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Process Evaluation of the CrossRoad to Freedom House and Peer I Therapeutic Communities

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Final Draft Report

Process Evaluation of the CrossRoad to Freedom House and Peer I Therapeutic Communities:

Project Summary

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Project Purpose

The purpose of this study was to conduct a process evaluation of the Crossroads to Freedom House TC and the Peer I transitional TC program. The overall goal of this study was to describe the services currently being rendered and to identify areas for improvement. Specific objectives included developing program and participant profiles and conducting an analysis of factors affecting treatment retention.

The participant profile was examined in an attempt to identify factors that affect retention in treatment. The participant profile consists of demographic, psychological, substance abuse, and criminal risk information, as well as a monthly measure of progress in treatment. Client variables were analyzed across three groups: 1) participants who completed at least 6 months in the program and made a progressive move, 2) participants who either quit or were expelled from the program, and 3) participants who made a progressive move out of the TC within 6 months of TC admission.

The program profile includes a description of therapeutic practices including setting, admissions and discharges, program structure and activities, staffing patterns, and a review of clinical files. The TC Scale of Essential Elements Questionnaire (SEEQ) was used to assess the program's level of adherence to a traditional TC model of treatment, notably, the concept of community as method of treatment. Additionally, therapy groups were observed and rated using a researcher developed form.

Project Findings

The Arrowhead TC clearly treats chronic substance abusing inmates who pose a serious recidivism risk to the public. Participants enter treatment as they approach release to the community, in order to maximize the program effects. Demographically, there are mild variations from the general prison population related to the facility's custody level and the program's admission criteria (Rosten, 2000). One interesting variation is the over-representation of the Caucasian inmate population and under-representation of the Latino population. This is more likely due to scoring variations on the SOA than any inherent program bias (O'Keefe, 1999).

This study yielded surprising results in terms of treatment retention. Factors traditionally associated with successful treatment completion, particularly motivation, were not identified. If unsuccessful participants did not double the number of successful participants, it could be postulated that the program works with clients at all levels of motivation. However, it seems more likely that there is a specific offender profile related to unsuccessful program terminations.

The characteristics that distinguish unsuccessful completers from successful completers may describe personality styles that are not acceptable in the program. Those personality styles include a tendency to be superficial and self-centered, characterized by their total lack of empathy for others. They tend to be free of marital commitments and isolate from others, perhaps as a result of their suspicious nature and inability to develop personal attachments. Furthermore, unsuccessful completers have long-standing patterns of conduct problems, dating back to early childhood.

This study found a relatively strong therapeutic milieu within this program, a difficult task to achieve within the confines of a prison. The program faces special challenges in this area because of its integration with the general prison population. It is an oft-cited finding in the literature that separation from the general population is key to the success of any prison TC. The researchers found this to hold true for the Arrowhead program.

The successes within the program are no small feat given the many challenges they face. The lack of group space for running treatment groups in this modality is shocking. Group space limitations were not a temporary matter of weeks or months, but rather years. The space most often available for groups was prone to such frequent interruptions by security staff and non-TC inmates that privacy and confidentiality could not be assured to clients.

The evidence that treatment groups were last priority in this *therapeutic* community was equally dismaying. It seems logical that treatment should take top priority after security, given that the need for treatment is driving their placement in the program. The low intensity of treatment is contrary to the TC model. Not only does the infrequency of groups contribute to the decreased intensity, but so do the lack

of staff-led groups for the orientation clients. The already resistant admits are not making that interpersonal connection with staff that could potentially win their allegiance. Most clients are expelled from treatment, and the average length of stay is less than 4 months in this long-term program. This is further evidence of the program's continuing need to motivate new clients (O'Keefe et al, 1997). It is difficult to establish and maintain a positive peer culture with a constantly changing clientele

The SEEQ ratings indicate that the program is meeting national TC standards. The program's perspective of the TC model, treatment approach and structure, administration, and educational and work activities were at or above national standards. Areas that might need some enhancement include formal therapeutic elements, process, use of the community as the healing agent, and operations within a correctional environment. In brief, the actual practice of therapeutic aspects presents a challenge to the TC program. There was an undoubtedly therapeutic, respectful atmosphere in the TC, suggesting that the community mechanisms were at work in informal ways despite the paucity of formal staff-led groups. Formalizing those mechanisms can only enhance the therapeutic aspect of the program.

The staff's philosophy on TC treatment espouses the community as the healing agent. They hold onto this tenant so tightly that they do not schedule individual sessions. Nonetheless, researchers observed that clients had frequent one-on-one interactions with staff. They were just unscheduled and informal; they occurred as situations arose or as the client needed. Therefore, the clients appeared to have more control than the staff in setting individual sessions. Furthermore, this observation would suggest that quiet, less demanding clients received less attention than the louder, more demanding clients. This runs counter to the concept of using incentives for positive behavior, where it would seem that the disruptive clients receive more attention.

While the program clearly treats the target population in terms of severe recidivism risk and substance abuse needs, the findings indicate that the program regularly violates its own admission criteria. There were high numbers of clients not assessed as needing this modality, who had too little time before release, had a disciplinary infraction prior to admission, or had acute psychiatric needs.

Presumably, these criteria are in place to ensure the appropriateness of inmates' treatment placement; when they are admitted regardless of these criteria, the program's preparedness for treating them must be questioned.

The Arrowhead program has made substantial improvement in the number of progressive moves for treatment participants over the past three years (O'Keefe et al., 1997). While this change is a positive move, the pendulum seems to have swung too far to the other side. In the interest of progressing clients to the community, the program has dramatically shortened lengths of stays for this group. The findings herein showed that 38% released to the community, but only 21% did so after completing a minimum of 6 months in treatment. The adage "something is better than nothing" does not necessarily apply to TCs. There is substantial research to show that less than 6 months in TC has little impact, and that maximal benefits are obtained from 9 to 12 months (see Condelli & Hubbard, 1994). Previous research on this same program strongly indicated that at least 6 months are necessary to reduce recidivism (O'Keefe et al., 1998).

Staffing of prison substance abuse counselors presents a department-wide problem. It is a problem statewide, but poses particular challenges within DOC. In a traditional TC, residents who successfully complete treatment in the TC are qualified to become staff members. This is not the case today in Colorado prisons, where convicted felons are ineligible to work as paid employees. Unfortunately, this requirement, with no moratorium on long-term crime-free lifestyles, has effectively reduced the recovering staff, produced frequent vacancies, and increased the rate of uncredentialed staff. Hiring of untrained, unskilled, and uncertified staff devalues the field and in essences dictates this as an unskilled job classification. A disservice is paid to clients when they are pressured into treatment staffed with unqualified personnel. The difficulty of attracting and keeping culturally diverse, recovered, skilled, credentialed staff is duly noted, given the low salary ranges associated with addictions counseling.

Clinical supervision is available regularly during staff meetings where clients' cases are discussed. The supervisor, or another qualified staff member, is usually available on a daily basis to address more

pressing caseload issues. However, supervision that directly addresses counselors' clinical skills was not found to occur. Clinical supervision was not perceived as a mechanism for giving feedback and training to counselors, but rather as a problem-solving tool. The skills and experience of the core staff could provide invaluable training to the newer, unqualified staff if put into action.

Vast improvements in the paperwork were found since the most recent process evaluation (O'Keefe et al., 1997). In particular, the progress notes were much more complete and timely than before. There are still some areas where the paperwork is lacking, but are easily remedied. There are simply some forms not included in the intake packet, or information not included on existing forms.

Additionally, the lack of individualized treatment plans with regular plan reviews and updates continues to be a program limitation. During this evaluation period, there was a unique opportunity for developing individualized treatment plans using the progress in treatment measure. It was expected that the staff and clients would use such a tool for planning treatment program and discussing progress. It was the program staff who wanted to include this measure into the program. However, once implemented it became clear that the staff viewed this as just another set of paperwork to complete. The ratings were not used to develop treatment plans nor were there ever conversations between clients and staff to compare ratings. This is a newly developed measure (Kressel et al., 2000) and it may have not been useful for the purpose it was adopted. However, the seeming lack of effort to use this measure for individualizing treatment and the lack of individualized treatment plans found in the file reviews, suggests this is an area for improvement by the TC staff.

The transitional program at Peer I is an anomaly. The Peer I TC itself was found to be a therapeutically sound program, as measured by the SEEQ. In fact, as a whole, the program was able to carry out unique TC components that are often not feasible with prison programs. While Peer I is an excellent program, a serious problem was uncovered by this research. Very few offenders actually transition from Arrowhead to Peer I. In fact, the two TCs operate as if they are two distinct programs, rather than a prison-based TC with a continuing care component. Additional monitoring and

investigation is needed to determine why the prison TC clients are not continuing with the Peer I TC program.

Recommendations

Taken together, the findings indicate that the Arrowhead TC is meeting departmental, statewide, and national standards. The recommendations herein are suggested as enhancements to move the program to a higher level.

Many of the program changes that are indicated will require the collaboration of the TC, the prison facility, and the department. The TC staff needs to advance their relationship with administration in order to establish treatment as a priority within the facility. The benefits to DOC for accommodating program needs will be immeasurable in terms of increased manageability and lowered recidivism. There are several areas that can only be addressed through this collaboration, such as more separation from the general population and group space. Strategic planning should emphasize the practice of formal therapeutic elements. More groups, particularly for newer residents, should be foremost in planning.

The present study describes who does well in this program and who does not. It may be that those individuals are not suited for the TC modality. But given the high rate of unsuccessful program terminations, the staff needs to consider different approaches to involve individuals with these personality characteristics in the community process. These factors extend beyond addictions and criminology to personality pathology, which may require more mental health training for the staff to better understand their clientele.

While this study uncovered some factors related to treatment retention, they might not relate to treatment outcomes. Additional research is needed to determine whether these results are replicable and what factors may relate to long-term indicators of program success.

Process Evaluation of the CrossRoad to Freedom House and Peer I Therapeutic Communities: Research Highlights

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The purpose of this study was to conduct a process evaluation of the Crossroads to Freedom House TC and the Peer I transitional TC program. The overall goal of this study was to describe the services currently being rendered and to identify areas for improvement. Specific objectives included developing program and participant profiles and conducting an analysis of factors affecting treatment retention.

The participant profile was examined in an attempt to identify factors that affect retention in treatment. The participant profile consists of demographic, psychological, substance abuse, and criminal risk information, as well as a monthly measure of progress in treatment. Client variables were analyzed across three groups: 1) participants who completed at least 6 months in the program and made a progressive move, 2) participants who either quit or were expelled from the program, and 3) participants who made a progressive move out of the TC within 6 months of TC admission.

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Findings

Participant Profile

The Arrowhead TC clearly treats chronic substance abusing inmates who pose a serious recidivism risk to the public. Participants enter treatment as they approach release to the

community, in order to maximize the program effects. Demographically, there are mild variations from the general prison population related to the facility's custody level and the program's admission criteria. One interesting variation is the over-representation of the Caucasian inmate population and under-representation of the Latino population.

This study yielded surprising results in terms of treatment retention. Factors traditionally associated with successful treatment completion, particularly motivation and progress in treatment, were not related to length of stay in program. The characteristics that did distinguish unsuccessful completers from successful completers may describe personality styles that are not acceptable in the program. Those personality styles include a tendency to be superficial and self-centered, characterized by their total lack of empathy for others. They tend to be free of marital commitments and isolate from others, perhaps as a result of their suspicious nature and inability to develop personal attachments. Furthermore, unsuccessful completers have long-standing patterns of conduct problems, dating back to early childhood.

Program Description

This study found a relatively strong therapeutic milieu within the two TC programs, a difficult task to achieve within the confines of a prison. The SEEQ ratings indicate that the two programs are meeting or exceeding national TC standards. The programs' perspective of the TC model, treatment approach and structure, administration, and educational and work activities were at or above national standards. Areas that might need some enhancement in both programs are the formal therapeutic elements. Additionally, the Arrowhead program could work on the areas of process, use of the community as the healing agent, and operations within a correctional environment.

The Arrowhead program faces special challenges in this area because of its integration with the general prison population. The successes within the program are no small feat given the many challenges they face. The lack of group space for running treatment groups in this modality is shocking. Group space limitations were not a temporary matter of weeks or months, but rather years. The space most often available for groups was prone to such frequent interruptions by security staff and non-TC inmates that privacy and confidentiality could not be assured to clients.

The evidence that treatment groups were last priority in this *therapeutic* community was equally dismaying. The Arrowhead program offered a broad range of educational, therapeutic, and support groups facilitated either by staff, residents, or both. Treatment groups were often canceled, either due to lack of space or staffing issues. The low intensity of treatment (9 – 12 hours/week) is contrary to the TC model.

The staff's philosophy on TC treatment espouses the community as the healing agent. They hold onto this tenant so tightly that they do not schedule individual sessions. Nonetheless, researchers observed that clients had frequent one-on-one interactions with staff. They were just unscheduled and informal; they occurred as situations arose or as the client needed.

While the program clearly treats the target population in terms of severe recidivism risk and substance abuse needs, the findings indicate that the program regularly violates its own admission criteria. There were high numbers of clients not assessed as needing this modality, who had too little time before release, had a disciplinary infraction prior to admission, or had acute psychiatric needs.

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to the community, the program has dramatically shortened lengths of stays for this group. The findings herein showed that 38% released to the community, but only 21% did so after completing a minimum of 6 months in treatment. The adage "something is better than nothing" does not necessarily apply to TCs. There is substantial research to show that less than 6 months in TC has little impact, and that maximal benefits are obtained from 9 to 12 months.

Staffing of prison substance abuse counselors presents a department-wide problem and is a problem for this program as well. There is difficulty of attracting and keeping culturally diverse, recovered, skilled, credentialed staff, given the low salary ranges associated with addictions counseling.

Clinical supervision is available regularly during staff meetings where clients' cases are discussed. The supervisor, or another qualified staff member, is usually available on a daily basis to address more pressing caseload issues. However, supervision that directly addresses counselors' clinical skills was not found to occur. Clinical supervision was not perceived as a mechanism for giving feedback and training to counselors. The skills and experience of the core staff could provide invaluable training to the newer, unqualified staff if put into action.

Vast improvements in the paperwork were found since the most recent process evaluation. In particular, the progress notes were much more complete and timely than before. There were some forms simply not included in the intake packet, or information not included on existing forms. Additionally, the lack of individualized treatment plans with regular plan reviews and updates continues to be a program limitation.

The transitional program at Peer I is an anomaly. The Peer I TC itself was found to be a therapeutically sound program and was able to carry out unique TC components that are often not feasible with prison programs. While Peer I is an excellent program, a serious problem was

uncovered by this research. Very few offenders actually transition from Arrowhead to Peer I. In fact, the two TCs operate as if they are two distinct programs, rather than a prison-based TC with a continuing care component. Additional monitoring and investigation is needed to determine why the prison TC clients are not continuing with the Peer I TC program.

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INTRODUCTION

In the current political climate, it is increasingly important to demonstrate that funding for drug and alcohol treatment programs is money well spent. Recent research indicating that the therapeutic community (TC) is effective has created a resurgence of interest in the use of this modality (De Leon, Inciardi, & Martin, 1995). The intent of the current research project is to study a prison-based TC that has a transitional community-based TC component in Colorado.

Prison TCs are now considered to be major innovations and are becoming the preferred treatment modality in American prisons (Wexler, 1995). The inception of prison TCs was based on the concept that drug use and criminal activity are closely related. It was postulated that reduction of drug usage would result in reduced crime, decreased recidivism, and fewer parole revocations (Wexler). In fact, it was found that persons who have undergone TC treatment have the lowest rate of recidivism (Bleiberg, Devlin, Croan, & Briscoe, 1994).

TC MODALITY

The therapeutic community (TC) is a highly structured treatment program designed for substance abusers with long histories of abuse, multiple failed treatment attempts, and criminal behavior. The TC model embraces the concept that substance abuse is a disorder of the whole person (De Leon, 1989b). The TC endeavors to create comprehensive lifestyle changes related to substance abuse, employment, criminal behavior, and basic societal values and attitudes.

De Leon (1994) noted the difficulty of defining, describing, and comparing TC programs. He reported that a variety of residential programs are considered to be TCs, some TCs may not be residential programs, and not all TCs employ the same model. Consequently, merely defining the TC program is essential. He theorized that the essence of the TC is the focus on the community as the mechanism of change. The community itself is considered the healing agent as well as the context in

which change occurs. The community models acceptable social behavior while reinforcing (negatively and positively) behaviors that do and do not conform to community expectations.

De Leon (1994) hypothesized that eight essential elements distinguish the TC from other approaches. The elements are as follows: (1) use of participant roles, (2) use of membership feedback, (3) use of the membership as role models, (4) use of collective formats for guiding individual change, (5) use of shared norms and values, (6) use of structure and systems, (7) use of open communication, and (8) use of relationships.

TC EFFECTIVENESS

The effectiveness of TCs in the community, as well as prison TC programs, is well documented. In several studies of TCs in the general community, TC participation was found to reduce drug use and predatory crimes while increasing full-time employment (Condelli & Hubbard, 1994; De Leon, 1994; Simpson & Sells, 1982).

Recent research has demonstrated the effectiveness of prison TCs in Delaware, California, and Texas. Prison-based programs coupled with aftercare TC services have the best success rates. The Amity program in California found successful 3-year outcomes, with those undergoing prison and community aftercare TC nearly three times less likely to recidivate than those receiving no treatment or those completing prison TC only (Wexler, Melnick, Lowe, & Peters, 1999). Another study found similar outcomes for TC treatment in Texas for the same follow-up period. Participants of a prison TC and aftercare program were half as likely to return to prison than the comparison groups (Knight, Simpson, & Hiller, 1999). In Delaware, 77% of participants who attended prison and aftercare TC treatment remained arrest-free at the one year follow-up period whereas only 46% of the untreated group was arrest-free (Martin, Butzin, Saum, & Inciardi, 1999). Prison treatment or aftercare treatment alone had better outcomes than no treatment, but were not as effective as both. However, the effect declined at 3 years post-release. Martin et al. determined that by taking into account program participation, program completion, and aftercare components, the program effects remained significant.

PROGRAM RETENTION

Successful client outcomes were found to be dependent on the length of time individuals remain in the TC (Condelli, 1994; Condelli & Dunteman, 1993; De Leon et al., 1995; Wexler, 1995). However, TC programs experience a high rate of dropouts, those in Colorado being no exception. Thus, if variables that affect retention can be uncovered, length of stay can be increased and more positive outcomes will be affected (Condelli & Dunteman).

How long is long enough? A review of the literature revealed inconsistencies in the purported length of time required to produce successful outcomes (Condelli & Hubbard, 1994). In one study, 6 months was found to result in more successful outcomes than one month (Bleiberg et al., 1994). Wexler (1995) cited one study that found that success rates improved for participants who remained in the program for 9 to 12 months. After 12 months, positive results declined. Unfortunately, most people drop out within the first 3 months and, particularly, within the first month (Condelli & De Leon, 1993).

In De Leon's delineation of the TC process, primary treatment optimally occurs from the second to twelfth months. During this phase, the objective is to improve personal growth, socialization, and psychological awareness (De Leon, 1989b). Bleiberg et al. (1994) suggest possible explanations for the benefits that accrue in 12 months as compared to 6 months of treatment. More available treatment hours, more attended groups, and more contact time with the staff who serve as positive role models allow an individual to obtain more insight, practice emotional and behavioral changes, and learn stronger control mechanisms. Additionally, longer time in the TC may allow inmates more opportunity to distance themselves psychologically from their former less desirable cohorts. De Leon (1991) suggests that a possible reason for the greater improvement of those who stay in the TC for 12 months is that the highest risk of relapse for drug users occurs in the first 6 to 12 months of abstinence. Probability of relapse diminishes after one year.

FACTORS AFFECTING RETENTION

Condelli (1994) reviewed studies that focused on determining predictors of retention. From this review, he categorized the variables as fixed, dynamic, treatment entry, or program treatment variables. Some types of variables were found to be more influential than others in predicting retention.

Fixed variables are those that are static and unchanging, such as age, gender, employment history and criminal history. No fixed variable consistently predicted retention, although education, age, ethnicity, marital status, and drug use pattern predicted retention in more than one study (Condelli & De Leon, 1993).

Dynamic variables are those which are more flexible and which may change through therapy, such as self-esteem, motivation, or comfort level in large groups (Condelli, 1994; Condelli & De Leon, 1993). Co-morbidity of psychological disorders is one such dynamic variable that was investigated. Severe psychopathology is associated with low retention (De Leon, 1989a). A few psychological disorders such as antisocial personality disorder, attention-deficit/hyperactivity disorder, and depression have been considered as possible factors associated with low retention (Ravndal & Vaglum, 1994a; Wexler, 1995; Williams & Roberts, 1991). Although retention was not addressed, Wexler cites studies of a TC that found antisocial personality disorder in 51% of the individuals and attention deficit hyperactivity disorder in 42% of the individuals. Using the Beck Depression Inventory (Beck, Rush, Shaw, & Emery, 1979), Williams and Roberts found depression to be significantly related to retention rate in women in a residential treatment facility. However, Ravndal and Vaglum (1994a) used the Millon Clinical Multiaxial Inventory (Millon, 1982) and did not find that depression predicted retention rates.

An individual's readiness to effect change is another dynamic variable which may influence whether or not they remain in treatment. Clients may be in a stage of precontemplation, contemplation, preparation, action, or maintenance (DiClemente, 1993; McConnaughy, DiClemente, Prochaska, & Velicer, 1989). In the precontemplation stage, the individual is not cognizant of the need for change and has not yet initiated the change. During contemplation, the person becomes aware of the problem and

how it might be overcome. In the preparation stage, the individual decides to commit to making a change. The action stage involves seeking help and implementing changes. Finally, the maintenance stage involves focusing on relapse avoidance through sustaining the changes that have occurred during the action phase.

Treatment entry variables are variables that describe factors influencing the client at the time of admission, such as legal pressure or pressure from significant others (Condelli, 1994). Difficulties in any of the following areas at the time of entry into the TC are considered to be treatment entry variables: physical health, mental health or emotional well-being, work or school, family and friends, legal, and money (Condelli & Dunteman, 1993). In their analysis of data from prior retention studies, Condelli and Dunteman found that two of these variables, client involvement in the criminal justice system and client participation in a Treatment Alternatives to Street Crime program at the time of admission, predicted longer retention.

Program treatment variables are those specific to a program's method of treatment, such as using a traditional or nontraditional regimen and identification with graduates of the TC (Condelli, 1994). Ravndal and Vaglum (1994b) found that a lack of attachment and identification with program goals, staff members, or other residents can decrease retention in a TC. Most drug abusers have relational problems. Since an attachment or connection to others is an essential element of a therapeutic community, a lack of connection and underlying trust could undermine retention (Bell, 1994; Ravndal & Vaglum, 1994b). Therefore, such program treatment variables have been found to affect retention (Condelli & De Leon, 1993).

Most studies have focused on fixed and dynamic variables. Although both fixed and dynamic variables were found to predict retention, dynamic variables were found to be the better predictor of the two (Condelli & De Leon, 1993). Even when both fixed and dynamic variables are examined, most of the variance in retention is left unexplained (Condelli, 1994; Condelli & De Leon, 1993; Condelli &

Dunteman, 1993). Thus, treatment entry variables and program treatment variables may account for more of the reasons for low retention.

PRESENT STUDY

The Crossroad to Freedom House TC at the Arrowhead Correctional Center in Colorado was studied in two process evaluations and one outcome evaluation (O'Keefe, Arens, Hughes, & Owens, 1996; O'Keefe, Crawford, Hook, Garcia, & McGuffey, 1997; O'Keefe et al., 1998). The first process evaluation primarily focused on describing the program and the treatment participants. The second study probed further to evaluate the delivery of treatment services. The study revealed a generally successful treatment program. However, a serious problem with retention rates was detected. The median length of stay in this 12-month program was 74.5 days with approximately one third leaving in the first month.

The outcome study revealed that length of stays improved over an 18-month period following the previous process evaluation (O'Keefe et al., 1998). Recidivism rates were 43% lower for participants who stayed in treatment at least 6 months than for the comparison group who received no TC treatment.

Since the completion of these studies, the Arrowhead program developed a relationship with the Peer I community TC in Denver, Colorado. The programs established a transitional program to ease the continuity of care between the two programs. Several treatment beds were reserved especially for Arrowhead program completers, and a Peer I counselor worked with inmates at Arrowhead to prepare them for their release to the community program.

The purpose of this study was to conduct a process evaluation of the Crossroads to Freedom House TC and the Peer I transitional TC program. The overall goal of this study was to describe the services currently being rendered and to identify areas for improvement. Specific objectives included developing program and participant profiles and conducting an analysis of factors affecting treatment retention.

The program profile includes a description of therapeutic practices including setting, admissions and discharges, program structure and activities, staffing patterns, and a review of clinical files. The TC Scale of Essential Elements Questionnaire (Criminal Justice Committee of Therapeutic Communities of

America, 1999) was used to assess the program's level of adherence to a traditional TC model of treatment, notably, the concept of community as method of treatment. The participant profile consists of demographic, psychological, substance abuse, and criminal risk information. The participant profile also includes repeated measures of progress in treatment.

The participant profile was examined in an attempt to identify factors that affect retention in treatment. Client variables were analyzed across three groups: 1) participants who completed at least 6 months in the program and made a progressive move, 2) participants who either quit or were expelled from the program, and 3) participants who made a progressive move out of the TC within 6 months of TC admission.

METHOD

PARTICIPANTS

Participants included male inmates (N = 527) entering the Arrowhead TC between January 1997 and December 1999. Program observation extended from February 1999 until August 2000. An analysis of ethnic groups revealed that 59% of participants were Anglo (n = 309), 21% were African-American (n = 109), 18% were Latino (n = 95), and 3% were Native American (n = 14). The age of offenders ranged from 17 to 62 years with a mean age of 34 years (SD = 7.97).

MATERIALS

Participants completed a battery of assessment instruments within three weeks of entry into the program. The intake battery consisted of the Millon Clinical Multiaxial Inventory-III (Millon, Davis, & Millon, 1997), Barkley Attention Deficit Hyperactivity Disorder (ADHD) Rating Scale (Barkley, 1990), Wender Utah Rating Scale (Ward, Wender, Reimherr, 1993), University of Rhode Island Change Assessment (McConnaughy, Prochaska, & Velicer, 1983), and Circumstances, Motivation, Readiness, and Suitability Scale (De Leon, Melnick, Kressel, & Jainchill, 1994).

Additionally, both staff and clients completed monthly assessments that were designed to provide a measure of client progress in treatment over repeated intervals using the Therapeutic Community Client Assessment Survey and the Therapeutic Community Staff Assessment Survey (Kressel, De Leon, Palij, & Rubin, 2000).

To assess program elements, researchers completed two measures. The Scale of Essential Elements Questionnaire (Melnick & De Leon, 1993) was used to rate a program's adherence to both the philosophy and practices considered fundamental to traditional TC programs. A measure developed by the researchers (see Appendix A) was used to rate the effectiveness of treatment groups.

Millon Clinical Multiaxial Inventory (MCMI-III). The MCMI (Millon, 1997) consists of 175 True-False items. The inventory provides diagnostic information in the areas of personality disorders and clinical syndromes. Internal consistency for the clinical scales ranges from .66 to .90 with 20 of the 26 scales having alpha coefficients in excess of .80. Test-retest reliability coefficients for the subscales range from .82 to .96 (Millon).

Barkley ADHD Rating Scale. The Barkley ADHD Rating Scale (Barkley, 1990) is an 18-item measure that assesses the frequency of ADHD symptoms related to inattention and impulsivity or hyperactivity. Symptoms occurring over the past 6 months are rated on a 4-point Likert-like scale from 1 (never or rarely) to 4 (very often).

Wender Utah Rating Scale (WURS). The WURS (Ward et al., 1993) is a 61-item instrument designed to assess criteria for a retrospective diagnosis of childhood ADHD in order to meet the DSM-IV criteria that ADHD be present before the age of eight. Individuals are asked to indicate how accurately each item or descriptive phrase characterizes him as a child. Items are rated on 5-point Likert-like scales from 1 (not at all or very) to 5 (very much). The WURS has demonstrated reliability. Validity of the WURS has been established through comparing WURS filled out by adult participants to a subjective rating of childhood behaviors provided by the participants' mothers. The correlations were modest, .49 for those without a diagnosis and .41 for those with a retrospective diagnosis (Ward et al., 1993).

University of Rhode Island Change Assessment (URICA). The URICA (McConnaughy et al., 1983) is a 32-item inventory designed to assess an individual's placement along a theorized continuum of behavioral change. Items describe how a person might think or feel when starting therapy and elicit the level of agreement with the statements. Participants answer on 5-item Likert scales that range from 1 (strongly disagree) to 5 (strongly agree). Each stage of change, precontemplation, contemplation, action, and maintenance, is measured using an 8-item subscale. For each of the four subscales, Cronbach's alpha was .69, .75, .82, and .80, respectively (DiClemente & Hughes, 1990).

Circumstances, Motivation, Readiness, and Suitability Scale (CMRS). The CMRS (De Leon et al., 1994) inventory assesses external pressures (circumstances), intrinsic pressures (motivation), readiness, and suitability for residential TC treatment. The 52 items on the CMRS are answered on 5-point Likert-like scales ranging from 1 (strongly disagree) to 5 (strongly agree) or 9 (not applicable). The four subscales are: circumstances (C; 11 items), motivation (M; 17 items), readiness (R; 8 items), and suitability (S; 16 items). Internal consistency of the M, R, and S scales is adequate, with Cronbach's alphas ranging between .70 and .86; the reliability of the C scale was lower (approximately .34). For the total scale, internal consistency reliability is .91 (personal communication, Jean Peters, March, 2000). The CMRS has limited predictive validity for retention in treatment. Validity coefficients for 30-day retention ranged from .19 to 31, whereas those for 10- and 12-month retention ranged from .16 to .21 (DeLeon et al., 1994).

Therapeutic Community Client Assessment Survey (Kressel et al., 2000). This self-report assessment is comprised of 117 items that are rated on 5-point Likert-like scales ranging from 1 (strongly disagree) to 5 (strongly agree). The items describe a wide variety of prosocial and antisocial behaviors, attitudes, and beliefs that are grouped into 14 categories such as maturity, work ethic, self-esteem, and investment in the program. Participants complete this assessment on a monthly basis, thereby providing repeated measures of client change over time.

Therapeutic Community Staff Assessment Summary (Kressel et al., 2000). This instrument is a summary version of the client assessment described previously. Staff assign ratings for each of 14 items that correspond to the 14 subscales found in the client version. The items are rated using 5-point Likert-like scales that range from 1 (strongly disagree) to 5 (strongly agree).

Therapeutic Community Scale of Essential Elements Questionnaire (SEEQ): Criminal Justice Version. This instrument, based upon theoretical writings of De Leon (1995), was adapted for correctional settings by the Criminal Justice Committee of Therapeutic Communities of America (1999). It consists of 97 items rated on a 5-point Likert scale ranging from 0 (Program lacks this element or fails

to meet this standard.) to 4 (Program has element and is working very well. Additional work is not needed in this area.). There is an "N/A" category as well. Items are divided into eight sections that correspond with the TC standards. The number of items per section ranges from 7 to 22. The mean responses across applicable items are obtained for each of the eight sections and are used as subscale scores.

Group Rating Form. The Group Rating form was designed by the researchers to measure the presence of clinical skills as an indicator of the quality of educational and therapy groups (see Appendix A). The form is divided into three categories that describe didactic skills (i.e., teaching skills), co-therapist skills (skills used when a group has more than one therapist), and group therapy skills (e.g., counseling skills, personal therapist qualities). A dichotomous scale provides ratings of present, absent, or not applicable for 56 items divided into the three categories. A summary item utilizes a 6-point rating scale ranging from 6 (excellent) to 1 (unacceptable) to provide a global rating of the overall quality of the group.

Adult Substance Use Survey (ASUS). The ASUS (Wanberg, 1992) is a standardized self-report inventory to screen adults who indicate a history of substance use problems. The ASUS consists of five main subscales and a global scale. These subscales are designed to measure five domains: (1) involvement in ten common drug categories, (2) degree of disruption resulting from use of drugs, (3) antisocial attitudes and behavior, (4) emotional and mood adjustment difficulties, and (5) defensiveness and resistance to self-disclosure (Wanberg, 1997). Each subscale of the ASUS consists of between 5 and 20 items set up on either a 4 or 5-point Likert-type scale. An overall, or Global scale is obtained by combining the scores of the involvement, disruption, social, and mood subscales. This measure is assessed for offenders as they enter the Colorado Department of Corrections.

Level of Supervision Inventory (LSI). The LSI (Andrews, 1982) is a semi-structured interview administered by the Department of Corrections to assess criminal risk. It consists of 54 items with 10 subscales including criminal history, accommodation, companions, alcohol/drug problems,

education/employment, financial, attitude/orientation, family/marital, leisure/recreation, and emotional/personal. Information obtained in the interview is verified whenever possible through official offender records and other sources. Each item is scored using a coding system of either 0 or 1, with a score of 1 indicating that an item is true. The resulting overall LSI score can range from 0 to 54. This total score is used to assign the level of supervision for the offender and to determine allocation of services (Motiuk, Motiuk, & Bonta, 1992). When used in the Colorado criminal justice system, treatment levels are set by combining the LSI total score (supervision) with the score on the Disruption subscale of the ASUS (substance abuse).

PROCEDURE

Numerous data elements were collected to describe the treatment program and participants. Program information was collected from program literature, direct observation, and interviews with staff and residents. Participants completed a survey pertaining to their treatment experiences. A random sample of client files was examined to check for consistency with record-keeping guidelines in effect through the Colorado Department of Human Services, Alcohol and Drug Abuse Division (ADAD, 1998).

Twelve encounter groups and eight other groups were observed and critiqued by two researchers using the Group Rating Form. The two researchers completed the SEEQ based on frequent contact with the program during the 1½-year evaluation period. The researchers completed the SEEQ independently of each other.

Participant data was collected from a program database and department database. This information included entry and exit dates, demographics, and criminal history information. The majority of participant data was furnished through client self-report assessments. A researcher met with all participants in a group setting within three weeks of program admission. At that time, the purpose of the research, voluntary nature of participation, and confidentiality of participant information was described.

Those who chose to participate signed a consent form and were given a copy for their records. Participants then completed the intake battery, which took approximately 1½ hours.

Each month, staff members completed the TC Staff Assessment Summary and clients filled out the TC Client Assessment Summary. These progress ratings were not solely for research purposes and, therefore, were not kept confidential. The program staff adapted them for the duration of the study to use in a clinical manner. Staff forms were filled out during weekly staff meetings, where all staff members gave input about each client's progress. Participants filled out their forms in the housing unit, returning them to TC staff. The staff forms took a couple of minutes to complete per resident, and client forms took approximately 15 minutes.

RESULTS

PARTICIPANT PROFILE

Baseline data collected routinely by the program or captured by the DOC database system was analyzed for all program admissions (N = 527). Results from these analyses are presented in Table A. Notably, only 366 out of the 527 participants were assessed on the research intake battery used to profile participants. There were various reasons for participants not completing the battery: termination from treatment prior to testing, refusals to participate, and researcher vacancies. To ascertain whether the sample used to profile participants resembled the larger TC population, a series of one-way t-tests and chi-square tests were conducted. No differences were found on any of the following factors: ethnicity, age, scored or final custody level, degree of most serious offense, diagnostic needs levels, ASUS scales, or LSI.

Participant profiles were analyzed for each of the following groups: (1) successful participants who remained in treatment a minimum of 6 months and made a progressive move, (2) participants who either quit or were expelled from the program, and (3) participants who made a progressive move out of the TC within 6 months of TC admission. Participants who had not discharged from treatment at the close of the study were excluded from the analyses, bringing the sample size to 292 participants. Descriptive statistics were analyzed for the three groups, as well as comparative analyses to establish whether each factor influenced program retention.

Table A. Baseline Client Information

	Percent
Ethnic Heritage	
Caucasian	58%
African American	21%
Latino	18%
Native American	3%
Scored Custody Level	
Minimum	14%
Minimum-Restricted	71%
Medium	15%
Final Custody Level	
Minimum	14%
Minimum-Restricted	85%
Medium	1%
Degree/Most Serious Offense	
1-3	23%
4	49%
5	22%
6	6%
Needs Levels	
Sex Offender	1%
Psychiatric	20%
Seriously Mentally Ill	13%
	M (SD)
Age	34.4 (8.0)
ASUS Scales	
Involvement	14.4 (8.3)
Disruption	31.6 (20.8)
Social	8.2 (5.6)
Mood	12.4 (5.9)
Defensive	6.6 (3.6)
LSI	32.9 (6.2)

Several fixed factors were explored in relation to treatment retention, and included age, ethnicity, marital status, education level and time to parole eligibility and mandatory release dates (see Table B). One-way analysis of variances tests and chi-square analyses were conducted to determine differences between groups. Successful participants had more time until their parole eligibility date than the other groups, and the early release group had less time to their mandatory release date than the others. Marital status was the only other fixed variable that related to retention. Unsuccessful participants were more likely to be single than the successful or early release participants.

Table B. Relationship of Fixed Factors to Treatment Retention

	Unsuccessful	Successful	Early Release		
	M (SD)	M (SD)	M (SD)	*F*	η^2
Age	32.8 (8.0)	35.3 (7.4)	34.3 (8.3)	2.74	.07
Months to Parole Eligibility	8.5(23.4)	16.6 (19.3)	7.0(14.7)	4.88**	.91
Months to Mandatory Release	49.1(41.0)	52.8 (30.2)	32.5(21.6)	6.81**	.90
	%	%	%	χ^2	
Ethnicity				3.11	
Anglo	54	56	59		
African American	19	21	16		
Latino	19	13	20		
Other	7	9	5		
Marital Status				13.52**	
Single	51	28	33		
Married	24	35	30		
Divorced/Separated/Widowed	26	37	38		
Education				4.55	
Less than 12th Grade	22	19	25		
Graduated High School	5	7	9		
GED	29	27	22		
Vocational/ Trade School	17	13	13		
Attended College	27	35	31		

* $p < .05$; ** $p < .01$

Prevalence rates of personality pathology and clinical syndromes, as measured by the MCMI-III, are charted in Figures 1 and 2. Not surprisingly, the most common personality disorder was found to be antisocial personality disorder. A noticeable incidence was found across other personality scales, including Avoidant, Schizoid, Passive-Aggressive, Self-Defeating, Depressive, and Narcissistic personality disorders. The results also revealed high prevalence rates of alcohol and drug dependence, along with anxiety disorder. There was a relatively low frequency for the other clinical syndrome scales. Table C presents central tendencies, univariate results, and effect sizes for the MCMI-III data. Univariate differences were found between groups for the following scales: Narcissistic, Aggressive, Compulsive, Passive-Aggressive, Schizotypal, Paranoid, Bi-polar: Manic Disorder, and Delusion Disorder.

Figure 1. Percent Scoring > 75 on MCMI Personality Scales

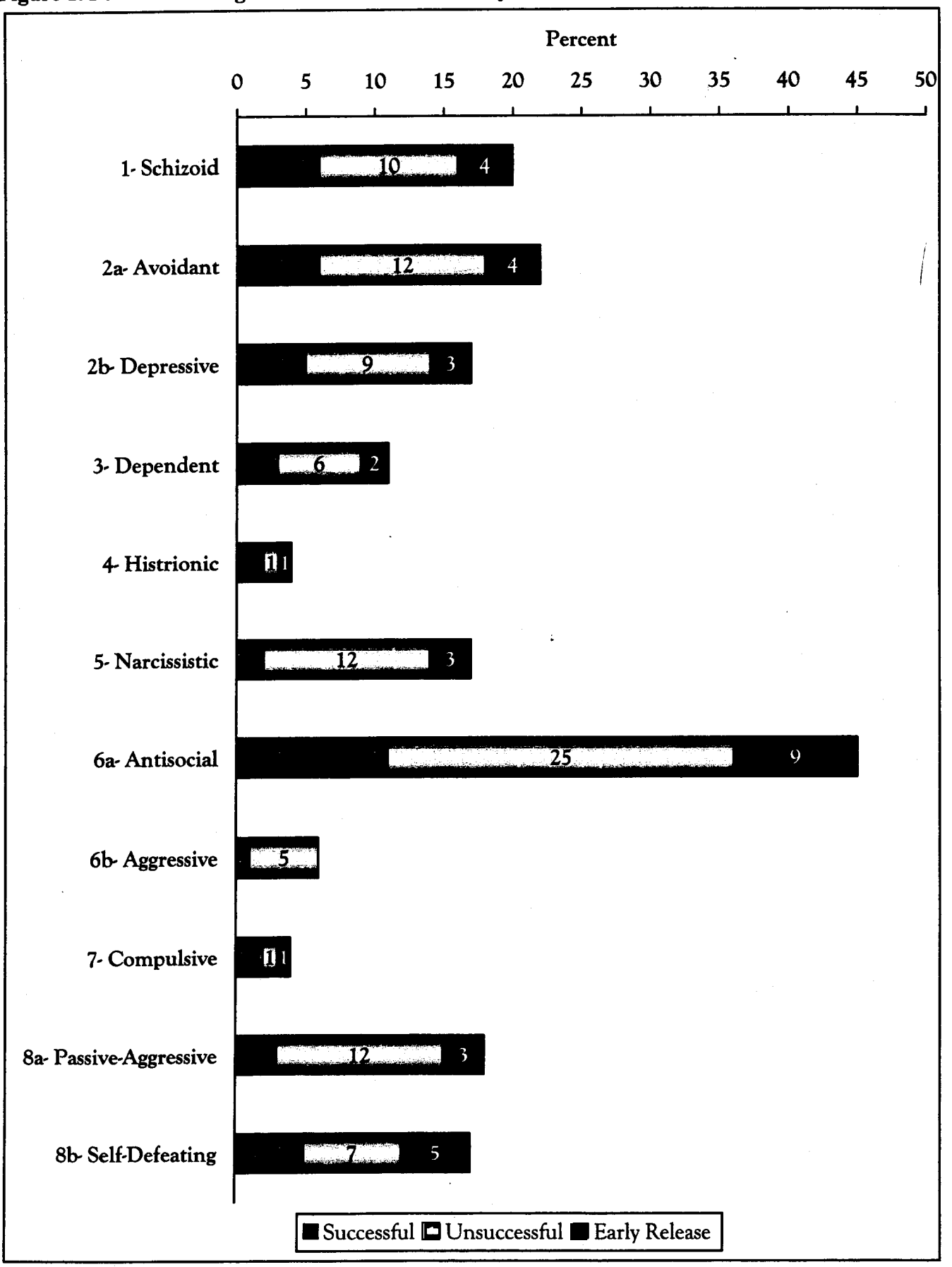


Figure 2. Percent Scoring > 75 on MCMI Clinical Syndromes

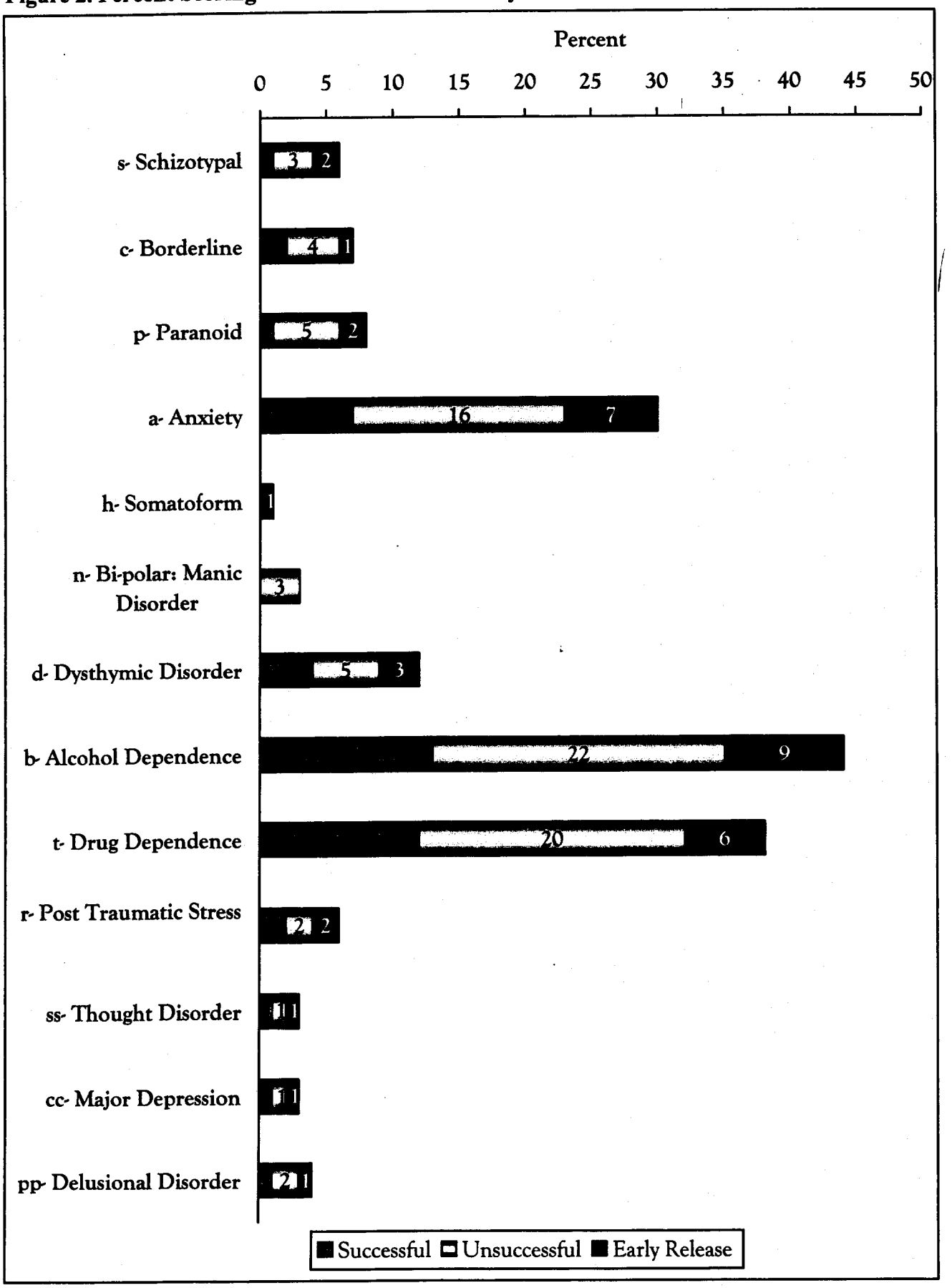


Table C. Relationship of Dynamic Factors to Treatment Retention

	Unsuccessful M (SD)	Successful M (SD)	Early Release M (SD)	*F*	η^2
MCMI Personality Scales (BR Scores)					
1- Schizoid	57.4 (23.8)	54.4 (28.4)	51.7 (27.1)	1.13	.16
2a- Avoidant	47.2 (29.5)	41.5 (30.8)	41.5 (31.1)	1.29	.15
2b- Depressive	46.6 (31.8)	42.4 (33.0)	42.2 (33.5)	.63	.19
3- Dependent	40.2 (26.7)	40.4 (26.4)	36.8 (28.1)	.39	.18
4- Histrionic	48.2 (13.8)	47.5 (17.4)	52.3 (15.3)	2.02	.19
5- Narcissistic	65.2 (17.0)	56.3 (15.6)	62.2 (15.5)	7.39**	.20
6a- Antisocial	72.2 (17.4)	71.1 (18.0)	68.5 (18.9)	.93	.17
6b- Aggressive	53.6 (20.3)	46.8 (20.2)	44.1 (20.2)	5.87**	.23
7- Compulsive	47.4 (13.7)	51.2 (15.8)	52.6 (12.8)	3.70*	.18
8a- Passive-Aggressive	49.0 (27.0)	40.1 (26.5)	36.0 (29.5)	5.98**	.14
8b- Self-Defeating	47.3 (29.0)	50.6 (28.7)	41.0 (31.6)	1.87	.18
MCMI Clinical Syndromes (BR Scores)					
s- Schizotypal	44.8 (28.2)	32.5 (29.5)	36.4 (30.5)	4.97**	.16
c- Borderline	47.1 (22.6)	44.8 (24.5)	40.7 (23.0)	1.68	.20
p- Paranoid	47.7 (29.3)	35.4 (29.8)	40.8 (30.6)	4.48*	.15
a- Anxiety	47.0 (36.3)	40.8 (37.4)	43.4 (37.3)	.73	.12
h- Somatoform	29.4 (27.8)	26.1 (28.0)	25.9 (30.0)	.51	.09
n- Bi-polar: Manic Disorder†	53.0 (20.6)	46.8 (21.5)	47.0 (22.4)	6.04*	--
d- Dysthymic Disorder	38.1 (31.1)	37.7 (31.5)	37.0 (31.7)	.03	.15
b- Alcohol Dependence	70.8 (22.0)	72.4 (22.6)	71.9 (18.8)	.16	.21
t- Drug Dependence†	72.7 (18.0)	76.0 (14.7)	67.8 (20.2)	5.34	--
r- Post Traumatic Stress	38.5 (28.3)	34.2 (31.9)	35.5 (30.7)	.58	.11
ss- Thought Disorder	37.0 (26.6)	31.8 (28.5)	32.4 (27.9)	1.18	.13
cc- Major Depression	26.7 (26.1)	25.3 (29.0)	27.9 (28.3)	.16	.16
pp- Delusional Disorder†	38.9 (29.2)	29.0 (29.2)	34.9 (30.2)	8.57*	--
WURS					
Total	87.1 (38.0)	75.9 (37.5)	73.5 (38.9)	3.74*	.55
Conduct Problems	15.0 (8.7)	11.1 (8.3)	10.9 (6.8)	8.40**	.14
Learning Difficulty	8.6 (7.3)	7.0 (6.6)	6.9 (6.3)	1.87	.08
Irritability†	11.2 (7.6)	9.4 (7.7)	8.7 (8.8)	8.08*	--
Attention Problems	8.8 (4.6)	8.8 (4.6)	8.2 (4.9)	.33	.08
Unpopularity	11.7 (6.1)	12.3 (5.6)	12.0 (6.2)	.27	.16
Barkley ADHD Scale					
Inattention	.7 (1.3)	.5 (1.1)	.8 (1.8)	.67	.05
Impulsive	1.2 (1.6)	.9 (1.3)	1.1 (1.8)	1.13	.03
URICA					
Precontemplation	50.3 (10.0)	48.0 (10.3)	48.7 (9.7)	1.50	.04
Contemplation	43.6 (12.8)	45.1 (13.4)	43.1 (13.7)	.43	.07
Action	48.8 (8.5)	49.7 (8.8)	48.9 (8.9)	.23	.03
Maintenance	47.2 (10.1)	49.2 (8.6)	47.7 (9.0)	1.17	.02
CMRS					
Circumstances	28.4 (4.2)	28.0 (3.7)	28.5 (4.2)	38.50	.14
Motivation	65.1 (10.3)	65.1 (9.6)	64.5 (10.3)	.07	.29
Readiness	24.9 (5.7)	26.2 (5.4)	24.9 (6.1)	1.39	.15
Suitability	53.8 (9.9)	56.3 (8.3)	53.5 (11.4)	1.77	.38

† Kruskal-Wallis chi-square values are reported because of ANOVA assumption violations.
* $p < .05$; ** $p < .01$

Mean URICA scores indicated that Arrowhead participants were within normal ranges of motivation on each of the four scales (see Table C). Because URICA scores are scaled as T-scores, any scores ranging from 40 to 60 can be interpreted as the norm. Interestingly, TC participants model a precontemplation cluster, characterized by the belief that they do not have a problem, which is inconsistent with their placement in treatment. Curiously, participants' scores on the CMRS yielded somewhat contrary findings. Participants likely would have scored in the high range on the Circumstances scale were it not for two items that did not apply to incarcerated offenders (normal range is 25 to 33). Participants scored above the normal range on the Motivation scale (42 to 56) and in the normal range for Readiness (27 to 36) and Suitability (49 to 64) scales. There were no differences across groups, however, on either measure.

Prevalence rates of ADHD were examined by the WURS and Barkley Rating Scale (see Table C). The Barkley Rating Scale did not indicate the presence of adult ADHD in the Arrowhead TC population. Neither did this scale differentiate between the groups. On the other hand, the WURS was found to discriminate between successful and unsuccessful treatment participants.

All significant comparisons differentiated successful from unsuccessful participants, except for time to mandatory release. In most cases, the early release group aligned with the successful group. However, they were similar to the unsuccessful group on the narcissistic scale and time to parole eligibility. Early releases were not different from either group on the Compulsive, Schizotypal, Paranoid, and Delusional Disorder scales. Interestingly, the measures of motivation and readiness for treatment did not differentiate between successful and unsuccessful participants.

A discriminant function analysis was conducted to determine if a combination of variables could predict group membership into two groups (successful and unsuccessful). Predictor variables included in the equation were Narcissistic, Aggressive, Passive-Aggressive, Compulsive, Schizotypal, Paranoid, Delusional, WURS conduct, months to parole eligibility, and marital status (coded as single/non-single). The discriminant function resulted in an eigenvalue of .23 and a canonical correlation of .43. The pooled

within-groups correlations found the best predictors to be narcissistic personality disorder (.52), marital status (-.49), WURS conduct problems (.45), schizotypal disorder (.44), and paranoid disorder (.43). Classification results revealed that the discriminant function correctly classified 70% of all cases.

PROGRESS IN TREATMENT

To assess progress in treatment, the client ratings on the Client Assessment Summary (Kressel et al. 2000) and the staff ratings on the Staff Assessment Summary (Kressel et al.) were used. The 14 items on the staff and counselor summary versions are listed in Table D. Residents of the program completed the client version each month they were enrolled in the program. Program counselors completed the staff version for each client on monthly basis, beginning the second month of treatment. The entire staff completed the staff version.

Table D. Subscales for Progress in Treatment Measure

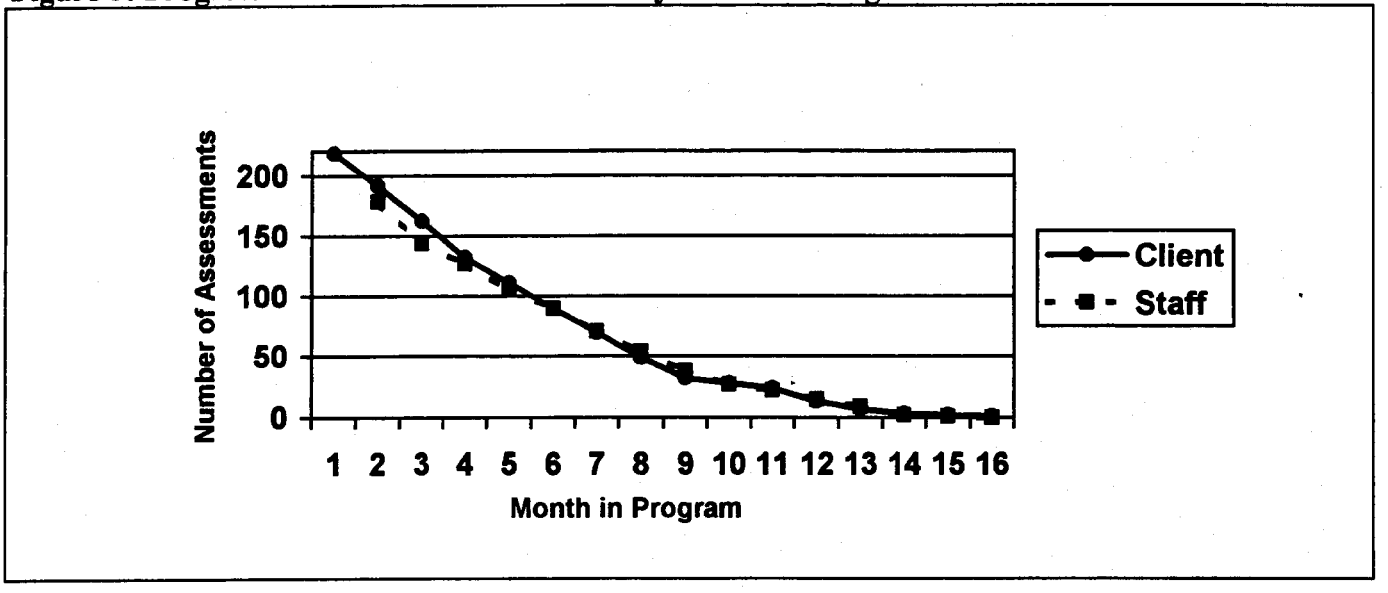
1	My behavior and attitude show that I am a mature person.
2	I consistently meet my obligations and responsibilities.
3	I strive to live with positive values and integrity.
4	I still have the attitudes and behaviors associated with the drug/criminal lifestyle.
5	I often present an image rather than my true self.
6	My job function helps me learn about myself and is a valuable part of treatment.
7	I get along with and interact well with people.
8	Overall, I have good awareness, judgment, decision-making and problem solving skills.
9	I'm able to identify my feelings and express them in an appropriate way.
10	I feel good about who I am (my self esteem is high).
11	I understand and accept the program rules, philosophy and structure.
12	I enthusiastically participate in program activities.
13	I feel an investment, attachment and stake in the program.
14	My behavior and attitude set a good example for other members of the community.

Note: Items 4 and 5 are reversed scored. The items listed here are from the client version. The staff version has the same items but worded in the third person (e.g., The client is a mature person ...)

Participant Assessment Information. The progress in treatment measure was administered from January 1998 to June 2000. Only participants who were admitted to after January 1, 1998 and who had at least one client and one staff assessment were used for this data analysis. There were 218 participants who fit these criteria. This is a biased sample, as participants who left program within the first one month were not considered. In addition, length of stay in program was determined from admission date to an April 2001 cutoff date.

Residents remained in the program from 35 days to 1050 days with a mean length of stay in treatment of 272.87 days (*SD* = 153.20). The number of monthly client assessments ranged between 1 and 16 with a mean of 5.21 (*SD* = 3.38). The number of staff assessments ranged between 1 and 15 with a mean of 5.06 (*SD* = 3.55). Figure 3 gives the number of assessments at each monthly period, with staff ratings not starting until the second month. For data analyses, only the first six time periods are used, as the number of participants in the remaining time periods decreases dramatically, especially for the unsuccessful group.

Figure 3: Progress in Treatment Assessments by Month in Program



Clients were classified as to whether they were successful in the program. A successful client is defined as one who remains in the program for at least 6 months and who is not expelled from or does not quit the program. This is a slightly different definition of program success than used in previous analyses. In previous analyses there were three groups, including a group who left the program for neutral reasons. Because of the small number of people in this group for these analyses, this group was considered a positive move for purposes of determining if a program success. The percentage of clients who complete the program (stay in treatment for 6 months or longer) was 70%. The percentage of clients who are considered to be a success in the program is 51%. Table E shows the length of stay in the

program and reason for leaving the program (if they have left; some clients were still in the program at the end of the data collection period). Successful conditions are in blue.

Table E. Relationship between length of stay in the program and discharge status

Discharge Reason	< 6 months	≥ 6 months
Still in Program	0%	2%
Positive Move	10%	49%
Neutral Move	1%	.5%
Quit or Terminated	19%	18%

There is a significant relationship between length of time in program and discharge reason, $\chi 2(3, N = 218) = 27.73$, $p < .00$, with people staying in the program longer having more positive reasons for discharge. Table F gives descriptive information concerning number of assessments for the successful and unsuccessful groups.

Table F. Descriptive Information for Successful and Unsuccessful Clients

	Successful	*Unsuccessful*
N	112	106
%	51%	49%
Number of Days in Treatment		
Minimum	182	35
Maximum	1050	514
Mean	367.60	172.78
Standard Deviation	130.00	104.65
Number of Client Assessments		
Minimum	1	1
Maximum	16	13
Mean	6.96	3.35
Standard Deviation	3.30	2.31
Number of Staff Assessments		
Minimum	1	1
Maximum	15	13
Mean	6.86	3.15
Standard Deviation	3.40	2.60

Relationship between client and staff ratings. To assess the relationship between staff and client ratings, correlation coefficients were computed between the staff and client ratings at each assessment period, beginning with the second assessment. Table G shows the relationship between client and staff

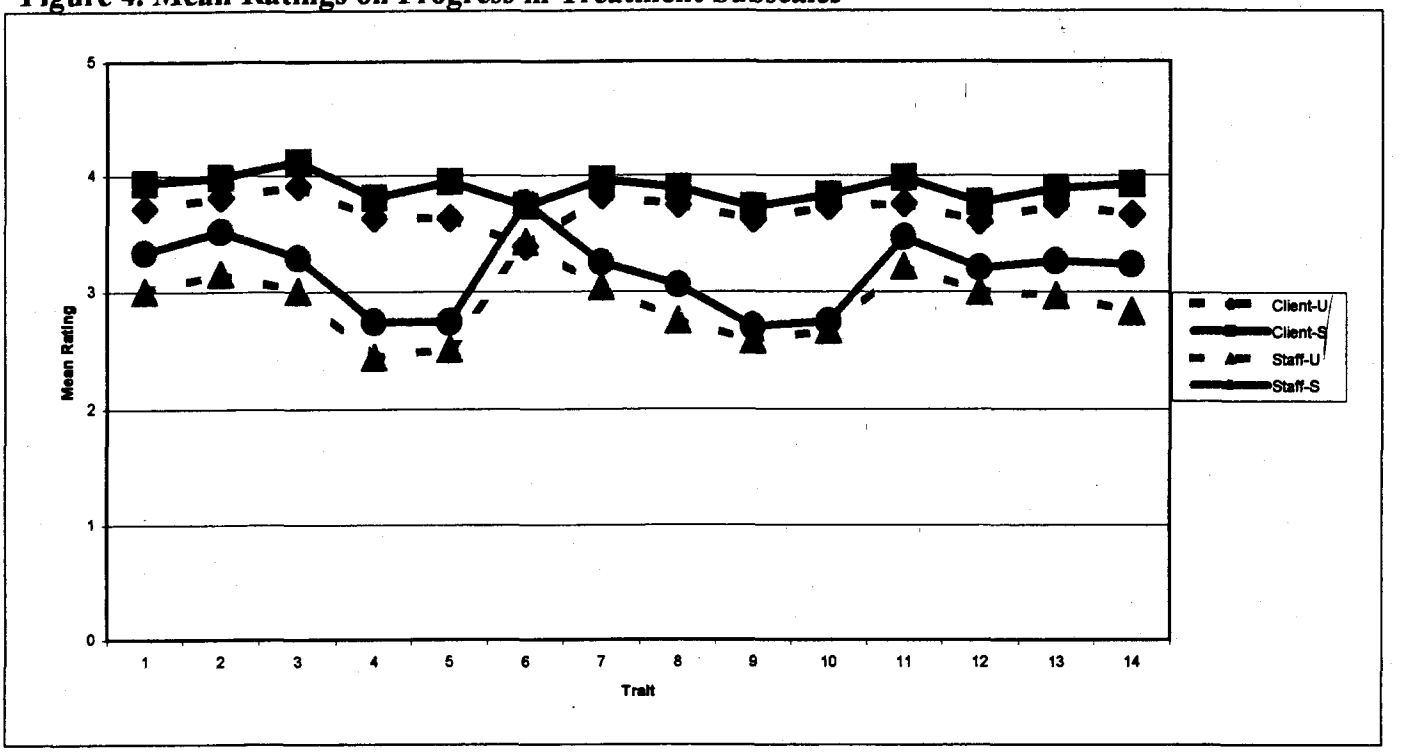
ratings for the 14 subscales across five assessment periods. The correlations between staff and client ratings are very low, indicating that clients and staff do not view clients in a similar way.

Table G. Correlation between staff and client ratings for each scale at each time period.

	Time Period				
Scale	**2**	**3**	**4**	**5**	**6**
1	.11	.24	.10	.28	.17
2	.18	.16	.08	.23	.22
3	.02	.12	.19	.11	.07
4	.14	.02	.13	.15	-.01
5	-.06	.15	.01	.04	.10
6	.21	.03	.04	-.06	-.09
7	.18	.19	.20	.09	.38
8	-.01	.15	.08	.20	.08
9	.12	.11	.07	.15	.15
10	.14	.18	.16	.09	.03
11	.10	.16	.10	.21	.17
12	.23	.15	.25	.08	.26
13	.18	.12	.08	-.01	.13
14	.18	.08	.12	.12	.16

Changes across time. To investigate if changes occur across time, a repeated-measures ANOVA was completed on both staff and client ratings for participants who remained in the program at least 6 months. There were only 67 clients who had client and staff ratings for the 5 rating periods. For this select group of participants the following results were obtained. Clients gave significantly higher ratings than staff, $F(1, 66) = 181.61, p < .000, \eta^2 = .73$. Ratings changed significantly across time, $F(4, 264) = 7.41, p < .000, \eta^2 = .10$. Scores increased from the second to the third month, and from the third to the fourth month, but were steady from the fourth through the sixth months. There were significant differences in subscale ratings, $F(13, 858) = 33.08, p < .000, \eta^2 = .33$. There was also a significant interaction between rater and subscale, $F(13, 858) = 27.02, p < .000, \eta^2 = .29$. The interaction is best described by less variability in mean ratings by the client (fairly straight line across the 14 subscales); and more variability in mean ratings across the subscales. Figure 4 shows the ratings for each trait comparing raters as well as successful and unsuccessful clients. There were no other significant differences found, including no significant effects including the client success variable.

Figure 4. Mean Ratings on Progress in Treatment Subscales



Prediction of length of treatment. To assess if any of the scales were useful in predicting length of stay in treatment, client and staff ratings of the 14 subscales across six time periods were correlated with length of time in the program. The correlations were small (all $r < .30$). Correlations between length of stay and client ratings tended to be smaller and fewer (33%) were statistically significant; whereas correlations between length and staff ratings tended to be higher and more (46%) were statistically significant.

To further investigate the relationship between program retention and progress in treatment measure, a discriminant analysis was done using program success as the dependent variable and the staff and client ratings on the 14 subscales across the first six time periods as the independent variables. These variables were not useful for predicting group membership beyond chance levels.

Additionally, regression analyses were completed for each time period (from 1 to 6 months) in order to evaluate if any measures were useful for predicting length of stay in the program. Although

overall R^2's were statistically significant, they were small in magnitude ranging from .04 to .12. There were no consistent predictors across the time periods.

There is a problem in investigating changes across time with this type of data due to the nonrandom dropout rates. However, even with a select group of participants who remained in the program for six months, small increases in scores were seen across time. The largest effects in comparing scores across time were found for a rater effect, subscale score effect, and perhaps, more importantly, an interaction between raters and subscales. These similarities and discrepancies may provide a clinical opportunity for client and staff to compare ratings and discuss such differences. Indeed, this is how we thought such a tool would be used in the first place. It was expected that the staff and clients would use such a tool for planning treatment program and discussing progress. It was the program staff who wanted to include this treatment into the program. However, once implemented it became clear that the staff viewed this as just another set of paper work that the research team was making them complete. The ratings were not used to decide treatment plans nor were there ever conversations between client and staff comparing ratings. There is evidence to suggest that there are discrepancies in how clients and staff rate themselves and as such this measure could provide a mechanism for dialogue between clients and staff around treatment issues. The lack of use of the measure could have impacted both the staff ratings and the client ratings. The clients may not have taken this seriously since the measure was never used with them. If such a measure is to be used, there needs to be ongoing training for staff on how to use such a measure for clinical intervention. In summary, the progress in treatment measure gives us limited information about the process evaluation of the program.

PROGRAM PROFILE

This program profile describes various aspects of the program as it operated during the period from February 1999 to August 2000. The areas described include program setting, admission criteria, discharge criteria, program structure, treatment groups, staff, and treatment files. Each section addressing a program aspect contains a description of standard operations followed by the related research findings.

Program Setting. The TC was situated in a minimum-restricted (lower security level) prison located in Cañon City, Colorado. Participants resided in a 96-bed living unit housing only TC participants. Five additional living units were located in this facility; four for general population inmates and one for sex offender treatment participants. Sex offender participants were also treated in a TC environment; however, the sex offender and substance abuse programs operated independently of each other.

Treatment groups were held in a variety of locations depending on space availability. Groups were conducted in the visiting room, the day room in the TC unit, or one of four group rooms in the TC modular units. The TC modular units were part of a greenhouse work site situated outside the main prison gate. Although there are four group rooms in the modular units, this space was at a premium due to their frequent use by other programs and greenhouse employees.

The majority of program staff, including three counselors, the director, and the administrative assistant, had offices in the TC modular units. The remaining three clinical staff used offices in the TC housing unit or a closely situated building located in the prison.

The kitchen and greenhouse were the primary work sites for TC participants, although at least a few offenders were assigned to janitorial positions in the TC housing unit. Substance abuse and sex offender TC participants shared work assignments. TC participants were segregated from non-TC offenders at their work sites and during therapeutic activities, but not in recreation, medical, or dining areas.

Findings: The most significant observation about the setting was the severe lack of space. The lack of space primarily posed a problem for conducting group sessions. Researchers occasionally observed group cancellations due to unavailability of a group space. Other times, groups were held in areas where there was no privacy. For example, groups held in the visiting room were subject to frequent interruptions by correctional officers and other inmates walking through the room. In other instances, groups were held in the TC modular unit, where a thin divider was used to split one large room into two small rooms. In this setting, it was very easy to hear what was going on in the other room.

Counselors had adequate office space; however, they were spread across the facility. While the distance between counselors did not pose a serious problem, it presented a challenge for the team to remain connected with each other and share important information. The team leader had a cubicle office in the modular unit that did not allow privacy to meet with her staff. Anyone in the vicinity, including other staff and inmates, could overhear meetings held by the team leader. This setting prevented the team leader to engage in sensitive conversations with her staff, related to clinical supervision or personnel issues.

The TC clientele were not well separated from general population inmates. TC staff and residents were in agreement that the single largest obstacle to a positive peer culture was the close proximity of the general population. Even though they were separated in groups, there was plenty of opportunity for interactions. In the yard and other common areas, TC clients were subjected to ridicule from non-TC inmates.

Admission Criteria. Admission criteria are used to help ensure the appropriateness of participants for the TC modality and that they have enough time left before release to benefit from participation. This program's criteria (listed in Table H below) took into account inmates' recommended treatment level, parole eligibility date (PED) or mandatory release date (MRD), security level, mental health needs and institutional misconduct. The primary admission criterion involved the recommended standardized offender assessment (SOA) treatment level.

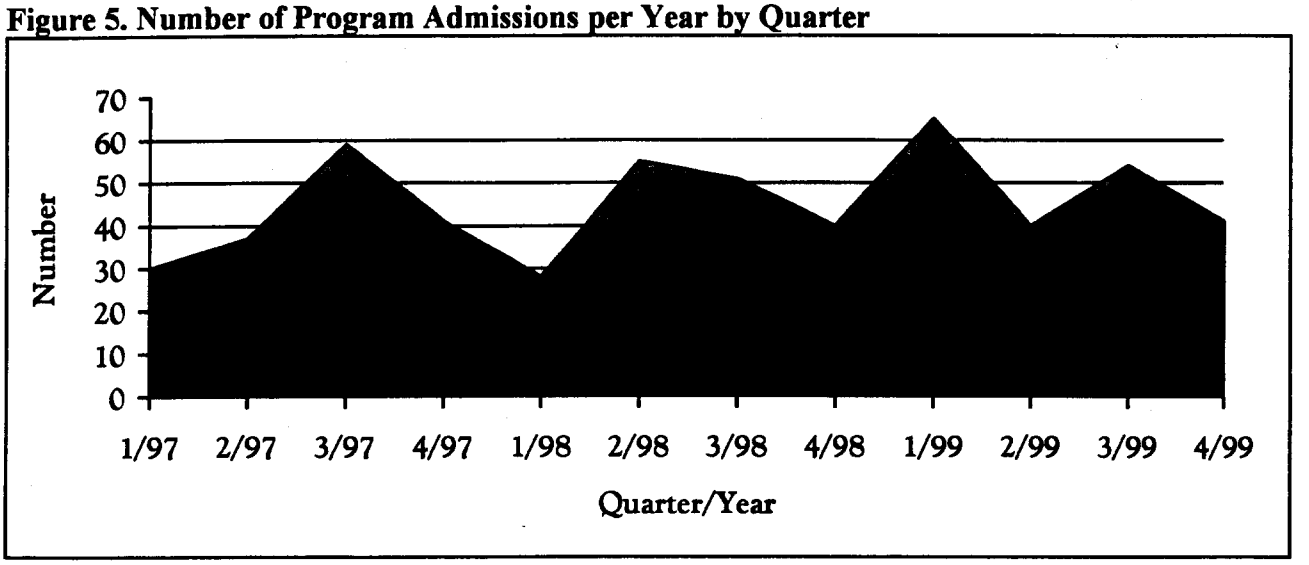
The program began admitting residents with a co-existing mental health diagnosis in 1998. Accordingly, the admission criteria were modified for substance abusing offenders who have a co-morbid psychiatric diagnosis. As a general rule, services rendered are equivalent for inmates regardless of their mental health concerns.

Table H. Admission Criteria

Criteria	Standard Admissions	Dually-diagnosed Admissions
Recommended SOA level	5-6	5-6
Security level	Minimum-Restricted or Minimum	Minimum-Restricted or Minimum
Months until PED/MRD	>= 6	>= 6
Months since last disciplinary action	>= 6	>= 6
Mental health severity level (P-code)	1-2	3-5 C/O
Medical needs severity level (M-code)	1-2	1-2
Sex-offender severity level (S-code)	1-2	1-2
Psychotropic medications	None	Stabilized

Findings: The number of admissions over the 3-year period of the study was analyzed. Figure 5 displays the number of admissions per year by quarter. On average, 45 inmates were admitted a quarter, or 15 per month. Fourteen inmates were admitted twice to the program during this period.

Figure 5. Number of Program Admissions per Year by Quarter



This study examined whether the program adhered to its own admission criteria. It was not possible to verify criteria regarding psychotropic medications. Also, months until MRD was not evaluated because the program only tracks PED, and both MRD and PED change on a monthly basis, making it impossible to gather the data archivally.

A review of participant assessments revealed that 79% received a recommendation for either level 5 or 6 treatment. Seven percent were recommended to treatment other than level 5 or 6, and 14% were never assessed prior to admission or within the first 45 days of treatment. This translates into 21% of participants who were either not assessed at all or assessed as needing non-TC types of treatment. It should be noted that just over half of the missing assessments were for admissions in 1997 when the SOA battery was not fully implemented; however, nearly half were missing for 1998-99 admissions when the SOA was a standard admission criterion.

Using scored custody ratings, 70% of participants were classified as minimum-restricted and 14% were minimum, with 16% scoring at the medium level. After classification overrides, all but three offenders were classified as either minimum or minimum-restricted. An examination of disciplinary actions revealed that 11% of TC participants were found guilty of a violation within the 6 months prior to admission.

An examination of parole eligibility revealed that 58% were at least 6 months from their PED. Forty-two percent did not meet this criterion, with 18% past their eligibility date. PED data should be considered in combination with MRD, as both dates differ from each other and impact actual release dates. This study did not evaluate MRD.

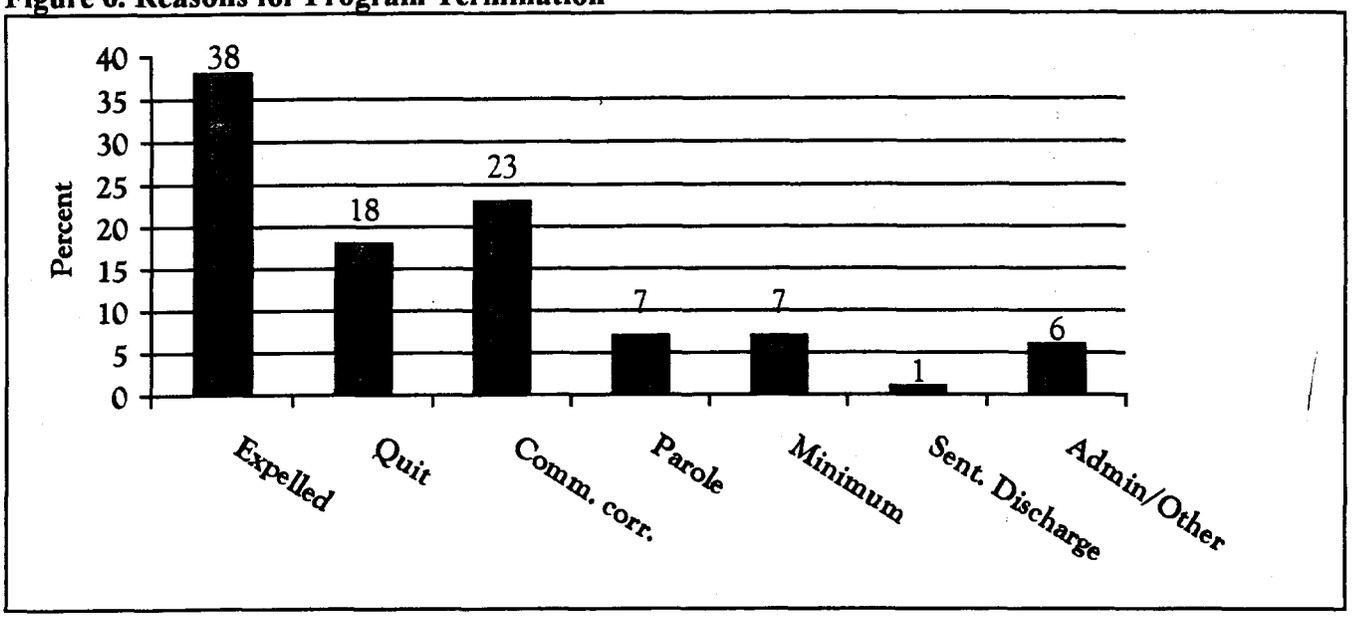
Relevant needs levels were examined to determine appropriate TC placements. Five percent of participants were found to have medical needs level above two and 1 percent were classified as sex offenders. Seriously mentally ill offenders comprised 13% of admissions. However, there were an additional 7% with elevated mental health needs who were not classified as seriously mentally ill. It is unclear as to whether or not this 7% were admitted as dually diagnosed offenders.

Program Discharges. Residents exited the TC for a number of reasons including successfully completing treatment, being terminated by staff, making a progressive move in the system, or quitting. Participants were occasionally discharged for non-treatment related administrative terminations, such as medical problems preventing their continued placement at ACC. Successful participants were considered those who remained in the program for at least 6 months and made a progressive move (i.e., halfway house, parole, minimum-security prison).

Residents could be expelled from the program for a variety of reasons such as violating a Department of Corrections' (DOC) regulation, being fired from their prison job, or violating one of the program's "cardinal rules." The cardinal rules outlined a code of conduct for participants and included the following: no use of drugs or alcohol, no violence or threats of violence, no stealing, no sexual acting out, no violating confidentiality, and no gambling. Participants might also be terminated for committing multiple smaller offenses such as a lack of treatment progress or poor job site performance.

Findings: The program tracked program admissions and discharges electronically. Lengths of stay and reasons for discharge were examined for the 447 participants who terminated treatment prior to January 2000. The median length of stay was 119 days (SD = 129), ranging from 1 day to 21 months. The majority of offenders were expelled; however, the second most common reason for termination was for a community corrections placement. Figure 6 displays reasons for treatment discharge. Overall, 56% left the program for negative reasons, 38% left for a progressive move (regardless of time spent in treatment), and 6% left for a neutral reason. Taking into account both progressive moves and time in treatment, 21% of participants successfully completed treatment.

Figure 6. Reasons for Program Termination



Program Structure. The TC program was structured as a hierarchical system with identifiable, progressive phases, each with specific goals and requirements. The four phases included orientation, community, senior, and maintenance. Participants who completed all the requirements of their current phase could be recommended by staff to progress to the next phase.

New TC members were placed in the orientation phase, the goal of which was to help them become familiar with all aspects of the program. This phase lasted approximately three months, although, as with the other phases, the individual's progress in treatment was the primary determinant of how long it took to progress to the next phase. A requirement of the orientation phase was that participants make and present a brief speech to the TC community. This speech detailed the individual's commitment to change. Residents were also assigned a "big brother," whose primary role was to support the new resident during his transition into the program.

During orientation phase, all participants attended two client-run classes, each held twice weekly, where they learned program rules, expectations, and procedures, and cognitive and behavioral strategies. Participants were required to demonstrate mastery of the information presented through passing written tests. A final requirement of the orientation phase was that each participant initiates and participates in a therapy group where he is the focal point of group.

The next phase, called community phase, lasted approximately 4 months. Goals of this phase included that participants take personal responsibility and function as role models for newer members. These goals were reinforced through the practice of assigning community phase residents a "little brother" from the orientation phase. Residents in community phase attended classes to address criminal and addictive lifestyles and to develop relapse prevention skills. Under the guidance of a staff member, residents at this treatment phase could also teach educational seminars.

Participants were required to complete a relapse prevention plan and a written exercise exploring their abuse cycle in order to progress to senior phase. Residents needed to complete an application for senior phase, the purpose of which was to ascertain the level of the individual's self-knowledge to determine if he was ready to progress into senior phase. In addition to the written application, two letters of reference from peers were required.

Senior phase lasted an indeterminate length of time, but it began at approximately the seventh month of treatment. Goals for senior phase included developing increased self-responsibility and leadership skills, providing appropriate self-disclosure in treatment groups, and consistently role modeling pro-social behavior throughout the TC. Senior phase residents were eligible to present seminars (educational groups) to the community and to co-facilitate educational groups with staff members. As senior TC members, they were expected to function as role models for all other TC members, not just newer members. Presenting seminars accounted for some of the time that senior residents would spend attending groups; however, they were still required to attend groups.

The final phase, maintenance phase, was targeted towards participants who were awaiting release from prison. A primary goal of maintenance phase was for members to continue as positive role models for the treatment community, while simultaneously receiving the benefit of remaining in a therapeutic environment until release. To be eligible for maintenance phase, residents must have completed all groups and other required goals of the prior three phases. Individuals in maintenance were required to

complete a written contract outlining their plan for continued participation in the TC. Attendance in at least one therapeutic group per week was mandatory for all participants in this phase.

The Arrowhead program has a "Structure," which was comprised of a select group of TC residents who demonstrated their ability to take personal responsibility. Staff appointed community or senior phase members to Structure to serve as liaisons between staff and the TC community. Structure members essentially functioned as role models in the TC; they were thoroughly familiar with the program and made themselves available to help newer members. There were three levels within the Structure: expeditor, coordinator, and senior; and it functioned as a chain of command in the TC environment. If a resident encountered a problem he was unable to resolve on his own, he was expected to seek assistance from the lowest level and move to the higher levels as needed. In general, staff became involved only when Structure members were unable to work out a particularly challenging issue. The purpose was to teach them to rely on peers rather than a higher authority.

Rational office was a formal method of providing feedback to residents. This technique was used to provide positive feedback in recognition of prosocial behavior, as well as corrective action when an individual had difficulty functioning within the confines of the program. Two structure members and one staff person met individually with residents to discuss their progress in the program. Behavioral assignments were usually given for inappropriate behavior, although the resident was encouraged to choose his own assignments. By choosing his own assignments, he was believed to make a greater commitment to them. These assignments were referred to as learning experiences.

Learning experiences were behavioral techniques designed to increase personal awareness. The program had a printed list of approximately 30 learning experiences from which participants chose during rational office. A sample of frequently selected learning experiences is provided in Table I.

Table I. TC Learning Experiences

Learning Experience	Description
Pull-up	This was the most basic and frequently used learning experience. A pull-up is merely a verbal statement made by one individual to another to raise his awareness of unacceptable behavior.
Concept paper	A written assignment 8 to 10 pages long that included information such as why it was assigned, what behavior was displayed, how the behavior related to their criminal thinking errors, and what they will do to correct the behavior.
Game slip	The resident would write a brief note to describe a behavior he saw in himself or was confronted with by another resident. Dropping a game slip on self indicated that he intended to address the behavior in an encounter group.
Sign	A visual learning tool carried at all times to remind the resident and his peers what he must do to correct his behavior. Each day, affirming statements that described what improvements he made were written on the back of the sign.
Apologies	This learning experience entailed the resident standing up in front of house meeting and making a verbal apology to the entire community. The apology included both describing the problem that occurred and taking ownership for it.
Support at all times	Having support at all times meant that the resident was required to always be in the company of another TC resident when outside of the TC living unit.
Chair	A more serious consequence, assigned only by staff, involved the participant sitting in a chair facing the wall for a predetermined length of time. The participant was also required to complete a written note describing his thought distortions, the irrational thoughts that led to his behavior, and a rational alternative to his behavior.

Findings: Evaluation of program activities and TC milieu were measured using the SEEQ. Mean scores by both raters for each section of the SEEQ are shown in Table J. The highest overall means were found for sections 1, 2, 4, and 7, while the areas posing the greatest challenges included sections 3, 5, 6, and 8.

Table J. SEEQ Mean Section Ratings

	Researcher #1	Researcher #2	Average
1. TC Perspective	3.00	3.89	3.45
2. The Agency: Tx Approach & Structure	3.23	3.23	3.23
3. Community as Therapeutic Agent	2.59	3.12	2.86
4. Educational and Work Activities	3.40	3.30	3.35
5. Formal Therapeutic Elements	2.63	2.75	2.69
6. Process	2.89	2.89	2.89
7. Administration	3.18	3.27	3.23
8. Corrections Programs	2.50	2.67	2.59
TOTAL	2.93	3.14	3.04

The TC averaged 3.0 or higher within each subsection of the TC Perspective scale. One area for further consideration included increased urinalysis testing, in order to assess the frequency of drug use and as a tactic to reduce drug use. Furthermore, view of 'right living', as modeled by staff and committed to by clients, comprised a minimal challenge to the program Right living focuses on living in the present whereby values related to truth and honesty, personal accountability, family responsibilities, community involvement, and good citizenry are emphasized.

The Agency scale revealed several strengths, such as established "cardinal" rules, community versus individual focus, experiential learning, multidimensional program that links all elements together, staff redirecting individual members to community healing process, and clearly defined roles and functions. Areas of challenge included maintaining positive relationship with all stakeholders, financial resources enough to maintain TC autonomy, recovery backgrounds of staff, and education about prevention and control of threatening diseases.

Scores on the third scale, Community as Therapeutic Agent, indicated strengths in the following areas: positive peer pressure as the prevailing mode of interaction, informal daily interactions between members for actual help, regular interactions between staff and residents that indicate shared mission and experience, residents' participation in activities to mark significant program milestones, and clearly defined behavioral norms. Challenging areas for the TC included the infrequency of group sessions, time lags in addressing personal issues, negative attitudes about "snitching," limited privileges and incentives, and treatment's role in surveillance.

The Arrowhead TC scored high on virtually all items within the Educational and Work Activities scale; there appeared to be no areas of difficulty for the program within this topic.

There were both strengths and limitations found within the Formal Therapeutic Elements section. Strengths included peer feedback, use of "act as if" to develop a positive attitude, and a variety of staff counseling techniques. Items across which the program scored lower included confrontation of negative

behavior and attitudes rather than of the individual, groups as the primary clinical intervention, and individual counseling sessions.

The strong points within the Process section included that the TC has three main stages of treatment with clearly defined goals and expectations. The community phase stage was the most compelling of the stages. The orientation phase did not include enough motivational material to engage new residents, nor was it individualized as evidenced by lack of intake psychosocial assessment and the identical initial treatment plans for each resident. Preparation for the reintegration into the community, as well, was somewhat limited.

The Administration scale received high ratings on nearly all items, likely a result of the lead counselors' involvement in establishing policies and procedures for TC programs department-wide. One significant area needing improvement involved regular review and update of written treatment plans.

The final section, Corrections Programs, revealed substantial challenges to the program. The program was not separate from the general prison population, resulting in an environment that was not supportive of identification with the TC culture. Particularly difficult was the operation of groups in common areas, such as the visiting room where officers and other inmates frequently interrupted the process. On the other hand, the TC housing and program areas were extremely clean and well maintained, and a system of sanctions was imposed for program infractions.

Treatment Groups. The TC program offered a broad range of educational, therapeutic, and support groups facilitated either by staff, residents, or both. All groups incorporated a strong cognitive component wherein it was common to focus on thoughts preceding maladaptive behaviors. A primary goal for treatment participants was to change these maladaptive thoughts in order to maintain ongoing recovery from substance abuse and criminal behavior. The emphasis on thoughts and their behavioral consequences formed the foundation of this TC's treatment approach. A complete listing of TC groups is found in Table K.

Findings: Treatment schedules had to take into account various aspects of the facility and program: count times, group space, work sites, and GED classes. Unfortunately, treatment groups took last priority among scheduling concerns. Clearly, it was not possible to facilitate groups without space or during inmate count periods. GED classes always took precedence over treatment groups, meaning that residents missed treatment sessions in lieu of education. Treatment groups were scheduled to coordinate with work sites. Given that there were two work sites, operating on different split-schedules, it was a considerable task to assign participants a treatment schedule.

Table K. TC Groups

Staff Led Groups	
Encounter Group ("Game")	All TC members were required to attend a weekly encounter group. The focus could be any issue of concern to individuals in the group. Game slips, which were written requests to address a particular recovery issue or problem, determined the focus of the group.
Lack of Progress (LOP)	LOP was required for residents on probationary contracts due to lack of progress within the TC. This group was generally small, often with only 4-5 participants, providing a safe forum for discussing issued related to treatment. The purpose of LOP was to encourage residents to become more invested in their recovery program.
Structure Group	Structure members met twice weekly. One group was used to discuss community events or conduct house business. The other group was a therapeutic or encounter-type of group, and it included all maintenance phase TC members.
Domestic Violence	This 10-week education/therapy class was attended by participants, as individual needs presented. It provided members with information covering various topics, including the cycle of abuse, perceptions of men and women, and different types of abuse (e.g., physical, emotional). The group culminated with each participant making a presentation outlining their abuse history as well as what they have learned.
Kitchen Group-Problem Solving	This was a bi-weekly group attended by TC kitchen workers, kitchen staff, and TC staff. The focus was on problem-solving, although the overall goal was to enhance communication and boost morale between kitchen staff, TC staff, and residents.
Peer I Transition Group	Residents who planned to transfer to the Peer I community-based TC attended this group to gain a realistic idea of what to expect from that program. The primary focus was on the transition process and preparing members for the change. An intense confrontational style was employed so that those who transferred were better prepared to succeed in the more confrontive environment at Peer I.

Staff/Resident Led Groups	
Introduction to Journaling *(orientation*)*	The purpose of journaling was to help residents analyze their criminal thinking, behaviors, and attitudes. This group is a prerequisite for REBT group.
REBT *(community*)*	Based on Albert Ellis' rational emotive behavior therapy, REBT was attended by residents who completed Introduction to Journaling and were prepared to examine irrational beliefs, attitudes and behaviors in greater depth. This group is, essentially, the culmination of TC programming focusing on cognitive skills training.
Relapse Prevention *(community*)*	Participants explored the consequences of their substance use history and shared this with other participants. Participants focused specifically on personal relapse triggers and developed an individualized relapse prevention plan. A senior resident of the TC co-facilitated group with staff.
Parenting	Participants with approximately 3 months or longer in the program, who were making good progress, were eligible to attend parenting class. Ten weeks long, it was designed for members to explore parenting from a distance. Topics covered were dealing with separation when in prison, parental rights of prisoners, and parental responsibilities.
House Meeting	Usually upbeat and positive, a primary goal of this weekly group was to foster a sense of community among TC members. Activities may include entertainment, personal sharing, the presentation of a treatment speech or apology, and recognition for various achievements. All residents and staff attended this group together.
Resident Led Groups	
Orientation Training *(orientation*)*	New residents in the TC attended this group in order to learn the program rules, expectations, and procedures. A written test was required to demonstrate knowledge of the program.
Basic Orientation Training *(orientation*)*	This group was designed to orient newer members to criminal thinking errors and behavioral tactics that obstruct effective treatment. The group was supplemented with written exercises to provide participants with an opportunity to engage in self-exploration outside the group setting.
Morning and Night Meetings	These meetings brought all residents together at the start and close of each day to reinforce a sense of community. Held in the TC housing unit or at work sites, they were brief, often lasting only 10 minutes, and might include entertainment, personal sharing and announcements.
Seminars	Seminars are educational groups led by residents. They can address a variety of life-skills topics, such as mental health, physical health and interpersonal skills.
Strategies for Self-Improvement and Change (Spanish speaking group)	The purpose of this group was to provide Spanish-speaking members with the opportunity to learn about and practice cognitive skills building. Participants learned to identify maladaptive attitudes and beliefs in order to develop more prosocial attitudes and beliefs.
Self-Help Groups	Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Rational Recovery (RR) self-help groups were held weekly in the TC unit.

*Note. Phase-specific groups.

The TC was staffed 8:00 a.m. to 5:00 p.m. Monday through Friday, with every Friday allotted solely to staff meetings. Given the complex scheduling, it was difficult to ascertain how much direct formal contact the participants actually received. Relying on the group schedule and researcher observation, the intensity of direct contact was found to be quite modest. At a maximum, groups were offered an estimated 20 hours per week. Considering that participants were at work sites half of the time, they really could only attend 10 hours maximum. Furthermore, all residents who were not working were not always in a group session. For example, a Structure meeting and LOP group may be held simultaneously, but some residents may be assigned to neither one. Thus, the schedule of structured, therapeutic contact between staff and clients did not even meet the standards for intensive outpatient therapy (level 4), which requires a minimum of 9 to 12 hours per week.

Groups generally ran 10-15 minutes late, but usually ended on time. In addition to the groups running behind schedule, there was usually some distance involved in getting to the group rooms. For example, there were lengthy checkout procedures to take inmates to the modular units, compounded by an 8-minute walk. Hence, groups really were 1½ hours in length rather than 2 hours. During the course of this evaluation, it was found that group cancellations occurred relatively frequently, which effectively limited the number of groups provided by staff. Facility reasons for cancellations included inadequate group space or a lock-down of the facility. Staff reasons for group cancellations included additional staff meetings, extra time allocated for clinical paperwork, staff training and vacation time. Groups were regularly cancelled two days each month to provide additional time for staff to complete clinical paperwork.

Notwithstanding, there were resident-led groups that bolstered the therapeutic content of the program. Senior residents were solely responsible for delivering the curriculum to the orientation phase clients. Other meetings, such as morning/night meetings or seminars, were brief but enriched the therapeutic milieu. Much of the actual therapy was found to take place outside of groups, in regular interactions among peers and staff.

The program staff embraced the philosophy of the TC wherein the community was encouraged as the healing agent. Thus, individual sessions were not scheduled between clients and staff. However, it was noted by the researchers that individual contact was frequent. Rather than occurring on a formal, scheduled basis, staff met with clients as the need arose.

Despite the infrequency of group sessions, groups led by staff were generally of exceptional quality. TC residents actively participated in all types of groups. Group facilitators did an excellent job of integrating psycho-educational material with individual examples and discussions of client questions or ideas. Even those groups led by senior residents were observed to be very engaging and informative. Encounter group particularly characterized the TC's focus on community living and cognitive therapy. In group, members openly confronted one another to address personal or interpersonal issues.

Group sizes varied according to the group. Encounter groups were intentionally smaller, approximately 10-15 clients per group. Psycho-educational groups might include up to 30 clients at a time, while the entire TC community attended house meetings.

Eighteen groups were evaluated using the Group Process Measure, in an effort to quantify the quality of groups. Of those 18 groups, 12 were encounter groups and 6 were didactic or educational groups. Groups led by inmates were not evaluated. An overall rating of each group's quality was measured on a 6-point scale where higher scores indicated better quality groups. The average rating of groups was 4.25, which can be interpreted to mean that the quality of groups was good to very good. Clearly the quality was found to vary by the experience and tenure of the staff member. Table L lists the clinical skills and the frequency of their use in encounter groups.

Table L. Use of Clinical Skills in Encounter Groups

Clinical Skill	Yes	No	N/A
Suggesting	100%	0%	0%
Interpreting	92%	8%	0%
Facilitating	92%	8%	0%
Clarifying	83%	17%	0%
Eliciting group members' perceptions	83%	17%	0%
Reality testing	83%	17%	0%
Summarizing	75%	25%	0%
Questioning	75%	25%	0%
Confronting	75%	25%	0%
Giving feedback	75%	25%	0%
Restating	58%	42%	0%
Evaluating	58%	33%	8%
Modeling	58%	33%	8%
Reflecting feelings	50%	50%	0%
Linking	50%	33%	17%
Blocking	33%	17%	50%

Staff. The 1996 program expansion resulted in a twofold increase in the number of TC residents, with a corresponding increase in staff. Positions then allocated were the lead counselor, a mental health clinician, seven addictions counselors, and an administrative assistant/research technician. Additionally, there was a transitional counselor who worked primarily at Peer I. This counselor worked approximately four days per month at the Arrowhead program.

The Department of Regulatory Agencies provided oversight for Colorado addictions counselors. Three levels of certification corresponded to a counselor's level of education, training, and experience, with level III being the highest.

Findings. The Crossroads to Freedom TC experienced numerous staff changes between 1997 and 1999. Nearly 20 employees were hired during this timeframe to fill vacancies created by departing staff or expansion of the program. Although the program experienced what appears to be a great deal of staff turnover (approximately three staff leaving per year on average), two of the current staff were long-term employees of the program, both with over 6 years tenure. Staff reasons for leaving varied, but modest

wages was the most often cited reason. While a certain degree of staff turnover was not unusual in the substance abuse field, it did create a challenge for consistency in treatment programming.

In addition to the eight staff positions, there were two counselor vacancies as of July 1999. Of those employed at that time, four held bachelor's degrees, three held master's degrees, and one was working toward a bachelor's degree. The breakdown of staff by addiction counseling certification in July 1999 included four senior level counselors (CAC III), one Level 2 counselor (CAC II), and three uncertified counselors. ADAD program licensure required that 50% of the staff be fully certified (level II or III), a standard met by the Arrowhead TC. However, no more than 25% were supposed to be uncertified, indicating that the TC did not meet this standard.

Over the course of this study, staff was comprised of an approximately equal ratio of recovering to non-recovering individuals. Of eight staff employed in July 1999, three were male and five were female. Despite efforts to employ across diverse cultural groups, the ethnic breakdown of staff included seven Caucasian and one Hispanic staff member.

Clinical supervision occurred in a group setting in the form of weekly staff meetings. Considering that staffings lasted an entire day, there was more than sufficient time allocated to supervision. Other supervision occurred on an informal basis as problematic situations arose that required consultation with the team leader or another CAC III counselor. However, supervision that directly addressed counselors' clinical skills was not found to occur. Clinical supervision was not perceived as a mechanism for giving feedback and training to counselors, but rather as a problem-solving tool.

File review. The DOC maintains information for all inmates in the system. Information was available from both hard files and a department-wide computerized database. In addition, TC staff compiled treatment files for each resident. These files were kept in the TC administration area where inmates did not have access. Client treatment files were intended to serve as a complete record of the inmates' treatment experience.

ADAD provided oversight for alcohol and drug abuse treatment services in Colorado. ADAD regulated alcohol and drug education and treatment, including client record keeping guidelines. Required documents encompassed three general areas: client consent forms, client acknowledgments, and treatment documents.

Client consent forms included consent to treat, consent to follow-up, and release of information. Client acknowledgments included descriptions of federal confidentiality regulations, client rights, and client responsibilities. Clients must also receive information about risk factors such as HIV, TB, other infectious diseases, and their relationship to alcohol and other drug abuse. A final area detailed client advisement of counselor credentials, appropriate therapeutic practices and boundaries, and agencies governing counselor conduct. Treatment documents included a substance abuse assessment, treatment plan, continuing care plan, discharge summary, progress notes, and treatment plan updates. Consent and acknowledgement forms were to be discussed, signed by both clinician and participant, and placed in client charts. ADAD required treatment documents to be signed by fully certified clinicians.

Findings: Client charts were examined with respect to Alcohol and Other Drug Abuse Treatment Rules (ADAD, 1998). A random sample of 50 offenders was generated from TC participants admitted January 1999 through September 1999. This sample included 25 active and 25 discharged clients. The results of the file review are shown in Table M. Percentages are shown for documents found in client charts and documents with appropriate signatures.

Table M. ADAD Required Documents (n = 50)

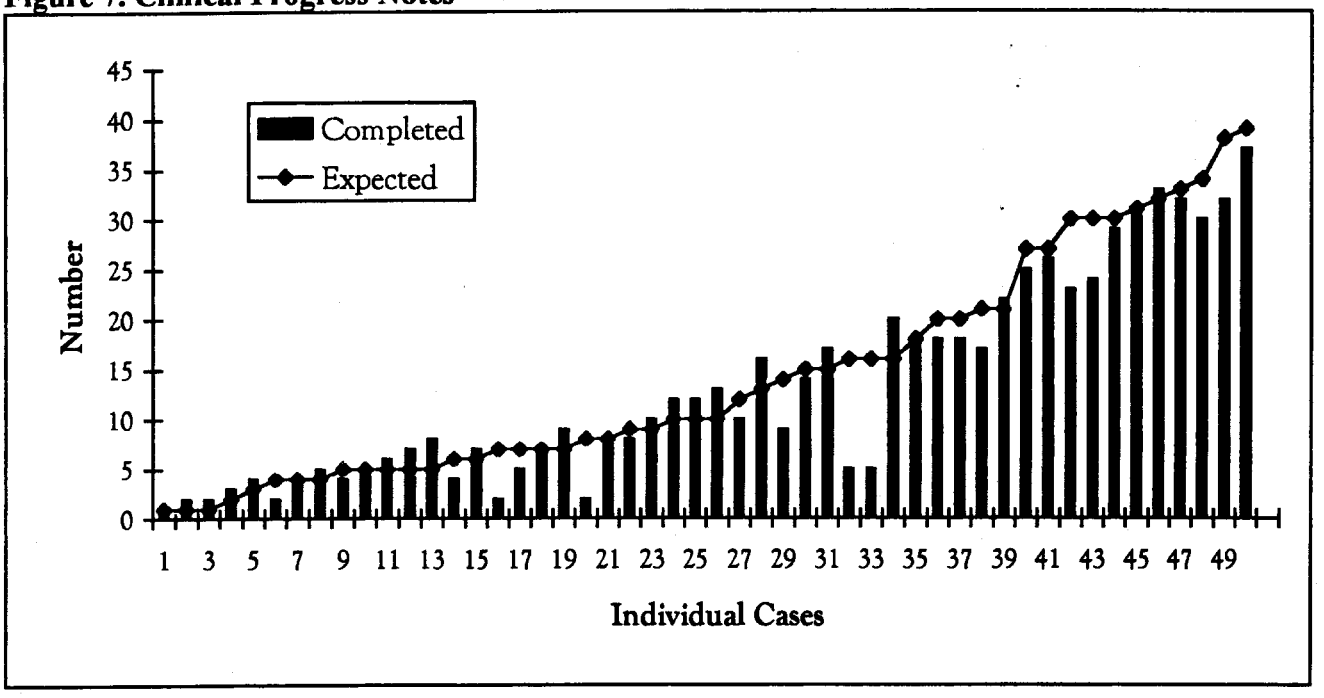
Documents	Present in Chart	Present with Appropriate Signatures
Client Consent Forms		
Consent to Treat	94%	86%
Consent to Follow Up	0%	0%
Consent to Release Information	94%	94%
Client Acknowledgments		
Federal Confidentiality Advisement	96%	96%
Client Rights	92%	70%
Client Responsibilities	100%	94%
Risk Factors	0%	0%
Counselor Credentials	0%	0%
Treatment Documents		
Offender Assessment	90%	90%
Treatment Plan	88%	80%
Continuing Care Plan*	100%	100%
Discharge Summary*	100%	100%

* n = 25.

Progress notes and treatment plan reviews were required on a regular basis throughout the course of treatment. ADAD required that treatment plan reviews be conducted at regular intervals, and this program's practice was to complete them every 90 days. Nevertheless, regular treatment plan reviews were not conducted. For 12 residents with more than 90 days in the program, only 33% had a treatment plan review in their chart. For 10 residents with more than 180 days in the program, only 20% had two treatment plan reviews. One resident who had over 270 days in the program did not have any treatment plan reviews in his clinical chart.

ADAD standards regarding the number of treatment progress notes was vague: "Treatment notes...shall be conducted at regular intervals based on expected lengths of stay" (ADAD, 1998). Standard practice at the Arrowhead TC was to complete a progress note weekly. A comparison of actual and expected number of progress notes is presented in Figure 7. On average, charts for discharged clients had .7 more progress notes than required. Current client charts were missing an average of 2.8 progress notes. Progress notes were nearly 3 weeks in arrears in active client charts, but appeared to be brought up-to-date after clients discharged from the program.

Figure 7. Clinical Progress Notes



Transition Program. The Peer I TC is located on the grounds of the Ft. Logan campus in Denver. This residential facility is spread across two large buildings that were once officers' housing. Dormitory-style rooms are located in both buildings. The first floor of each building has common living areas, which were generally used for dining, relaxation, and treatment groups. Counselors' offices were also located in both buildings

Arrowhead transitional clients were not separated from other Peer I clients. Program admission criteria relied primarily upon the SOA; recommended treatment levels of 6 were required. Placement in Peer I generally required approval by the local community corrections board. Citizens who must make decisions that impact public safety staff the board. The board is generally concerned with escape and violence risks as well as past placements in community corrections.

The Peer I program clearly delineated rules and expectations for clients. There were "cardinal" rules; violations of these generally resulted in a regression to jail or prison. Lesser infractions could be handled on an individualized basis. Generally, clients were given behavioral consequences for noncompliance or rule infractions. For more frequent or severe problems, clients could be returned to custody. Lack of progress in treatment could also result in an unsuccessful program termination.

The treatment orientation of Peer I was largely behaviorally based. Noncompliance with treatment standards frequently resulted in outward exhibitions of their treatment issues. The addition of the Strategies for Self-Improvement and Change (SSC) curriculum influenced a more cognitive-behavioral approach to treatment within the community. This new focus emphasized the linkage between criminal thinking, feelings, and behaviors.

The residential component of Peer I had two primary phases, orientation and transition, although both phases had multiple shorter phases within. Peer I had a non-residential component that was located -site in another region of Denver. In the orientation phase, treatment activities were rigidly structured and intense. During this phase, clients did not leave the center even to work. The only acceptable reasons for leaving during this phase included court appearance, meetings with parole or probation officers, doctor's appointments, or structured program activities. In the transition phase, clients worked off-site in various job placements. They attended groups in the evenings and on weekends.

Dedicated counseling staff for the Arrowhead transition program included one transition counselor. This individual met with potential candidates at the Arrowhead TC to motivate clients for Peer I, dispel myths about it, and assist with the referral process. At Peer I, the clients attended groups with the other treatment participants. Prior to the implementation of the SSC curriculum, Arrowhead transition clients had weekly group sessions with the transition counselor who covered SSC material. Following the integration of SSC into the entire Peer I program, the transition counselor continued to meet with the clients to address personal issues or any problems associated with the change from Arrowhead to Peer I.

Findings. Qualitative comparisons were made between the two programs. Table N presents this comparison across several dimensions. There were many apparent similarities between the programs. Program variations differed greatly in terms of actual operations. The Arrowhead program was less intense, as anticipated for a prison-based treatment setting. Surprisingly, the prison-based program

embodied a more cognitive approach whereas the community-based program imparted a more behavioral approach.

Table N. Comparison of Arrowhead and Peer I TC Programs

	Arrowhead TC	Peer I TC
Setting	Minimum-restricted prison Canon City	Officer housing on Ft. Logan campus Denver
Admission Criteria	SOA treatment level of 5 or 6 Time release criteria	SOA treatment level of 6 Comm. corrections board approval
Discharge Criteria	Positive: minimum 6 months in treatment with a progressive move Negative: clearly established rules and consequences	Positive: minimum 6 months in treatment with a progressive move Negative: clearly established rules and consequences
Theoretical Orientation	Strongly cognitive with behavioral influences	Strongly behavioral with cognitive influences
Program Activities	Formalized schedule Moderately structured Moderate intensity	Formal and informal structure Highly structured Very intense
Program Structure	3 phases, with a 4th phase added for long-term residents awaiting community release	3 primary phases, with multiple smaller phases encompassed within
Work Activities	Integral to treatment Work composes 50% of formal activities	Integral to treatment Work responsibilities vary by phase

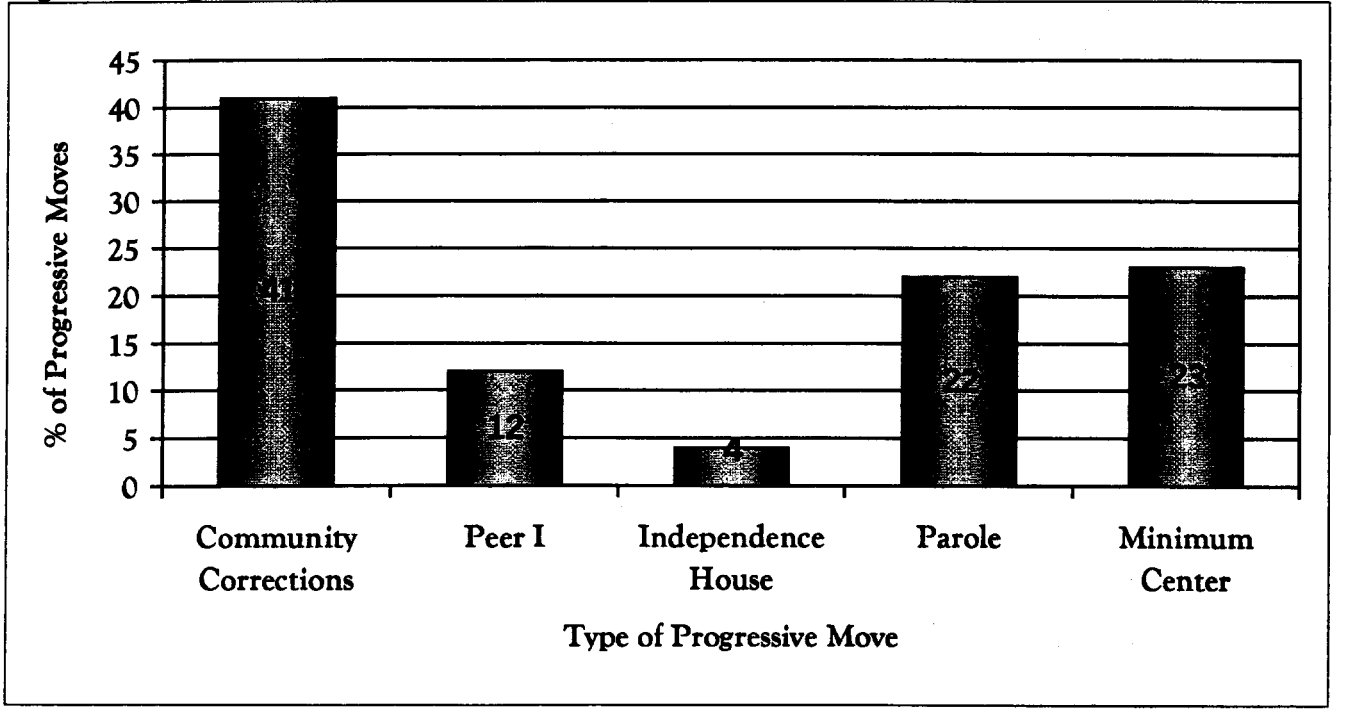
The SEEQ was completed for the Peer I program (see Table O). The ratings pertain to Peer I as a whole, not merely the transitional program for Arrowhead clients. As evidenced by the program ratings, Peer I strictly adheres to the TC model. There was only one area that scored below 3.0 (standard is met). This area was formal therapeutic elements, and the lower score was attributable to staff's use of derogatory terms to address clients rather than their negative behaviors. All other areas were found to satisfy or exceed national TC standards.

Table O. SEEQ Section Mean Ratings for Peer I

	Rating
1. TC Perspective	3.33
2. The Agency: Tx Approach & Structure	3.23
3. Community as Therapeutic Agent	3.58
4. Educational and Work Activities	3.60
5. Formal Therapeutic Elements	2.90
6. Process	3.44
7. Administration	3.36
8. Corrections Programs	4.00
TOTAL	3.43

The research found that only 23 clients transitioned from Arrowhead to Peer I during the study period of 1997 through 1999. While there was an increase during this period, it peaked in 1998 and had a decline in 1999. Because this small number of Peer I admissions was incongruent with the findings around the increase of Arrowhead successful completions, progressive moves for Arrowhead clients were examined (see Figure 8). Of the 33% of Arrowhead admissions who made progressive moves, the majority was being released to community corrections centers. However, very few went to Peer I; they mostly transferred to other community corrections centers.

Figure 8. Progressive Moves for Arrowhead TC Clients



DISCUSSION

PARTCIPANTS

The Arrowhead TC clearly treats chronic substance abusing inmates who pose a serious recidivism risk to the public. Participants enter treatment as they approach release to the community, in order to maximize the program effects. Demographically, there are mild variations from the general prison population related to the facility's custody level and the program's admission criteria (Rosten, 2000). One interesting variation is the over-representation of the Caucasian inmate population and under-representation of the Latino population. This is more likely due to scoring variations on the SOA than any inherent program bias (O'Keefe, 1999).

This study yielded surprising results in terms of treatment retention. Factors traditionally associated with successful treatment completion, particularly motivation, were not identified. If unsuccessful participants did not double the number of successful participants, it could be postulated that the program works with clients at all levels of motivation. However, it seems more likely that there is a specific offender profile related to unsuccessful program terminations.

The characteristics that distinguish unsuccessful completers from successful completers may describe personality styles that are not acceptable in the program. Those personality styles include a tendency to be superficial and self-centered, characterized by their total lack of empathy for others. They tend to be free of marital commitments and isolate from others, perhaps as a result of their suspicious nature and inability to develop personal attachments. Furthermore, unsuccessful completers have long-standing patterns of conduct problems, dating back to early childhood.

PROGRAM

This study found a relatively strong therapeutic milieu within this program, a difficult task to achieve within the confines of a prison. The program faces special challenges in this area because of its

integration with the general prison population. It is an oft-cited finding in the literature that separation from the general population is key to the success of any prison TC. The researchers found this to hold true for the Arrowhead program.

The successes within the program are no small feat given the many challenges they face. The lack of group space for running treatment groups in this modality is shocking. Group space limitations were not a temporary matter of weeks or months, but rather years. The space most often available for groups was prone to such frequent interruptions by security staff and non-TC inmates that privacy and confidentiality could not be assured to clients.

The evidence that treatment groups were last priority in this *therapeutic* community was equally dismaying. It seems logical that treatment should take top priority after security, given that the need for treatment is driving their placement in the program. The low intensity of treatment is contrary to the TC model. Not only does the infrequency of groups contribute to the decreased intensity, but so do the lack of staff-led groups for the orientation clients. The already resistant admits are not making that interpersonal connection with staff that could potentially win their allegiance. Most clients are expelled from treatment, and the average length of stay is less than 4 months in this long-term program. This is further evidence of the program's continuing need to motivate new clients (O'Keefe et al, 1997). It is difficult to establish and maintain a positive peer culture with a constantly changing clientele

The SEEQ ratings indicate that the program is meeting national TC standards. The program's perspective of the TC model, treatment approach and structure, administration, and educational and work activities were at or above national standards. Areas that might need some enhancement include formal therapeutic elements, process, use of the community as the healing agent, and operations within a correctional environment. In brief, the actual practice of therapeutic aspects presents a challenge to the TC program. There was an undoubtedly therapeutic, respectful atmosphere in the TC, suggesting that the community mechanisms were at work in informal ways despite the paucity of formal staff-led groups. Formalizing those mechanisms can only enhance the therapeutic aspect of the program.

The staff's philosophy on TC treatment espouses the community as the healing agent. They hold onto this tenant so tightly that they do not schedule individual sessions. Nonetheless, researchers observed that clients had frequent one-on-one interactions with staff. They were just unscheduled and informal; they occurred as situations arose or as the client needed. Therefore, the clients appeared to have more control than the staff in setting individual sessions. Furthermore, this observation would suggest that quiet, less demanding clients received less attention than the louder, more demanding clients. This runs counter to the concept of using incentives for positive behavior, where it would seem that the disruptive clients receive more attention.

While the program clearly treats the target population in terms of severe recidivism risk and substance abuse needs, the findings indicate that the program regularly violates its own admission criteria. There were high numbers of clients not assessed as needing this modality, who had too little time before release, had a disciplinary infraction prior to admission, or had acute psychiatric needs. Presumably, these criteria are in place to ensure the appropriateness of inmates' treatment placement; when they are admitted regardless of these criteria, the program's preparedness for treating them must be questioned.

The Arrowhead program has made substantial improvement in the number of progressive moves for treatment participants over the past three years (O'Keefe et al., 1997). While this change is a positive move, the pendulum seems to have swung too far to the other side. In the interest of progressing clients to the community, the program has dramatically shortened lengths of stays for this group. The findings herein showed that 38% released to the community, but only 21% did so after completing a minimum of 6 months in treatment. The adage "something is better than nothing" does not necessarily apply to TCs. There is substantial research to show that less than 6 months in TC has little impact, and that maximal benefits are obtained from 9 to 12 months (see Condelli & Hubbard, 1994). Previous research on this same program strongly indicated that at least 6 months are necessary to reduce recidivism (O'Keefe et al., 1998).

Staffing of prison substance abuse counselors presents a department-wide problem. It is a problem statewide, but poses particular challenges within DOC. In a traditional TC, residents who successfully complete treatment in the TC are qualified to become staff members. This is not the case today in Colorado prisons, where convicted felons are ineligible to work as paid employees. Unfortunately, this requirement, with no moratorium on long-term crime-free lifestyles, has effectively reduced the recovering staff, produced frequent vacancies, and increased the rate of uncredentialed staff. Hiring of untrained, unskilled, and uncertified staff devalues the field and in essences dictates this as an unskilled job classification. A disservice is paid to clients when they are pressured into treatment staffed with unqualified personnel. The difficulty of attracting and keeping culturally diverse, recovered, skilled, credentialed staff is duly noted, given the low salary ranges associated with addictions counseling.

Clinical supervision is available regularly during staff meetings where clients' cases are discussed. The supervisor, or another qualified staff member, is usually available on a daily basis to address more pressing caseload issues. However, supervision that directly addresses counselors' clinical skills was not found to occur. Clinical supervision was not perceived as a mechanism for giving feedback and training to counselors, but rather as a problem-solving tool. The skills and experience of the core staff could provide invaluable training to the newer, unqualified staff if put into action.

Vast improvements in the paperwork were found since the most recent process evaluation (O'Keefe et al., 1997). In particular, the progress notes were much more complete and timely than before. There are still some areas where the paperwork is lacking, but are easily remedied. There are simply some forms not included in the intake packet, or information not included on existing forms.

Additionally, the lack of individualized treatment plans with regular plan reviews and updates continues to be a program limitation. During this evaluation period, there was a unique opportunity for developing individualized treatment plans using the progress in treatment measure. It was expected that the staff and clients would use such a tool for planning treatment program and discussing progress. It was the program staff who wanted to include this measure into the program. However, once

implemented it became clear that the staff viewed this as just another set of paperwork to complete. The ratings were not used to develop treatment plans nor were there ever conversations between clients and staff to compare ratings. This is a newly developed measure (Kressel et al., 2000) and it may have not been useful for the purpose it was adopted. However, the seeming lack of effort to use this measure for individualizing treatment and the lack of individualized treatment plans found in the file reviews, suggests this is an area for improvement by the TC staff.

The transitional program at Peer I is an anomaly. The Peer I TC itself was found to be a therapeutically sound program, as measured by the SEEQ. In fact, as a whole, the program was able to carry out unique TC components that are often not feasible with prison programs. While Peer I is an excellent program, a serious problem was uncovered by this research. Very few offenders actually transition from Arrowhead to Peer I. In fact, the two TCs operate as if they are two distinct programs, rather than a prison-based TC with a continuing care component. Additional monitoring and investigation is needed to determine why the prison TC clients are not continuing with the Peer I TC program.

RECOMMENDATIONS

Taken together, the findings indicate that the Arrowhead TC is meeting departmental, statewide, and national standards. The recommendations herein are suggested as enhancements to move the program to a higher level.

Many of the program changes that are indicated will require the collaboration of the TC, the prison facility, and the department. The TC staff needs to advance their relationship with administration in order to establish treatment as a priority within the facility. The benefits to DOC for accommodating program needs will be immeasurable in terms of increased manageability and lowered recidivism. There are several areas that can only be addressed through this collaboration, such as more separation from the general population and group space. Strategic planning should emphasize the practice of formal therapeutic elements. More groups, particularly for newer residents, should be foremost in planning.

The present study describes who does well in this program and who does not. It may be that those individuals are not suited for the TC modality. But given the high rate of unsuccessful program terminations, the staff needs to consider different approaches to involve individuals with these personality characteristics in the community process. These factors extend beyond addictions and criminology to personality pathology, which may require more mental health training for the staff to better understand their clientele.

While this study uncovered some factors related to treatment retention, they might not relate to treatment outcomes. Additional research is needed to determine whether these results are replicable and what factors may relate to long-term indicators of program success.

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APPENDIX A: Group Rating Form

Agency Name: _____ **Group:** _____ **# Clients:** _____

Counselor(s): _____ **Reviewer:** _____ **Date:** _____

Teaching

y	n	n/a	State the purpose of the class, what clients can gain from the session?
y	n	n/a	Seem at ease with the material?
y	n	n/a	Emphasize or restate the most important ideas?
y	n	n/a	Begin and end groups promptly?
y	n	n/a	Summarize the main points or ask clients to do so?
Style of Presentation			
y	n	n/a	Speak in a clear, strong voice that can be easily heard?
y	n	n/a	Speak neither too quickly or too slowly?
y	n	n/a	Talk to the clients, not to the board or windows?
y	n	n/a	Listen carefully to clients' comments and questions without interruption?
Clarity of Presentation			
y	n	n/a	Define terms, concepts, and principles?
y	n	n/a	Give examples, illustrations, or applications to clarify abstract concepts?
y	n	n/a	Relate new ideas to familiar ones?
y	n	n/a	Seem to know whether or not the class understands?
y	n	n/a	Use alternate explanations when clients do not understand?
y	n	n/a	Slow down when discussing complex or difficult ideas?
y	n	n/a	Refrain from needlessly digressing from the main topic?
y	n	n/a	Pay particular attention to make sure those with difficulty reading/understanding English understand what is being presented?
y	n	n/a	Use of different ways to present material (e.g. handouts, board, other audio visual, in-class exercises)
Questioning Skills			
y	n	n/a	Ask questions to determine what clients know about the topic?
y	n	n/a	Ask different levels and kinds of questions to challenge and engage clients?
y	n	n/a	Encourage clients to answer difficult questions by providing cues or rephrasing?
y	n	n/a	When necessary, ask clients to clarify their questions?
y	n	n/a	Ask follow-up questions if a student's answer is incomplete or superficial?
Student Interest and Participation			
y	n	n/a	Encourage questions?
y	n	n/a	Provide opportunities for clients to practice what they are learning?
Classroom Climate			
y	n	n/a	Address clients by name (with correct pronunciation?)
y	n	n/a	Call on clients of different ethnic groups in equal numbers?
y	n	n/a	Listen attentively and respond to clients' comments and questions?
y	n	n/a	Give feedback, encouragement, criticism, and praise evenhandedly?
Discussion			
y	n	n/a	Encourage all clients to participate in the discussion?
y	n	n/a	Draw out quiet clients and prevent dominating clients from monopolizing the discussion?
y	n	n/a	Refrain from monopolizing the discussion his or her self?
y	n	n/a	Encourage clients to challenge one another?
y	n	n/a	Mediate conflicts or differences of opinion?
y	n	n/a	Bring closure to the discussion?

Rate your impression of the overall effectiveness of the counselor's (or counselors') use of the above skills in providing a learning experience for clients:

6	5	4	3	2	1
Excellent	Very Good	Good	Fair	Poor	Unacceptable

Therapeutic

y	n	n/a	**Restating** in slightly different words what a participant has said to clarify its meaning. To determine whether leader has understood correctly the client's statement; to provide support and clarification.
y	n	n/a	**Clarifying**. Grasping the essence of a message at both the feeling and thinking levels; simplifying client statements by focusing on the core of the message.
y	n	n/a	**Summarizing**. Pulling together the important elements of an interaction or session.
y	n	n/a	**Questioning**. Asking open-ended questions that lead to self-exploration of the "what" and "how" of behavior.
y	n	n/a	**Interpreting**. Offering possible explanations for certain behaviors, feelings, or thoughts.
y	n	n/a	**Confronting**. Challenging clients to look at discrepancies; pointing to conflicting information or messages.
y	n	n/a	**Reflecting Feelings**. Communicating understanding of the content of feelings.
y	n	n/a	**Evaluating**. Verbally appraising the ongoing group process and the individual and group dynamics.
y	n	n/a	**Giving Feedback**. Expressing concrete and honest reactions based on observation of members' behaviors. To offer an external view of how the person appears to others; to increase client's self-awareness
y	n	n/a	**Suggesting**. Offering advice and information, direction, and ideas for new behavior.
y	n	n/a	**Modeling**. Demonstrating desired behavior through actions. To provide examples of desirable behavior; to inspire members to fully develop their potential.
y	n	n/a	**Blocking**. Intervening (both verbally and nonverbally) to stop counterproductive behavior in the group. Nonverbal interventions may include eye contact or physically moving closer to the individual.
y	n	n/a	**Linking**. Pointing out that other group members may share a person's concerns. It promotes interaction within the group.
y	n	n/a	**Eliciting group members' perceptions** of how realistic other members are in their perceptions, feelings, or behavior strategies.
y	n	n/a	**Facilitating**: Opening up clear and direct communication within the group; helping members assume increasing responsibility for the group's direction.
y	n	n/a	**Reality Testing**. Having group members give feedback to someone on how realistic his thinking, feelings, or strategies are.

Rate your impression of the overall effectiveness of the counselor's (or counselors') use of the above skills in facilitating a group process:

6	5	4	3	2	1
Excellent	Very Good	Good	Fair	Poor	Unacceptable

Comments: _____

_____

_____

_____