was to elicit participants' opinions about the Forever Free program, especially regarding supports for and barriers to remaining drug free and crime free, motivations for entering or not entering community residential treatment, personal and other factors contributing to success or failure on parole, and the women's perceptions of the community treatment component. Below is a summary of our findings.

A total of 40 current and former Forever Free clients participated in the focus group interviews. Our analysis of the focus group transcripts made use of content analysis, the most common method of analysis used by researchers who employ focus groups (Krueger, 1994; Morgan, 1997).

Focus group participants gave two main reasons for entering the Forever Free program: (1) their lives felt out of control and they had been unable to stay clean in the past, and (2) they wished to transfer to CIW from a prison in the north.

Overall, both current and former program participants were very positive about the program. The women overwhelmingly praised the program for educating them about addiction and its relationship to other aspects of their lives. Given the literature showing the importance of the client-counselor therapeutic alliance in treatment success (Horvath & Symonds, 1991), the strong connection of Forever Free participants to their counselors and the program is notable, although some women voiced concerns about staff turnover, lack of fit between counselor and client, and unmet commitments.

Focus group participants felt that their inadequate vocational training was or would be a barrier to their long-term success. Some felt that they were handicapped by having to give up vocational classes in order to enter the Forever Free program. Women noted having had problems with the *institutional* context within which the program is situated. That is, although they lived in a housing unit just for Forever Free participants, there was nothing about the housing unit itself that distinguished it from the others, including the negative attitudes of some correctional officers.

Despite the fact that there were meaningful differences among the five community residential treatment programs in which the women in the focus groups had participated, the women's comments about these programs were very positive overall. Women mentioned a number of different positive aspects of these programs, among them "unconditional love," education, social and emotional support from counselors and other clients, networking, and working the 12 Steps.

Those who chose to enter residential treatment differed from those who did not. For the long-term success and residential treatment groups, the most common underlying theme was their realistic attitudes about the chances of staying clean on their own.

Despite the strong efforts by Forever Free counselors to persuade clients to enter residential treatment following release to parole, many of the women decided not to do so. Most of the returnees interviewed had not attended residential treatment after leaving CIW and 8 of the 12 women interviewed while they were in treatment at Forever Free were not planning to go. The most commonly stated reasons for not entering residential treatment involved family and financial obligations, a desire for freedom, and the belief that they had learned their lesson and could remain drug free on their own or with the support of 12-Step meetings. The scarcity of residential programs that accepted children was also mentioned as a barrier. Women also did not want to spend any more time than they had to in a structured environment.

Reactions to the question, "Should residential treatment be mandatory upon parole?" were mixed. Some women believed that such a requirement would deter women from volunteering for the program, whereas others believed that they would volunteer for the program regardless of a mandate to participate in residential treatment.

The women voiced their concerns about difficulties in finding employment and about how money worries could lead to relapse. Most women believed that vocational training was important to their success after release and that it was lacking in the Forever Fee program. In addition, they indicated that institutional assistance to address their vocational needs while on parole was not well coordinated by the residential treatment programs or by their parole agents.

The women discussed their needs for other basic resources during parole and the lack of assistance from institutions, friends, or family. Most of the women viewed support during recovery as essential to getting through the initial difficulties of life in recovery.

All 12 women interviewed in the group of women with long-term success (more than three years clean after release) went to residential treatment in a county other than their county of commitment. The women felt strongly that they needed to avoid the old patterns and bad influences that were present in their old neighborhoods.

Discussion

The institutional context is an important factor in the successful operation of a prison-based treatment program. At the time the study was conducted, Forever Free faced a number of institutional challenges, despite strong support of the program by the warden at CIW. Forever Free had great difficulty recruiting women for the six-month program required by RSAT funding. Not only do women generally have shorter sentences than men, but most of the women sent to the California Institution for Women were (and are) parole violators staying six months or less. Since the women spend one or two months in the reception center, many of them lack sufficient time until parole to qualify for the Forever Free program. As a result, the program had difficulty operating at full capacity, despite diligent efforts by institutional and treatment staff to conduct outreach efforts at both CIW and other women's prisons in the state. Now that the other women's prisons in California have treatment programs of their own, we anticipate greater difficulty filling the Forever Free program. (In order to recruit larger numbers of women, the Department of Corrections has recently shortened Forever Free from a six-month to a four-month program, with state rather than RSAT funding.)

While it is true that the studies of prison-based treatment that provided the foundation for the RSAT program have generally found that successful outcomes require at least six months of treatment in prison, these studies focused almost exclusively on men. At least from the

experience at Forever Free, the RSAT requirement with respect to program duration appears to be inappropriate for prison treatment programs for women.

During the period of our study, women in Forever Free did not receive half-time credit for the time they participated in the program. This meant that they attended their full-time (eight-hour) work or education assignment, then spent an additional four hours in treatment. (This policy has recently been changed, now women attend the program four hours a day and work four hours a day.) Not receiving half-time credit for Forever Free participation probably discouraged some otherwise eligible women from volunteering. On the other hand, it suggests that those women who did choose to enter the program had a relatively high level of motivation, as demonstrated by the treatment motivation measures at baseline.

The Forever Free program is enthusiastically supported by CIW's warden, Susan Poole. The focus groups revealed, however, that not all of the correctional staff are as supportive and this can undermine the therapeutic environment. In the housing unit, during their work assignments, or in other locations around CIW, Forever Free participants may encounter correctional staff who are unsupportive or hostile to the goals of the treatment program. This represents a training challenge for the institution.

One of the important issues identified in the literature on treatment for substance-abusing women offenders is addressing mother-child relationships, parenting skills, and opportunities for improving bonding between mother and child. The concerns of mothers for their children represent one of the most compelling influences on human behavior. In Forever Free, the women receive parenting education, which includes role play. Also, parenting issues are discussed in individual counseling sessions when requested. As is the case in most prison programs for women, however, the institutional environment of Forever Free severely limits

opportunities for the women to strengthen bonding with their children and their significant others, to interact in real life situations with their children, or to play a role in decision-making within their families. The Forever Free program did not have a formal structure to assist or supervise women in their contacts with children through letters, telephone calls, or family visits. The Forever Free program could assist women in building and sustaining appropriate mother-child interaction by providing opportunities for monitored face-to-face child visits. Although, as noted above, it is widely recognized that training in parenting and services to increase bonding are important goals in substance abuse treatment for women, the primary program objectives of Forever Free do not specifically mention them. During study intake, we collected participants' self-reports of parenting activities during the year before incarceration. At follow up, we will compare these reports with those of the year following release. We suggest that Forever Free improve its program goals to include measurable outcomes (in addition to recidivism, disciplinary actions, and reduced substance use) in relation to the needs of women in recovery. Goals should include improved knowledge of appropriate parenting techniques, gender-specific issues related to addiction, and interpersonal violence issues (i.e., incest, rape, battering, and other abuse).

Forever Free program objectives stress services for psychosocial needs and cognitive functioning of the participants. Assessment of the psychosocial status of Forever Free participants indicated that the women did show significant improvement in measures of anxiety, depression, and self-esteem between the beginning of treatment and the time just before discharge. There is thus evidence that the program does have a positive impact on the women's psychosocial needs. Although Forever Free's program goals do not explicitly mention improvement in cognitive functioning, a substantial portion of the curriculum is

devoted to it. Cognitive functioning was not a focus of this evaluation, however, and we did not include any direct measure of change in this area of functioning. We suggest that Forever Free improve its program goals to include measurable outcomes in relation to psychosocial and cognitive functioning.

As Superintendent Lord (1995) and others (Heney & Kristiansen, 1998; Wilson & Anderson, 1997) have argued, imprisonment itself may intensify feelings of powerlessness that many women bring with them into prison. To the extent that these feelings continue when women leave prison, they likely contribute to risk of relapse or recidivism. From this perspective, treatment programs in prison need to provide activities that attempt to increase self-esteem and self-efficacy, to return to women some of the power and control that they have lost through sexual and physical abuse, and to help them develop social skills needed for functioning after they leave prison. Although the Forever Free program does not explicitly embrace an empowerment approach advocated by some authors, it does provide program elements that provide women with techniques to improve self-esteem, self-assertiveness, and their ability to manage post-acute withdrawal to prevent relapse. As noted above, we found a significant improvement in self-esteem from near the beginning of treatment to discharge. Although we did not measure drug-related locus of control at intake, we found that, at discharge, Forever Free participants' drug-related locus of control compared favorably to that of women in residential treatment in another study.

Forever Free women had generally high scores on the treatment motivation measures, and one of these measures (treatment readiness) was associated with higher levels of alliance with counselors and with fellow clients. As stated earlier, although the Forever Free program makes no attempt to match clients with counselors, our results indicating an association between

alliance and improvements in depression and self-esteem for those with greater severity suggest that clients with high severity might achieve even greater benefits if matched with counselors who have more experience or training in these areas.

The Forever Free model of treatment includes six months of continuing care in residential treatment upon release to parole and places a heavy emphasis on persuading women to enter community treatment. Given the limited time available for in-prison treatment, the program must make choices about which issues and problems to address during the in-prison phase of the program and which to postpone until the women enter community treatment. If all women entered community treatment, this strategy would help provide the women with relatively long-term (up to one year at the time of the study) continuity of care, in which different needs would be addressed at different phases of treatment. But this strategy for addressing multiple needs becomes less effective if, as is the case in Forever Free (and other prison treatment programs), many women either do not volunteer for community treatment or drop out of treatment after a short time. Thus, for these women, the strategy of staging attention to different treatment needs breaks down.

More specifically, from program documents, discussions with staff, and comments of women in the focus groups, the in-prison program relies upon the continuing residential program to prepare women for re-entering the community. One of the stated objectives of the program is to "provide in-prison treatment with individualized case planning and linkages to community based aftercare." Because participation in a community residential program was not mandatory, and because fewer than half of the women actually entered such programs upon release, many women did not receive the full array of services that would prepare them for re-entry into the community. Not only were vocational training and other services needed for

successful rehabilitation not included in the Forever Free program, but program scheduling often prohibited clients from fully participating in the vocational services provided by CIW. (Recently, this situation has improved, and a larger percentage of the women are receiving vocational training at CIW.) Moreover, comments by some of the women in the focus groups suggested that some counselors stressed continuing treatment to the extent that women who indicated that they were not going to enter residential treatment tended to receive less attention. Through the outcome evaluation, we will be able to determine the kinds and duration of vocational and other services received by study participants (both within CIW and in the community) and whether higher levels of such services are associated with long-term success. The Forever Free program has been able to increase the percentage of women who volunteer to enter community treatment from about one-third to one-half. In order to increase the percentage of Forever Free graduates choosing to attend residential treatment, Forever Free should continue its efforts to involve successful graduates in its programming. Successful graduates act as role models that the women in the program can easily identify with. They also provide participants with contacts in the community and with real-world advice about the importance of community residential treatment and about staying clean in the face of daily pressures. Forever Free recently added counselors who are themselves Forever Free graduates, and this is an important step in providing direct role models and in encouraging continued participation in treatment.

A one-year follow up of the women in this study (currently in progress) will provide information about the effectiveness of the Forever Free Substance Abuse Treatment Program and subsequent community residential treatment. The follow-up study will also investigate possible predictors of long-term treatment success (psychosocial functioning, therapeutic

alliance, locus of control, CJS history, primary drug of abuse, and other factors). The follow-up study will also provide additional information about the role that transitional services play in outcome.

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CONSENT TO PARTICIPATE IN

CLIENT RESEARCH INTERVIEWS

FOR AN EVALUATION OF THE FOREVER FREE

SUBSTANCE ABUSE TREATMENT PROGRAM

WHAT IS THE PURPOSE OF STUDY?

The UCLA Drug Abuse Research Center is conducting this study to better understand the Forever Free Substance Abuse Treatment Program. This study is part of a national evaluation of prison substance abuse treatment. Program staff and clients will participate.

You are eligible to be a **treatment participant** in this study if you are 18 years old or older and are a client in the Forever Free Substance Abuse Treatment Program.

The study is being directed by Michael Prendergast, Ph.D., and his associates.

WHAT WILL I BE ASKED TO DO?

If you are a **treatment participant** in this study, you may participate in an interview and/or a focus group interview, and will be asked to complete a Locator Form. In addition, once you have left the California Institution for Women at Frontera, you may be contacted for a follow-up interview.

(1) The first interview for treatment participants will take approximately 60 minutes. It will take place in an office at the Forever Free Substance Abuse Treatment Program. The focus group for treatment participants will take approximately 90 minutes, will take place in a meeting room at the Forever Free Substance Abuse Treatment Program, and will cover the same topics covered by the interview.

We will ask questions about background information such as your age, ethnicity, employment, finances, participation in illegal activities, legal status, education, marital history, number of children, custody status of your children, your current substance abuse treatment, and your future treatment plans. Your responses will not be shared with your counselors or other program staff.

In addition, the study staff will get information about treatment and non-treatment participants from official data sources. These sources are: the California Alcohol and Drug Data System (which maintains information on all clients in treatment programs in California), the Offender Based Information System (which contains your criminal record), and your application to the Forever Free Substance Abuse Treatment Program.

We will ask both treatment and non-treatment participants to give us information so we can locate you for a follow-up interview in approximately a year's time, after your release to parole. The Locator Form includes questions about things like your nicknames, driver's license number, car license number, where you live and who lives with you, people who see you regularly, agencies who pay you money regularly, places where your relatives live, and

identifying physical characteristics. We will get other locating information from various government sources, such as by consulting the Offender Based Information System, the California Alcohol and Drug Data System, the Los Angeles County Jail list, and the incarceration lists of other jurisdictions. This procedure will give us many sources for contacting you about your second interview.

In gathering this information for locating you, we will only say we are trying to locate you for a "Health Study." We will not disclose the nature of the study or give any study-based information to locator sources.

(2) About a month before you are released, we will ask you to fill out a short Pre-release Survey for treatment participants, which will take approximately 15 minutes. The survey contains questions about your post-release plans, your relationship to your counselor, and your emotional state. It will take place in a classroom at the Forever Free Substance Abuse Treatment Program.

(3) If the second phase of the study is funded by the National Institute of Justice, you may be asked to participate in a follow-up interview approximately one year after release. The follow-up interview will take approximately 90 minutes. It will take place at the UCLA Drug Abuse Research Center offices in Westwood, California, or at a place convenient to you. We will ask for information about your drug use, and treatment history. We will also ask questions to help us assess your treatment needs, the services you have received, and your satisfaction with the program. We will ask questions about background information such as your age, sex, ethnicity, employment, finances, participation in illegal activities, legal status, education, marital history, number of children, and custody status of your children. In addition, we will ask about your physical health, mental health, and social support.

(4) At the time of the follow-up interview we will also ask you to give a urine sample which will be analyzed to detect use of illicit drugs within the past two to seven days. If you agree to provide a urine sample, you will sign a separate consent form. You can still participate in the interview, even if you do not want to provide the urine.

(5) You may be contacted to participate in other studies in the future. Your participation in any new study is voluntary, and separate consent will be obtained from you.

HOW WILL PARTICIPATION BENEFIT ME?

You will derive no direct benefits from participating in this research. The information you give us could help improve prison and post-release drug treatment programs. This in turn can benefit society and other clients of prison drug treatment programs.

PAYMENT

If the second phase of the study is funded by the National Institute of Justice, you will be paid for completing the follow-up interview and for providing a urine sample at the follow-up interview.

ARE THERE ANY RISKS INVOLVED?

(1) You may be embarrassed to answer some of the questions about drug use and illegal activities.

(2) You do not have to answer any questions you do not wish to answer; skipping some questions will not change your payment for the follow-up interview.

(3) There is little risk that others can get access to the information we collect.

CONFIDENTIALITY

The researchers will protect the confidentiality of the data at all times in the following ways:

a. The Forever Free program director will be required to agree to take measures to protect the confidentiality of the counselor and client responses. No data will be shared across administrator, counselor, correctional staff, or client populations. All data reported will be in aggregate form, meaning that no individual person will be identified.

b. All information except the Locator Form and this Informed Consent Form will be recorded by a code number only. The information that links your name with the code number will be kept on a computer disk which will be stored in a locked desk drawer and available only to the research staff. The Locator and Informed Consent Forms will be kept in a locked file cabinet available only to the research staff and will be destroyed five years after the completion of the study.

c. The information that you provide to us is protected from subpoena by the Department of Justice, and, unless you provide separate written consent, cannot be released. You are to further understand that it is the policy of UCLA and the research staff to resist demands made on them to release information that identifies any research subject, including you.

   However, this protection is not absolute. If you reveal intent to harm yourself or others or if you reveal practices of child abuse or neglect or practices of elder abuse or neglect, or intent to commit a specific crime, the interviewer must report this information to officials.

d. With regard to child abuse specifically, you are to understand that under California law, the privilege of confidentiality does not extend to information about sexual or physical abuse of a child. If any member of the research staff has or is given such information, he or she is required to report it to the authorities. The obligation to report includes alleged or probable abuse as well as known abuse.

e. The information that you provide in the focus group will be kept confidential by the researchers. In addition, we will ask all focus group participants to keep this information confidential. However, we cannot ensure that participants will comply with this request.

f. No information that identifies you will be released without your separate consent except as specifically required by law, as described above.

g. When results of this study are published, your name will not be used and you will not be identified in any way.

DO I HAVE TO TAKE PART?

Your participation is voluntary. You may refuse to participate or may withdraw from this study at any time without any negative consequences.

Your participation in this study will have no effect on your parole release date.

The investigator may stop the study or your participation at any time.

If the study design or the use of the data is to be changed, you will be so informed and your consent reobtained.

RIGHTS AND RESPONSIBILITIES

The research team is to protect the confidentiality of the information to the full extent of their ability at all times. The subject names and code numbers will be kept on a computer disk stored in a locked desk drawer. Only members of the research team will have access to this information.

Michael Prendergast, Ph.D., the Principal Investigator, is available to answer any questions you may have at any time about the study. Dr. Prendergast can be reached at the UCLA Drug Abuse Research Center, 1100 Glendon Avenue, Suite 763, Los Angeles, CA 90024. You can call him there collect at (310) 825-9057.

If you have any other questions, comments or concerns about the study or the informed consent process, you may write or call the UCLA Office for the Protection of Research Subjects, 2107 Ueberroth Bldg., Box 971694, Los Angeles, CA 90095-1694, (310) 825-8714.

CONSENT TO PARTICIPATE

The above information has been explained to me and I give my consent to participate in this study. I acknowledge that I have received a copy of this form.

_____
Subject's Name (please print)

_____ _____
Subject's Signature Date

_____ _____
Interviewer's Signature Date

APPROVED
MAY 2 8 1999
UCLA GENERAL CAMPUS
INSTITUTIONAL REVIEW BOARD

CONSENT TO PARTICIPATE IN

RESEARCH INTERVIEWS

FOR AN EVALUATION OF THE FOREVER FREE

SUBSTANCE ABUSE TREATMENT PROGRAM

WHAT IS THE PURPOSE OF THE STUDY?

The UCLA Drug Abuse Research Center is conducting this study to better understand the Forever Free Substance Abuse Treatment Program. This study is part of a national evaluation of prison substance abuse treatment. Program staff and clients will participate.

You are eligible to be a **non-treatment participant** in this study if you reside at the California Institution for Women at Frontera, are 18 years old or older, are eligible to apply to the Forever Free program but did not receive the program, and are of similar age, ethnicity, and criminal background to the treatment participants.

The study is being directed by Michael Prendergast, Ph.D., and his associates.

WHAT WILL I BE ASKED TO DO?

(1) If you are a **non-treatment participant** in this study, you will be asked to complete a Locator Form. In addition, once you have left the California Institution for Women at Frontera, you may be contacted for a follow-up interview.

We will ask you to give us information so we can locate you for a follow-up interview in approximately a year's time, after your release to parole. The Locator Form includes questions about things like your nicknames, driver's license number, car license number, where you live and who lives with you, people who see you regularly, agencies who pay you money regularly, places where you meet with friends, where your relatives live, and identifying physical characteristics. We will get other locating information from various government sources, such as by consulting the Offender Based Information System, the California Alcohol and Drug Data System, the Los Angeles County Jail list, and the incarceration lists of other jurisdictions. This procedure will give us many sources for contacting you about your second interview.

In gathering this information for locating you, we will only say we are trying to locate you for a "Health Study." We will not disclose the nature of the study or give any study-based information to locator sources.

The study staff will get information about you from official data sources. These sources are: the California Alcohol and Drug Data System (which maintains information on all clients in treatment programs in California), the Offender Based Information System (which contains your criminal record), and your application to the Forever Free Substance Abuse Treatment Program.

(2) If the second phase of the study is funded by the National Institute of Justice, you may be asked to participate in a follow-up interview approximately one year after your release. The

follow-up interview will take approximately 90 minutes. It will take place at the UCLA Drug Abuse Research Center offices in Westwood, California, or at a place convenient to you. We will ask for information about your drug use, and treatment history. We will also ask questions to help us assess your treatment needs, the services you have received, and your satisfaction with treatment you may have received. We will ask questions about background information such as your age, sex, ethnicity, employment, finances, participation in illegal activities, legal status, education, marital history, number of children, and custody status of your children. In addition, we will ask about your physical health, mental health, and social support.

(3) At the time of the follow-up interview we will also ask you to give a urine sample which will be analyzed to detect use of illicit drugs within the past two to seven days. If you agree to provide a urine sample, you will sign a separate consent form. You can still participate in the interview, even if you do not want to provide the urine.

(4) You may be contacted to participate in other studies in the future. Your participation in any new study is voluntary, and separate consent will be obtained from you.

HOW WILL PARTICIPATION BENEFIT ME?

You will derive no direct benefits from participating in this research. The information you give us could help improve prison and post-release drug treatment programs. This in turn can benefit society and other clients of prison drug treatment programs.

PAYMENT

If the second phase of the study is funded by the National Institute of Justice, you will be paid for completing the follow-up interview and for providing a urine sample at the follow-up interview.

ARE THERE ANY RISKS INVOLVED?

(1) You may be embarrassed to answer some of the questions about drug use and illegal activities.

(2) You do not have to answer any questions you do not wish to answer; skipping some questions will not change your payment for the follow-up interview.

(3) There is little risk that others can get access to the information we collect.

CONFIDENTIALITY

The researchers will protect the confidentiality of the data at all times in the following ways:

a. Prison officials will be required to agree to take measures to protect the confidentiality of your responses. No data will be shared with administrator, counselor, correctional staff, or client populations. All data reported will be in aggregate form, meaning that no individual person will be identified.

b. All information except the Locator Form and this Informed Consent Form will be recorded by a code number only. The information that links your name with the code number will be kept on a computer disk which will be stored in a locked desk drawer and available only to the research staff. The Locator and Informed Consent Forms will be kept in a locked file cabinet available only to the research staff and will be destroyed five years after the completion of the study.

c. The information that you provide to us is protected from subpoena by the Department of Justice, and, unless you provide separate written consent, cannot be released. You are to further understand that it is the policy of UCLA and the research staff to resist demands made on them to release information that identifies any research subject, including you.

However, this protection is not absolute. If you reveal intent to harm yourself or others or if you reveal practices of child abuse or neglect or practices of elder abuse or neglect, or intent to commit a specific crime, the interviewer must report this information to officials.

d. With regard to child abuse specifically, you are to understand that under California law, the privilege of confidentiality does not extend to information about sexual or physical abuse of a child. If any member of the research staff has or is given such information, he or she is required to report it to the authorities. The obligation to report includes alleged or probable abuse as well as known abuse.

e. No information that identifies you will be released without your separate consent except as specifically required by law, as described above.

f. When results of this study are published, your name will not be used and you will not be identified in any way.

DO I HAVE TO TAKE PART?

Your participation is voluntary. You may refuse to participate or may withdraw from this study at any time without any negative consequences.

Your participation in this study will have no effect on your parole release date.

The investigator may stop the study or your participation at any time.

If the study design or the use of the data is to be changed, you will be so informed and your consent reobtained.

RIGHTS AND RESPONSIBILITIES

The research team is to protect the confidentiality of the information to the full extent of their ability at all times. The subject names and code numbers will be kept on a computer disk stored in a locked desk drawer. Only members of the research team will have access to this information.

Michael Prendergast, Ph.D., the Principal Investigator, is available to answer any questions you may have at any time about the study. Dr. Prendergast can be reached at the UCLA Drug Abuse Research Center, 1100 Glendon Avenue, Suite 763, Los Angeles, CA 90024. You can call him there collect at (310) 825-9057.

If you have any other questions, comments or concerns about the study or the informed consent process, you may write or call the UCLA Office for the Protection of Research Subjects, 2107 Ueberroth Bldg., Box 971694, Los Angeles, CA 90095-1694, (310) 825-8714.

CONSENT TO PARTICIPATE

The above information has been explained to me and I give my consent to participate in this study. I acknowledge that I have received a copy of this form.

_____
Subject's Name (please print)

_____ _____
Subject's Signature Date

_____ _____
Interviewer's Signature Date

APPROVED
MAY 2 8 1999
UCLA GENERAL CAMPUS
INSTITUTIONAL REVIEW BOARD

Appendix A: Evaluation Instruments

Forever Free Evaluation Project
UCLA Drug Abuse Research Center
Michael Prendergast, Ph.D., Principal Investigator
Jean Wellisch, Ph.D. Project Consultant
Elizabeth A. Hall, Ph.D., Project Director
(310) 825-9057x275

UCLA DRUG ABUSE RESEARCH CENTER
1997

Study 23
Contact 0

DARC ID# ..... _____

Gender 2

Interview Month ..... _____

Interview Day ..... _____

Interview Year ..... _____

Minus Values
-7 R refused to answer
-8 R doesn't know
-9 Not applicable
-11 Response not obtained

Date coded _____/_____/_____ By _____

Date checked _____/_____/_____ By _____

(INTERVIEWER TO COMPLETE QUESTIONS 1-9)

1-3. DATE OF INTERVIEW _____/_____/_____

4. INTERVIEWER ID# _____

5. IS R CURRENTLY INCARCERATED?
YES 1

6. PRIMARY DRUG
ALCOHOL 15
NARCOTICS 7
COCAINE 10
CRACK 33
MARIJUANA 2
AMPHET/METHAMPH 4
OTHER 13
SPECIFY _____

7. RECORD INTERVIEW START TIME (USE MILITARY TIME) _____ :_____

8. RECORD INTERVIEW END TIME (USE MILITARY TIME) _____ :_____

BACKGROUND

10-12. What is your date of birth?

_____/_____/_____
MONTH DAY YEAR

13. What is your race? (CIRCLE ONE)

WHITE.....1
BLACK/AFRICAN AMERICAN.....2
ASIAN/PACIFIC ISLANDER.....3
NATIVE AMERICAN/ALASKAN.....4
HISPANIC.....5
MULTI-RACIAL.....6
OTHER.....7
SPECIFY_____

14. What was your job when you were last employed?

_____
JOB TITLE

15. From these income ranges, please check the one that comes closest your total 1996 household income from all sources before taxes? **CHECK ONE**:

_____ [0]In prison for all of 1996
_____ [1]Under $10,000
_____ [2]$10,000 to $14,999
_____ [3]$15,000 to $19,999
_____ [4]$20,000 to $24,999
_____ [5]$25,000 to $29,999
_____ [6]$30,000 to $34,999
_____ [7]$35,000 to $39,999
_____ [8]$40,000 to $44,999
_____ [9]$45,000 to $49,999
_____ [10]$50,000 to $59,999
_____ [11]$60,000 to $69,999
_____ [12]$70,000 to $79,999
_____ [13]$80,000 to $89,999
_____ [14]$90,000 to $99,999
_____ [15]$100,000 to $124,999
_____ [16]$125,000 to $149,999
_____ [17]$150,000 to $174,999
_____ [18]$175,000 to $199,999
_____ [19]$200,000 or more

EDUCATION

16. What is the highest education you have obtained?

LESS THAN HIGH SCHOOL GRADUATION.....0
HIGH SCHOOL GRADUATION.....1
GED.....2
2 YR COLLEGE (AA).....3
4 YR COLLEGE (BA, BS).....4
MASTERS.....5
Ph.D.....6
SOME COLLEGE (NO DEGREE).....8
TRADE OR TECHNICAL TRAINING.....9
OTHER.....7
SPECIFY _____

The next set of questions is about arrests and incarcerations. Remember that what you tell us is strictly confidential.

17. During 1996, how many months were you incarcerated (in jail or prison)? _____ MONTHS

18. How many times in your life have you been arrested, including detained as a juvenile? ..... _____

19. How old were you the first time you were arrested? ..... _____

20. What was the charge against you? _____ _____ (CODE)

21. How many of your (total) arrests were before the age of 18? ..... _____

22. How many of your (total) arrests were before you first began using illegal drugs? ..... _____

23. How many times in your life have you been convicted? Include probation sentences, time served, fines, and community service, along with sentences to jail or prison. ..... _____

24. For the convictions above, how many times in your life have you been incarcerated? .... _____

25. How old were you when you were first incarcerated? ..... _____

26. How many times have you been incarcerated for more than 30 days? ..... _____ TIMES

27. Did you ever receive drug education or treatment while you were incarcerated ? DON'T COUNT FOREVER FREE HERE
NO 0
YES 1

28. What is your controlling case? _____
DON'T INCLUDE PAROLE VIOLATION _____

RELATIONSHIP STATUS

31. Do you currently have a partner or spouse? (CIRCLE ONE)
NO (SKIP TO Q35) 0
YES 1

32. Has your partner or spouse visited you during your current incarceration?
..... NO 0
YES 1

33. Has your current spouse/partner used illegal drugs during your relationship?
NO 0
YES 1

34. Has your current spouse/partner been in drug treatment during your relationship?
NO 0
YES 1

35. What type of place (RESIDENCE) did you live in before you were incarcerated? (CIRCLE ONE)

RENTED HOUSE 2
RENTED APARTMENT 3
HOTEL/ROOMING, BOARDING HOUSE 4
HOSPITAL/THERAPEUTIC COMMUNITY 5
HALFWAY HOUSE/SOBER LIVING 7
DORMITORY 8
PARENTS' HOUSE 9
BROTHERS AND SISTERS 10
OTHER RELATIVES 11
FRIENDS 12
RENTED ROOM IN HOUSE 13
NO REGULAR PLACE (HOMELESS) 14
OTHER 15
SPECIFY _____

36. Did anyone else who lived there use illegal drugs?

NO 0
YES 1
LIVED ALONE 2

37. What was your zip code before incarceration? _____

CHILDREN

41. Do you have any children? CIRCLE ONE:

NO **(SKIP TO FORM 2, PAGE 9)** 0
YES 1

42. How many of your children are under 18 years of age? ..... _____

IF ALL CHILDREN ARE OVER 18, SKIP TO FORM 2, PAGE 9

43-49. Starting with the youngest, please give the ages of all your children who are under 18 years of age.

	AGE
Child #1 (YOUNGEST)	43. _____
Child #2	44. _____
Child #3	45. _____
Child #4	46. _____
Child #5	47. _____
Child #6	48. _____
Child #7	49. _____

50. Do you have legal custody of your children? (CIRCLE ONE)

YES - ALL 2
YES - SOME 1
NO 0
DON'T KNOW ..... -8
NOT APPLICABLE ..... -9

51-57. Write in how many of your children are living in each of the places below

1 ___ CHILD'S FATHER

2 ___ YOUR CURRENT SPOUSE/PARTNER WHO **IS NOT** CHILD'S FATHER

3 ___ CHILD'S GRANDPARENT(S)

4 ___ OTHER RELATIVES

5 ___ FOSTER CARE

6 ___ OTHER SPECIFY _____

58. How far away from this prison does your child (who lives the farthest) live? _____ MILES

59. Did any of your children witness your arrest?

NO.....0
YES.....1

60. When you were first arrested, what happened to your children? (CHECK ONE)

1 __ POLICE ALLOWED ME TO MAKE ARRANGEMENTS WITH PARTNER/FAMILY

2 __ POLICE ALLOWED ME TO MAKE ARRANGEMENTS WITH FRIENDS

3 __ CHILD PROTECTIVE SERVICES/SOCIAL WORKER TOOK THEM

4 __ CHILDREN DIDN'T LIVE WITH ME

5 __ DON'T KNOW

6 __ OTHER SPECIFY _____

CHILDREN: CONTACT AND VISITING

We are interested in how much contact you have had with your children since your incarceration.

61-63. Since you have been here, about how often do you call your children? (CHECK AND FILL IN ONE)

1 __ At least once a month?➞ FILL IN TIMES PER MONTH _____62

2 __ At least once a year?➞ FILL IN TIMES PER YEAR _____63

3 __ Less than once a year

4 __ Never

5 __ Not able to due to rules/custody

6 __ Other➞ SPECIFY _____

64-66. Since you have been here, how often do you receive letters from your children? (CHECK AND FILL IN ONE)

1 __ At least once a month?➞ FILL IN TIMES PER MONTH _____65

2 __ At least once a year?➞ FILL IN TIMES PER YEAR _____66

3 __ Less than once a year

4 __ Never

5 __ Not able to due to rules/custody

6 __ Other➞ SPECIFY _____

67-69. Since you have been here, how often do you write letters to your children? (CHECK ONE)

1 __ At least once a month?➡ FILL IN TIMES PER MONTH _____68

2 __ At least once a year?➡ FILL IN TIMES PER YEAR _____69

3 __ Less than once a year

4 __ Never

5 __ Not able to due to rules/custody

6 __ Other➡ SPECIFY _____

70-72. Since you have been here, how often do you have visits with your children? (CHECK ONE)

1 __ At least once a month?➡ FILL IN TIMES PER MONTH _____71

2 __ At least once a year?➡ FILL IN TIMES PER YEAR _____72

3 __ Less than once a year

4 __ Never

5 __ Not able to due to rules/custody

6 __ Other➡ SPECIFY _____

73-74. If you answered NEVER in Question 70 above, what are the **two** most important reasons why your children do not visit? (CHECK ONLY TWO)

1 __ Too far

2 __ Caregiver doesn't have car

3 __ Caregiver doesn't want to bring them

4 __ Don't want my children to come here

5 __ Children too young to come here

6 __ Children don't know I'm in prison

7 __ Other➡ SPECIFY _____

Go to the next page.

Next, I'm going to list several activities that some parents do with their children. Please tell me how often you did each of these things. In the year before incarceration, about how often did you spend time with your child or at least 1 of your children...

	NOT AT ALL	LESS THAN ONCE A WEEK	AT LEAST ONCE A WEEK	ALMOST DAILY	NA
75. In leisure activities away from home-- such as picnics, movies, or sports	1	2	3	4	-9
76. At home working on a project or playing together	1	2	3	4	-9
77. Helping with reading or homework	1	2	3	4	-9
78. Eating meals together	1	2	3	4	-9

79. Before incarceration, how well were you doing as a parent or guardian? Would you say...

Poor 1
Fair 2
Well 3

80. Before incarceration, how difficult was it for <u>you</u> to go places or do things because of problems in finding someone to take care of the child(ren) living with you? Would you say...

Not at all 0
Somewhat 1
Very difficult 2
Not applicable ..... -9

81. Will your participation in Forever Free affect who has custody of [your child/any of your children]?

No 0
Yes 1
Somewhat/Maybe 2

Go to the next page.

BRIEF DRUG HISTORY

Now I would like you to summarize your drug use history. For each drug group, please indicate: the age of your first use, the age of your first regular use, and how many days you used in the month before you were incarcerated.

DRUG GROUP	A. How old were you the first time you tried **[the drug]**? 0=Never Used; (SKIP TO NEXT DRUG)	B. How old were you when you started using regularly **[drug]**? 0=Never Used Regularly	C. How many days did you use **[drug non-medically]** in the 30 days before you were incarcerated? 0=Didn't use in that month
Inhalants such as Glue, spray cans, gasoline, poppers, etc. (1)	1	2	3
Marijuana or hashish (2)	4	5	6
Hallucinogens (LSD, mescaline, peyote (3)	7	8	9
Amphetamines or any other speed (crystal, methedrine, methamphetamine, ice) (4)	10	11	12
Downers, bartiturates (6)	13	14	15
Heroin (7)	16	17	18
Other opiates (methadone, morphine, codeine, demerol, dilaudid, percodan, opium, vicodin) (9)	19	20	21
Crack, Rock Cocaine (33)	22	23	24
Cocaine (powder, intranasal, or Intravenous) (10)	25	26	27
Tranquilizers (valium, librium, xanax, roofies, etc.) (11)	28	29	30
PCP (angel dust) (12)	31	32	33
Fentanyl, Synthetic H (17)	34	35	36
Alcohol (15)--any use at all	37	38	39
Alcohol--to intoxication (5+ drinks per sitting)	40	41	42
Ecstasy, Adam, Eve, MDA, MDMA (35)	43	44	45

51-53. What other illegal drugs have you taken?
(WRITE IN NAME OF DRUG OR WRITE NONE)

51._____
52._____
53._____

CODE
_____
_____
_____

54. In the 30 days before incarceration, how much money would you say you spent on **alcohol**? (If you didn't pay, how much would it have cost if you had?) $_____

55. In the 30 days before incarceration, how much money would you say you spent on **illegal drugs**? (If you didn't pay, what was the street value of the drugs you used?) $_____

56. At present do you have an [illegible]

YES 1

57. Have you ever injected any drugs?

NO ..... **(GO TO Q75)** 0
YES 1

DRUG GROUP	A. How old were you when you started to inject **[drug]** regularly? 0=never	B. How many days in the 30 days before you were incarcerated did you inject **[drug]**?
Amphetamines or any other speed like Crystal, methadrine, meth-amphetamine (4)	61	62
Heroin by itself (7)	63	64
Other opiates like Opium, morphine, codeine, demerol, dilaudid, percodan (9)	65	66
Cocaine by itself (10)	67	68
Speedball (COCAINE and HEROIN COMBINED) (18)	69	70
Have you injected any other drugs? (SPECIFY) 71._____	72	73

Go to the next page.

75-78. Which substance do you consider the major problem for you now? [CIRCLE ONE]

ALCOHOL 15

ALCOHOL AND DRUG (DUAL ADDICTION) 45

WRITE IN NAME OF DRUG:

76. _____

AMPHETAMINES 4

BARBITURATES 6

COCAINE (POWDER) 10

CRACK (ROCK) 33

DESIGNER DRUGS (ECSTASY, ADAM, EVE, MDMA, ETC.) 35

HALLUCINOGENS 3

HEROIN 7

INHALANTS 1

MARIJUANA, HASH 2

METHADONE 8

NONE 0

OTHER OPIATES/PAIN KILLERS 9

OVER-THE-COUNTER DRUGS 21

PCP 12

POLYDRUG (WITHOUT ALCOHOL) 23

WRITE IN THE NAMES OF THE DRUGS: 77. _____

78. _____

TRANQUILIZERS (VALIUM, LIBRIUM, XANAX, ETC) 11

79. How many times in your lifetime have you had alcohol d.t.'s (the shakes)? ..... _____ # times

80. How many times in your lifetime have you overdosed on drugs? ..... _____ # times

TOBACCO

81. Do you currently smoke cigarettes?

NO **(SKIP TO Q84)** 0
YES 1

82. About how many cigarettes do you smoke each day? ..... _____
CONVERT FROM PACKS (20 cigs = 1 pack)

83. How many cigarettes have you smoked in the last 24 hours? ..... _____

84-87. Do you smoke cigars, smoke a pipe, or use smokeless tobacco or snuff? **(CIRCLE EACH TYPE YOU USE)**

CIGARS 85
PIPE 86
SMOKELESS TOBACCO OR SNUFF 87

88. Would you try a stop smoking program if it were available?

NO 0
YES 1
DON'T USE TOBACCO 2

LIFETIME TREATMENT HISTORY

91. Now, I'm going to ask you about other drug treatment you may have received. Before Forever Free, were you ever in a program or in treatment for drug or alcohol problems, including self-help groups or sober living houses?

NO .. **[SKIP TO PAGE 13]** 0
YES 1

In your lifetime, how many times have you been in any of the program types listed below for drug/alcohol abuse treatment? DON'T COUNT FOREVER FREE	Total # Times
92. Prison or Jail Drug Treatment	
93. Hospital Inpatient (Includes Detox)	
94. Partial Hospitalization (Day treatment based in hospital)	
95. Day Treatment (Outpatient that lasts all day)	
96. Residential Treatment	
97. Outpatient Drug Free	
98. Outpatient with Medications (such as Naltrexone, Antabuse, etc.)	
99. Methadone Treatment	
100. Halfway House	
101. Sober Living Home	
102. Support groups such as AA, CA, NA, and other self-help groups, including spiritually-based groups (Count only if you went to 3 or more meetings in a one-month period)	
103. (CODING STAFF USE: TOTAL)	

FORM 3: CALPAS-P

Instructions: Below is a list of questions that describe attitudes people might have about their counseling experience or case manager. Think about your counseling experience and your Forvever Free case manager and decide which category best describes your attitude for each question.

Reminder: Your responses on this form are confidential and will not be seen by your case manager. You are of course free to discuss with your case manager any of these questions. In answering the questions below, please think about your drug counseling overall.

Categories: Circle the number that fits your experience in drug counseling here at Forever Free

Not at all	A little bit	Somewhat	Moderately	Quite a bit	Quite a lot	Very much
1	2	3	4	5	6	7

1. Do you find yourself tempted to stop participating in Forever Free when you find yourself upset or disappointed with it?	1	2	3	4	5	6	7
2. Do you feel pressured by your case manager to make changes before you are ready?	1	2	3	4	5	6	7
3. When your case manager comments about one situation, does it bring to mind other related situations in your life?	1	2	3	4	5	6	7
4. Do you feel that even though you might have moments of doubt, confusion, or mistrust, that overall drug abuse treatment is worthwhile?	1	2	3	4	5	6	7
5. Do your case manager's comments lead you to feel that your case manager places his or her needs before yours?	1	2	3	4	5	6	7
6. When important things come to mind, how often do you keep them to yourself, that is, choose not to share them with your case manager?	1	2	3	4	5	6	7
7. Do you feel accepted and respected by your case manager for who you are?	1	2	3	4	5	6	7
8. How much do you hold back your feelings during counseling?	1	2	3	4	5	6	7
9. Do you find your case manager's comments unhelpful, that is, confusing, mistaken, or not really applying to you?	1	2	3	4	5	6	7
10. Do you feel you are working together with your case manager, that the two of you are joined in a struggle to overcome your problems?	1	2	3	4	5	6	7
11. How free are you to discuss personal matters that you are ordinarily ashamed or afraid to reveal?	1	2	3	4	5	6	7
12. How willing are you to continue struggling with your problems, even though you can not always see an immediate solution?	1	2	3	4	5	6	7
13. How dedicated is your case manager to helping you overcome your difficulties?	1	2	3	4	5	6	7

Categories: Circle the number that fits your experience in drug counseling

Not at all 1	A little bit 2	Somewhat 3	Moderately 4	Quite a bit 5	Quite a lot 6	Very much 7

14. Have you disagreed with your case manager about the kind of changes you would like to make in your drug treatment?	1	2	3	4	5	6	7
15. How much do you resent the time or other demands of your drug treatment?	1	2	3	4	5	6	7
16. Do you feel that your case manager understands what you hope to get out of your sessions?	1	2	3	4	5	6	7
17. How important is it for you to look at the ways you might be contributing to your own problems?	1	2	3	4	5	6	7
18. How much do you find yourself thinking that drug treatment isn't the best way to get help with your problems?	1	2	3	4	5	6	7
19. Does the treatment you receive match with your ideas about what helps people in drug treatment?	1	2	3	4	5	6	7
20. Do you feel you are working at cross purposes with your case manager and that you don't share the same sense of how to proceed so that you can get the help you want?	1	2	3	4	5	6	7
21. How confident do you feel that through your own efforts and those of your ·se manager you will gain relief from your problems?	1	2	3	4	5	6	7
22. Do you have the feeling that you are unable to deepen your understanding of your problems?	1	2	3	4	5	6	7
23. How much do you disagree with your case manager about what issues are most important to work on during treatment?	1	2	3	4	5	6	7
24. How much does your case manager help you to gain a deeper understanding of your problems?	1	2	3	4	5	6	7

Circle the number that fits your experience in drug counseling

Strongly Disagree 1	2	3	Not Sure 4	5	6	Strongly Agree 7

25. What I am doing in drug counseling gives me new ways of looking at my problem.	1	2	3	4	5	6	7
26. I feel that the things I do in drug treatment will help me to accomplish the changes I want to make.	1	2	3	4	5	6	7
27. I have obtained some new understanding.	1	2	3	4	5	6	7
28. I believe that drug counseling is helping me.	1	2	3	4	5	6	7
.9. I believe that my case manager is helping me.	1	2	3	4	5	6	7
30. As a result of these drug counseling sessions I am clearer as to how I might be able to change.	1	2	3	4	5	6	7

Below are some statements about your interactions with the other participants in Forever Free (such as in group sessions or in a social setting). Using this scale indicate how often you feel this way.

1	2	3	4	5	6	7
NEVER			SOMETIMES			ALWAYS

31. _____ When I need someone to tell my feelings to, the other participants in Forever Free are there to help me.

32. _____ I don't like being with other participants because it makes me uncomfortable to hear about their problems.

33. _____ Hearing about the other participant's problems helps me with mine.

34. _____ Hearing other participants talk about their problems with drugs makes it hard for me to move on.

35. _____ Talking things out with the other participants helps me to understand my problems better.

36. _____ I have been hurt by other participants.

37. _____ The other participants give me support.

38. _____ The other participants pick fights with me and each other.

39. _____ I feel that I don't gain anything from hanging out with the other participants.

40. _____ The other participants understand my problems because they have similar problems.

41. _____ It is hard to be around the other participants because their conversations make me think about doing drugs.

42. _____ Talking with other participants can sometimes be more helpful than talking to the case manager.

43. _____ When I'm out, I'll be able to use the relapse prevention skills I learned in Forever Free.

INSTRUCTIONS: Circle the answer that shows how much you agree or disagree each item describes you the way you have been feeling lately.

Strongly Disagree 1	2	3	Not Sure 4	5	6	Strongly Agree 7

51. Your drug use is a problem for you.	1	2	3	4	5	6	7
52. You feel sad or depressed.	1	2	3	4	5	6	7
53. You need help in dealing with your drug use.	1	2	3	4	5	6	7
54. You have too many outside responsibilities now to be in this treatment program.	1	2	3	4	5	6	7
55. You have much to be proud of.	1	2	3	4	5	6	7
56. Your drug use is more trouble than it's worth.	1	2	3	4	5	6	7
57. In general, you are satisfied with yourself.	1	2	3	4	5	6	7
58. You have thoughts of committing suicide.	1	2	3	4	5	6	7
59. You have trouble sitting still for long.	1	2	3	4	5	6	7
60. Your drug use is causing problems with the law.	1	2	3	4	5	6	7
61. This treatment program seems too demanding for you.	1	2	3	4	5	6	7
62. You feel lonely.	1	2	3	4	5	6	7
63. Your drug use is causing problems in thinking or doing your work.	1	2	3	4	5	6	7
64. You feel like a failure.	1	2	3	4	5	6	7
65. You have trouble sleeping.	1	2	3	4	5	6	7
66. Your drug use was causing problems with your family or friends.	1	2	3	4	5	6	7
67. You feel interested in life.	1	2	3	4	5	6	7
68. This treatment may be your last chance to solve your drug problems.	1	2	3	4	5	6	7

Strongly Disagree 1	2	3	Not Sure 4	5	6	Strongly Agree 7

69. You are tired of the problems caused by drugs. 1 2 3 4 5 6 7

70. You feel you are basically no good. 1 2 3 4 5 6 7

71. This kind of treatment program will not be very helpful to you. 1 2 3 4 5 6 7

72. Your drug use was causing problems in finding or keeping a job. 1 2 3 4 5 6 7

73. You plan to stay in this treatment program for awhile. 1 2 3 4 5 6 7

74. You feel anxious or nervous. 1 2 3 4 5 6 7

75. You will give up your friends and hangouts to solve your drug problems. 1 2 3 4 5 6 7

76. You can quit using drugs without any help. 1 2 3 4 5 6 7

77. You have trouble concentrating or remembering things. 1 2 3 4 5 6 7

78. Your drug use was causing problems with your health. 1 2 3 4 5 6 7

79. You feel extra tired or run down. 1 2 3 4 5 6 7

80. You are in this treatment program because someone else made you come. 1 2 3 4 5 6 7

81. You feel afraid of certain things, like elevators, crowds, or going out alone. 1 2 3 4 5 6 7

82. Your life has gone out of control. 1 2 3 4 5 6 7

83. Your drug use was making your life become worse and worse. 1 2 3 4 5 6 7

84. You wish you had more respect for yourself. 1 2 3 4 5 6 7

85. You worry or brood a lot. 1 2 3 4 5 6 7

86. This treatment program can really help you. 1 2 3 4 5 6 7

87. You feel tense or keyed-up. 1 2 3 4 5 6 7

Strongly Disagree 1	2	3	Not Sure 4	5	6	Strongly Agree 7

88. You are very careful and cautious. 1 2 3 4 5 6 7

89. You want to be in a drug treatment program. 1 2 3 4 5 6 7

90. Your drug use is going to cause your death if you do not quit soon. 1 2 3 4 5 6 7

91. You feel you are unimportant to others. 1 2 3 4 5 6 7

92. You want to get your life straightened out. 1 2 3 4 5 6 7

93. You feel tightness or tension in your muscles. 1 2 3 4 5 6 7

Thank you for completing this form!

Forever Free Evaluation Project
Pre-Release Survey Instrument
UCLA Drug Abuse Research Center
Michael Prendergast, Ph.D., Principal Investigator
Jean Wellisch, Ph.D. Project Consultant
Elizabeth A. Hall, Ph.D., Project Director
(310) 825-9057x275

UCLA DRUG ABUSE RESEARCH CENTER
1998

Study 23
Contact 1

DARC ID# ..... _____

Source 1

Gender 2

Interview Month ..... _____

Interview Day ..... _____

Interview Year ..... _____

Minus Values
-7 R refused to answer
-8 R doesn't know
-9 Not applicable
-11 Response not obtained

Source
1 - Forever Free
2 - Comparsion Non Treatment Group
3 - Future

Date coded _____/_____/_____ By _____

Date checked _____/_____/_____ By _____

FORM 11

'NTERVIEWER TO COMPLETE QUESTIONS 1-6)

1-3. DATE OF INTERVIEW _____/_____/_____

4. INTERVIEWER ID# _____

5. IS R CURRENTLY INCARCERATED? YES 1

6. PRIMARY DRUG

ALCOHOL 15
NARCOTICS 7
COCAINE 10
CRACK 33
MARIJUANA 2
AMPHET/METHAMPH 4
OTHER 13
SPECIFY _____

Please start here.

BACKGROUND

10-12. What is your date of birth? _____/_____/_____
MONTH DAY YEAR

13-15. What is your release date? (USE YOUR BEST GUESS) _____/_____/_____
MONTH DAY YEAR

16-17. Do you plan to continue treatment after release?

No 0
Yes, I plan to go to residential treatment 1
Yes, I plan to go to another type of treatment program (SPECIFY TYPE) 2

_____

FORM 12: CALPAS-P

Instructions: Below is a list of questions that describe attitudes people might have about their counseling experience or case manager. Think about your counseling experience and your Forvever ɜe case manager and decide which category best describes your attitude for each question.

Reminder: Your responses on this form are confidential and will not be seen by your case manager. You are of course free to discuss with your case manager any of these questions. In answering the questions below, please think about your drug counseling overall.

Categories: Circle the number that fits your experience in drug counseling here at Forever Free

Not at all 1	A little bit 2	Somewhat 3	Moderately 4	Quite a bit 5	Quite a lot 6	Very much 7

1. Do you find yourself tempted to stop participating in Forever Free when you find yourself upset or disappointed with it?	1	2	3	4	5	6	7
2. Do you feel pressured by your case manager to make changes before you are ready?	1	2	3	4	5	6	7
3. When your case manager comments about one situation, does it bring to mind other related situations in your life?	1	2	3	4	5	6	7
4. Do you feel that even though you might have moments of doubt, ɔnfusion, or mistrust, that overall drug abuse treatment is worthwhile?	1	2	3	4	5	6	7
5. Do your case manager's comments lead you to feel that your case manager places his or her needs before yours?	1	2	3	4	5	6	7
6. When important things come to mind, how often do you keep them to yourself, that is, choose not to share them with your case manager?	1	2	3	4	5	6	7
7. Do you feel accepted and respected by your case manager for who you are?	1	2	3	4	5	6	7
8. How much do you hold back your feelings during counseling?	1	2	3	4	5	6	7
9. Do you find your case manager's comments unhelpful, that is, confusing, mistaken, or not really applying to you?	1	2	3	4	5	6	7
10. Do you feel you are working together with your case manager, that the two of you are joined in a struggle to overcome your problems?	1	2	3	4	5	6	7
11. How free are you to discuss personal matters that you are ordinarily ashamed or afraid to reveal?	1	2	3	4	5	6	7
12. How willing are you to continue struggling with your problems, even though you can not always see an immediate solution?	1	2	3	4	5	6	7
13. How dedicated is your case manager to helping you overcome your lifficulties?	1	2	3	4	5	6	7

Categories: Circle the number that fits your experience in drug counseling

Not at all 1	A little bit 2	Somewhat 3	Moderately 4	Quite a bit 5	Quite a lot 6	Very much 7

14. Have you disagreed with your case manager about the kind of changes you would like to make in your drug treatment?	1	2	3	4	5	6	7
15. How much do you resent the time or other demands of your drug treatment?	1	2	3	4	5	6	7
16. Do you feel that your case manager understands what you hope to get out of your sessions?	1	2	3	4	5	6	7
17. How important is it for you to look at the ways you might be contributing to your own problems?	1	2	3	4	5	6	7
18. How much do you find yourself thinking that drug treatment isn't the best way to get help with your problems?	1	2	3	4	5	6	7
19. Does the treatment you receive match with your ideas about what helps people in drug treatment?	1	2	3	4	5	6	7
20. Do you feel you are working at cross purposes with your case manager and that you don't share the same sense of how to proceed so that you can get the help you want?	1	2	3	4	5	6	7
21. How confident do you feel that through your own efforts and those of your case manager you will gain relief from your problems?	1	2	3	4	5	6	7
22. Do you have the feeling that you are unable to deepen your understanding of your problems?	1	2	3	4	5	6	7
23. How much do you disagree with your case manager about what issues are most important to work on during treatment?	1	2	3	4	5	6	7
24. How much does your case manager help you to gain a deeper understanding of your problems?	1	2	3	4	5	6	7

Circle the number that fits your experience in drug counseling

Strongly Disagree 1	2	3	Not Sure 4	5	6	Strongly Agree 7

25. What I am doing in drug counseling gives me new ways of looking at my problem.	1	2	3	4	5	6	7
26. I feel that the things I do in drug treatment will help me to accomplish the changes I want to make.	1	2	3	4	5	6	7
27. I have obtained some new understanding.	1	2	3	4	5	6	7
28. I believe that drug counseling is helping me.	1	2	3	4	5	6	7
29. I believe that my case manager is helping me.	1	2	3	4	5	6	7
30. As a result of these drug counseling sessions I am clearer as to how I might be able to change.	1	2	3	4	5	6	7

FEELINGS ABOUT DRUG USE

Please read both statements carefully and choose the one that best describes how you feel now.
(CIRCLE ONE LETTER FOR EACH STATEMENT)

31. a. I feel so helpless in some situations that I need to get high.
    b. Abstinence is just a matter of deciding that I no longer want to use drugs.

32. a. I have the strength to withstand pressures at work or home.
    b. Trouble at work or home drives me to use drugs.

33. a. Without the right breaks you cannot stay clean.
    b. Drug abusers who are not successful in curbing their drug use often have not taken advantage of help that is available.

34. a. There is no such thing as an irresistible temptation to use drugs.
    b. Many times there are circumstances that force you to use drugs.

35. a. I get so upset over small arguments that they cause me to use drugs.
    b. I can usually handle arguments without using drugs.

36. a. Successfully kicking substance abuse is a matter of hard work, luck has little or nothing to do with it.
    b. Staying clean depends mainly on things going right for you.

37. a. When I am at a party where others are using, I can avoid taking drugs.
    b. It is impossible for me to resist drugs if I am at a party where others are using.

38. a. I feel powerless to prevent myself from using drugs when I am anxious or unhappy.
    b. If I really wanted to, I could stop using drugs.

39. a. It is easy for me to have a good time when I am sober.
    b. I cannot feel good unless I am high.

40. a. I have control over my drug use behaviors.
    b. I feel completely helpless when it comes to resisting drugs.

41. a. Sometimes I cannot understand how people can control their drug use.
    b. There is a direct connection between how hard people try and how successful they are in stopping their drug use.

42. a. I can overcome my urge to use drugs.
    b. Once I start to use drugs I can't stop.

43. a. Drugs aren't necessary in order to solve my problems.
    b. I just cannot handle my problems unless I get high first.

44. a. Most of the time I can't understand why I continue to use drugs.
    b. In the long run I am responsible for my drug problems.

45. a. Taking drugs is my favorite form of entertainment.
    b. It wouldn't bother me if I could never use drugs again.

46. a. If it weren't for pressure from the law, I'd still be using drugs.
    b. I could stop using drugs, even without pressure from the law.

DATAR SCALES

INSTRUCTIONS: Circle the answer that shows how much you agree or disagree each item describes you the way you have been feeling lately.

Strongly Disagree 1	2	3	Not Sure 4	5	6	Strongly Agree 7

51. You feel sad or depressed.	1	2	3	4	5	6	7
52. You have much to be proud of.	1	2	3	4	5	6	7
53. In general, you are satisfied with yourself.	1	2	3	4	5	6	7
54. You have thoughts of committing suicide.	1	2	3	4	5	6	7
55. You have trouble sitting still for long.	1	2	3	4	5	6	7
56. You feel lonely.	1	2	3	4	5	6	7
57. You feel like a failure.	1	2	3	4	5	6	7
58. You have trouble sleeping.	1	2	3	4	5	6	7
59. You feel interested in life.	1	2	3	4	5	6	7
60. You feel you are basically no good.	1	2	3	4	5	6	7
61. You feel anxious or nervous.	1	2	3	4	5	6	7
62. You have trouble concentrating or remembering things.	1	2	3	4	5	6	7
63. You feel extra tired or run down.	1	2	3	4	5	6	7
64. You feel afraid of certain things, like elevators, crowds, or going out alone.	1	2	3	4	5	6	7
65. You wish you had more respect for yourself.	1	2	3	4	5	6	7
66. You worry or brood a lot.	1	2	3	4	5	6	7
67. You feel tense or keyed-up.	1	2	3	4	5	6	7
68. You feel you are unimportant to others.	1	2	3	4	5	6	7
69. You feel tightness or tension in your muscles.	1	2	3	4	5	6	7

Thank you for completing this form!

Forever Free Evaluation Project
Comparison Group Instrument
UCLA Drug Abuse Research Center
Michael Prendergast, Ph.D., Principal Investigator
Jean Wellisch, Ph.D. Project Consultant
Elizabeth A. Hall, Ph.D., Project Director
(310) 825-9057x275

UCLA DRUG ABUSE RESEARCH CENTER
1997

Study 23
Contact 0

DARC ID# ..... _____

Source 2

Gender.....2

Interview Month..... _____

Interview Day..... _____

Interview Year ..... _____

Minus Values
-7 R refused to answer
-8 R doesn't know
-9 Not applicable
-11 Response not obtained

Source
1 - Forever Free
2 - Comparison Non-treatment Group
3 - Future

Date coded _____/_____/_____ By _____

Date checked _____/_____/_____ By _____

FORM 21

(INTERVIEWER TO COMPLETE QUESTIONS 1-8)

1-3.	DATE OF INTERVIEW	_____/_____/_____
4.	INTERVIEWER ID#	_____
5.	IS R CURRENTLY INCARCERATED?	YES 1
6.	PRIMARY DRUG	ALCOHOL ..... 15 NARCOTICS ..... 7 COCAINE ..... 10 CRACK ..... 33 MARIJUANA ..... 2 AMPHET/METHAMPH ..... 4 OTHER ..... 13 SPECIFY _____

BACKGROUND

12. What is your date of birth?

_____/_____/_____
MONTH DAY YEAR

13. What is your race? (CIRCLE ONE)

WHITE.....1
BLACK/AFRICAN AMERICAN.....2
ASIAN/PACIFIC ISLANDER.....3
NATIVE AMERICAN/ALASKAN.....4
HISPANIC.....5
MULTI-RACIAL.....6
OTHER.....7
SPECIFY_____

14. From these income ranges, please check the one that comes closest your total 1996 household income from all sources before taxes? **CHECK ONE**:

_____ [0]In prison for all of 1996
_____ [1]Under $10,000
_____ [2]$10,000 to $14,999
_____ [3]$15,000 to $19,999
_____ [4]$20,000 to $24,999
_____ [5]$25,000 to $29,999
_____ [6]$30,000 to $34,999
_____ [7]$35,000 to $39,999
_____ [8]$40,000 to $44,999
_____ [9]$45,000 to $49,999
_____ [10]$50,000 to $59,999
_____ [11]$60,000 to $69,999
_____ [12]$70,000 to $79,999
_____ [13]$80,000 to $89,999
_____ [14]$90,000 to $99,999
_____ [15]$100,000 to $124,999
_____ [16]$125,000 to $149,999
_____ [17]$150,000 to $174,999
_____ [18]$175,000 to $199,999
_____ [19]$200,000 or more

'UCATION

15. What is the highest education you have obtained?

LESS THAN HIGH SCHOOL GRADUATION.....0
HIGH SCHOOL GRADUATION.....1
GED.....2
2 YR COLLEGE (AA).....3
4 YR COLLEGE (BA, BS).....4
MASTERS.....5
Ph.D.....6
SOME COLLEGE (NO DEGREE).....8
TRADE OR TECHNICAL TRAINING.....9
OTHER.....7
SPECIFY _____

CRIME

The next set of questions is about arrests and incarcerations. Remember that what you tell us is strictly confidential.

16. During 1996, how many months were you incarcerated (in jail or prison)? _____ MONTHS

17. How many times in your life have you been arrested, including detained as a juvenile? ..... _____

18. How old were you the first time you were arrested? ..... _____

19. How many times in your life have you been convicted? Include probation sentences, time served, fines, and community service, along with sentences to jail or prison. ..... _____

20. For the convictions above, how many times in your life have you been incarcerated? .... _____

21. Did you ever receive drug education or treatment while you were incarcerated ? DON'T COUNT CURRENT PROGRAM
NO.....0
YES.....1

22. What is your controlling case? _____
DON'T INCLUDE PAROLE VIOLATION _____

RELATIONSHIP STATUS

Do you currently have a partner or spouse? (CIRCLE ONE)
NO **(SKIP TO Q26)** 0
YES 1

24. Has your current spouse/partner used illegal drugs during your relationship?
NO 0
YES..... 1

25. Has your current spouse/partner been in drug treatment during your relationship?
NO 0
YES..... 1

CHILDREN

26. Do you have any children? CIRCLE ONE:
NO **(SKIP TO NEXT PAGE, Q28)** 0
YES 1

27. How many of your children are under 18 years of age? ..... _____

SUBSTANCE ABUSE

28-31. Which substance do you consider the major problem for you now? **[CIRCLE ONLY ONE]**

ALCOHOL 15

ALCOHOL AND DRUG (DUAL ADDICTION) 45

WRITE IN NAME OF DRUG:

29. _____

AMPHETAMINES 4

BARBITURATES 6

COCAINE (POWDER) 10

CRACK (ROCK) 33

DESIGNER DRUGS (ECSTASY, ADAM, EVE, MDMA, ETC.) 35

HALLUCINOGENS 3

HEROIN 7

INHALANTS 1

MARIJUANA, HASH 2

METHADONE 8

NONE 0

OTHER OPIATES/PAIN KILLERS 9

OVER-THE-COUNTER DRUGS 21

PCP 12

POLYDRUG (WITHOUT ALCOHOL) 23

WRITE IN THE NAMES OF THE DRUGS: 30. _____

31. _____

TRANQUILIZERS (VALIUM, LIBRIUM, XANAX, ETC) 11

32-43. For the drug(s) you listed above, please complete the information below:

1. Drug(s) you listed above:	A. How old were you the first time you tried **the drug**?	B. How old were you when you started using **drug** regularly?	C. How many days did you use **drug non-medically** in the 30 days before you were incarcerated?
32	33	34	35
36	37	38	39

40. Have you ever injected any drugs? NO 0
YES 1

41-43. What is your release date? (USE YOUR BEST GUESS) _____/_____/_____
MONTH DAY YEAR

Thank you for completing this form!

Appendix B: Study Summaries and Consent Forms

APPROVAL NOTICE

OFFICE FOR PROTECTION OF RESEARCH SUBJECTS
2107 Ueberroth Building
169407

DATE: May 28, 1999

TO: Michael Prendergast
Principal Investigator

FROM: Keith T. Kernan, Ph.D.
Chair, General Campus Institutional Review Board

RE: UCLA IRB #G97-05-027-03
Approved by Full Committee Review
(**Approval Period from** 05/28/1999 **through** 05/27/2000)
An Evaluation of the Forever Free Substance Abuse Treatment Program

Please be notified that the UCLA Institutional Review Board (UCLA IRB) has approved the above referenced research project involving the use of human subjects in research. The UCLA's Multiple Project Assurance (MPA) with the National Institutes of Health, Office for Protection from Research Risks is M-1127.

Keith T. Kernan

Approval Signature of the UCLA IRB Chair

PRINCIPLES TO BE FOLLOWED BY PRINCIPAL INVESTIGATORS:

As the Principal Investigator, you have ultimate responsibility for the conduct of the study, the ethical performance of the project, the protection of the rights and welfare of human subjects, and strict adherence to any stipulations imposed by the UCLA IRB. You must abide by the following principles when conducting your research:

1. Perform the project by qualified personnel according to the approved protocol.
2. Do not implement changes in the approved protocol or consent form without prior UCLA IRB approval (except in a life-threatening emergency, if necessary to safeguard the well-being of human subjects.)

3. If written consent is required, obtain the legally effective written informed consent from human subjects or their legally responsible representative using only the currently approved UCLA-IRB stamped consent form.
4. Promptly report all undesirable and unintended, although not necessarily unexpected adverse reactions or events, that are the result of therapy or other intervention, within five working days of occurrence. All fatal or life-threatening events or events requiring hospitalization must be reported to the UCLA IRB in writing within 48 hours after discovery.
5. In clinical medical research, any physician(s) caring for your research subjects must be fully aware of the protocol in which the subject is participating.

FUNDING SOURCE(S):

According to the information provided in your application, the funding source(s) for this research project may include the following: extramural.

PI of Contract/Grant: Michael Prendergast
Funding Source: National Institute of Justice
Contract/Grant No: 97-RT-VX-K003
Contract/Grant Title: An Evaluation of the Forever Free Substance Abuse Treatment Program

Forever Free Evaluation Study Summary for Forever Free Clients

UCLA Drug Abuse Research Center. The study is being conducted by the UCLA Drug Abuse Research Center (DARC) and is support by the National Institute of Justice. Since 1974, DARC's multidisciplinary staff of public health and social science researchers have investigated a wide array of issues related to drug use and treatment. The study is led by Dr. Michael Prendergast, who has written extensively on drug treatment in the criminal justice system. Your participation in this research study is completely voluntary. You are not obligated to continue to participate even if you have previously consented to participate in this study.

Study Description. The UCLA Drug Abuse Research Center is conducting a study on the Forever Free Substance Abuse Treatment program. The focus of the study will be an evaluation of the in-prison portion of the program. The purpose of the study is: (1) to understand the history of the Forever Free Program, especially its philosophy, the characteristics of its participants and staff members, and its links with community treatment programs, (2) to prepare for an evaluation of paroled Forever Free participants by selecting groups of women in-treatment and not-in-treatment and collecting background information on them, (3) to study program participants' relationships with their children by collecting information about custody, visitation, and reunification plans following release, and (4) to provide policy makers, researchers, and treatment providers with information from the research findings of the study.

What will participants do? In Stage 1 of the study, all participants completed an informed consent form and a locator form. Forever Free clients took part in a short interview and some were selected for participation in a focus group. In addition, about a month before release, Forever Free clients were asked to complete a short survey (15 minutes). Subjects from the general prison population who were not in Forever Free completed the informed consent form and locator form, only.

In Stage 2 of the study, the researchers will conduct a post-release interview with those women who completed an informed consent form and locator form. Fifty participants in Los Angeles County or nearby counties will be randomly selected for a face to face interview and a voluntary urine sample. All other particpants will be asked to participate in a phone interview. Those selected for the face-to-face interview will be compensated $45 for the interview, plus $5 for a voluntary urine sample. Those selected for the phone interview will be compensated $45 for their time.

The interview. In addition to confirming basic information from Forever Free clients such as age, race and ethnicity, marital or relationship status and education, the research staff will interview you about your drug use history, criminal history, social and psychological functioning, employment status, and about parenting and custody issues. The interview will take 30-45 minutes to complete.

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UCLA IRB #G97-05-027-03

Expiration date: May 27, 2000

Voluntary participation. Your participation is voluntary and will have no effect on the date of your release to parole or your parole completion date. You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this study. If you have questions regarding your rights as a research subject, you may contact the Office for the Protection of Research Subjects, UCLA, Box 951694, Los Angeles, CA 90095-1694, (310) 825-8714.

Confidentiality. Your responses will be kept confidential. No court or law enforcement official will have access to your UCLA records. They are protected from subpoena by a certificate of confidentiality issued by the Federal Government. The only exceptions to this are reports of child or elder abuse, or if you intend to harm yourself or others. To protect your privacy during the interview, the responses to most questions will be numerical so that anyone overhearing your responses will not hear answers that you might consider sensitive.

Who is helped by the information from the study? The information that you provide could help other prisoners like you by improving both in-prison and post-release drug treatment programs.

Contacting us. Michael Prendergast, Ph.D., the Principal Investigator, and Betsy Hall, Ph.D., the Project Director, are available to answer any questions you may have at any time about the study. They can be reached at the UCLA Drug Abuse Research Center, 1640 S. Sepulveda Blvd., Suite 200, Los Angeles, CA 90025, (310) 445-0874 x275.

Your participation is greatly appreciated!

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Expiration date: May 27, 2000

Forever Free Evaluation Study Summary for Non-Treatment Participants

UCLA Drug Abuse Research Center. The study is being conducted by the UCLA Drug Abuse Research Center (DARC) and is support by the National Institute of Justice. Since 1974, DARC's multidisciplinary staff of public health and social science researchers have investigated a wide array of issues related to drug use and treatment. The study is led by Dr. Michael Prendergast, who has written extensively on drug treatment in the criminal justice system. Your participation in this research study is completely voluntary. You are not obligated to continue to participate even if you have previously consented to participate in this study.

Study Description. The UCLA Drug Abuse Research Center is conducting a study on female prisoners who are in the Forever Free Substance Abuse Treatment program. As part of this study, women who are similar in age, ethnicity, and incarceration offense but who have not received treatment will be also be included. The focus of the study will be an evaluation of the in-prison portion of the program. The purpose of the study is: (1) to understand the history of the Forever Free Program, especially its philosophy, the characteristics of its participants and staff members, and its links with community treatment programs, (2) to prepare for an evaluation of paroled Forever Free participants by selecting groups of women in-treatment and not-in-treatment and collecting background information on them, (3) to study program participants' relationships with their children by collecting information about custody, visitation, and reunification plans following release, and (4) to provide policy makers, researchers, and treatment providers with information from the research findings of the study.

As part of this study, women who who were similar in age, ethnicity, and incarceration offense but who did not receive treatment in Forever Free were included.

What will participants do? In Stage 1 of the study, all participants completed an informed consent form and a locator form. Forever Free clients took part in a short interview and some were selected for participation in a focus group. Participants from the general prison population who were not in Forever Free completed the informed consent form and locator form, only.

In Stage 2 of the study, the researchers will conduct a post-release interview with those women who completed an informed consent form and locator form. Fifty participants in Los Angeles County or nearby counties will be randomly selected for a face to face interview and a voluntary urine sample. All other particpants will be asked to participate in a phone interview. Those selected for the face-to-face interview will be compensated $45 for the interview, plus $5 for a voluntary urine sample. Those selected for the phone interview will be compensated $45 for their time.

The interview. In addition to obtaining basic information such as age, race and ethnicity, marital or relationship status and education, the research staff will interview you about your drug use history, criminal history, social and psychological functioning, employment status, and about parenting and custody issues. The interview will take 30-45 minutes to complete.

UCLA IRB #G97-05-027-03

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Voluntary participation. Your participation is voluntary and will have no effect on the date of your release to parole or your parole completion date. You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this study. If you have questions regarding your rights as a research subject, you may contact the Office for the Protection of Research Subjects, UCLA, Box 951694, Los Angeles, CA 90095-1694, (310) 825-8714.

Confidentiality. Your responses will be kept confidential. No court or law enforcement official will have access to your UCLA records. They are protected from subpoena by a certificate of confidentiality issued by the Federal Government. The only exceptions to this are reports of child or elder abuse, or if you intend to harm yourself or others. To protect your privacy during the interview, the responses to most questions will be numerical so that anyone overhearing your responses will not hear answers that you might consider sensitive.

Who is helped by the information from the study? The information that you provide could help other prisoners like you by improving both in-prison and post-release drug treatment programs.

Contacting us. Michael Prendergast, Ph.D., the Principal Investigator, and Betsy Hall, Ph.D., the Project Director, are available to answer any questions you may have at any time about the study. They can be reached at the UCLA Drug Abuse Research Center, 1640 S. Sepulveda Blvd., Suite 200, Los Angeles, CA 90025, (310) 445-0874 x275.

Your participation is greatly appreciated!

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Forever Free Follow-up Script

[Interviewer is to positively identify subject by requesting birth date. Until positive identification is made, the study is to be referred to as the UCLA Health Study.]

Hi. As you might remember, UCLA is doing an evaluation of the Forever Free program at CIW. During the first phase of the study, you agreed to participate in a follow up interview, so that we could see how women in the Forever Free program and in the comparison group were doing a year after their release from CIW.

As you know, your participation is completely voluntary and you do not have to participate in this phase of the study. The interview will take 30-45 minutes. Those selected for the phone interview will be compensated $45 for their time. Those selected for the face-to-face interview will be compensated $45 for the interview, plus $5 for a voluntary urine sample.

Your responses will be confidential. No court or law enforcement official will have access to your UCLA records. They are protected from subpoena by a certificate of confidentiality issued by the Federal Government. The only exceptions to this are reports of child or elder abuse, or if you intend to harm yourself or others.

To protect your privacy during the interview, the responses to most questions will be numerical so that anyone overhearing your responses will not hear answers that you might consider sensitive.

Would you like to continue participating in the follow-up interview portion of the study? [If yes, schedule interview and mail or fax study summary to respondent. If no, thank respondent and say good bye.]

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Expiration date: **May 27, 2000**

TONI-2

Test of Nonverbal Intelligence
Second Edition

FORM A
ANSWER BOOKLET
AND RECORD FORM

Section I. Identifying Information

Subject's Name _____

Subject's Parent/Guardian _____

Subject's School _____ Subject's Grade _____

Examiner's Name _____

Examiner's Title _____

	Year	Month
Date of Testing	____	____
Date of Birth	____	____
Age at Testing	____	____

Section II. Profile of Test Results

TONI-2 QUOTIENT

RESULTS OF OTHER MEASURES

X = 100, SD = 15	Form A	Form B	1.	2.	3.	4.	5.
160	•	•					
155	•	•					
150	•	•					
145	•	•					
140	•	•					
135	•	•					
130	•	•					
125	•	•					
120	•	•					
115	•	•					
110	•	•					
105	•	•					
100	---	---	---	---	---	---	---
95	•	•					
90	•	•					
85	•	•					
80	•	•					
75	•	•					
70	•	•					
65	•	•					
60	•	•					
55	•	•					
50	•	•					
45	•	•					
40	•	•					

TONI-2 Quotient | Percentile Rank | SEm

Section III. Other Test Data

Test Name	Date of Testing	Equivalent Quotient
1.		
2.		
3.		
4.		

Section IV. Administration Conditions

Who referred the subject? _____

What was the reason for referral? _____

_____

_____

Who discussed the referral with the subject (and with the subject's parent/guardian, if appropriate)? _____

_____

Please describe the administration conditions for the TONI-2 by completing or checking the appropriate categories below.

Group (G) or Individual (I) Administration ____

Location Variables [Interfering (I) or Noninterfering (N)]

- Noise level ____
- Interruptions, distractions ____
- Light, temperature ____
- Privacy ____
- Other _____ ____

Respondent Variables [Interfering (I) or Noninterfering (N)]

- Understanding of test content ____
- Understanding of test format ____
- Energy Level ____
- Attitude toward testing ____
- Health ____
- Rapport with examiner ____
- Other _____ ____

Appendix C: Counselor Training Outline

1 Forever Free Training Program
- Forever Free Program Organization
- Forever Free Program Overview
- Forever Free Program Components
- Forever Free Training Overview

2 Forever Free Program Organization

3 Forever Free Program Overview
- Program is supervised by OSAP Project Director
- CC III Program Manager
- PAII Parole Liaison
- Six months long
- Inmates participate M-F four hours a day

4 Forever Free Program Overview
- Additional Training will be Provided by CDC Staff in the following areas
- New Staff Orientation (8 Hours)
- Specific Concerns for Forever Free Staff
- Inmate Work Incentive Procedures

5 Department of Corrections Fact Sheet
- The California Department of Corrections operates all state prisons, oversees a variety of community correctional facilities, and supervises all parolees during their re-entry into society.
- Budget: $3.7 billion (1997-1998 Budget Act)
- Avg. yearly cost: per inmate, $21,098; per parolee, $2,145.
- Staff: 44,161 currently employed including 38,443 in Institutions, 2,592 in Parole, and 2,911 in Administration (about 27,387 sworn peace officers).

6 Department of Corrections Fact Sheet
- FACILITIES:
- 33 state prisons ranging from minimum to maximum custody; 38 camps, minimum custody facilities located in wilderness areas where inmates are trained as wildland firefighters; and 6 prisoner mother facilities.
- POPULATION:
- All Institutions: 155,740. One year change: 9,559. +6.5%.
- Prisons: 144,897. Capacity: 75,079; Occupied: 193.0%.
- Camps: 3,959. Capacity: 3,908; Occupied: 101.3%.
- Community Facilities: 6,616 Outside CDC: 1,769 At large: 422 USINS (Immigration) Holds: 19,006.
- Top 5 counties: 35.5% LA; 8.0% San Diego; 5.9% San Bernardino; 5.4% Orange; 5.1% Riverside.

7 Department of Corrections Fact Sheet
- CHARACTERISTICS:
- Males: 93.0% Females: 7.0% Parole Violators: 17.5%.
- Race: 30.0% white; 31.1% black; 34.0% hispanic; 4.9% other.

- Offense: 41.5% violent; 25.3% property; 26.4% drugs; 6.7% other.
- Classifications (males): 32% Level I; 21.5% Level II; 24.4% Level III; 19.7% Level IV; 2.5% Special Security.
- Lifers: 17,871 LWOPs: 2,097 Condemned: 503
- Avg Reading Level: Eighth grade Median Age: 32.
- Employed: 57.7% Unavail: 30% Waiting List: 12.3%
- Avg Sentence: 41.4 months; Avg Time Served: 22.6 months.
- Commitment Rate: 388.3 per 100,000 Calif. population.
- Assault Rate (per 100 ADP): 3.3 in '96; 3.2 in '95; 3.4 in '94.
- Escape Rate (per 100 ADP): 0.05 in '96; 0.06 in '95; 0.05 in '94.

8 Department of Corrections Fact Sheet

- About Parole
-
- FACILITIES: 31 re-entry centers, 1 restitution, 1 drug treatment, 1 boot camp and 16 community correctional facilities (CCFs). Most are operated by public or private agencies under contract to CDC. Parole staff monitor the security measures and oversee the day-to-day operations of these facilities.
- OFFICES: 130 parole offices in 71 locations. 4 parole outpatient clinics and 56 clinicians.

9 Department of Corrections Fact Sheet

- Parole Population:
- Total: 105,847. One year change: 4,715. +4.7%.
- Paroled to committing county: 90.4% Paroled to another county: 9.6%
- Region I (North/Central Valley): 21,200;
- Region II (Bay Area/North, Central Coast): 21,639
- Region III (most of LA County): 36,705;
- Region IV (San Diego/San Gabriel Valley/S.Ca) : 26,303
- Return rate (per 100 avg daily pop) with new prison term: 15.9;
- Return rate (per 100 avg daily pop) as parole violator: 52.9
- Top 5 counties: 29.5% LA; 6.5% San Diego; 5.7% Orange; 5.5% San Bernardino; 3.9% Riverside.

10 Department of Corrections Fact Sheet

- CHARACTERISTICS:
- Males: 89.8%
- Females: 10.2%
- Race: 30.0% white; 26.1% black; 39.0% hispanic; 4.9% other.
- Offense: 26.8% violent; 28.2% property; 34.3% drugs; 10.6% other.
- Median Age: 34

11 Yearly cost per inmate

- It costs $21,470 a year to house an inmate in a California state prison in 1997-98. Many people ask, "Why so much when we can educate a child

for less than one-fourth that amount?" A prison, however, is not a school. Therein lies the answer. The state must meet all basic needs of an inmate-food, shelter, clothing and health care. Numerous laws, court actions and regulations mandate the level and the extent of these basic support services. There are also costs to diagnose and process inmates. But by far the greatest expense-and the greatest need-in prison is security. The state must make sure that the prisons are safe for both inmates and staff.

12 Yearly cost per inmate

13 Forever Free Program Overview

- Mental Health Systems Licensed Staff will present the following:
- Dr. Bill Mead - Cognitive testing
- Sylvia Taylor & Don Snookal - PTSD & Abuse Issues
- Steve Corsi - Grief and Loss Issues

14 Forever Free Program Components

- Recovery Education
- Relapse Prevention
- Women's Workshops
- Reasoning and Rehabilitation
- 12 Step groups and step study
- Case Management

15 Recovery Education

- Addictive Disease
- Internal Dysfunction
- Process of Recovery
- Relapse Process
- Relapse Prevention

16 Relapse Prevention

- Addiction history
- Mistaken Beliefs
- Warning Sign Identification
- Warning Sign Management

17 Women's Workshops

- Communication Skills
- Self Esteem
- Co-Dependency
- Parenting
- Abuse Issues

18 Reasoning and Rehabilitation

- Cognitive Skills
- Social Skills
- Life Skills

19 12 Step groups and step study
- On going support upon parole
- Step Study
- Topic Meetings

20 Case Management
- Meets with Case Manager Weekly
- History taken
- Treatment Plan
- Treatment Plan Review
- Parole Planning

21 Forever Free Program Training Overview
- Training Format
- Program Philosophy
- Addictive Disease
- Criminal Personality
- Recovery Approach
- Treatment Process
- Treatment component Procedures

22 Forever Free Program Training Format
- Training will be conducted in task group setting
- Morning sessions will be attended by new employees
- Current employees will be added to afternoon sessions
- Each Training Day will end with report from each participant on what they learned and which of the other participants stood out to them

23 Program Philosophy
- Addiction is a chronic disease
- Participants will be treated with dignity and respect
- Every area of a person's life is affected
- Life long support is required

24 Addictive Disease
- At the core of whether or not a person has choice in matters that effect their addiction, is whether or not addiction is a physical disease.
- We treat and feel different about people who do negative things depending on if free choice is involved.

25  Neurotransmitters

26 Neurotransmitters
- The gap where an electrical signal jumps from one neuron to another is called the synaptic cleft. This is a closeup of the cleft between one neuron and another. Since the impulse cannot cross a gap as electricity, it crosses as a chemical message by means of "messengers" called neurotransmitters. One important neurotransmitter involved in the experience of pleasure is called dopamine.

- Here, dopamine, shown in yellow, is produced in the neuron shown at the top and packaged in containers called vesicles. As an electrical impulse arrives at the neuron's terminal, the vesicle moves to the neural membrane and releases its load of dopamine into the synaptic cleft.
- The dopamine crosses the gap and binds to receiver sites, or receptors, on the membrane of the next neuron. When dopamine occupies a receptor, various actions take place in that neuron: certain ions, shown in green, exit or enter, and certain enzymes are released or inhibited. The result is that a new electrical impulse is generated in this neuron, and the "message" continues on.After the dopamine has bound to the receptor, eventually it comes off again and is removed fom the synaptic cleft and back into the first neuron by reuptake pumps. (For normal nerve transmission, it is important that the dopamine not stay in the cleft)
-

27 Neurotransmitters with Cocaine

28 Neurotransmitters with Cocaine

- WHEN COCAINE IS ADDED
- This is what happens to nerve cell transmission when cocaine, shown in red, enters the brain's reward pathway. Cocaine blocks the reuptake pumps which act to remove dopamine from the synapse. More dopamine accumulates in the synapse, resulting in feelings of intense pleasure.
- Unfortunately, prolonged cocaine use may cause the brain to adapt, such that it comes to depend on the presence of cocaine to function normally, "downregulating" the amount of dopamine present naturally.
- Then, if the person stops using cocaine, there is not enough dopamine in the synapses, and the person experiences the opposite of pleasure--depression, fatigue, and low mood. The immediate, worst symptoms are called withdrawal.
- Even long after the person has stopped using cocaine, brain abnormalities can persist, causing feelings of discomfort andcraving for more of the drug to relieve these feelings.

29 Normal GABA Function

30 Neurotransmitters and Alcohol

- Normal GABA Function
- The gap where an electrical signal jumps from one neuron to another is called the synaptic cleft. This is a closeup of the cleft between one neuron and another. Since the impulse cannot cross a gap as electricity, it crosses as a chemical message by means of "messengers" called neurotransmitters. This animation shows the action of a neurotransmitter called GABA, which acts to quiet electrical activity in parts of the brain. The GABA is produced in one neuron, here the shown at the top It is stored in packages called vesicles that move to the cell membrane and relaese the GABA into the cleft. The GABA crosses the gap between the neurons, and then binds to receiver sites, or receptors, on the neighboring neuron, shown at the bottom.
- When GABA occupies a receptor, it decreases the neuron's electrical

activity. After a while, the GABA come off the receptor and is removed from the synapse by reuptake pumps that return it to the first neuron

31 GABA Function and Alcohol

32 GABA Fuction and Alcohol

- When GABA binds to its receptors, channels in the neuron flicker open and closed, allowing negatively charged molecules called ions (shown here in white) to move into the neuron. This decreases the neuron's activity.
- This close-up shows the opening of the ion channels in normal GABA binding, and then when alcohol is added.
- Alcohol, shown in black, also binds to the GABA receptors, and increases the quieting effect that GABA has on neurons. Researchers are not sure exactly how it does so, but one theory holds that it causes the ion channels to stay open longer, thus increasing the ion flow. The result is a much greater quieting effect on the brain.
- Because there are GABA receptors in many parts of the brain, many different parts are affected. This accounts for alcohol's sedating effect on many functions controlled by the brain--judgment, movement, and even breathing.
- Unfortunately, prolonged alcohol use may cause the brain to adapt, so it comes to depend on the presence of alcohol to function normally. Then, if the person stops drinking, he or she experiences anxiety, jitteriness, emotional discomfort, insomnia, possibly tremors, and, in severe alcoholism, sometimes convulsions and/or death.
- Even long after the person has stopped drinking alcohol, brain abnormalities can persist, causing feelings of discomfort and craving for more alcohol to relieve these feelings.

33 Neurotransmitters and Opiates

34 Neurotransmitters and Opiates

- WHEN OPIATES ARE ADDED
-
- This animation shows what happens to dopamine transmission when an opiate drug such as heroin or morphine enters the brain's reward pathway.
- The opiate, shown in red, binds to opiate receptors on another neuron, shown here at the right. (The reason that some neurons have special receptors for opiates is probably that there are naturally occuring opiates in the brain.)
- This causes the amount of dopamine in the synaptic clefts in the reward pathway to increase dramatically, as shown in the close-up of the synaptic cleft to the left.
- Researchers are still not sure exactly how opiate drugs cause this increase in dopamine, but one theory says that when the opiate binds to the receptors on the third neuron shown, that neuron releases less GABA, which is a neurotransmitter that inhibits dopamine. (If there is less GABA, therefore, there is more dopamine.)

- The increase in dopamine results in feelings of intense pleasure for the person taking the opiate drug.
-

35 Neurotransmitters and Opiates

- Unfortunately, prolonged opiate use may cause the brain to adapt, so it comes to depend on the presence of the drug just to function normally. Then, if the person stops using the drug, he or she experiences the opposite of pleasure--anxiety, irritability, and low mood. The immediate, worst symptoms are called withdrawal.
- Opiate withdrawal has physical symptoms as well as psychological ones; these include nausea, chills, cramps, and sweating.
- Even long after the person has stopped using opiates, brain abnormalities can persist, causing feelings of discomfort and craving for more of the drug to relieve these feelings.

36 Addictive Disease Factors

- Increase in tolerance happens when it takes more of the drug to produced the same effect.
- Stimulants effect receptor sites, where depressants and narcotics such as heroin reduce the sending neurons, making the whole cell dependent on more artificial sending units

37 Addictive Disease Factors (Increase in tolerance)

- The changes in the brain create a demand for more of the substance that is being used.
- This takes more time and money which changes a persons priorities
- Priorities that many people are judged by.

38 Addictive Disease Factors (cell metabolism changes)

- Cell metabolism changes refer the chemical changes in the brain and other organs.
- One of the main changes that occur is how the liver metabolizes alcohol.
- In alcoholics, it is turned in to a very addictive substance similar to heroin.

39 Addictive Disease Factors (cell metabolism changes continued)

- The result is that the person's neurotransmitters do not work adequately enough to permit normal functioning on or off the drug.
- This severely effects the person's ability to function in their lives.
- They are not comfortable and do not function normally.

40 Addictive Disease Factors (withdrawal symptoms)

- Withdrawal symptoms have a profound effect on a person's ability to choose when to stop using.
- Withdrawal symptoms are drug specific, however all psychoactive drugs produce these very powerful effects.

41 Addictive Disease Factors (withdrawal symptoms cont..)

- These symptoms range from irritability to convulsions.
- A person in withdrawal will use just to relieve these symptoms

- Withdrawal is especially traumatic to people addicted to heroin and alcohol

42 Addictive Disease As Bio - Psycho - Social

- Bio - Brain dysfunction caused by addictive use in genetically predisposed people
- Psycho - Personality change caused by brain dysfunction
- Social - Lifestyle problems caused by the personality changes

43 Criminal Personality

- Bio - Brain functioning that predisposes to self-centered and antisocial behavior
- Psycho - Personality constructed around antisocial thrill seeking and pathological independence
- Social - Lifestyle preferences that support antisocial behavior

44 Genetic Predisposition for Criminal Personality Disorder

- High sensation seeking
- Poor impulse control
- Preference for concrete thinking
- Difficulty with abstract and symbolic reasoning
- Insensitivity to others due to self-absorption

45 Common Criminal Thinking

- If you don't care, why should I care
- What's mine is mine and what is yours is mine too.
- The world owes me a living
- I want what I want when I want it
- Rules are for you not me

46 Criminal Personality Disorder Basic Treatment Principals

- Abstinence from antisocial behaviors and alcohol and drug use
- Identifying and changing criminal thoughts, feelings and lifestyle patterns
- Deep personality and Value Change

47 Recovery Approach

- Cognitive Approach
- Think Feel

48 Recovery Approach (think, feel and act barriers)

-
-
-

49 Recovery Approach (empowerment)

- Reestablishing the internal process in the think, feel and act model will bring a sense of identify and relief to a person. To this end, cognitive therapy and the twelve steps have the same goal. In applying the twelve steps to the above model, they can be stated as follows:

50 Recovery Approach (adapted 12 steps)

- Step one: We admitted we were powerless over our addictive thinking - that our lives (our feelings and actions) had become unmanageable.
- Step Two: Came to believe that our still small voice could restore us to sanity.

51 ☐ Recovery Approach (adapted 12 steps)

- Step Three: Made a decision to turn our will and our lives over to the care of the still small voice as we understood him.
- Step Four: We made a through and searching moral inventory of our addictive thinking and the Still Small Voice, looking for the influences on our feelings and actions.

52 ☐ Recovery Approach (adapted 12 steps)

- Step Five: Admitted to the Still Small Voice, our conscious thinking and another human being the exact nature of our wrongs.
- Step Six: Were entirely ready to have the Still Small Voice remove all these defects of our addictive thinking.

53 ☐ Recovery Approach (adapted 12 steps)

- Step Seven: Humbly asked the Still Small Voice to restore our instincts to their intended purpose.
- Step Eight: Made a list of the all persons we had harmed and became willing to make amends to them all. (no change)

54 ☐ Recovery Approach (adapted 12 steps)

- Step Nine: Made direct amends to such people wherever possible, except when to do so would injure them or others. (no change)
- Step Ten: Continued to take personal inventory and when we were wrong promptly admitted it. (no change)

55 ☐ Recovery Approach (adapted 12 steps)

- Step Eleven: Sought through prayer and meditation to improve our conscious contact with the Still Small Voice as we understand it, praying only for knowledge of Its will for us and the power to carry that out.

56 ☐ Recovery Approach (adapted 12 steps)

- Step Twelve: Having had a spiritual awakening as the result of these steps, we tried to carry this message to others and to practice these principles in all our affairs.

57 ☐ Recovery Approach

- Alcoholics Anonymous in the chapter to agnostics on page 55 is quoted: "....for deep down in every man, woman and child, is the fundamental idea of God." In the next paragraph it also states: "We found the Great Reality deep down within us. In the last analysis it is only there He may be found. It was so with us." The change agent being within us is still a change in control. By using this instead of our addictive and criminal thinking a change in locus of control occurs.

58 ☐ CENAPS Post Acute Withdrawal (PAW)

- Difficulty in thinking
- Difficulty with emotions

- Memory problems
- Sleep problems
- Difficulty in handling stress
- Physical coordination problems

59 PAW Patterns
- Regenerative and Intermittent
- Stable
- Degenerative

60 Experiences that create difficult PAW recovery patterns
- Poly drug use
- Prolonged use
- Dual diagnosis
- Life threatening situations
- Abuse

61 Ten PAW management strategies
- Professional Counseling
- 12 step group involvement
- Reality testing conversations
- Prompt problem solving
- Proper Diet

62 Ten Paw management strategies (cont)
- Exercise
- Stress reduction
- Recreation
- Spirituality
- Balanced living

63 CENAPS Developmental Model of Recovery (DMR)
- Transition
- Stabilization
- Early recovery
- Middle recovery
- Late recovery
- Maintenance

64 DMR - Transition
- Developing motivating problems
- Attempting normal problem solving
- Attempting to cut back or control
- Attempting to stop without help
- Accepting help

65 DMR - Stabilization

- Using a structured recovery program
- Stabilizing crisis
- Breaking addictive and criminal preoccupation
- Managing stress (paw)
- Developing hope and motivation

66 ☐ DMR - Early Recovery
- Understanding that CD criminal personality disorders are treatable diseases
- Recognizing & accepting that they have these diseases and need to recover
- Developing sober & responsible ways of thinking, feeling and acting
- Developing a sober and responsible value system

67 ☐ DMR - Middle Recovery
- Repairing lifestyle damage
- adjusting their recovery programs to deal with lifestyle problems
- Balancing their lifestyle
- Learning to manage change

68 ☐ DMR - Late Recovery
- Recognizing current personality problems
- Linking current problems to training in their family of origin
- Examining their childhood to identify values, attitudes and coping styles
- Applying this knowledge to current problems
- Changing Personality and lifestyle patterns

69 ☐ DMR - Maintenance
- Maintaining a recovery program
- Practicing daily coping
- Continuing to grow and develop as a person
- Coping with life transitions

70 ☐ Relapse Prone Coping Style - ESCAPE

E = Evade and Deny
S = Stress
C = Compulsive Behavior
A = Avoidance
P = Problems
E = Evade, Deny and Recycle

71 ☐ Recovery Prone Coping Style - RADAR

R = Recognize
A = Accept
D = Detach
A = Ask for help

R = Respond with Action

72 ☐ Relapse Warning Sign Phases for Chemical Dependency & Criminal Behavior

- Internal Change
- Denial
- Avoidance and Defensiveness
- Crisis
- Immobilization
- Confusion and overreaction
- Depression
- Behavioral loss of control
- Recognition of loss of control
- Option reduction
- Criminal behavior alcohol and drug use

73 ☐ Relapse Warning Signs for CD - Internal Change

- Increased Stress
- Change in Thinking
- Change in Feeling
- Change in Behavior

74 ☐ Relapse Warning Signs for CD - Denial

- Worrying about myself
- Denying that I'm worried

75 ☐ Relapse Warning signs for CD -Avoidance and Defensiveness

- Believing I'll Never Use Alcohol or Drugs
- Worrying about others instead of Self
- Defensiveness
- Compulsive Behavior
- Implusive Behavior
- Tendencies toward Loneliness

76 ☐ Relapse Warning Signs for CD -Crisis Building

- Tunnel Vision
- Minor Depression
- Loss of Constructive Planning
- Plans Begin to Fail

77 ☐ Relapse Warning Signs for CD - Immobilization

- Daydreaming and Wishful Thinking
- Feelings that Nothing Can Be Solved
- Immature Wish to be Happy

78 ☐ Relapse Warning Signs for CD - Confusion and Overreaction

- Difficulty in Thinking Clearly
- Difficulty in Managing Feelings and Emotions
- Difficulty in Remembering Things
- Periods of Confusion
- Difficulty in Managing Stress
- Irritation with Friends
- Easily Angered

79 ☐ Relapse Warning Signs for CD - Depression
- Irregular Eating habits
- Lack of Desire to take Action
- Difficulty Sleeping Restfully
- Loss of Daily Structure
- Periods of Deep Depression

80 ☐ Relapse Warning Signs for CD - Behavioral Loss of Control
- Irregular attendance at AA and Treatment Meetings
- An "I Don't Care" Attitude
- Open Rejection of Help
- Dissatisfaction with Life
- Feelings of Powerlessness and Helplessness

81 ☐ Relapse Warning Signs for CD - Recognition of Loss of Control
- Difficulty with Physical Coordination and Accidents
- Self-Pity
- Thoughts of Social Use
- Conscious Lying
- Complete Loss of Self-Confidence

82 ☐ Relapse Warning Signs for CD - Option Reduction
- Unreasonable Resentment
- Discontinues All Treatment and AA
- Overwhelming Loneliness, Frustration, Anger and Tension
- Loss of Behavioral Control

83 ☐ Relapse Warning Signs for CD -Alcohol and Drug Use
- Attempting Controlled Use
- Disappointment, Shame and Guilt
- Loss of Control
- Life and Health Problems

84 ☐ Relapse Warning Signs for Criminal Behavior - Internal Change
- Thinking Different
- Feeling Different
- Acting Different

85 ☐ Relapse Warning Signs for Criminal Behavior - Return of Denial
- Worrying about Myself
- Denying that I'm Worried

86 ☐ Relapse Warning Signs For Criminal Behavior - Avoidance and Defensiveness
- Believing I'll Never Get in Trouble again
- Needing to Have It my Way
- Privately Putting Others Down
- Feeling Uncomfortable around "Straight" People
- Being Alone

87 ☐ Relapse Warning Signs for Criminal Behavior - Crisis Building
- Bored and Craving Excitement
- Compulsive Behavior
- Building Up for a Fall
- Not Planning Ahead
- Making Bad Decisions
- Nothing is Going My Way

88 ☐ Relapse Warning Signs for Criminal Behavior - Immobilization
- Bummed Out
- Stop Making an Effort
- Feeling Like a Zero

89 ☐ Relapse Warning Signs for Criminal Behavior - Confusion & Overreaction
- Feeling Put Down
- Feeling Like a Victim
- Blaming Others
- Getting Back

90 ☐ Relapse Warning Signs for Criminal Behavior -Depression
- Irregular Eating Habits
- Not Being Able to Sleep Right
- Loss of Daily Structure
- Periods of Deep Depression

91 ☐ Relapse Warning Signs for Criminal Behavior - Loss of Control
- Feeling Afraid but Denying It
- avoiding Responsibility
- Envying Others
- Hurting Others
- Pushing Others Away

92 ☐ Relapse Warning Signs for Criminal Behavior - Recognition of Loss of Control
- Wanting to Use Alcohol and Drugs

- Hanging Out with Old Friends
- Being Irresponsible

93 Relapse Warning Signs for Criminal Behavior - Option Reduction
- I Want What I Want, When I Want it
- Believing I Must Win at All Costs
- Refusing to Back Down
- Losing My Temper

94 Relapse Warning Signs for Criminal Behavior - Criminal Behavior, Alcohol and Drug Use
- Just this Time
- Using Alcohol and Drugs
- Things Get Worse
- Getting Caught

95 Treatment Process
- Recovery is a process rather than an event
- Forever Free uses an multi-faceted process
- The process does the challenging for the participants to change - Counselors support the participants and trust the process

96 Recovery Education Procedures
- Relapse prevention begins with basic drug education, which introduces the women to the biopsychosocial disease concept of drug addiction. While this section talks some about the biological concommitants of susceptibility to drug addiction, the bulk of the section describes the biological, psychological and social effects of addiction. These Include physical dependence, personality changes and lifestyle changes. Addiction is presented as a chronic, deteriorating disease which begins with continued heavy use, progresses through dependency and loss of control and ends with deterioration and death.

97 Recovery Education Procedures
- Education is based on Staying Sober: A Guide for Relapse Prevention By Terence Gorski and Merlene Miller
- Presentations are from Staying Sober Recovery Education Modules by Merlene Miller and Terence Gorski

98 Recovery Education Procedures
- Modules are designed for people with learning disabilities
- Each modules consist of a pre/post test and detailed presentation

99 Recovery Education Procedures
- Each module is given in the following order:
- Pretest
- Presentation notes are taken by participants
- The subject is then read aloud out of Staying Sober Book
- Group discussion
- Post test

100 Recovery Education Main Topics

- Addictive Disease
- Post Acute Withdrawal
- Recovery Process
- Relapse Process
- Relapse Prevention
- Relapse Prevention network

101 Recovery Education Procedures

- The subjects covered in recovery education are identical to those topics reviewed in the Recovery Approach section of this training
- The presentation is adapted for clearer understanding
- It is easier of accept something once it is understood

102 Recovery Education Practicum

- The Training group will be divided into three groups
- Each of the three Groups will select a module and present for 20 minutes to the rest of the group

103 Relapse Prevention Procedures

- Relapse prevention is a proven technique for substance abuse treatment (Derks, 1996), and it forms the core of the Forever Free program. The relapse prevention program is adapted from Gorski's Relapse Prevention program for criminal offenders (Gorski, 1994). Treatment is based on the identification of triggers that occasion relapse and the cognitive activities that accompany relapse.

104 Relapse Prevention Procedures

- Inmates are assisted to identify their own triggers for relapse and to analyze their thinking about these triggers in a manner that is virtually identical to the methods associated with traditional cognitive change therapy as described by Ellis (1979) and many others. Inmates are then assisted to develop ways of managing their reactions to relapse triggers and to develop recovery plans. The program provides a comprehensive educational and treatment package dealing with drug abuse, its etiology, course and treatment. Those who finish the program are equipped with a variety of coping skills and new ways of thinking about their lives and their addiction.

105 Relapse Prevention Procedures

- Relapse Prevention is done in a task group setting
- The Tasks are designed to identify and manage relapse signs and symptoms
- CENAPS eight part Video Tape Series will be used to teach group procedures

106 Cenaps Problem Solving Group Therapy Video Tape Series

- Basic principals
- Integrating Group Therapy with other modalities
- Specialty Groups for CD Patients

- Problem Solving Group Therapy
- Problem Solving Group Therapy Demo
- Prep and warm-up procedures
- Report on assignments and setting agenda
- Problem Solving Group Process
- Closure and debriefing

107 Relapse Prevention - Calendars

- Calendaring" refers to a process of historical review conducted by the inmate under the direction of the counselor and with her assistance. Because of the extensive drug abuse history of most of the women and their concomitant histories of traumatic abuse and crime, these calendars can be quite long and complicated. Also, as they recall their drug abuse history, they also recall traumatic abuse episodes and these can be emotionally wrenching experiences for the women. Sufficient time must be given to allow the counselor and inmate an opportunity to work this through in a sensitive manner.

108 Relapse Prevention - Calendars

- One of the strongest group therapy influences is the members discovering their commonality with one another. This helps to relieve the isolation they have felt from believing that somehow their problems are unique and that no one else has these burdens. The time allotted gives each woman approximately two hours of group time to review her history, but additional time is allotted if necessary. The calendars that the women create then forms the basis for work on identifying triggers for relapse and understanding the relationship between their traumatic abuse history, substance abuse history and criminal history.

109 Relapse Prevention - Calendars

- Counselor guides participant through their history of drug use and significant events in their life.
- The group asks clarifying questions and helps point out signs of addiction
- Counselor uses white board to show progression of the disease and to note mistaken beliefs

110 Relapse Prevention - Calendars

- Client always has the right of refusal
- Feedback is given in verbal and written form on 3x5 cards in group closure
- Feedback consists of how they feel about the person sharing in group and how they can relate

111 Relapse Prevention Calendar Demonstration and Practicum

- Presenter will ask for volunteer and do a calendar with the person in the group setting using Problem solving group process.
- Following the calendar the procedure will be explained in detail
- Participants will be given opportunity to conduct calendars with the group

112 Relapse Prevention Procedures - Warning Sign Identification

- Participants are given exercises 8 Relapse Warning signs for Criminal Behavior & 9 Relapse Warning signs for Chemical Dependency out of The Relapse Prevention Workbook for the Criminal Offender by Terence Gorski
- They are asked to check items that interest them

113 Relapse Prevention Procedures - Warning Sign Identification

- Exercise 10 Initial Warning List starts the process of translating the warning signs from a professionally published version to a highly personalized version that matches the experiences of the individual recovering offender.
- The detail of responses vary widely

114 Relapse Prevention Procedures - Warning Sign Identification

- Exercise 11 Warning Sign Analysis is designed to uncover hidden warning signs and bring them to a conscious level
- Additional techniques of sentence completion and circle work may be necessary to assist this process

115 Relapse Prevention Procedures - Warning Sign Identification

- Exercise 12 Final Warning Sign List
- The goal of creating a Final Warning sign list is to help the recovering offender to write a clear and concise list of the situations, thoughts, feelings and actions that leads her from stable, sober and responsible living back to the use of alcohol, drugs and criminal behaviors

116 Relapse Prevention Procedures - Warning Sign Identification

- Exercise 12 - G Relapse Justifications
- Very important exercise in identifying how addictive thinking can lead them into relapse
- allows women to see how important continuing vigilance and support is

117 Relapse Prevention Procedures - Warning Sign Management

- Exercises 13 through 16 identify critical warning signs and the management of thoughts, feelings and actions that lead to relapse.

118 Relapse Prevention Procedures -Recovery Planning

- These exercises allow for healthly recovery activities to be planned into their activities
- Morning and evening inventories are encouraged

119 Relapse Prevention with Difficult Clients Video Tape Series

- Overview of CENAPS Dual Diagnosis
- Post Traumatic Stress Disorder and Relapse Prevention
- Antisocial Personality Disorder and Relapse Prevention
- Craving and Relapse Prevention

120 Advanced Relapse Prevention Techniques - Sentence Completion and Circle Work

- uses paradoxical therapy for participants to come to new understanding

of themselves

- Sentence Completion lets participants express both negative and positive thoughts feelings and actions
- Mistaken Beliefs are surfaced

121 ☐ Advanced Relapse Prevention Techniques - Sentence Completion and Circle Work

- Have participant describe the event or circumstance that is causing them concern
- Have the group write down the persons responses to the beginning of the following sentences

122 ☐ Advanced Relapse Prevention Techniques - Sentence Completion and Circle Work

- When this happens I think -
- When this happens I feel -
- When this happens I want to -
- Repeat each sentence stem until there are no new responses
- Have the group read back responses starting with " I heard you say -

123 ☐ Advanced Relapse Prevention Techniques - Sentence Completion and Circle Work

- Ask the participant what she got from her responses
- Identify Mistaken beliefs from her responses
- With her permission have her address each group member one at a time using exaggerated responses from the counselor

124 ☐ Advanced Relapse Prevention Techniques - Sentence Completion and Circle Work

- When she sees the response to be false, have her make it a true statement
- When the participant begins to correct their perceptions - they tend to get embarrassed that they had believed something that is false
- Let them know this is a normal reaction

125 ☐ Advanced Relapse Prevention Techniques - Sentence Completion and Circle Work

- Ask the participant if they would like feedback from the group
- Have group give verbal and written feedback using 3x5 cards stating how they feel about the person doing the work and how they can relate
- The feedback allows the participant to feel accepted at a deep emotional level

126 ☐ Women's Issues Topic Groups

- Women's issues are dealt with in topic groups that provide the opportunity for didactic presentations regarding the issues, sharing among the inmate and group process. WITGs are organized to flow logically from one subject to another.

127 ☐ Women's Issues Topic Groups

- It should be noted, that while traumatic abuse of the women will be a

major emphasis of this section, it is delayed to later in the course of the program so that the women will have developed trust with counselors and one another and will have gained some of the other skills necessary for this to be a healing experience.

128 Women's Issues Topic Groups

- To initiate discussions of abuse early in the program would be to open wounds that the women might not yet have the skills to deal with. Not only would this be counterproductive, it could seriously disrupt and interfere with the program as a whole and it could result in the women acting out in a manner that would bring them into conflict with prison regulations. It is for these reasons that abuse will be dealt with during the last half of the program.

129 Women's Issues Topic Groups - Communications

- The first sessions are devoted to the basics of communication including one way communications, simple requests, two way communication, active listening and ethnic/cultural differences in communication style. Like most of the WITGs, these will utilize brief didactic presentations followed by role playing, group discussion and sharing.

130 Women's Issues Topic Groups -Cognitive Change Worksheets

- A = Action or event experienced
- B = Belief about the action or themselves
- C = Consequence (emotional or behavioral)
- D = Disputing their beliefs or thoughts
- E = Energization by this Process

131 Women's Issues Topic Groups - Self Esteem

- The external and internal validation sources of self esteem will be explored, and that will be followed by the avoidant response trap in low self esteem. This will show the women how, when they feel bad about themselves, they avoid confronting issues. This in turn leads to poor performance, criticism and even lower self esteem.

132 Women's Issues Topic Groups - Self Esteem

- After exploring constructive ways of dealing with faults and the connection between low self esteem and drug abuse, the women will be helped to make a personal self esteem inventory. This will be the first time the women will have to begin confronting their own issues in group, but they will be a full month into the program and trust should have developed to a sufficient degree to allow this to be done successfully.

133 Women's Issues Topic Groups - Self Esteem

- After completing their inventories, they will be helped to do an A,B,C,D,&E analysis of some of the issues they have identified. Self esteem will be completed by showing the women through role play how they can now begin to be more revealing of themselves and, through mutual support, actually gain self esteem.

134 Women's Issues Topic Groups - Stress Management

- Stress management techniques will be demonstrated and practiced including breathing and progressive relaxation exercises. Emphasis will

be placed on the importance of finding relief from stress because of the difficulty in thinking clearly during a strong emotional experience. The women will be shown that there is a place for emotions and a place for emotional control. When they need to problem solve and think, they need to be able to control emotions.

135 Women's Issues Topic Groups - Anger Management

- Anger management and provides a way to control one of the emotions that gets people in the most trouble. After constructing personal anger inventories, which now should be easier since they will have been doing calendars for six weeks in relapse prevention, the women will work on A,B,C,D,&E analyses of their anger.

136 Women's Issues Topic Groups - Anger Management

- The anger management section concludes with a reiteration of the relationship between anger and frustration as a lead into the next section on assertiveness. Anger will be shown to occur in its most destructive form when the women are blocked from dealing with an issue because of fear, lack of skills, or a societal rule.

137 Women's Issues Topic Groups - Assertiveness

- The assertion section will begin with a description and demonstration of assertion to show how it differs from hostility and aggression. Fear of being assertive will be dealt with using the A,B,C,D,&E analysis. The women will then be taught specific assertion techniques which they will practice through role playing.

138 Women's Issues Topic Groups - Relationships

- This section starts with discussions of the kinds of relationships the women have from intimate to casual and the basic differences between healthy and unhealthy relationships. From there the discussions will move to the need for relationship followed by the women making personal inventories of their relationships.

139 Women's Issues Topic Groups -Unconscious Survival Roles

- Dependent
- Codependent
- Family Hero
- Scapegoat
- Lost Child
- Mascot

140 Women's Issues Topic Groups - Codependency

- Codependency will be narrowly defined as pathological selflessness. This discussion will then move into enabling. The women will do A,B,C,D,&E analyses of codependent behavior and then explore getting out of codependent relationships. Codependency will finish with self exploration of how the woman may have exploited other codependents to their own advantage.

141 Women's Issues Topic Groups -Parenting

- After an initial discussion, the women will be assisted to develop personal inventories or histories or their parenting experience. Using

some of the techniques learned in self esteem, the women will be assisted to confront their own parenting deficits. Parenting will be subject to an A,B,C,D,&E analysis to help the women deal with mistaken beliefs.

142 Women's Issues Topic Groups - Parenting-Discipline and Abuse

- Discipline will be distinguished from punishment and the role of punishment or emotional abuse and the developing child's own self esteem will be discussed. This section will continue with several sessions devoted to role playing appropriate parent-child interactions and will conclude with a discussion of inappropriate dependencies of parents on children, particularly in single parent households.

143 Women's Issues Topic Groups - Gender Roles

- Gender roles in society will be discussed in light of ex-offender status. This will be followed with gender roles in-prison, at work and in the family. Cultural and ethnic variations in gender roles will be explored next. Finally, the women will do personal inventories to discover how they fit into gender roles and how they will cope with the conflicts modern women experience dealing with outdated roles.

144 Women's Issues Topic Groups - Abuse

- Abuse will be introduced with a discussion of the kinds of abuse the women may have suffered. It can be expected that many horrible examples will be described by the women. How the women have dealt with abuse through denial and self blame will be discussed next. Because the exploration of abuse is likely to be emotionally wrenching, a group will be devoted to how the women will deal with this in the prison environment so as to avoid conflict with prison rules.

145 Women's Issues Topic Groups - Abuse

- This will be followed with several process groups where the women will be free to explore their abuse backgrounds at their own pace. From here the women will deal their own inappropriate guilt about abuse which will lead to an expected catharsis of feminist, moral outrage about the abuse to which they have been subject. The elements of anger management and assertion will then be re-explored in light of this new found reaction to abuse.

146 Women's Issues Topic Groups - Abuse

- The women will explore PTSD and abuse and then develop ways to use their self esteem training to begin a program of recovery from abuse.

147 Women's Issues Topic Groups - Helplessness

- Helplessness as a technical concept about reactions to unavoidable punishment will be explained, and this will be followed with a session on learned optimism as a counter to helplessness. The women will, once again, do A,B,C,D,&E exercises to work on countering helplessness.

148 Women's Issues Topic Groups -Grief Process

- Shock
- Denial
- Bargaining

- Anger
- Depression
- Unbuilding
- Acceptance

149 Women's Issues Topic Groups - Sexual Relations

- For most women, sexual abuse will be their first sexual experience, thus coloring sexuality with all of the conflicts, anger, guilt and avoidance that abuse produces. One of the things that the women need to be ready to deal with is drug free sex. This is frequently a time when PTSD flashbacks can occur with devastating consequences. Previously, sex may have always been accompanied by drugs.

150 Women's Issues Topic Groups - Sexual Relations

- Drugs will have deadened the reality of the situation and assisted the women temporarily and inappropriately in dealing with abuse associated to sex. After finding recovery, a drug free sexual experience may stimulate PTSD reactions, and without preparation, all of recovery can be jeopardized.

151 Women's Issues Topic Groups - HIV

- Six Hours of HIV training is given
- It is given in three one and a half hour sessions.
- It is presented by the Medical Departments Inmate HIV Program

152 Women's Issues Topic Groups - Women's Health Issues

- Topics Covered are:
- General Health
- Dental
- Reproductive
- Nutritional

153 Women's Issues Topic Groups -Vocational Issues

- The Choose-Get-Keep model of vocational adjustment developed at Boston University will be used (Boston University, 1985). This program helps the women see vocational adjustment as a cycle of choosing, getting and keeping. This cycle is repeated over and over as one progresses vocationally.

154 Women's Issues Topic Groups -Budgeting&Money Management

- The women will be helped to explore sources of income support and work. They will review catalogs and newspapers to get a realistic idea of the cost of living and they will then make a budget.

155 Reasoning & Rehabilitation

- Reasoning and Rehabilitation (R&R) is a program of cognitive change, social skills training and values enhancement (Ross et al., 1986).
- R&R starts with problem solving to begin the process of having the women begin to think about thinking.

156 Reasoning & Rehabilitation - Problem Solving

- R&R starts with problem solving to begin the process of having the

women begin to think about thinking.

- By beginning with problem solving, the women will be assisted to begin to consider how they think about problems generally.

157 ☐ Reasoning & Rehabilitation - Social Skills

- The social skills section starts with very simple skills like starting a conversation. It moves to more complicated skills such as persuading others and to more emotionally difficult skills such as apologizing. It concludes with the development of skills to recognize and respond to cons.

158 ☐ Reasoning & Rehabilitation - Negotiating Skills

- The women will be taught the elements of negotiating and then be given an opportunity to use those skills in role playing.

159 ☐ Reasoning & Rehabilitation - Emotional Control

- The women will be brought to understand that strong emotions are the enemy of clear thinking. They will then be taught emotional control techniques.

160 ☐ Reasoning & Rehabilitation - Values Enhancement

- The women will be taught the developmental model of morals that starts with the most primitive moral stance which might be characterized as: "I get mine, before you get yours." They are then shown that moral development involves taking a longer and broader view of behavior so that others are considered and gratification is delayed. At the highest level, the persons role in society and the implications of their behavior for society as a whole is considered.

161 ☐ Reasoning & Rehabilitation - Critical Thinking

- The focus is on thinking carefully, logically and systematically. It is intended to foster curiosity, objectivity, flexibility, judgment and decisiveness. The women will participate in workshops devoted to analyzing arguments and doing small group exercises where they dissect a written argument and then present their analyses to the group

162 ☐ Reasoning & Rehabilitation - Practicum

- Group will be divided into presenting teams of three each
- Each team will select a R&R Module and present it to the group
- Each presentation will be reviewed

163 ☐ Twelve Step Groups

- It is widely recognized that 12-Step programs are a highly effective means of assisting individuals to gain and maintain sobriety. They emphasize the need for the individual to accept help because of the inability to attain sobriety without that help and emphasize constructive coping with the consequences of abuse, including making reparation to those who have been harmed.

164 ☐ Twelve Step Groups

- H & I Panels and Staff lead 12 Step Groups
- Meeting use participation, speaker and step study formats
- Women are strongly encouraged to go to meetings immediately upon

parole whether going to residential or outpatient treatment

165 Twelve Step Groups - Components
- Meetings
- 12 Steps
- Sponsor
- Home Group
- 12 Traditions
- Service Work
- Trusted Servants

166 Twelve Step Groups - Some Meeting Types
- Topic Participation
- Step or Book Study
- Speaker
- Women and Men Only
- Gay
- As Bill Sees It
- Open
- Closed

167 Case Management
- Weekly Half Hour Sessions
- Provides Individual Support
- Treatment Planning and Monitoring
- Cognitive Testing
- Parole Planning and Transition
- Emphasis on need for Residential Treatment

168 Case Management - Treatment Planning & Monitoring
- Psycho/Social Form
- Drug Use History
- Health Problems Check List for Women
- ASI
- Treatment Plan
- Weekly Progress Notes

169 Case Management - Cognitive Testing
- Toni - 2
- Memory for Design
- Trailmaking

170 Case Management - Client Chart Procedures
- Each of the above forms are maintained in a Client Chart along with other important treatment documents
- Each Chart element will be reviewed in detail

- Case Management Practicum will be used to become familiar with procedures

Appendix D: Forever Free Intake and Exit Forms

FOREVER FREE

a program of Mental Health Systems, Inc.

CONSENT TO RELEASE INFORMATION

Consent to Release Confidential Client Information

I, _____ hereby , authorize California Institution for Women Substance Abuse Program - Forever Free to disclose records obtained in the course of my diagnosis and treatment to

_____

(Name of agency or individual to which disclosure is made)

All information and records obtained in the course of providing services to any client is confidential and such disclosure of records shall be limited to the following specific types of information.

_____

_____

This consent shall be in effect through _____; however, this contract is subject to revocation by the undersigned client or guardian by written notice at any time.

Date: _____

Client: _____

_____

Parent, Guardian or Authorized Representative of Client

Witness: _____

FF2(8/96)

CALIFORNIA INSTITUTION FOR WOMEN
16756 CHINO-CORONA ROAD
FRONTERA, CALIFORNIA 91720
(909) 597-1771

CONSENT TO RELEASE MEDICAL, PSYCHIATRIC, AIDS/ARC/HIV ALCOHOL OR DRUG ABUSE PATIENTS RECORDS

I hereby authorize:_____

_____

To release the following information from the health record of:
PATIENT NAME:_____
PATIENT NUMBER/CDC#_____
BIRTHDATE:_____
Covering the dates of treatment:_____
_____

Information to be released: (Check box)
- ( ) Copy of complete health record
- ( ) History and Physical
- ( ) Psychiatric
- ( ) AIDS/ARC/HIV (if applicable)
- ( ) Alcohol/drug abuse care
- ( ) Pathology
- ( ) Radiology
- ( ) Other_____

Information is to be released to:_____

_____

Purpose of disclosure:_____

I understand this consent can be revoked at any time except to the extend that disclosure made in good faith has already occurred in reliance on this consent.

This authorization shall become effective immediately and shall remain in effect for this one request only otherwise specified. This authorization will terminate on_____.

I further understand that I have a right to receive a copy of this authorization upon my request.

The facility, its employees, and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

_____ _____
DATE SIGNATURE OF PATIENT

_____ _____
WITNESS PRINT NAME

_____ _____
REQUESTING M.D. A.K.A. (Name)

PRINCIPLES OF CONDUCT

As a client of this program, you are expected to behave at all times in accordance with our Principles of Conduct. If for any reason you fail to follow these principles, you may be asked to leave the program so that your behavior does not become a barrier to the recovery of others.

Our Principles of Conduct are as follows:

1. I will be honest about matters related to my recovery.
2. I will sincerely attempt to understand my addictions problem.
3. I will follow the directives and advice offered by the staff.
4. I will not use drugs or alcohol at any time during the program. (Clients taking prescribed medications will be allowed to participate in the program with the approval of the Director.)
5. I will submit to breath tests or random urine drug screening or searches when asked.
6. I will honor the confidentiality and rights of other clients, staff, and volunteers.
7. I will be considerate and respectful of other clients, staff, and volunteers.
8. I will not engage in or tolerate violence, threats of violence, and/or antisocial behavior.
9. I will not engage in sexual contact of any kind—physical or verbal—with others in the program, the staff, or volunteers.
10. I will be on time for all meetings and sessions assigned by my Counselor, except when excused for good reason in advance by the Director of the program.
11. I will not smoke during group sessions.
12. I will not eat or drink during group sessions.

The Principles of Conduct have been clearly read and explained to me. I have been given a copy for my own use. My signature below is an acknowledgement that I understand and agree to abide by these Principles of Conduct.

_____ _____

Client Signature and Date Staff Person Signature and Date

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PSYCH/SOCIAL FORM

1. IDENTIFYING DATA

_____ is a _____,

_____, _____,

who is _____. _____ has completed

_____ and worked as _____.

2. CURRENT RELATIONSHIPS

Describe current relationships. Do you want to continue the current relationship you're in?

How do they interact with current relationships?

Marriages/divorces and name.

Number of children and ages.

Where are the children now and who has custody?

3. FAMILY OF ORIGIN

Are your parents natural, adoptive or step and are they living?

Who raised you? Number of brothers and sisters?

Do you have any family members with alcohol or drug problems?

4. SCHOOL DEVELOPMENT

How did you do in school?

What grade did you complete?

What impact did alcohol and drug use have on you while you were in school?

5. WORK HISTORY

What type of jobs have you held?

Pattern of reliability.

Briefly describe job pattern.

What impact did alcohol and drug use have on you at work?

6. PERSONAL RELATIONSHIPS

How did, the individual who raised you, interact with others?

7. HISTORY OF RELATIONSHIPS

Age first dated? Describe your experiences and reactions.

Describe relationship patterns. Are they similar to your parents? If so, how?

How did alcohol and drugs affect your relationships?

8. MEDICAL HISTORY

Current Medications:

Major Operations:

Psychological diagnosis or problems (such as suicide attempts and depression).

Have you had previous drug treatment?

Are you effected by PMS? If yes, how?

Have you ever had a traumatic pregnancy?

9. DIAGNOSTIC IMPRESSION

1. _____ appears to be a _____ stage alcohol/drug addict.

2. _____ background of abuse in both childhood and adulthood includes:

Based upon the above information, _____ appears to have

(circle one) regenerative and intermittent pattern stable pattern degenerative pattern of

lys[illegible]tion.

Based upon the following data, _____ appears to be in the

_____ stage phase of recovery.

The problem list appears to be:

1.
2.
3.

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DRUG USE HISTORY

Name_____

Frequency

0 - No use during past month
1 - Once per month
2 - Once per week
3 - Two to three times per week
4 - More than three times per week
5 - Once Daily
6 - Two to three times daily
7 - More than three times daily

How Taken

1 - Oral
2 - Smoking
3 - Inhalation
4 - Intramuscular
5 - Intravenous

	Past History			Current use (During one month prior to incarceration)				
Types of Drugs Used	Year and age of first use yr/age	Year of first regular use	Max. Use/dose and Freq.	Current use (yes or no)	Freq. of use code	Dosage	Usual route of admin. (use code)	Problem Rank
Heroin								
Non -Rx Methadone								
Other Opiates or Synthetics								
Alcohol								
Barbituates								
Other Sedative, Hypnotics, Methaqualone								
Amphetamines								
Cocaine								
Marijuana/Hashish								
Hallucinogens (Specify if possible)								
Inhalants								
Over the counter drugs								
Tranquilizers								
Others(s) (Specify)								

Current drug of preference: PRIMARY_____ SECONDARY_____

Current cost of drugs per day_____

FF3(8/96)

INSTRUCTIONS

...e N- Blanks - Where appropriate code
...: X = question not answered
N = question not applicable
only one character per item.

...numbers circled are to be asked at follow-
...items with an asterisk are cumulative and
...ld be rephrased at follow-up (see Manual).

...ace is provided after sections for additional
...mments

ADDICTION SEVERITY INDEX

SEVERITY RATINGS

The severity ratings are interviewer estimates of the patient's need for additional treatment in each area. The scales range from 0 (no treatment necessary) to 9 (treatment needed to intervene in life-threatening situation). Each rating is based upon the patient's history of problem symptoms, present condition and subjective assessment of his treatment needs in a given area. For a detailed description of severity ratings' derivation procedures and conventions, see manual. Note: These severity ratings are optional.

Elon Edition

SUMMARY OF PATIENTS RATING SCALE

0 - Not at all
1 - Slightly
2 - Moderately
3 - Considerably
4 - Extremely

...BER

...ST 4 DIGITS ...SSN

...TE OF ...MISSION

...TE OF ...TERVIEW

...M ...GUN

...IME ENDED

...LASS:
1 - Intake
2 - Follow-up

CONTACT CODE:
1 - In Person
2 - Phone

GENDER:
1 - Male
2 - Female

INTERVIEWER CODE NUMBER

SPECIAL:
1 - Patient terminated
2 - Patient refused
3 - Patient unable to respond

GENERAL INFORMATION

NAME _____

CURRENT ADDRESS _____

_____

_____

GEOGRAPHIC CODE

1. How long have you lived at this address? YRS. MOS.

2. Is this residence owned by you or your family?
0 - No 1 - Yes

3. DATE OF BIRTH

4. RACE
1 - White (Not of Hispanic Origin)
2 - Black (Not of Hispanic Origin)
3 - American Indian
4 - Alaskan Native
5 - Asian or Pacific Islander
6 - Hispanic - Mexican
7 - Hispanic - Puerto Rican
8 - Hispanic - Cuban
9 - Other Hispanic

5. RELIGIOUS PREFERENCE
1 - Protestant 4 - Islamic
2 - Catholic 5 - Other
3 - Jewish 6 - None

6. Have you been in a controlled environment in the past 30 days?
1 - No
2 - Jail
3 - Alcohol or Drug Treatment
4 - Medical Treatment
5 - Psychiatric Treatment
6 - Other _____

ADDITIONAL TEST RESULTS

Shipley C.Q.

Shipley I.Q.

Beck Total Score

SCL-90 Total

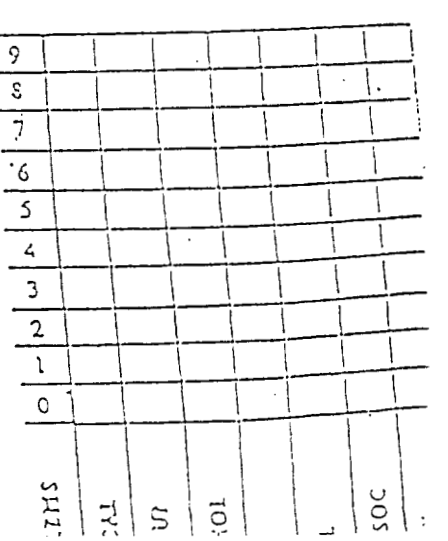
MAST

_____

_____

_____

SEVERITY PROFILE



DRUG/ALCOHOL USE

	PAST 30 Days:	LIFETIME Yrs.	Rt of adm.
(01) Alcohol - Any use at all			
(02) Alcohol - To Intoxication			
(03) Heroin			
(04) Methadone			
(05) Other opiates/ analgesics			
(06) Barbiturates			
(07) Other sed/ hyp/tranq.			
(08) Cocaine			
(09) Amphetamines			
(10) Cannabis			
(11) Hallucinogens			
(12) Inhalants			

(13) More than one substance per day (Incl. alcohol).

Note: See manual for representative examples for each drug class

* Route of Administration: 1 = Oral, 2 = Nasal 3 = Smoking, 4 = Non IV inj., 5 = IV inj.

(14) Which substance is the major problem? *Please code as above or 00-No problem; 15-Alcohol & Drug (Dual addiction); 16-Polydrug: when not clear, ask patient.*

15. How long was your last period of voluntary abstinence from this major substance? *(00 - never abstinent)* MOS.

16. How many months ago did this abstinence end? *(00 - still abstinent)*

* (17) How many times have you:

Had alcohol d.t.'s

Overdosed on drugs

* (18) How many times in your life have you been treated for:

Alcohol Abuse:

Drug Abuse:

* (19) How many of these were detox only?

Alcohol

Drug

(20) How much would you say you spent during the past 30 days on:

Alcohol

Drugs

(21) How many days have you been treated in an outpatient setting for alcohol or drugs in the past 30 days: *(Include NA, AA).*

(22) How many days in the past 30 have you experienced:

Alcohol Problems

Drug Problems

FOR QUESTIONS 23 & 24 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

(23) How troubled or bothered have you been in the past 30 days by these:

Alcohol Problems

Drug Problems

(24) How important to you now is treatment for these:

Alcohol Problems

Drug Problems

INTERVIEWER SEVERITY RATING

(25) How would you rate the patient's need for treatment for:

Alcohol Abuse

Drug Abuse

CONFIDENCE RATINGS

Is the above information significantly distorted by:

(26) Patient's misrepresentation? 0 - No 1 - Yes

(27) Patient's inability to understand? 0 - No 1 - Yes

Comments

LEGAL STATUS

Was this admission prompted or ordered by the criminal justice system (judge, probation/parole officer, etc.)

0 - No 1 - Yes

Are you on probation or parole?

0 - No 1 - Yes

How many times in your life have you been arrested and charged with the following:

- (03) - shoplifting/vandalism
- (04) - parole/probation violations
- (05) - drug charges
- (06) - forgery
- (07) - weapons offense
- (08) - burglary, larceny, B & E
- (09) - robbery
- (10) - assault
- (11) - arson
- (12) - rape
- (13) - homicide, manslaughter
- (14A) - prostitution
- (14B) - contempt of court
- (14C) - other

(15) How many of these charges resulted in convictions?

How many times in your life have you been charged with the following:

- (16) Disorderly conduct, vagrancy, public intoxication
- (17) Driving while intoxicated
- (18) Major driving violations (reckless driving, speeding, no license, etc.)
- (19) How many months were you incarcerated in your life? MOS.

20. How long was your last incarceration? MOS.

21. What was it for? *(Use code 3-14, 16-18. If multiple charges, code most severe)*

(22) Are you presently awaiting charges, trial or sentence? 0 - No 1 - Yes

(23) What for *(If multiple charges, use most severe)*.

(24) How many days in the past 30 were you detained or incarcerated?

(25) How many days in the past 30 have you engaged in illegal activities for profit?

FOR QUESTIONS 26 & 27 PLEASE ASK PATIENT TO USE THE PATIENTS RATING SCALE

(26) How serious do you feel your present legal problems are? *(Exclude civil problems)*

(27) How important to you *now* is counseling or referral for these legal problems?

INTERVIEWER SEVERITY RATING

(28) How would you rate the patient's need for legal services or counseling?

CONFIDENCE RATINGS

Is the above information significantly distorted by:

(29) Patient's misrepresentation? 0 - No 1 - Yes

(30) Patient's inability to understand? 0 - No 1 - Yes

Comments

FAMILY HISTORY

Have any of your relatives had what you would call a significant drinking, drug use or psych problem: one that did or should have led to treatment?

Mother's Side

	Alc	Drug	Psych
Grandmother			
Grandfather			
Mother			
Aunt			
Uncle			

Father's Side

	Alc	Drug	Psych
Grandmother			
Grandfather			
Father			
Aunt			
Uncle			

Siblings

	Alc	Drug	Psych
Brother #1			
Brother #2			
Sister #1			
Sister #2			

Direction: Place "0" in relative category where the answer is clearly no for all relatives in the category; "1" where the answer is clearly yes for relative within the category; "X" where the answer is uncertain or "I don't know" and "N" where there never was a relative from this category. Code most problematic relative in cases of multiple members per category.

FAMILY/SOCIAL RELATIONSHIPS

(1) al Status

1 - Married
2 - Remarried
3 - Widowed
4 - Separated
5 - Divorced
6 - Never Married

2 How long have you been in this marital status? YRS. MOS.
(If never married, since age 18).

(3.) Are you satisfied with this situation?
0 - No
1 - Indifferent
2 - Yes

(4.) Usual living arrangements (past 3 yr.)
1 - With sexual partner and children
2 - With sexual partner alone
3 - With children alone
4 - With parents
5 - With family
6 - With friends
7 - Alone
8 - Controlled environment
9 - No stable arrangements

5. How long have you lived in these arrangements. YRS. MOS.
(If with parents or family, since age 18).

(6.) Are you satisfied with these living arrangements?
0 - No
1 - Indifferent
2 - Yes

Do you live with anyone who:
0 = No 1 = Yes

6A. Has a current alcohol problem?

6B. Uses non-prescribed drugs?

7. With whom do you spend most of your free time:
1 - Family 3 - Alone
2 - Friends

8. Are you satisfied with spending your free time this way?
0 - No 1 - Indifferent 2 - Yes

9. How many close friends do you have?

Direction for 9A-18: Place "0" in relative category where the answer is clearly no for all relatives in the category; "1" where the answer is clearly yes for any relative within the category; "X" where the answer is uncertain or "I don't know" and "N" where there never was a relative from that category.

9A. Would you say you have had close, long lasting, personal relationships with any of the following people in your life:

Mother
Father
Brothers/Sisters
Sexual Partner/Spouse
Children
Friends

Have you had significant periods in which you have experienced serious problems getting along with:

0 - No 1 - Yes

	PAST 30 DAYS	IN YOUR LIFE
(10) Mother		
(11) Father		
(12) Brothers/Sisters		
(13) Sexual partner/spouse		
(14) Children		
(15) Other significant family _____		
(16) Close friends		
(17) Neighbors		
(18) Co-Workers		

Did any of these people (10-18) abuse you: 0 = No; 1 = Yes

18A. Emotionally (make you feel bad through harsh words)?

18B. Physically (cause you physical harm)?

18C. Sexually (force sexual advances or sexual acts)?

(19) How many days in the past 30 have you had serious conflicts:

A with your family?
B with other people? (excluding family)

FOR QUESTIONS 20-23 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

How troubled or bothered have you been in the past 30 days by these:

(20) Family problems
(21) Social problems

How important to you now is treatment or counseling for these:

(22) Family problems
(23) Social problems

INTERVIEWER SEVERITY RATING

(24) How would you rate the patient's need for family and/or social counseling?

CONFIDENCE RATINGS

Is the above information significantly distorted by:

(25) Patient's misrepresentation?
0 - No 1 - Yes

(26) Patient's inability to understand?
0 - No 1 - Yes

Comments:

PSYCHIATRIC STATUS

(1) How many times have you been treated for any psychological or emotional problems?

In a hospital

As an Opt or Priv. patient

(2) Do you receive a pension for a psychiatric disability?

0 - No 1 - Yes

Have you had a significant period, (that was not a direct result of drug/alcohol use), in which you have:

0 - No 1 - Yes	PAST 30 DAYS	IN YOUR LIFE
(3) Experienced serious depression		
(4) Experienced serious anxiety or tension		
(5) Experienced hallucinations		
(6) Experienced trouble understanding, concentrating or remembering		
(7) Experienced trouble controlling violent behavior		
(8) Experienced serious thoughts of suicide		
(9) Attempted suicide		
(10) Been prescribed medication for any psychological/emotional problem		

(11) How many days in the past 30 have you experienced these psychological or emotional problems?

FOR QUESTIONS 12 & 13 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

(12) How much have you been troubled or bothered by these psychological or emotional problems in the past 30 days?

(13) How important to you now is treatment for these psychological problems?

THE FOLLOWING ITEMS ARE TO BE COMPLETED BY THE INTERVIEWER

At the time of the interview, is patient

0 - No 1 - Yes

(14) Obviously depressed/withdrawn

(15) Obviously hostile

(16) Obviously anxious/nervous

(17) Having trouble with reality testing thought disorders, paranoid thinking

(18) Having trouble comprehending, concentrating, remembering.

(19) Having suicidal thoughts

Comments

INTERVIEWER SEVERITY RATING

(24) How would you rate the patient's need for psychiatric/psychological treatment?

CONFIDENCE RATINGS

Is the above information significantly distorted by:

(25) Patient's misrepresentation?
0 - No 1 - Yes

(26) Patient's inability to understand?
0 - No 1 - Yes

ADDICTION ATTITUDE QUESTIONNAIRE

1. Drug Addiction

a. is a disease due to increased in tolerance, subtle changes in the brain, and withdrawal symptoms.
b. is a maladjustment to the stresses and problems that people experience in life.
c. doesn't really exit but is just as a cop out used by people who don't have the will power to control their use.
d. goes away when you don't use drugs.

2. While a drug addicted person is using drugs

a. they are freely choosing to use.
b. they care more about drugs than their family.
c. their use is dictated by the disease process.
d. they can choose to stop as soon as they are clean.

3. In recovery

a. support is needed to stay sober.
b. all you need is will power.
c. full feelings and thinking can return.
d. both a and c are true.

4. Staying clean and sober requires

a. complete abstinence, that is complete avoidance of drug and alcohol use.
b. just wanting not to have problems and using occasionally.
c. a complete course of in-depth psychotherapy.
d. will power and desire to stop using.

5. Recovery patterns

a. are the same for everyone.
b. don't vary due to experience.
c. requires management.
d. don't really exist.

6. Internal dysfunction of thinking and emotions

a. is a condition that happens only if you want to continue drug use.
b. is a natural part of addiction.
c. only rarely occurs.
d. is an imagined experience resulting from a lack of familiarity with sobriety.

7. People who ask for help

a. are aware of how powerful addiction is.
b. believe they are worth the effort that recovery.
c. are generally weak willed and immature.
d. both a and b.

8. Shame and guilt

a. are not important to deal with once you are clean and sober.
b. go away automatically once you are clean and sober.
c. take on a clearer perspective once you understand the power of addiction
d. should be the only reason necessary to stay clean and sober.

9. 12 Step programs (AA and NA)

a. are only needed if you feel like returning to drinking or using.
b. help to develop a way of life based upon spiritual principles and behavior change.
c. force you to change you beliefs and adopts a new religion.
d. have membership fees and take attendance like any other club.

10. Anger

a. disappears once you become clean and sober.
b. is the only effective way to handle problems.
c. can be managed with proper social skills.
d. should never be talked about, but only acted upon.

Section VII. Responses to the TONI-2 Form A

r	____	1.	1	2	3	4	(5)	6	____	29.	(1)	2	3	4	5	6
	____	2.	1	2	3	4	5	(6)	____	30.	(1)	2	3	4	5	6
	____	3.	1	2	(3)	4	5	6	____	31.	(1)	2	3	4	5	6
	____	4.	1	(2)	3	4	5	6	____	32.	1	2	3	(4)	5	6
yrs. >	____	5.	1	2	3	(4)	5	6	____	33.	1	2	(3)	4	5	6
	____	6.	1	2	(3)	4	5	6	____	34.	1	(2)	3	4	5	6
	____	7.	(1)	2	3	4	5	6	____	35.	1	2	(3)	4	5	6
	____	8.	1	2	(3)	4	5	6	____	36.	1	2	3	4	(5)	6
	____	9.	1	2	3	(4)	5	6	____	37.	1	2	3	4	(5)	6
2 yrs. >	____	10.	1	2	3	4	(5)	6	____	38.	1	(2)	3	4	5	6
	____	11.	(1)	2	3	4	5	6	____	39.	(1)	2	3	4	5	6
	____	12.	(1)	2	3	4	5	6	____	40.	1	(2)	3	4		
	____	13.	1	2	(3)	4	5	6	____	41.	1	2	3	(4)		
	____	14.	1	2	3	4	5	(6)	____	42.	1	2	(3)	4	5	6
-17 yrs. >	____	15.	1	2	3	(4)			____	43.	1	(2)	3	4	5	6
	____	16.	(1)	2	3	4	5	6	____	44.	1	2	3	4	5	(6)
	____	17.	1	2	3	(4)	5	6	____	45.	1	(2)	3	4		
	____	18.	1	2	3	4	(5)	6	____	46.	(1)	2	3	4	5	6
	____	19.	1	2	3	(4)			____	47.	(1)	2	3	4		
8-20 yrs. >	____	20.	1	2	(3)	4	5	6	____	48.	1	2	3	(4)	5	6
	____	21.	(1)	2	3	4	5	6	____	49.	1	(2)	3	4	5	6
	____	22.	1	2	3	(4)	5	6	____	50.	(1)	2	3	4	5	6
	____	23.	1	2	3	(4)	5	6	____	51.	(1)	2	3	4	5	6
	____	24.	(1)	2	3	4	5	6	____	52.	1	2	(3)	4	5	6
21 + yrs. >	____	25.	(1)	2	3	4	5	6	____	53.	1	2	3	4	5	(6)
	____	26.	1	(2)	3	4			____	54.	1	2	(3)	4	5	6
	____	27.	1	2	3	(4)	5	6	____	55.	(1)	2	3	4	5	6

Section VIII. Score Summary

sal Item #

mber of Correct Responses Between Basal Item and Ceiling Item #_____ + _____

tal Raw Score _____

Section IX. Interpretation and Recommendations

Were the results of the TONI-2 interpreted to the:

subject? ____ If yes, by whom? _____

subject's parent/guardian (if appropriate)? ____ If yes, by whom? _____

Section V. Administration Instructions

ıe ıg location should include a chair for the examiner, a chair for the test subject, and a surface to display the Picture Book. emble the appropriate testing materials, including the Picture Book, a copy of the Form A Answer Booklet and Record Form, and ncil. Establish rapport with the individual taking the test and complete the identifying information on the front of the Answer Booklet Record Form. Place the Picture Book in front of the subject with the stimulus items at the top of the page and the response choices ıe bottom. Both the subject and the examiner should be able to see the items and the response choices.

dminister the first training item, Item T1. Gesture through the sequence of the stimulus pattern and then point to the empty square ne pattern. Look questioningly at the subject and then back to the empty square in the stimulus. Shake your head "yes" or "no" ıending on the correctness of the response. Do this for each response choice. Encourage subjects to join you in indicating correctness allow them to complete the remaining five training items without prompting if they clearly understand the process. Readminister the ning items if the subject does not understand what is expected or appears to be responding impulsively. If the subject still does not em to understand after the training items have been administered twice, discontinue testing. If you believe the subject does understand task, then proceed to the actual test items.

Turn to the Form A portion of the Picture Book. Begin testing with Item A1 if the subject is very young or very old, if the subject is spected of having a significant intellectual impairment, or if the subject had difficulty completing the training items. Otherwise begin sting with the item designated in Section VII by the arrow adjacent to the subject's approximate chronological age in years. Use the me pantomime administration procedure employed for the training items. Allow the subject to indicate her or his choice by pointing it or by making some other meaningful nonverbal response. Record the subject's responses in Section VII by placing an "X" over e number of the response selected by the subject. Correct response numbers are printed in boldface type inside a circle.

Continue testing until Item A55 has been administered or until the subject has achieved ceiling by making three incorrect responses five consecutive items. At this point discontinue testing and review the earlier responses to determine if a basal of five consecutive ırrect responses was achieved. If the subject did not achieve a basal and if testing did not begin with Item A1, return to the first item dministered and test downward until a basal is established or Item A1 is administered.

Discontinue testing when both a ceiling (i.e., three incorrect responses in five consecutive items, or administration of Item A55) and basal (i.e., five consecutive correct responses, or administration of Item A1) have been established.

Detailed instructions for administering and scoring the TONI-2 are provided in chapter 2 of the Examiner's Manual. Please consult ıe manual if there are any questions about correct procedure.

Section VI. Anecdotal Comments

] Health
] Problems
] Checklist™
] for Women

ohn A. Schinka, Ph.D.

The Health Problems Checklist (HPC) is a structured survey designed to facilitate the rapid assessment of the health status and potential health problems of clients typically seen in psychotherapy settings. The HPC is not a substitute for a medical evaluation; this survey is intended as a detailed data form from which the clinician or therapist can make an appropriate referral.

The HPC can be completed by most adults in ten to twenty minutes. It can be used with any adult who is literate and has at least low average intelligence. The HPC consists of over 200 checklist items which provide a comprehensive survey of health symptoms and complaints in the following areas: General Health (GEN), Dermatological (DERM), Cardiovascular/Pulmonary (CARD/PUL), Visual (VIS), Auditory/Olfactory (AUD/OLF), Mouth/Throat/Nose (M/T/N), Gastrointestinal (GI), Endocrine/Hematology (END/HEM), Orthopedic (ORTHO), Neurological (NEURO), Genitourinary (GU), Habits (HAB), and History (HX).

Since the HPC is essentially a structured information-gathering instrument, scoring is accomplished by listing the problem areas and item endorsements. Clinicians familiar with the HPC typically employ it as part of a comprehensive intake survey and as the basis for an informed referral to an appropriate physician.

PAR PSYCHOLOGICAL ASSESSMENT RESOURCES, INC.

P.O. Box 98 / Odessa, Florida 33556 / Telephone (813) 968-3003

Check all items which apply

GEN/12

___ poor health
2 ___ recent change in health
3 ___ always feel sick
4 ___ trouble sleeping
5 ___ trouble falling asleep
6 ___ feeling weak all over
7 ___ get tired easily
8 ___ loss of strength
9 ___ get sick often
10 ___ loss of appetite
11 ___ weight has changed
12 ___ often have fever or chills

DERM/10

13 ___ texture of skin has changed
14 ___ itching
15 ___ have rashes
16 ___ skin drying out
17 ___ new warts, moles, or other growth on skin
18 ___ have areas of discolored skin
19 ___ skin breaking out in blemishes
20 ___ loss of hair
21 ___ change in appearance of fingernails
22 ___ change in texture of fingernails

VIS/14

23 ___ change in vision
24 ___ double vision
25 ___ trouble seeing at night
26 ___ trouble seeing to the left or right
27 ___ blurred vision
28 ___ blind spots in vision
29 ___ flashing lights in vision
30 ___ inflamed eyes
31 ___ pain in eyes
32 ___ discharge from eyes
33 ___ itching eyes
34 ___ swollen eyelids
35 ___ soreness around eyes
36 ___ often have tears in eyes

AUD/OLF/14

37 ___ loss of hearing
38 ___ ringing in ears
39 ___ strange sounds in ears
40 ___ change in hearing in one ear
41 ___ earaches
42 ___ discharge from ear
43 ___ loss of sense of smell
44 ___ change in sense of smell
45 ___ smell bad odors
46 ___ runny nose
47 ___ stuffed up nose
48 ___ nosebleeds
49 ___ sinus problems
50 ___ pain around nose and sinuses

M/T/N/18

51 ___ sore tongue
52 ___ sore gums
53 ___ swollen lips
54 ___ toothache
55 ___ sores in or around mouth
56 ___ sore throat
57 ___ hoarseness
58 ___ change in voice
59 ___ difficulty swallowing
60 ___ dry mouth
61 ___ too much saliva
62 ___ change in sense of taste
63 ___ loss of sense of taste
64 ___ losing teeth
65 ___ stiff neck
66 ___ swollen glands in neck
67 ___ neck is sore and tender
68 ___ lump in neck

CARD/PUL/18

69 ___ pain in chest
70 ___ pain when taking a breath
71 ___ difficulty in breathing
72 ___ difficulty in taking a full breath
73 ___ wheezy or noisy breathing
74 ___ frequent cough
75 ___ coughing spells
76 ___ cough up blood or mucus
78 ___ cough up foamy mucus
79 ___ difficulty breathing during work or exercise
80 ___ breathing problems when lying down
81 ___ frequent colds
82 ___ frequently aware of heartbeat
83 ___ heartbeat seems irregular
84 ___ lips or fingernails turn blue
85 ___ swelling of legs or ankles
86 ___ high blood pressure

Check all items which apply

GI/26

87 ___ frequent nausea or upset stomach	100 ___ frequent stomach cramps
88 ___ heartburn	101 ___ change in bowel movements
89 ___ burning in back of throat	102 ___ diarrhea or loose stools
90 ___ stomach always feels full	103 ___ constipation
91 ___ frequently burp or belch	104 ___ frequent use of laxatives
92 ___ have a lot of gas	105 ___ often use medicine to settle stomach
93 ___ difficulty swallowing food	106 ___ bowel movement is bloody
94 ___ difficulty eating meat	107 ___ bowel movement is unusual color
95 ___ frequent vomiting	108 ___ painful bowel movements
96 ___ sudden and forceful vomiting	109 ___ pain in rectum
97 ___ vomiting blood	110 ___ hemorrhoids or piles
98 ___ vomiting undigested food	111 ___ unable to finish bowel movement
99 ___ stomach pain	112 ___ rectum itches

END/HEM/12

113 ___ bruise or bleed easily	119 ___ discomfort with heat or cold
114 ___ have many bruises	120 ___ excessive sweating
115 ___ gums bleed after brushing teeth	121 ___ change in size of head, hands, or feet
116 ___ skin heals slowly	122 ___ pale or yellow skin
117 ___ increased appetite	123 ___ change in amount of body hair
118 ___ often thirsty	124 ___ change in texture of hair

ORTHO/10

125 ___ bone pain	130 ___ muscle pain
6 ___ joint pain	131 ___ muscle cramps
127 ___ redness in joints	132 ___ change in posture
128 ___ stiffness in joints	133 ___ back pain
129 ___ fingers becoming crooked	134 ___ frequent back problems

NEURO/26

135 ___ muscle weakness	148 ___ seizures or fits
136 ___ tics or twitching muscles	149 ___ headaches
137 ___ muscle spasms	150 ___ having trouble keeping track of time
138 ___ trouble walking	151 ___ forgetting things
139 ___ balance problems	152 ___ having memory problems
140 ___ tremors or shakiness	153 ___ getting lost while driving
141 ___ problems with dropping things	154 ___ hearing unusual sounds or voices
142 ___ trouble walking up stairs	155 ___ seeing unusual things
143 ___ numbness in arms or legs	156 ___ having strange feelings
144 ___ tingling or burning skin	157 ___ getting confused
145 ___ loss of feeling on skin	158 ___ having trouble concentrating
146 ___ loss of sense of touch	159 ___ having trouble reading or writing
147 ___ blackouts or fainting spells	160 ___ having problems following a conversation

GU/22

161 ___ frequent urination	172 ___ irregular menstrual periods
162 ___ blood in urine	173 ___ sores in area of vagina
163 ___ trouble stopping urination	174 ___ pain or swelling in area of vagina
164 ___ pain or burning on urination	175 ___ discharge from breast
165 ___ lose or leak urine	176 ___ pain or tenderness in breast
166 ___ sudden and urgent need to urinate	177 ___ lumps or masses in breast
167 ___ change in color or odor of urine	178 ___ change in size of breasts
168 ___ vaginal discharge	179 ___ pain during sexual intercourse
169 ___ menstrual periods have stopped	180 ___ change in sexual performance
170 ___ painful menstrual periods	181 ___ change of life

:heck all items that apply

AB/30

83 ___ rarely exercise
84 ___ have a regular exercise plan
85 ___ exercise on weekends
86 ___ eat a balanced diet
87 ___ have a poor diet
88 ___ eat three meals a day
89 ___ eat at irregular times
90 ___ take vitamins
191 ___ always see doctor for yearly checkup
192 ___ have had checkup in last year
193 ___ have not seen a doctor for many years
194 ___ am currently being treated by physician
195 ___ always have regular dental checkups
196 ___ have not seen dentist in last year
197 ___ am taking medication prescribed by my doctor
198 ___ often use medicine like aspirin or laxatives
199 ___ do not drink alcohol
200 ___ have alcoholic drink a few times a week
201 ___ have alcoholic drink every day
202 ___ have several alcoholic drinks every day
203 ___ have a problem with alcohol
204 ___ have had a problem with alcohol in the past
205 ___ do not smoke cigarettes
206 ___ smoke less than a pack of cigarettes a day
207 ___ smoke a pack of cigarettes every day
208 ___ have smoked for less than five years
209 ___ have smoked for longer than five years
210 ___ work with chemicals or solvents
211 ___ work with fertilizers or weedkillers
212 ___ work with paint or glue

HX/8

213 ___ history of head injury
214 ___ history of heart attack
215 ___ history of stroke
216 ___ history of hypertension
217 ___ history of diabetes
218 ___ history of seizure disorder or epilepsy
219 ___ history of cancer
220 ___ hospitalization in last year

l .ny other health problem you might have:

List all medications that you are now taking:

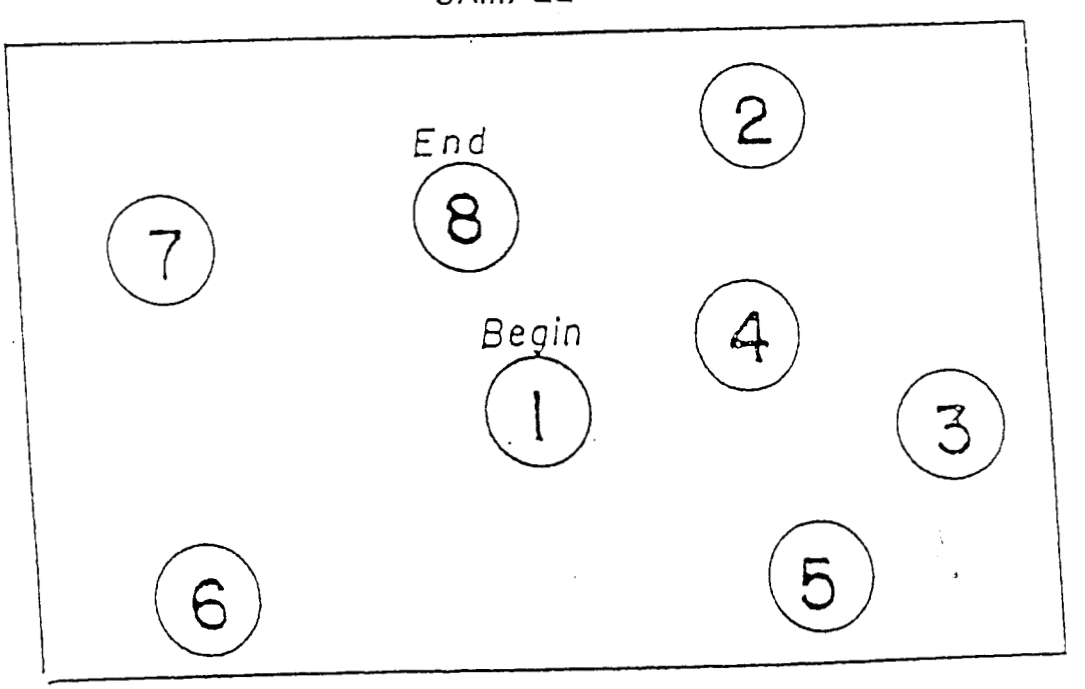
List the names of the doctors treating you and the illnesses you are being treated for:

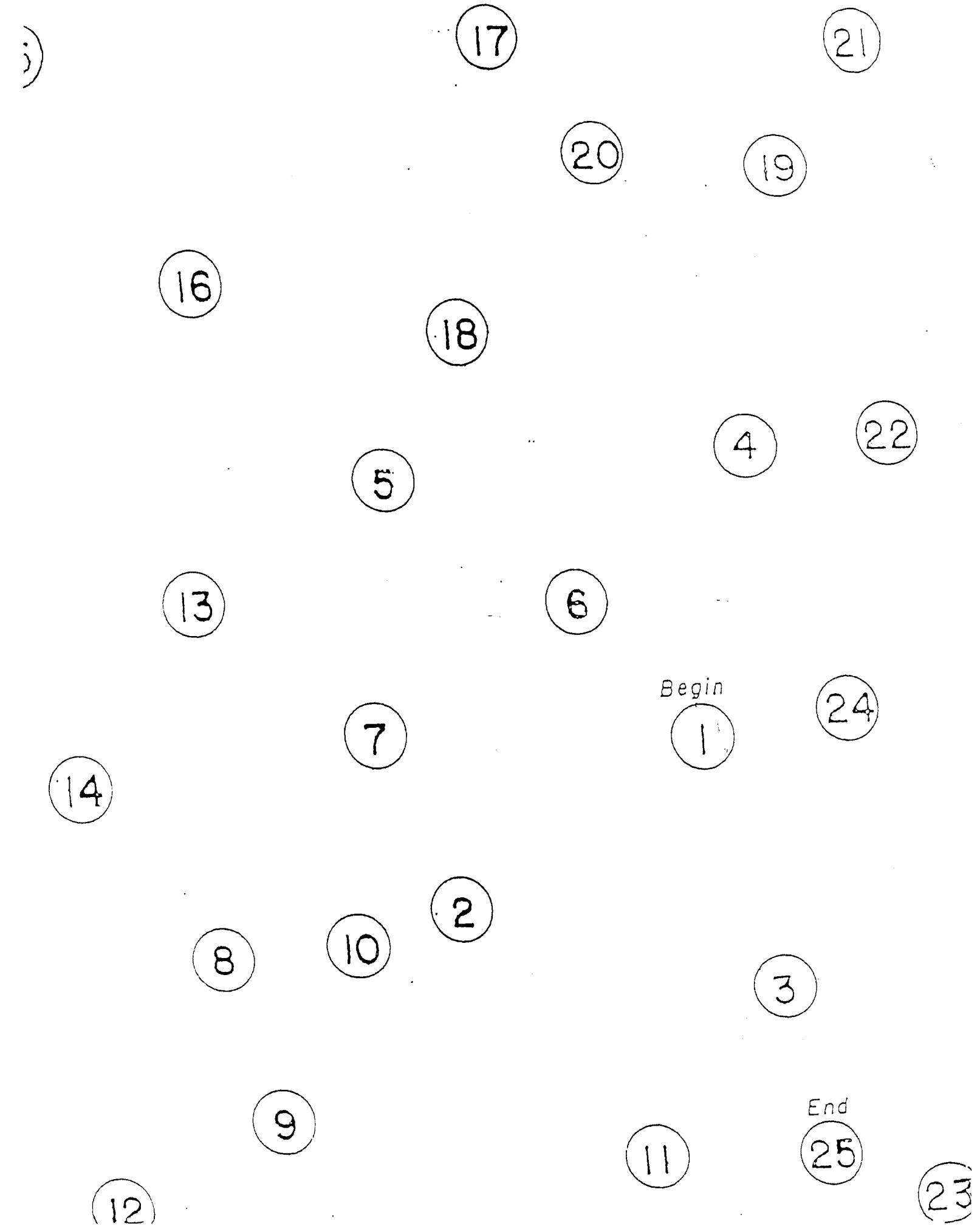
Doctor	Illness

TRAIL MAKING

Part A

SAMPLE

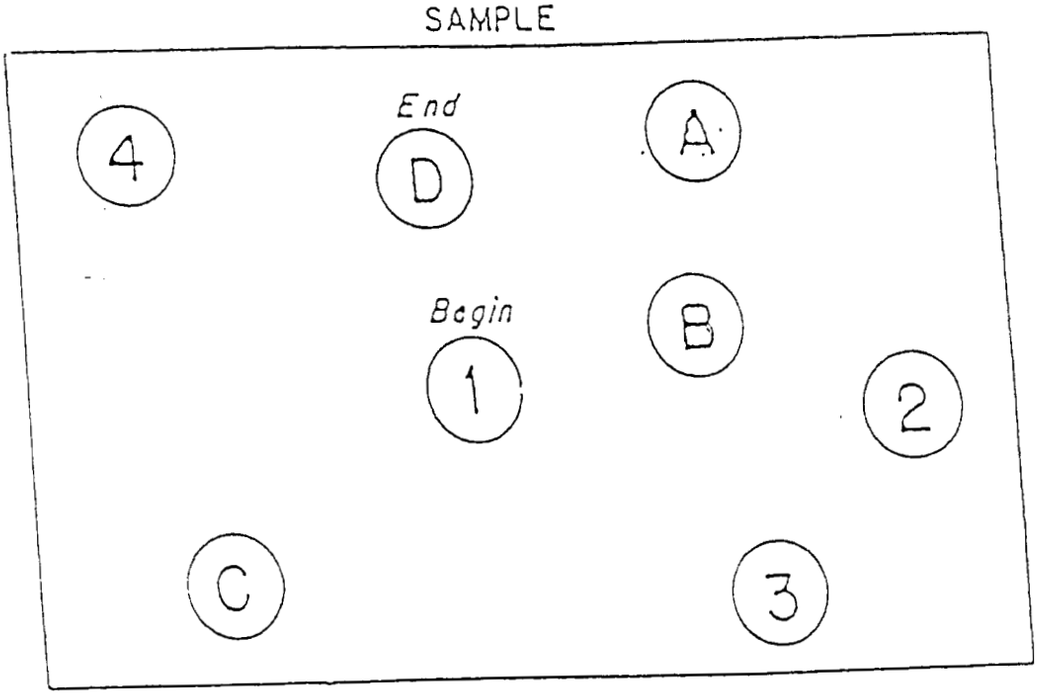


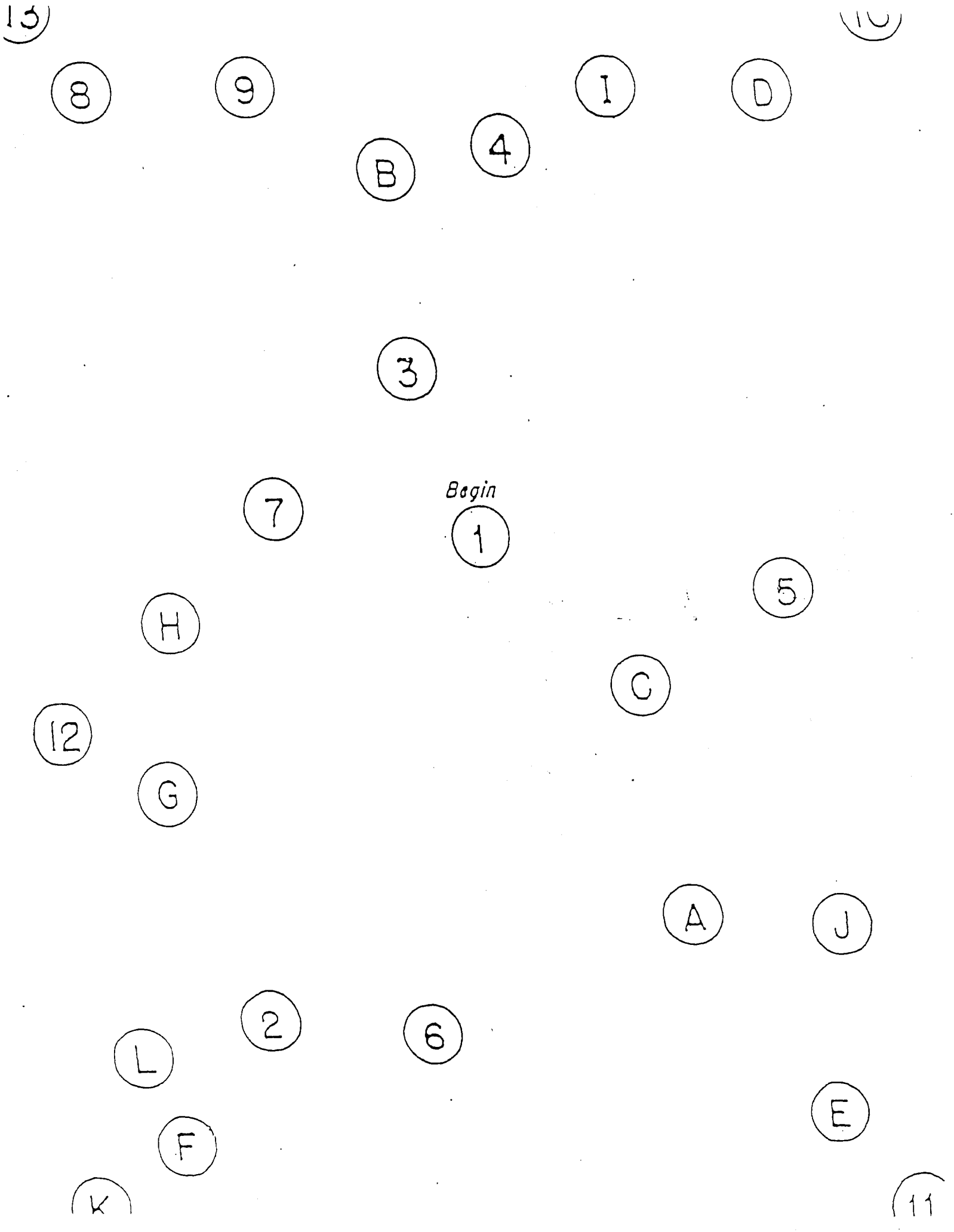


TRAIL MAKING

Part B

SAMPLE





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TREATMENT PLAN

Name_____ Case Manager_____ Date_____

PROBLEM 1
Description

Goal

Action Plan (Intervention)
1.
2.
3.
Expected Completion Date

PROBLEM 2
Description

Goal

Action Plan(Intervention)
1.
2.
3.

Expected Completion Date

PROBLEM 3
Description

Goal

Action Plan(Intervention)
1.
2.
3.

Expected Completion Date

_____ _____

Case Manager Program Coordinator

_____

Inmate

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CASE MANAGER SESSION NOTES CHECK LIST

Case Manager _____ Date _____

SESSION NOTES _____

SESSION NOTES _____

SESSION NOTES _____

SESSION NOTES _____

SESSION NOTES _____

SESSION NOTES _____

SESSION NOTES _____

SESSION NOTES _____

SESSION NOTES _____

SESSION NOTES _____

SESSION NOTES _____

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SESSION NOTES _____

SESSION NOTES _____

SESSION NOTES _____

SESSION NOTES _____

SESSION NOTES _____

SESSION NOTES _____

SESSION NOTES _____

FF7(8/96)

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WEEKLY PROGRESS SESSION NOTES

Client Name _____

Date _____ _____

Weekly Progress Weekly Session

WEEKLY PROGRESS STAFF INFORMATION

PROGRESS: Satisfactory / Unsatisfactory

Changes to treatment plan and/or new assignment

NO

YES specify: _____

WEEKLY SESSION NOTES

TOPIC COVERED:

CLIENT COMMENTS:

ASSESSMENT AND PLANS:

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CASE MANAGER'S CHECK LIST

(ITEMS MUST BE COMPLETED PRIOR TO PARTICIPANTS EXIT)

Client Name _____

Case Manager _____

ITEM	DATE COMPLETED	COMMENTS
Inmate Application *Form FF1(8/96)*		
Program Description and Consent Form *Form F11(8/96)*		
Treatment Plan *Form FF4(8/96)*		
Consent to Release Info *Form FF2(8/96)*		
Addiction Servcrity Index		
Women's Health Checklist		
Addictions Attitude Questionnaire *Form FF10(8/96)*		
Toni-2		
Memory Design		
Retain Trail Making Test		
Psych-Social and Drug History *Form FF3(8/96)*		
Exit Questionaire *Form FF11(8/96)*		
Discharge Summary *Form FF3(8/96)*		
*Participant Exit Form Program Form *Form FF9(8/96)*		
*Satisfaction Survey *Form FF8(8/96)*		

Please see that each item proceeded by an asterisk(*) is completed in a timely manner and forwarded to the Office of Substance Abuse Programs. These documents are vital to the evaluation of this project

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SURVEY OF PROGRAM PARTICIPANTS ON SATISFACTION WITH PROGRAM SERVICES AT END OF PROGRAM

The California Department of Corrections would like your opinion regarding the value and usefulness of the substance abuse treatment program that you have been attending. The overall purpose of the program has been to help you quit using drugs and have a better life when you are released on parole. Please answer the following questions and add any other information that you think may make the program better for others who participate in the future.

1. How long have you been in the program?
   _____ months _____ days

2. How useful do you think this program will be in helping you stop using drugs? Please check the answer below that best describes how you feel.
   - ☐ the program has been very helpful
   - ☐ the program has been somewhat helpful
   - ☐ the program has helped me a little
   - ☐ I don't think the program will help. (If you check this answer, please tell us why)

   _____
   _____
   _____

3. Which part or parts of the substance abuse program do you think will help drug users the most to quit using drugs? Check all of the following that apply to you. up to 3?
   - ☐ information regarding drugs and their effects to the body and mind
   - ☐ individual counseling sessions
   - ☐ group counseling sessions
   - ☐ attending Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Cocaine Anonymous (CA), or religious group meetings
   - ☐ employment information
   - ☐ helped in making me feel better about myself, raised my self esteem
   - ☐ being with others who have similar problems
   - ☐ other _____

   _____
   _____
   _____

4. Do you feel better about yourself as a result of participating in this program?
   - ☐ yes
   - ☐ no

   If you do feel better about yourself, please check the following reasons that make you feel better. up to 3?
   - ☐ I have more confidence in myself
   - ☐ I have more respect for myself
   - ☐ I know that there are others who have similar problems and I can ask them for help
   - ☐ I know where to go to get help for a substance abuse problem
   - ☐ Friends and family will help if I need it
   - ☐ I can go to an AA, NA, or CA meeting
   - ☐ Drugs can no longer control my life
   - ☐ I am more prepared to interview and get a job and keep the job
   - ☐ Other Please explain _____

5. Please help us make the program better. Tell us what part of the program needs to be changed to make it better for program participants. Check "yes" or "no" to each of the following questions.

a) Is the program facility OK?
- ☐ yes
- ☐ no please explain _____

b) Which type of counseling do you feel helps substance abusers more?
- ☐ individual
- ☐ both group and individual
- ☐ group

c) Do you feel that there should be more or less individual counseling during the program?
- ☐ more
- ☐ less

d) Do you think there should be substance abuse group counseling during the program? more or less ?
- ☐ yes
- ☐ no

e) Do you think there should be more or less group workshops during the program?
- ☐ more
- ☐ less

f) Should there be more or less information on getting and keeping a job?
- ☐ more
- ☐ less

g) How useful is the information regarding making yourself feel better as a person?
- ☐ very useful
- ☐ somewhat useful
- ☐ of little use
- ☐ not useful at all

5. We are interested in your opinion regarding attending self-help groups such as AA and NA.

a) Do you think that attending AA/NA group meetings are helpful in your recovery?
- ☐ yes
- ☐ no

b) Have you been attending AA/NA meetings while in the program?
- ☐ yes
- ☐ no

c) Do you plan to attend AA/NA meetings when you parole?
- ☐ yes
- ☐ no

6. Please tell us anything else that you think might be helpful in making the program better for program participants.

_____
_____
_____
_____

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DISCHARGE SUMMARY

Counselor: _____ Parole Agent: _____

Client Name: _____ Parole Unit: _____

Number of Days in Treatment: _____ W#: _____

Overall Level of Participation: _____

Overall Level of Attendance: _____

Date of Release: _____

1. Please complete one of the following:

   A. Reason for client being released and/or terminated from program:_____
   _____.

   B. _____ has successfully completed "Forever Free" Drug and Alcohol Program according to the length of time left of her incarceration at California Institution for Women.

2. Overall response to program:

3. Client's response to group: (see exit questions):

FF5 (8/96)

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NAME:_____ CDC#_____

PROGRAM COMPLETION STATUS: This data element is completed only for those who complete the program. Please circle the number on the 7-point scale below your rating as to the character of the participants program completion. A score of 1 indicates a completely unsatisfactory completion; 2-3 minimally met treatment plan goals; 4, satisfactorily met goals; 5-6, moderately exceeded goals; and 7, greatly exceeded plan goals.

1 2	3 4 5	6 7
Unsatis-factory	Satisfactory	Greatly Exceeded

COMMENTS: Please add any comments that you think are pertinent to the participant's overall progress or exit from the program.

_____

_____

_____

_____

_____

_____

_____

_____

(Form is to be completed by program staff)

FF9(8/96)

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Exit Questions

1. What did you learn in relapse group?

2. What did you learn in workshop?

What did you learn in education group?

4. What did you learn in twelve step group?

5. What did you get out of one on one sessions?

6. What did you learn in reasoning and rehabilitation?

Identify strengths and weaknesses:

Relapse warning signs identified:

Relapse warning sign management plan:

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PARTICIPANT EXIT FROM PROGRAM

NAME _____ CDC # _____

EXIT DATE ____/____/____

PROGRESS WHILE IN PROGRAM: Please rate overall program progress for each exiting participant, regardless as to whether she completed the program. Circle the number on the 7-point scale shown below that best indicates the participant's overall progress. 1 indicates no/little progress; 4, satisfactory; 5-6 exceeded standards for satisfactory progress; and 7, greatly exceeded standard progress.

1 2	3 4 5	6 7
None or little	Satisfactory	Greatly exceeded

TYPE OF PROGRAM EXIT

☐ Did not complete program (check reason below)

☐ Medical reasons

☐ Transferred out

☐ Discharged/paroled early

☐ Escaped

☐ Dismissed from program, violated program rules, failed to participate.
Reason:_____
_____

☐ Dismissed from program, violated custody rules, including dirty urine test; committed new offense.
Reason:_____
_____

☐ Other(specify) _____

☐ Completed program

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SURVEY OF PROGRAM PARTICIPANTS ON SATISFACTION WITH PROGRAM SERVICES AT END OF PROGRAM

The California Department of Corrections would like your opinion regarding the value and usefulness of substance abuse treatment program that you have been attending. The overall purpose of the program has been to help you quit using drugs and have a better life when you are released on parole. Please answer the following questions and add any other information that you think may make the program better for others who participate in the future.

1. How long have you been in the program?
   _____ months _____ days

2. How useful do you think this program will be in helping you stop using drugs? Please check the answer below that best describes how you feel.
   - ☐ the program has been very helpful
   - ☐ the program has been somewhat helpful
   - ☐ the program has helped me a little
   - ☐ I don't think the program will help. (If you check this answer, please tell us why)

   _____
   _____
   _____

3. Which part or parts of the substance abuse program do you think will help drug users the most to quit using drugs? Check all of the following that apply to you.
   - ☐ information regarding drugs and their effects to the body and mind
   - ☐ individual counseling sessions
   - ☐ group counseling sessions
   - ☐ attending Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Cocaine Anonymous (CA), or religious group meetings
   - ☐ employment information
   - ☐ helped in making me feel better about myself, raised my self esteem
   - ☐ being with others who have similar problems
   - ☐ other _____

   _____
   _____
   _____

4. Do you feel better about yourself as a result of participating in this program?
   - ☐ yes
   - ☐ no

   If you do feel better about yourself, please check the following reasons that make you feel better.
   - ☐ I have more confidence in myself
   - ☐ I have more respect for myself
   - ☐ I know that there are others who have similar problems and I can ask them for help
   - ☐ I know where to go to get help for a substance abuse problem
   - ☐ Friends and family will help if I need it
   - ☐ I can go to an AA, NA, or CA meeting
   - ☐ Drugs can no longer control my life
   - ☐ I am more prepared to interview and get a job and keep the job
   - ☐ Other Please explain _____

5. Please help us make the program better. Tell us what part of the program needs to be changed to make it better for program participants. Check "yes" or "no" to each of the following questions.

a) Is the program facility OK?
- ☐ yes
- ☐ no please explain _____

b) Which type of counseling do you feel helps substance abusers more?
- ☐ individual
- ☐ group
- ☐ both group and individual

c) Do you feel that there should be more or less individual counseling during the program?
- ☐ more
- ☐ less

d) Do you think there should be substance abuse group counseling during the program?
- ☐ yes
- ☐ no

e) Do you think there should be more or less group workshops during the program?
- ☐ more
- ☐ less

f) Should there be more or less information on getting and keeping a job?
- ☐ more
- ☐ less

g) How useful is the information regarding making yourself feel better as a person?
- ☐ very useful
- ☐ somewhat useful
- ☐ of little use
- ☐ not useful at all

5. We are interested in your opinion regarding attending self-help groups such as AA and NA.

a) Do you think that attending AA/NA group meetings are helpful in your recovery?
- ☐ yes
- ☐ no

b) Have you been attending AA/NA meetings while in the program?
- ☐ yes
- ☐ no

c) Do you plan to attend AA/NA meetings when you parole?
- ☐ yes
- ☐ no

6. Please tell us anything else that you think might be helpful in making the program better for program participants.

_____
_____
_____
_____

Appendix E: Raw Results

Forever Free Evaluation Project
Intake Interview
Form 1

6. PRIMARY DRUG[1]

N=119

ALCOHOL	5.9 (7)
NARCOTICS	25.2 (30)
COCAINE	4.2 (5)
CRACK	31.9 (38)
MARIJUANA	.8 (1)
AMPHET/METHAMPH	27.7 (33)
PCP	2.5 (3)
NONE	.8 (1)
Missing	.8 (1)

BACKGROUND

10-12. Age

N=119

Mean = 35.0
SD= 7.5

13. What is your race?

N=119

WHITE	36.1 (43)
BLACK/AFRICAN AMERICAN	31.1 (37)
ASIAN/PACIFIC ISLANDER	.8 (1)
NATIVE AMERICAN/ALASKAN	--
HISPANIC	24.4 (29)
MULTI-RACIAL	.8 (1)
Missing	6.7 (8)

14. What was your job when you were last employed?

	Frequency	Percent
None/Never worked	11	9.6
Unskilled	33	28.7
Semiskilled	17	14.8
Skilled	4	3.5
Sales/Service	43	37.4
Second-level executive/professional	3	2.6
Artist	3	2.6
Student	1	.9
Total	115	100.0

[1] This variable is an analyst recoding of Question 75, Form 2.

15. From these income ranges, please check the one that comes closest your total 1996 household income from all sources before taxes? (CHECK ONE)

N=108

0.7 (44)	In prison for all of 1996				
32.4 (35)	Under $10,000	1.9 (2)	$35,000 to $39,999	1.9 (2)	$80,000 to 89,999
5.6 (6)	$10,000 to $14,999	--	$40,000 to $44,999	--	$90,000 to $99,999
5.6 (6)	$15,000 to $19,999	.9 (1)	$45,000 to $49,999	--	$100,000 to $124,999
.9 (1)	$20,000 to $24,999	1.9 (2)	$50,000 to $59,999	.9 (1)	$125,000 to $149,999
2.8 (3)	$25,000 to $29,999	--	$60,000 to $69,999	--	$150,000 to $174,999
1.9 (2)	$30,000 to $34,999	1.9 (2)	$70,000 to $79,999	--	$175,000 to $199,999
				.9 (1)	$200,000 or more

N = 64
Mean = $15,000 to $19,999
SD = 4.2

EDUCATION

16. What is the highest education you have obtained?

N=119

LESS THAN HIGH SCHOOL GRADUATION	37.0 (44)
HIGH SCHOOL GRADUATION	6.7 (8)
GED	19.3 (23)
2 YR COLLEGE (AA)	2.5 (3)
4 YR COLLEGE (BA, BS)	1.7 (2)
MASTERS	--
Ph.D.	--
SOME COLLEGE (NO DEGREE)	11.8 (14)
TRADE OR TECHNICAL TRAINING	21.0 (25)
OTHER	--

CRIME

The next set of questions is about arrests and incarcerations. Remember that what you tell us is strictly confidential.

17. During 1996, how many months were you incarcerated (in jail or prison)?

N = 114
Mean = 7.2 months
SD = 4.6

18. How many times in your life have you been arrested, including detained as a juvenile?

N = 118
Mean = 14.7 times
SD = 16.4

19. **How old were you the first time you were arrested?**

N = 118
Mean = 19.1 years
SD = 6.4

21. **How many of your (total) arrests were before the age of 18?**

N = 117
Mean = 2.4 arrests
SD = 6.3

22. **How many of your (total) arrests were before you first began using illegal drugs?**

N = 116
Mean = 1.2 arrests
SD = 3.1

23. **How many times in your life have you been convicted? Include probation sentences, time served, fines, and community service, along with sentences to jail or prison.**

N = 116
Mean = 8.8 convictions
SD = 8.0

24. **For the convictions above, how many times in your life have you been incarcerated?**

N = 117
Mean = 8.3
SD = 7.1

25. **How old were you when you were first incarcerated?**

N = 114
Mean = 20.6 years
SD = 7.1

26. **How many times have you been incarcerated for more than 30 days?**

N = 116
Mean = 7.6
SD = 6.6

27. **Did you ever receive drug education or treatment while you were incarcerated ?** (DON'T COUNT FOREVER FREE HERE)

N=119

NO 74.8 (89)
YES 25.2 (30)

28. **What is your controlling case?** (DON'T INCLUDE PAROLE VIOLATION)

	Frequency	Percent
Possession offenses,	66	58.4
Shoplift, Theft, Forgery, Robbery, Burglary	39	34.5
Murder, Attempted Murder	5	4.4
Other violent crime, Arson, Manslaughter by vehicle	3	2.7
Total	113	100.0

RELATIONSHIP STATUS

31.	**Do you currently have a partner or spouse?** N=119	NO (SKIP TO Q35) YES	44.5 (53) 55.5 (66)
32.	**Has your partner or spouse visited you during your current incarceration?** N=66	NO YES	62.1 (41) 37.9 (25)
33.	**Has your current spouse/partner used illegal drugs during your relationship?** N=66	NO YES	47.0 (31) 53.0 (35)
34.	**Has your current spouse/partner been in drug treatment during your relationship?** N=66	NO YES	78.8 (52) 21.2 (14)

35. **What type of place (RESIDENCE) did you live in before you were incarcerated?** (CIRCLE ONE)
N=115

YOUR OWN HOUSE/CONDO (OWNED)	7.8 (9)
RENTED HOUSE	19.1 (22)
RENTED APARTMENT	33.0 (38)
HOTEL/ROOMING, BOARDING HOUSE	10.4 (12)
HOSPITAL/THERAPEUTIC COMMUNITY	--
HALFWAY HOUSE/SOBER LIVING	--
DORMITORY	--
PARENTS' HOUSE	15.7 (18)
BROTHERS AND SISTERS	2.6 (3)
OTHER RELATIVES	1.7 (2)
FRIENDS	5.2 (6)
RENTED ROOM IN HOUSE	1.7 (2)
NO REGULAR PLACE (HOMELESS)	2.6 (3)

36. **Did anyone else who lived there use illegal drugs?**

N=116

NO	52.6 (61)
YES	46.6 (54)
LIVED ALONE	.9 (1)

CHILDREN

41. Do you have any children?
N=119

NO (SKIP TO FORM 2).....21.8 (26)
YES.....78.2 (93)

42. How many of your children are under 18 years of age?

N=92
Mean = 2.0
SD = 1.6

43-49. How many women have children under the age of 6 years old:

31 women have at least one child under age 6
9 women have 2 children under age 6
1 woman has one child under age 6

50. Do you have legal custody of your children? (CIRCLE ONE)

N=76

YES - ALL.....40.8 (29)
YES - SOME 21.1 (16)
NO.....38.2 (31)

51-56. Do your children live in any of the following places? (Multiple Response)

	YES
CHILD'S FATHER (N=77)	33.8 (26)
YOUR CURRENT SPOUSE/PARTNER WHO **IS NOT** CHILD'S FATHER (N=78)	1.3 (1)
CHILD'S GRANDPARENT(S) (N=78)	51.3 (40)
OTHER RELATIVES (N=78)	29.5 (23)
FOSTER CARE (N=77)	10.4 (8)
OTHER (N=78)	7.7 (6)

56. Other place where children are now living.

	Frequency	Percent
Adopted parents	2	33.3
Ex roommate	1	16.7
Group home/teen mothers	1	16.7
Friends	1	16.7
Designated caregivers	1	16.7
Total	6	100.0

58. How far away from this prison does your child (who lives the farthest) live?
N = 70

Mean = 222.7
SD = 353.8

59. Did any of your children witness your arrest? N=74

NO	74.3 (55)
YES	25.7 (19)

60. When you were first arrested, what happened to your children? (CHECK ONE) N=77

POLICE ALLOWED ME TO MAKE ARRANGEMENTS WITH PARTNER/FAMILY	45.5 (35)
POLICE ALLOWED ME TO MAKE ARRANGEMENTS WITH FRIENDS	5.2 (4)
CHILD PROTECTIVE SERVICES/SOCIAL WORKER TOOK THEM	5.2 (4)
CHILDREN DIDN'T LIVE WITH ME	44.2 (34)

CHILDREN: CONTACT AND VISITING

We are interested in how much contact you have had with your children since your incarceration.

61-63. Since you have been here, about how often do you call your children?

N=78

67.9 (53)	At least once a month?➡ FILL IN TIMES PER MONTH		N=52 Mean = 6.2 SD = 7.0
--	At least once a year?➡	FILL IN TIMES PER YEAR	NA
--	Less than once a year		
20.5 (16)	Never		
10.3 (8)	Not able to due to rules/custody		
1.3 (1)	Social Worker needs to comply with court order to establish contact		

64-66. Since you have been here, how often do you receive letters from your children?

N=78

61.5 (48)	At least once a month?➡ FILL IN TIMES PER MONTH		N=46 Mean = 3.3 SD = 2.4
5.1 (4)	At least once a year?➡	FILL IN TIMES PER YEAR	N=4 Mean = 3.8 SD = 2.2
2.6 (2)	Less than once a year		
24.4 (19)	Never		
3.8 (3)	Not able to due to rules/custody		
1.3 (1)	Social Worker needs to comply with court order to establish contact		
1.3 (1)	Children too young to write		

67-69. Since you have been here, how often do you write letters to your children?

N=77

80.5 (62)	At least once a month?➡	FILL IN TIMES PER MONTH	N=59 Mean = 4.6 SD = 4.6
2.6 (2)	At least once a year?➡	FILL IN TIMES PER YEAR	N=2 Mean = 3.0 SD = 2.8
1.3 (1)	Less than once a year		
11.7 (9)	Never		
3.9 (3)	Not able to due to rules/custody		

70-72. Since you have been here, how often do you have visits with your children?

N=77

20.8 (16)	At least once a month?➡	FILL IN TIMES PER MONTH	N=16 Mean = 2.3 SD = 1.3
3.9 (3)	At least once a year?➡	FILL IN TIMES PER YEAR	N=3 Mean = 2.7 SD = 1.2
1.3 (1)	Less than once a year		
66.2 (51)	Never		
6.5 (5)	Not able to due to rules/custody		
1.3 (1)	Other		

73. If you answered NEVER in Question 70 above , what is the #1 reason why children don't visit?

	Frequency	Percent
Too far	18	35.3
Caregiver doesn't have car	1	2.0
Caregiver doesn't want to bring them	11	21.6
Don't want my children to come here	6	11.8
Children too young to come here	1	2.0
Children don't know I'm in prison	4	7.8
Not able to due to rules/custody	3	5.9
Caregivers do not agree if children should visit	1	2.0
Caregivers age	1	2.0
Lost contact	2	3.9
Approval of person to bring children to visit	2	3.9
Not approved to bring children to visit	1	2.0
Total	51	100.0

74. If you answered NEVER in Question 70 above , what is the #2 reason why children don't visit?

	Frequency	Percent
Caregiver doesn't have car	1	5.6
Caregiver doesn't want to bring them	3	16.7
Don't want my children to come here	6	33.3
Children too young to come here	2	11.1
Children don't know I'm in prison	1	5.6
Not able to due to rules/custody	1	5.6
Caregivers do not agree if children should visit	1	5.6
Caregivers age	2	11.1
Approval of person to bring children to visit	1	5.6
Total	18	100.0

CHILDREN: PARENTING

Next, I'm going to list several activities that some parents do with their children. Please tell me how often you did each of these things. **In the year before incarceration, about how often did you spend time with your child or at least 1 of your children...**

	NOT AT ALL (1)	LESS THAN ONCE A WEEK (2)	AT LEAST ONCE A WEEK (3)	ALMOST DAILY (4)	MEAN
75. **In leisure activities away from home-- such as picnics, movies, or sports** N=67	14.9 (10)	23.9 (16)	34.3 (23)	26.9 (4)	2.7
76. **At home working on a project or playing together** N=66	13.6 (9)	16.7 (11)	13.6 (9)	56.1 (4)	3.1
77. **Helping with reading or homework** N=66	19.7	12.1 (8)	16.7 (11)	51.5 (34)	3.0
78. **Eating meals together** N=68	10.3 (7)	11.8 (8)	4.4 (3)	73.5 (4)	3.4

79.	**Before incarceration, how well were you doing as a parent or guardian?** Would you say... N=70	Poor.....25.7 (18) Fair.....50.0 (35) Well.....24.3 (17)

80. **Before incarceration, how difficult was it for <u>you</u> to go places or do things because of problems in finding someone to take care of the child(ren) living with you?**
Would you say... N=53

Not at all 66.0 (35)
Somewhat 20.8 (11)
Very difficult 13.2 (7)

.. **Will your participation in Forever Free affect who has custody of [your child/any of your children]?**
N=56

No..... 64.3 (36)
Yes 14.3 (1.0)
Somewhat/Maybe 21.4 (12)

Go to the next page.

BRIEF DRUG HISTORY
FORM 2

Now I would like you to summarize your drug use history. For each drug group, please indicate: the age of your first use, the age of your first regular use, and how many days you used in the month before you were incarcerated.

DRUG GROUP	A. How old were you the first time you tried **[the drug]**? 0=Never Used; (SKIP TO NEXT DRUG) **Mean (N)**	B. How old were you when you started using regularly **[drug]**? 0=Never Used Regularly **Mean (N)**	C. How many days did you use **[drug non-medically]** in the 30 days before you were incarcerated? **Mean (N)**
Inhalants such as Glue, spray cans, gasoline, poppers, etc. (1)	12.9 (29) SD=2.2	13.1 (9) SD=3.0	7.5 (8) SD=13.9
Marijuana or hashish (2)	14.2 (104) SD=3.7	15.3 (72) SD=4.0	10.2 (72) SD=12.7
Hallucinogens (LSD, mescaline, peyote (3)	15.2 (49) SD=3.5	14.3 (17) SD=1.5	4.2 (17) SD=10.0
Amphetamines or any other speed (crystal methedrine, methamphetamine, ice) (4)	19.2 (72) SD=7.1	20.8 (55) SD=7.1	19.4 (55) SD=13.6
Downers, barbiturates (6)	16.1 (38) SD=4.3	16.5 (21) SD=5.8	4.9 (21) SD=9.5
Heroin (7)	21.6 (62) SD=6.7	21.4 (52) SD=6.2	18.6 (52) SD=14.0
Other opiates (methadone, morphine, codeine, Demerol, dilaudid, percodan, opium, vicodin) (9)	20.7 (39) SD=6.0	21.6 (34) SD=6.4	11.3 (33) SD=13.8
Crack, Rock Cocaine (33)	23.1 (74) SD=7.5	24.5 (53) SD=6.8	19.8 (52) SD=12.7
Cocaine (powder, intranasal, or Intravenous) (10)	19.7 (75) SD=6.3	20.5 (48) SD=5.7	10.4 (44) SD=13.7
Tranquilizers (valium, Librium, xanax, roofies, etc.) (11)	19.6 (44) SD=5.9	18.4 (62) SD=5.6	9.3 (21) SD=12.8
PCP (angel dust) (12)	17.8 (53) SD=5.7	18.0 (22) SD=6.3	8.9 (21) SD=13.7
Fentanyl, Synthetic H (17)	19.1 (7) SD=2.4	19.0 (4) SD=2.1	-0-
Alcohol --any use at all (15)	14.5 (95) SD=4.9	16.8 (70) SD=5.0	15.3 (68) SD=13.7
Alcohol--to intoxication (5+ drinks per sitting)	16.9 (61) SD=5.7	18.0 (50) SD=5.9	16.3 (48) SD=14.3
Ecstasy, Adam, Eve, MDA, MDMA (35)	20.7 (13) SD=6.2	21.2 (6) SD=9.5	.3 (6) SD=.8

51-53. What other illegal drugs have you taken? NONE

54. **In the 30 days before incarceration, how much money would you say you spent on alcohol?**
(If you didn't pay, how much would it have cost if you had?)

N=106
Mean = $125.0
SD=247.0

55. **In the 30 days before incarceration, how much money would you say you spent on illegal drugs?**
(If you didn't pay, what was the street value of the drugs you used?)

N=112
Mean = $1975.4
SD=2647.5

56. **At present do you have an alcohol problem?** NO 74.1 (86)
N=116 YES 25.9 (30)

57. **Have you ever injected any drugs?** NO (GO TO Q75) 36.1 (43)
N=119 YES 63.9 (76)

61-70.

DRUG GROUP	A. How old were you when you started to inject **[drug]** regularly? **Mean (N)**	B. How many days in the 30 days before you were incarcerated did you inject **[drug]**? **Mean (N)**
Amphetamines or any other speed like Crystal, methadrine, meth-amphetamine (4)	22.7 (42) SD=7.3	10.6 (40) SD=13.8
Heroin by itself (7)	22.0 (57) SD=6.7	16.7 (55) SD=14.5
Other opiates like Opium, morphine, codeine, Demerol, dilaudid, percodan (9)	21.5 (16) SD=5.6	7.0 (14) SD=11.7
Cocaine by itself (10)	21.4 (42) SD=6.4	8.4 (38) SD=12.8
Speedball (COCAINE and HEROIN COMBINED) (18)	21.8 (33) SD=5.9	16.5 (31) SD=13.9

71-73. Have you injected any other drugs? Specify.

	Frequency	Percent	Age Started Using Drug Regularly	Days used drug in 30 days before incarceration
Marijuana	1	20.0	15.0	-
Hallucinogens	1	20.0	0	-
Barbiturates	1	20.0	15.0	-
Tranquilizers	1	20.0	16.0	-
Designer drugs	1	20.0	25.0	-
Total	6	100.0		

75-78. Which substance do you consider the major problem for you now? [CIRCLE ONE]
N=117

ALCOHOL 6.0 (7)

ALCOHOL AND DRUG (DUAL ADDICTION) 22.2 (26)

WRITE IN NAME OF DRUG:

76. SEE TABLE BELOW

AMPHETAMINES 17.9 (21)

BARBITURATES ..... --

COCAINE (POWDER) 3.4 (4)

CRACK (ROCK) 19.7 (23)

DESIGNER DRUGS (ECSTASY, ADAM, EVE, MDMA, ETC.) ..... --

HALLUCINOGENS ..... --

HEROIN 17.9 (21)

INHALANTS ..... --

MARIJUANA, HASH ..... --

METHADONE ..... --

NONE 2.6 (3)

OTHER OPIATES/PAIN KILLERS ..... --

OVER-THE-COUNTER DRUGS ..... --

PCP 2.6 (3)

POLYDRUG (WITHOUT ALCOHOL) 7.7 (9)

77-78. *WRITE IN THE NAMES OF THE DRUGS:* SEE TABLES BELOW

TRANQUILIZERS (VALIUM, LIBRIUM, XANAX, ETC) ..... --

76. Other Substance with Alcohol (Dual Addiction)

	Frequency	Percent
Amphetamines	10	38.5
Heroin	5	19.2
Crack (rock)	11	42.3
Total	26	100.0

77. #1 Drug in Polydrug Substance Abuse

	Frequency	Percent
Marijuana	1	11.1
Amphetamines	2	22.2
Heroin	4	44.4
Cocaine powder	1	11.1
Crack (rock)	1	11.1
Total	9	100.0

78. #2 Drug in Polydrug Substance Abuse

	Frequency	Percent
Inhalants	1	10.0
Marijuana	1	10.0
Heroin	2	20.0
Other opiates/pain killers	1	10.0
Cocaine powder	2	20.0
Crack (rock)	3	30.0
Total	10	100.0

79. How many times in your lifetime have you had alcohol d.t.'s (the shakes)?

N = 28
Mean = 2.1 times
SD = 7.7

80. How many times in your lifetime have you overdosed on drugs?

N = 78
Mean = 1.6 times
SD = 2.9

TOBACCO

81. Do you currently smoke cigarettes?
N = 119

NO (SKIP TO Q84) 14.3 (17)
YES 85.7 (102)

82. About how many cigarettes do you smoke each day?
(CONVERT FROM PACKS [20 cigs = 1 pack])

N = 100
Mean = 13.9
SD = 8.6

83. How many cigarettes have you smoked in the last 24 hours?

N = 101
Mean = 13.8
SD = 10.8

84-87. Do you smoke cigars, smoke a pipe, or use smokeless tobacco or snuff?

	YES
84. NONE (N=0)	--
85. CIGARS (N=4)	66.7 (4)
86. PIPE (N=6)	--
87. SMOKELESS TOBACCO OR SNUFF (N=6)	33.3 (2)

88. Would you try a stop smoking program if it were available?

N=111		
	NO	30.6 (34)
	YES	57.7 (64)
	DON'T USE TOBACCO	11.7 (13)

LIFETIME TREATMENT HISTORY

91. Now, I'm going to ask you about other drug treatment you may have received. **Before Forever Free, were you ever in a program or in treatment for drug or alcohol problems, including self-help groups or sober living houses?**

N = 118

NO.. ..... 35.6 (42)
YES..... 64.4 (76)

In your lifetime, how many times have you been in any of the program types listed below for drug/alcohol abuse treatment? DON'T COUNT FOREVER FREE	**Mean (N)**
92. Prison or Jail Drug Treatment	2.0 (29) SD=1.5
93. Hospital Inpatient (Includes Detox)	2.1 (18) SD=3.3
94. Partial Hospitalization (Day treatment based in hospital)	4.0 (2) SD=4.2
95. Day Treatment (Outpatient that lasts all day)	1.4 (9) SD=1.0
96. Residential Treatment	1.5 (36) SD=.8
97. Outpatient Drug Free	2.3 (17) SD=2.4
98. Outpatient with Medications (such as Naltrexone, Antabuse, etc.)	1.0 (2) SD=0
99. Methadone Treatment	5.9 (19) SD=6.5
100. Halfway House	1.2 (6) SD=.4
101. Sober Living Home	2.1 (11) SD=3.0
102. Support groups such as AA, CA, NA, and other self-help groups, including spiritually-based groups (Count only if you went to 3 or more meetings in a one-month period)	3.9 (34) SD=5.5

103. **Total number had any treatment**

N = 73
Mean = 8.5 times
SD = 13.4

Have you ever been in any of the following types of program? DON'T COUNT FOREVER FREE	% (N)
92. Prison or Jail Drug Treatment N=74	39.2 (29)
93. Hospital Inpatient (Includes Detox) N=74	24.3 (18)
94. Partial Hospitalization (Day treatment based in hospital) N=74	2.7 (2)
95. Day Treatment (Outpatient that lasts all day) N=74	12.2 (9)
96. Residential Treatment N=74	48.6 (36)
97. Outpatient Drug Free N=74	23.0 (17)
98. Outpatient with Medications (such as Naltrexone, Antabuse, etc.) N=74	2.7 (2)
99. Methadone Treatment N=74	25.7 (19)
100. Halfway House N=74	8.1 (6)
101. Sober Living Home N=74	14.9 (11)
102. Support groups such as AA, CA, NA, and other self-help groups, including spiritually-based groups (Count only if you went to 3 or more meetings in a one-month period) N=72	50.0 (36)

FORM 3: CALPAS-P

Categories: Circle the number that fits your experience in drug counseling here at Forever Free

Not at all	A little bit	Somewhat	Moderately	Quite a bit	Quite a lot	Very much
1	2	3	4	5	6	7

	Mean (SD)
1. Do you find yourself tempted to stop participating in Forever Free when you find yourself upset or disappointed with it?	6.3 (1.3)
2. Do you feel pressured by your case manager to make changes before you are ready?	6.7 (1.0)
3. When your case manager comments about one situation, does it bring to mind other related situations in your life?	4.0 (2.1)
4. Do you feel that even though you might have moments of doubt, confusion, or mistrust, that overall drug abuse treatment is worthwhile?	6.0 (2.0)
5. Do your case manager's comments lead you to feel that your case manager places his or her needs before yours?	6.6 (1.2)
6. When important things come to mind, how often do you keep them to yourself, that is, choose not to share them with your case manager?	5.1 (2.0)
7. Do you feel accepted and respected by your case manager for who you are?	5.9 (1.8)
8. How much do you hold back your feelings during counseling?	5.2 (1.9)
9. Do you find your case manager's comments unhelpful, that is, confusing, mistaken, or not really applying to you?	6.3 (1.4)
10. Do you feel you are working together with your case manager, that the two of you are joined in a struggle to overcome your problems?	5.2 (2.1)
11. How free are you to discuss personal matters that you are ordinarily ashamed or afraid to reveal?	4.6 (2.3)
12. How willing are you to continue struggling with your problems, even though you can not always see an immediate solution?	5.9 (1.8)
13. How dedicated is your case manager to helping you overcome your difficulties?	6.2 (1.3)
14. Have you disagreed with your case manager about the kind of changes you would like to make in your drug treatment?	6.2 (1.5)

CALPAS-P (CONTINUED)

	Mean (SD)
15. How much do you resent the time or other demands of your drug treatment?	6.0 (1.5)
16. Do you feel that your case manager understands what you hope to get out of your sessions?	5.6 (1.8)
17. How important is it for you to look at the ways you might be contributing to your own problems?	6.1 (1.5)
18. How much do you find yourself thinking that drug treatment isn't the best way to get help with your problems?	6.1 (1.7)
19. Does the treatment you receive match with your ideas about what helps people in drug treatment?	5.2 (2.0)
20. Do you feel you are working at cross purposes with your case manager and that you don't share the same sense of how to proceed so that you can get the help you want?	6.2 (1.7)
21. How confident do you feel that through your own efforts and those of your case manager you will gain relief from your problems?	5.6 (1.7)
22. Do you have the feeling that you are unable to deepen your understanding of your problems?	5.9 (1.7)
23. How much do you disagree with your case manager about what issues are most important to work on during treatment?	6.0 (1.6)
24. How much does your case manager help you to gain a deeper understanding of your problems?	5.8 (1.7)

CALPAS-P (CONTINUED)

	Mean (SD)
25. What I am doing in drug counseling gives me new ways of looking at my problem.	6.4 (1.1)
26. I feel that the things I do in drug treatment will help me to accomplish the changes I want to make.	6.6 (1.0)
27. I have obtained some new understanding.	6.3 (1.1)
28. I believe that drug counseling is helping me.	6.3 (1.2)
29. I believe that my case manager is helping me.	6.3 (1.3)
30. As a result of these drug counseling sessions I am clearer as to how I might be able to change.	6.3 (1.2)

Below are some statements about your interactions with the other participants in Forever Free (such as in group sessions or in a social setting). Using this scale indicate how often you feel this way.

1	2	3	4	5	6	7
NEVER			SOMETIMES			ALWAYS

Means (SD)

5.7 (1.5)	31. When I need someone to tell my feelings to, the other participants in Forever Free are there to help me.
5.9 (1.7)	32. I don't like being with other participants because it makes me uncomfortable to hear about their problems.
5.3 (1.6)	33. Hearing about the other participant's problems helps me with mine.
6.5 (1.2)	34. Hearing other participants talk about their problems with drugs makes it hard for me to move on.
5.1 (1.8)	35. Talking things out with the other participants helps me to understand my problems better.
6.5 (1.2)	36. I have been hurt by other participants.
5.8 (1.5)	37. The other participants give me support.
6.4 (1.3)	38. The other participants pick fights with me and each other.
5.8 (1.8)	39. I feel that I don't gain anything from hanging out with the other participants.
5.5 (1.5)	40. The other participants understand my problems because they have similar problems.
5.7 (1.7)	41. It is hard to be around the other participants because their conversations make me think about doing drugs.
3.8 (1.6)	42. Talking with other participants can sometimes be more helpful than talking to the case manager.
	43. When I'm out, I'll be able to use the relapse prevention skills I learned in Forever Free.

INSTRUCTIONS: Circle the answer that shows how much you agree or disagree each item describes you or the way you have been feeling lately.

Strongly Disagree			Not Sure		Strongly Agree	
1	2	3	4	5	6	7

	Mean (SD)
51. Your drug use is a problem for you.	6.1 (1.9)
52. You feel sad or depressed.	3.7 (2.2)
53. You need help in dealing with your drug use.	6.3 (1.5)
54. You have too many outside responsibilities now to be in this treatment program.	6.2 (1.6)
55. You have much to be proud of.	5.5 (2.2)
56. Your drug use is more trouble than it's worth.	6.1 (2.0)
57. In general, you are satisfied with yourself.	4.9 (2.1)
58. You have thoughts of committing suicide.	1.3 (1.1)
59. You have trouble sitting still for long.	2.7 (2.2)
60. Your drug use is causing problems with the law.	6.3 (1.8)
61. This treatment program seems too demanding for you.	6.2 (1.5)
62. You feel lonely.	3.7 (2.4)
63. Your drug use is causing problems in thinking or doing your work.	4.2 (2.6)
64. You feel like a failure.	4.6 (2.4)
65. You have trouble sleeping.	3.1 (2.4)
66. Your drug use was causing problems with your family or friends.	6.2 (1.7)
67. You feel interested in life.	1.5 (1.2)
68. This treatment may be your last chance to solve your drug problems.	6.1 (1.8)

	Mean (SD)
69. You are tired of the problems caused by drugs.	6.8 (0.7)
70. You feel you are basically no good.	5.5 (2.0)
71. This kind of treatment program will not be very helpful to you.	6.2 (1.7)
72. Your drug use was causing problems in finding or keeping a job.	5.6 (2.2)
73. You plan to stay in this treatment program for awhile.	6.4 (1.2)
74. You feel anxious or nervous.	3.7 (2.3)
75. You will give up your friends and hangouts to solve your drug problems.	6.5 (1.3)
76. You can quit using drugs without any help.	5.8 (2.1)
77. You have trouble concentrating or remembering things.	4.2 (2.4)
78. Your drug use was causing problems with your health.	4.9 (2.3)
79. You feel extra tired or run down.	4.1 (2.4)
80. You are in this treatment program because someone else made you come.	6.6 (1.4)
81. You feel afraid of certain things, like elevators, crowds, or going out alone.	2.2 (1.9)
82. Your life has gone out of control.	5.5 (2.3)
83. Your drug use was making your life become worse and worse.	6.1 (1.8)
84. You wish you had more respect for yourself.	3.4 (2.6)
85. You worry or brood a lot.	4.2 (2.4)
86. This treatment program can really help you.	6.5 (1.3)
87. You feel tense or keyed-up.	3.4 (2.2)

	Mean (SD)
`8. You are very careful and cautious.	
89. You want to be in a drug treatment program.	6.2 (1.5)
90. Your drug use is going to cause your death if you do not quit soon.	6.2 (1.7)
91. You feel you are unimportant to others.	4.7 (2.3)
92. You want to get your life straightened out.	6.9 (0.6)
93. You feel tightness or tension in your muscles.	4.1 (2.3)

6. **PRIMARY DRUG**

N=94

NO DRUG USE.....1.1 (1)
ALCOHOL.....6.4 (6)
NARCOTICS.....22.3 (21)
COCAINE.....5.3 (5)
CRACK.....31.9 (30)
MARIJUANA.....2.1 (2)
AMPHET/METHAMPH.....26.6 (25)
TRANQUILIZERS.....1.1 (1)
PCP.....3.2 (3)

BACKGROUND

16-17. Do you plan to continue treatment after release?

5.6 (5)	No
41.6 (37)	Yes, I plan to go to residential treatment
51.7 (46)	Yes, I plan to go to another type of treatment program (Specify -- See table below)
1.1 (1)	Don't know

Type of Residential Treatment

	Frequency	Percent
Outpatient	30	96.8
Sober living	1	3.2
Total	31	100.0

Pre-release: CALPAS-P

Categories: Circle the number that fits your experience in drug counseling here at Forever Free

Not at all	A little bit	Somewhat	Moderately	Quite a bit	Quite a lot	Very much
1	2	3	4	5	6	7

	Mean (SD)
1. Do you find yourself tempted to stop participating in Forever Free when you find yourself upset or disappointed with it?	5.8 (1.7)
2. Do you feel pressured by your case manager to make changes before you are ready?	6.2 (1.6)
3. When your case manager comments about one situation, does it bring to mind other related situations in your life?	3.9 (1.9)
4. Do you feel that even though you might have moments of doubt, confusion, or mistrust, that overall drug abuse treatment is worthwhile?	6.2 (1.7)
5. Do your case manager's comments lead you to feel that your case manager places his or her needs before yours?	6.5 (1.3)
. When important things come to mind, how often do you keep them to yourself, that is, choose not to share them with your case manager?	5.3 (1.9)
7. Do you feel accepted and respected by your case manager for who you are?	6.0 (1.8)
8. How much do you hold back your feelings during counseling?	5.5 (1.8)
9. Do you find your case manager's comments unhelpful, that is, confusing, mistaken, or not really applying to you?	6.2 (1.5)
10. Do you feel you are working together with your case manager, that the two of you are joined in a struggle to overcome your problems?	5.2 (2.0)
11. How free are you to discuss personal matters that you are ordinarily ashamed or afraid to reveal?	5.0 (2.2)
12. How willing are you to continue struggling with your problems, even though you can not always see an immediate solution?	5.8 (1.6)
13. How dedicated is your case manager to helping you overcome your difficulties?	6.0 (1.5)

CALPAS-P (CONTINUED)

	Mean (SD)
14. Have you disagreed with your case manager about the kind of changes you would like to make in your drug treatment?	5.8 (1.7)
15. How much do you resent the time or other demands of your drug treatment?	6.0 (1.5)
16. Do you feel that your case manager understands what you hope to get out of your sessions?	5.7 (1.8)
17. How important is it for you to look at the ways you might be contributing to your own problems?	6.4 (1.2)
18. How much do you find yourself thinking that drug treatment isn't the best way to get help with your problems?	6.5 (1.2)
19. Does the treatment you receive match with your ideas about what helps people in drug treatment?	5.3 (2.0)
20. Do you feel you are working at cross purposes with your case manager and that you don't share the same sense of how to proceed so that you can get the help you want?	6.0 (1.6)
21. How confident do you feel that through your own efforts and those of your case manager you will gain relief from your problems?	5.9 (1.7)
22. Do you have the feeling that you are unable to deepen your understanding of your problems?	6.2 (1.3)
23. How much do you disagree with your case manager about what issues are most important to work on during treatment?	6.1 (1.4)
24. How much does your case manager help you to gain a deeper understanding of your problems?	5.9 (1.7)

CALPAS-P (CONTINUED)

	Mean (SD)
5. What I am doing in drug counseling gives me new ways of looking at my problem.	6.3 (1.3)
26. I feel that the things I do in drug treatment will help me to accomplish the changes I want to make.	6.5 (1.2)
27. I have obtained some new understanding.	6.6 (0.9)
28. I believe that drug counseling is helping me.	6.5 (1.1)
29. I believe that my case manager is helping me.	6.2 (1.4)
30. As a result of these drug counseling sessions I am clearer as to how I might be able to change.	6.3 (1.2)

FEELINGS ABOUT DRUG USE

Please read both statements carefully and choose the one that best describes how you feel now.

		% (N)	
31.	a. I feel so helpless in some situations that I need to get high.	4.3 (4)	N=93
	b. Abstinence is just a matter of deciding that I no longer want to use drugs.	95.7 (89)	
32.	a. I have the strength to withstand pressures at work or home.	88.2 (82)	N=93
	b. Trouble at work or home drives me to use drugs.	11.8 (11)	
33.	a. Without the right breaks you cannot stay clean.	12.8 (12)	N=94
	b. Drug abusers who are not successful in curbing their drug use often have not taken advantage of help that is available.	87.2 (82)	
34.	a. There is no such thing as an irresistible temptation to use drugs.	68.9 (62)	N=90
	b. Many times there are circumstances that force you to use drugs.	31.1 (28)	
35.	a. I get so upset over small arguments that they cause me to use drugs.	8.5 (8)	N=94
	b. I can usually handle arguments without using drugs.	91.5 (86)	
36.	a. Successfully kicking substance abuse is a matter of hard work, luck has little or nothing to do with it.	88.3 (83)	N=94
	b. Staying clean depends mainly on things going right for you.	11.7 (11)	
37.	a. When I am at a party where others are using, I can avoid taking drugs.	59.1 (55)	N=93
	b. It is impossible for me to resist drugs if I am at a party where others are using.	40.9 (38)	
38.	a. I feel powerless to prevent myself from using drugs when I am anxious or unhappy.	28.0 (26)	N=93
	b. If I really wanted to, I could stop using drugs.	72.0 (67)	
39.	a. It is easy for me to have a good time when I am sober.	92.5 (86)	N=93
	b. I cannot feel good unless I am high.	7.5 (7)	
40.	a. I have control over my drug use behaviors.	65.6 (61)	N=93
	b. I feel completely helpless when it comes to resisting drugs.	34.4 (32)	
41.	a. Sometimes I cannot understand how people can control their drug use.	13.8 (13)	N=94
	b. There is a direct connection between how hard people try and how successful they are in stopping their drug use.	86.2 (81)	
42.	a. I can overcome my urge to use drugs.	53.8 (49)	N=91
	b. Once I start to use drugs I can't stop.	46.2 (42)	
43.	a. Drugs aren't necessary in order to solve my problems.	93.5 (87)	N=93

	b. I just cannot handle my problems unless I get high first.	6.5 (6)	
44.	a. Most of the time I can't understand why I continue to use drugs.	29.1 (25)	N=86
	b. In the long run I am responsible for my drug problems.	70.9 (61)	
45.	a. Taking drugs is my favorite form of entertainment.	14.3 (13)	N=91
	b. It wouldn't bother me if I could never use drugs again.	85.7 (78)	
46.	a. If it weren't for pressure from the law, I'd still be using drugs.	43.5 (40)	N=92
	b. I could stop using drugs, even without pressure from the law.	56.5 (52)	

Pre-Release: DATAR SCALES

INSTRUCTIONS: Circle the answer that shows how much you agree or disagree each item describes you or the way you have been feeling lately.

Strongly Disagree			Not Sure			Strongly Agree
1	2	3	4	5	6	7

	Mean (SD)
51. You feel sad or depressed.	2.2 (1.8)
52. You have much to be proud of.	6.4 (1.2)
53. In general, you are satisfied with yourself.	5.9 (1.4)
54. You have thoughts of committing suicide.	1.1 (0.8)
55. You have trouble sitting still for long.	2.8 (2.1)
56. You feel lonely.	2.7 (1.9)
57. You feel like a failure	5.5 (2.1)
58. You have trouble sleeping.	2.7 (2.3)
59. You feel interested in life.	1.6 (1.1)
60. You feel you are basically no good.	6.6 (1.0)
61. You feel anxious or nervous.	3.1 (2.2)
62. You have trouble concentrating or remembering things.	3.4 (2.1)
63. You feel extra tired or run down.	3.2 (2.2)
64. You feel afraid of certain things, like elevators, crowds, or going out alone.	1.8 (1.5)
65. You wish you had more respect for yourself.	5.2 (2.3)
66. You worry or brood a lot.	2.6 (2.0)
67. You feel tense or keyed-up.	2.4 (2.0)
68. You feel you are unimportant to others.	5.6 (2.1)
69. You feel tightness or tension in your muscles.	3.0 (2.2)

Forever Free Evaluation Project
Comparison Group Data

J. PRIMARY DRUG

N=96

ALCOHOL	6.3 (6)
NARCOTICS	20.8 (20)
COCAINE	9.4 (9)
CRACK	44.8 (43)
MARIJUANA	1.0 (1)
AMPHET/METHAMPH	15.6 (15)
PCP	1.0 (1)
Missing	1.0 (1)

BACKGROUND

10-12. Age

N= 90
Mean = 33.9
SD-5.9

13. What is your race? (CIRCLE ONE)

N=96

WHITE	31.3 (30)
BLACK/AFRICAN AMERICAN	37.5 (36)
ASIAN/PACIFIC ISLANDER	--
NATIVE AMERICAN/ALASKAN	1.0 (1)
HISPANIC	18.8 (18)
MULTI-RACIAL	5.2 (5)
OTHER	1.0 (1)
Missing	1.0 (1)

14. From these income ranges, please check the one that comes closest your total 1996 household income from all sources before taxes? (CHECK ONE)

N=88

33.0 (29)	In prison for all of 1996				
46.6 (41)	Under $10,000	2.3 (2)	$35,000 to $39,999	--	$80,000 to 89,999
6.8 (6)	$10,000 to $14,999	--	$40,000 to $44,999	--	$90,000 to $99,999
3.4 (3)	$15,000 to $19,999	2.3 (2)	$45,000 to $49,999	--	$100,000 to $124,999
2.3 (2)	$20,000 to $24,999	1.1 (1)	$50,000 to $59,999	--	$125,000 to $149,999
--	$25,000 to $29,999	--	$60,000 to $69,999	--	$150,000 to $174,999
--	$30,000 to $34,999	--	$70,000 to $79,999	--	$175,000 to $199,999
				1.1 (1)	$200,000 or more

N = 59
Mean = $10,000-$14,999
SD = 3.2

EDUCATION

15. What is the highest education you have obtained?

N=96

LESS THAN HIGH SCHOOL GRADUATION	42.7 (41)
HIGH SCHOOL GRADUATION	12.5 (12)
GED	19.8 (19)
2 YR COLLEGE (AA)	5.2 (5)
4 YR COLLEGE (BA, BS)	--
MASTERS	--
Ph.D.	--
SOME COLLEGE (NO DEGREE)	7.3 (7)
TRADE OR TECHNICAL TRAINING	10.4 (10)
OTHER	--
Missing	2.1 (2)

CRIME

The next set of questions is about arrests and incarcerations. Remember that what you tell us is strictly confidential.

16. During 1996, how many months were you incarcerated (in jail or prison)?

N = 94
Mean = 6.6 months
SD = 4.5

17. How many times in your life have you been arrested, including detained as a juvenile?

N = 89
Mean = 16.6 times
SD = 18.7

18. How old were you the first time you were arrested?

N = 94
Mean = 18.3 years
SD = 6.0

19. How many times in your life have you been convicted? Include probation sentences, time served, fines, and community service, along with sentences to jail or prison.

N = 91
Mean = 9.1 convictions
SD = 9.8

20. For the convictions above, how many times in your life have you been incarcerated?

N = 88
Mean = 9.1
SD = 8.0

21. **Did you ever receive drug education or treatment while you were incarcerated ?** (DON'T COUNT FOREVER FREE HERE)

N=93

NO 61.3 (57)
YES 38.7 (36)

22. **What is your controlling case?** (DON'T INCLUDE PAROLE VIOLATION)

	Frequency	Percent
Possession offenses,	50	58.8
Shoplift, Theft, Forgery, Robbery, Burglary	32	37.6
Murder, Attempted Murder	3	3.5
Other violent crime, Arson, Manslaughter by vehicle	-	-
Total	85	100.0

RELATIONSHIP STATUS

23. **Do you currently have a partner or spouse?** N=90
NO (SKIP TO Q35) 46.7 (42)
YES 53.3 (48)

24. **Has your current spouse/partner used illegal drugs during your relationship?** N=48
NO 43.8 (21)
YES 56.3 (27)

25. **Has your current spouse/partner been in drug treatment during your relationship?** N=48
NO 81.3 (39)
YES 18.8 (9)

CHILDREN

26. **Do you have any children?** N=91
NO (SKIP TO FORM 2).....13.2 (12)
YES.....86.8 (79)

27. **How many of your children are under 18 years of age?**
N=77
Mean = 3.0
SD = 1.9

SUBSTANCE ABUSE

28-31. Which substance do you consider the major problem for you now? [CIRCLE ONE]
N=96

ALCOHOL 4.2 (4)

ALCOHOL AND DRUG (DUAL ADDICTION) 24.0 (23)
WRITE IN NAME OF DRUG:
29. SEE TABLE BELOW

AMPHETAMINES 9.4 (9)

BARBITURATES ..... --

COCAINE (POWDER) 4.2 (4)

CRACK (ROCK) 28.1 (27)

DESIGNER DRUGS (ECSTASY, ADAM, EVE, MDMA, ETC.) ..... --

HALLUCINOGENS ..... --

HEROIN 13.5 (13)

INHALANTS ..... --

MARIJUANA, HASH 1.0 (1)

METHADONE ..... --

NONE 1.0 (1)

OTHER OPIATES/PAIN KILLERS ..... --

OVER-THE-COUNTER DRUGS ..... --

PCP ..... --

POLYDRUG (WITHOUT ALCOHOL) 14.6 (14)
30-31. *WRITE IN THE NAMES OF THE DRUGS:* SEE TABLES BELOW

TRANQUILIZERS (VALIUM, LIBRIUM, XANAX, ETC) ..... --

29. Other Substance with Alcohol (Dual Addiction)

	Frequency	Percent
Amphetamines	1	4.5
Heroin	4	18.2
Cocaine powder	1	4.5
PCP	2	9.1
Crack (rock)	14	63.6
Total	22	100.0

30. #1 Drug in Polydrug Substance Abuse

	Frequency	Percent
Amphetamines	6	42.9
Heroin	3	21.4
Other opiates/pain killers	1	7.1
Crack (rock)	4	28.6
Total	14	100.0

31. #2 Drug in Polydrug Substance Abuse

	Frequency	Percent
Marijuana	4	28.6
Amphetamines	1	7.1
Heroin	3	21.4
Cocaine powder	2	14.3
Tranquilizers	2	14.3
Crack (rock)	1	7.1
Designer Drugs	1	7.1
Total	14	100.00

32-39. For the drug(s) you listed above, please complete the information below:

32. #1 Drug listed as major problem

	Frequency	Percent
Marijuana	2	2.1
Amphetamines	17	18.1
Heroin	20	21.3
Cocaine powder	3	3.2
PCP	1	1.1
Alcohol	14	14.9
Crack (rock)	37	39.4
Total	94	100.0

33. #1 Drug listed as major problem: Age first tried drug

	Mean (N)	SD
Marijuana	17.0 (2)	5.7
Amphetamines	17.3 (16)	5.0
Heroin	18.3 (19)	5.8
Cocaine powder	18.3 (3)	1.2
PCP	13.0 (1)	-
Alcohol	20.9 (37)	5.7
Crack (rock)	[redacted]	[redacted]

34. #1 Drug listed as major problem: Age started using drug regularly

	Mean (N)	SD
Marijuana	20.0 (2)	4.2
Amphetamines	19.7 (15)	6.4
Heroin	18.6 (19)	5.8
Cocaine powder	19.3 (3)	1.5
PCP	16.0 (1)	--
Alcohol	22.5 (37)	6.0
Crack (rock)	[redacted]	[redacted]

35. #1 Drug listed as major problem: Days used the drug non-medically in the 30 days before incarceration.

	Mean (N)	SD
Marijuana	17.0 (2)	18.4
Amphetamines	27.5 (13)	7.0
Heroin	22.6 (16)	13.2
Cocaine powder	25.0 (1)	--
PCP	30.0 (1)	--
Alcohol	21.1 (36)	12.9
Crack (rock)	[redacted]	[redacted]

36. #2 Drug listed as major problem

	Frequency	Percent
Marijuana	3	9.7
Heroin	3	9.7
Other opiates/pain killers	1	3.2
Cocaine powder	2	6.5
Tranquilizers	1	3.2
PCP	1	3.2
Alcohol	9	29.0
Crack (rock)	10	32.3
Designer drugs	1	3.2
Total	31	100.0

37. #2 Drug listed as major problem: Age first tried drug

	Mean (N)	SD
Marijuana	14.7 (3)	2.9
Heroin	20.0 (3)	2.6
Other opiates/pain killers	20.5 (2)	4.9
Cocaine powder	[redacted]	[redacted]
Tranquilizers	15.0 (1)	--
PCP	24.0 (1)	--
Alcohol	11.0 (4)	3.4
Crack (rock)	18.5 (8)	6.1
Designer drugs	20.0 (1)	--

38. #2 Drug listed as major problem: Age started using drug regularly

	Mean (N)	SD
Marijuana	15.0 (3)	2.6
Heroin	20.7 (3)	1.5
Other opiates/pain killers	--	--
Cocaine powder	[redacted]	
Tranquilizers	15.0 (1)	--
PCP	24.0 (1)	--
Alcohol	13.8 (4)	1.7
Crack (rock)	20.3 (8)	6.4
Designer drugs	20.0 (1)	--

39. #2 Drug listed as major problem: Days used the drug non-medically in the 30 days before incarceration.

	Mean (N)	SD
Marijuana	30.0 (3)	-0-
Heroin	18.0 (2)	17.0
Other opiates/pain killers	.0 (1)	--
Cocaine powder	[redacted]	[redacted]
Tranquilizers	15.0 (1)	--
PCP	--	--
Alcohol	28.3 (3)	2.9
Crack (rock)	19.4 (7)	13.6
Designer drugs	5.0 (1)	--

40. **Have you ever injected any drugs?** N=93

NO 50.5 (47)
YES 49.5 (46)