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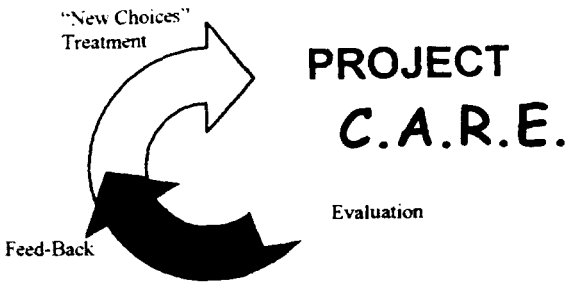


PROJECT CARE
FINAL REPORT

NIJ GRANT #97-RT-VX-K010

An Evaluation of the "New Choices" Substance Abuse Program in the Harris County Jail Houston, Texas

Kirk von Sternberg, M.S.W.
Joseph P. Carbonari, Ed.D.

Change Assessment Research
University of Houston

March 14, 2000

Introduction

There has been an aggressive drive on the part of federal, state, and local justice authorities and treatment professionals during this decade to incorporate substance abuse treatment in criminal justice settings. The move to provide treatment for offenders with substance abuse or dependence has for the most part been focused in prison settings. Providing substance abuse treatment in county jail facilities is a fairly recent undertaking offering unique challenges and opportunities. The following manuscript reviews findings from Project CARE, an evaluation of one such endeavor: The New Choices substance abuse treatment program, operating in the Harris County Central Jail in Houston, Texas. The authors discuss results from a process evaluation explicating the evolution of the new program in light of inherent obstacles related to the jail setting, the jail inmate, policies at the jail, and the operation of the courts. Primary areas of program implementation affected by these obstacles were staff recruitment, acceptable client time in treatment, and the Therapeutic Community (TC) treatment modality. Finally, results from a profile analysis of during-treatment change incorporating the Transtheoretical Model (TTM) Stage of Change constructs suggest that the New Choices program, despite its implementation challenges, has reached many of its program goals and has positively affected the lives of several hundred individuals.

The National Institute of Justice in response to the Crime Act of 1994 is addressing substance abuse treatment in our local jails, through its Residential Substance Abuse Treatment (RSAT) for State Prisoners Formula Grant program. Recognizing the need for a substance abuse treatment program for the Harris County Jail offender population, the HCSD submitted a proposal to the Criminal Justice Division, Office of

the Governor to establish through the RSAT funding mechanism a program to treat 400 of their substance abuse inmates yearly. "New Choices" was funded on March 1, 1997 and began admitting clients for substance abuse treatment in June of that year.

Setting

The Harris County Central Jail is a maximum-security jail in Houston, Texas operated by the Harris County Sheriff's Department (HCSD). The jail is the fourth largest in the United States with an inmate capacity of approximately 8,500. The average daily population for the past five years has ranged from 7,140 to 10,282. Of the approximately 100,000 persons confined in the Jail annually, the majority are: individuals being held awaiting trial, conviction, or sentencing; individuals being housed for State, Federal or other authorities awaiting transfer; and individuals serving sentences of generally one year or less. It has been estimated that 30-40% of the inmates are incarcerated for alcohol or drug related offenses or approximately 3600 inmates on any given day.

The RSAT "New Choices" program operates within the Medical Services Bureau/HIV Project of the Harris County Jail. The program is isolated from the general population on a dedicated floor in the Harris County Central Jail facility. The program clients are housed in "quads" containing individual cells. These quads hold between 6-8 clients with individual cells for each client flanking a common area with tables for socializing, holding groups, and eating meals. The inmate capacity of the floor is 200.

- There are three primary methods of entry into the New Choices program for new admissions. The most common method has been self-referral (65%) followed by referral from medical (21%) and court mandates (14%).

The New Choices substance abuse treatment program is a 6-12 month "quasi-Therapeutic Community which has as its stated goal, "to help the inmates develop a drug and/or alcohol free lifestyle by supporting changes in their attitude and behavior". The core program is based on the Hazelden substance abuse treatment module for the criminal offender, which is heavily based on the 12-steps of Alcoholics Anonymous. The Hazelden curriculum is composed of several components designed for delivery through didactic instruction and written exercise. The curriculum addresses issues associated with 3 steps of the treatment process, orientation and education, substance abuse treatment, and relapse prevention, as well as, issues specific to criminal behavior and criminal thinking.

Methods - Description of the Treatment Effort

The data collection for the process evaluation began in November 1998 and was completed by February 1999. *Record reviews* included a review of the program materials (i.e. policy manuals, recruitment materials, training materials) treatment materials (i.e. treatment manuals, educational materials, curriculum, screening and assessment tools) and schedules. The evaluators conducted *observations* of the assessment interviews, treatment components, support services operations, and discharge procedures on a weekly basis. The evaluation staff was on the unit weekly conducting interviews and observing program activities. *Interviews and pencil and paper questionnaires* were given to treatment staff, corrections staff, and key administration personnel.

Implementation in a Jail Setting

The implementation of the New Choices program in the jail setting was challenged by systemic obstacles involving certain jail policies, the relatively short term

of the majority of the inmates housed in the jail, and the necessary education and enlistment of the courts. Program areas directly affected by the implementation obstacles were staff recruitment, time in treatment, and the shape of the therapeutic community.

Staff Recruitment

It is policy in the Harris County Jail that individuals with a felony conviction or a misdemeanor drug conviction not be employed in the jail. Many substance abuse treatment counselors are recovering alcoholics and addicts and as such have often gone afoul of the law. Staff selection then was limited to those professionals without a criminal history. This proved to be a major obstacle for the New Choices program. The counselor to client ratio during the time of this evaluation was as high as 1 to 20 for the females and 1 to 40 for the males. In November 1998, after 18 months of diligent recruitment efforts by the New Choices supervisors and over 40 interviews of potential treatment staff, the jail operators allowed enough counselors for hire to effect an acceptable counselor-to-client ratio of 1 to 16 for the males and 1 to 13 for the females.

Time in Treatment

The target term for admission into the New Choices treatment program is 6-12 months. However, Harris County Jail policy and the daily census of the jail demanded that the dedicated floor afforded the substance abuse treatment program be fully occupied. Since a primary function of a county jail is to act as a holding facility, the majority of the inmates have relatively short-term stays. This presented a major hurdle initially in the recruitment of inmates who could satisfy the target length of stay. As a result, the program administrators found it necessary to temporarily ease the "time in treatment" requirement. The program director and staff, however, never lost sight of the

6-month minimum term goal and aggressively sought to recruit inmates with a minimum sentence of six months.

The Harris County Jail primarily houses three types of inmates and the status of any inmate may change over time. About ¼ of the inmates are individuals awaiting trial, hearing or sentencing and about ¼ are individuals who have been sentenced and are being held for state, federal or other authorities awaiting transfer. The remaining half of the inmates in the jail at any given time are sentenced directly to the jail for terms of a few days to as long as 12 months. During the first year of operation, clients for the New Choices program were admitted from each of the three types of inmate groups. For those clients awaiting a trial or hearing or those clients awaiting transfer to another criminal justice facility, their time in the program was variable and often of short duration. Clients who were sentenced directly to the Harris County Jail generally had stays of 3-12 months.

In an effort to increase the number of long-term clients, the treatment program staff continued to explore internal strategies in order to identify and enroll inmates from the general population who had long term sentences. As of December 1998, internal recruitment came only from the pool of sentenced inmates where "time in treatment" was established. In addition, the staff actively sought the cooperation of the courts in mandating more clients directly to the program. Each judge and court act autonomously and therefore the process requires an ongoing effort to formalize a process that is beneficial to both the program and the courts. Gradually the response from the individual courts has become more and more positive. The result is that more offenders with substance abuse or dependence are being mandated directly to the New Choices program.

Between June 1997 and July 1998, 426 clients had been admitted to the unit. The time in treatment for those clients ranged from 15-396 days with the average stay being 77 days. There were 48 clients during that time (11%) that had stays in excess of 180 days. As of April 1999, however, the percentage of male clients remanded to the unit directly by the courts for a minimum of 180 days had increased to 52% and the courts were mandating clients to the treatment program with increasing frequency.

The Therapeutic Community

Therapeutic Community (TC) programs although they differ in size, intensity, and treatment components share certain common attributes. TCs in criminal justice settings are generally modified to fit the unique physical environments of jails or prisons, as well as, the somewhat contrary philosophies of rehabilitation and punishment. The TC is a complex model, the implementation of which requires the greatest degree of commitment from the administration and the staff. The "New Choices" treatment program is still very much in a formative stage. Of the components believed to be inherent to a TC: 1) some are apparent in the New Choices program; 2) some have not been effectively incorporated but are planned for the program; 3) some do not lend themselves well to the unique environment of this county jail and definitively support the designation "quasi-therapeutic community".

1. A). As with traditional TCs, the New Choices program houses individuals with singularity of purpose. The New Choices clients are a diverse group of offenders with substance abuse or dependence who have a common goal of overcoming their addiction, changing their criminal thinking and behavior, and addressing issues of re-socialization.

B). It is critical to the incarcerated TC client that the environment be a safe place where one can develop a sense of belonging (Wexler, 1994). Inmate cultures can act to glamorize drugs and crime and promote an atmosphere of negativism and isolation, which are contrary to the support from and responsibility for the community that is the essence of a TC (Fields, 1989). New Choices has a dedicated floor of the jail facility, separate from the floors that house the general population. Separation is maintained with the exception of clinic visits (medical), law library weekly privileges, and recreation. In addition, those with jobs and those receiving GED education have additional exposure to the general population (The unit director is currently negotiating for GED classes to be held on the 9th floor for New Choices clients.).

2. In the process of sharing living quarters, participating in groups and learning and studying together the client's learn appropriate behavior, self-reliance and responsibility (Wexler, 1994; De Leon, 1984; von Sternberg & Carbonari, 1997). In the traditional TC, a primary function of the treatment staff is the monitoring of the health of the community overall, allowing for a treatment experience that promotes peer support, safety and communication. However, on the New Choices unit, the overall sense of community has been difficult to attain. The physical structure of the Harris County jail acts to limit the clients' interaction to between 6-8 clients for a substantial portion of each day. In addition, the emphasis of the New Choice's larger group functions is on didactic treatment delivery, which restricts the ability of the clients to exhibit behavior that would solicit either positive or negative recognition. Given the structural limitations, the New Choices treatment staff and corrections staff

must act as role models and provide support and guidance for the individual client where some opportunity for peer support may be lacking. The staff works to insure a safe environment conducive to open communication between peers and staff. As more long-term clients are being admitted, the program supervisors are placing groups of new admissions into "quads" together forming cohorts of clients. The formation of these cohorts allows for more community spirit as clients progress as groups through the treatment process.

3. A). A system of incentives and sanctions form the core of treatment interventions for a therapeutic community. Key to the TC approach is the belief that appropriate and consistent responses to behavior are critical in teaching new behavior skills and promoting responsibility for one's actions. Positive behavior in the TC is generally rewarded through peer recognition and advancement in the hierarchy. Negative behaviors are confronted in a variety of formal and informal means related to the severity and longevity of the behavior. Harris County Jail policy will not allow inmate government, hierarchy, or peer confrontation under any structure. Therefore, it is not possible to provide systematic recognition of positive behavior through advancement in a formal hierarchy nor is it possible to create a peer led entity for infraction resolution. Therefore, the treatment staff and correctional staff handle most of the feedback that addresses the clients' behavior.

   B). A job structure involving an increasing set of responsibilities is common to therapeutic communities and can be effective in teaching concepts of personal responsibility and social reward to the client and in facilitating increased self-esteem and self-confidence (Wexler, 1994). There is not the availability of a job structure

internal to the New Choices program that can provide the clients a simulation of work procurement and advancement. Recognition of good citizenship and taking personal responsibility for ones recovery must be provided in more subtle ways such as group affirmations rather than advancement through a community job hierarchy.

Process Evaluation Discussion

The New Choices program, although faced with major obstacles to implementation, by February 1999, was adequately staffed, had increased from 11%-52% the client's with minimum 6 month time-in treatment, and had implemented many of the TC components. From the evaluation it has been possible to identify the factors that affected treatment implementation for the New Choices program that may be unique to jail settings and of interest to other jails planning to provide inmate treatment. These factors have to do with a jail's primary function as a holding facility and the short term of incarceration of many of the inmates, its relationship to the sentencing courts, and its physical structure. In addition, jail policies can impact the processes of staffing and client selection for the treatment program.

- As holding facilities, jails house many inmates with shorter terms than considered optimum for a TC modality. To compensate jails could:
  - Develop short term programs;
  - Allow for TC programming by enlisting the courts to sentence offenders directly to the unit for terms of 6 months or longer;
  - Provide two treatment tracks, short term and a TC program, for maximum coverage of those inmates in need of treatment.

- Jail operators must balance the need for isolated space for a treatment program and the overall housing needs of the general population of inmates. For the New Choices treatment program, being afforded adequate isolated space allowed for the TC programming but affected recruitment (easing of time-in-treatment) in that space had to be filled from the onset.
- Also for jails wanting to establish treatment, hiring policies will have to be reviewed or established considering the effect of criminal background restrictions on the acquisition of appropriate treatment staff.

Methods – During Treatment Evaluation

From January 1998 through August 1998, 208 treatment clients were enlisted into the evaluation study, and from March 1998 to December 1998, the evaluators interviewed 119 inmates from the general population who had entered the jail through the medical detoxification unit. Assessments were administered within 30 days of entrance to the program and again at 45 and 90 days. General Population clients were administered assessments within 2 weeks of discharge from the medical detoxification unit and (when length of stay allowed) again at 45 days.

Transtheoretical Model (TTM)

In spite of the initial roadblocks and conditions that restricted the implementation of the substance abuse treatment program, the New Choices program treated 260 clients between December 1997 and June 1998. Significant change was found between the intake and the 45-day Transtheoretical Model (TTM) profiles in a sample of 91 of those treatment clients that had both an intake and a 45 day assessment.

The TTM which originated approximately sixteen years ago (Prochaska & DiClemente, 1982) posits a mechanism by which people make purposive behavior change. The major dimensions of the model, *Stages of Change, Processes of Change, Self-Efficacy* and *Decisional Balance* have proven to be important constructs in understanding and explaining the process of intentional change of problem behaviors. The model has shown consistency, predictability and explanatory power across a large number of behaviors and populations.

The *Stages of Change* are the temporal, motivational aspects of the change process which provide a rising continuum of a readiness to change. The *Processes of Change* are the strategies and behavioral mechanisms that move individuals through these stages. (DiClemente, 1993; Prochaska & DiClemente, 1984, 1992a; Prochaska, DiClemente, & Norcross, 1992). Within the TTM, *Self-Efficacy* is conceptualized as both the confidence to abstain from a behavior and the ability to resist temptation to engage in that behavior across different life situations. *Decisional Balance* is an index of an individual's assessment of the positives or "pros" and the negatives or "cons" of engaging in a specific behavior (i.e. substance use). The Transtheoretical Model constructs have been shown to capture an individual's shift in attitude and behavior in both amount and kind as a function of treatment or at least during treatment.

TTM

A change profile was created employing the 10 TTM variables examined. The intake TTM change profile for the treatment group was indicative of a group well advanced in the change process. A stage of change profile created by plotting the means of the four subscales of the URICA, mapped on to the DiClemente and Hughes (1990)

"participation" profiles, indicating that as a group, the treatment clients were motivated to change their drinking and drug use behavior. The other TTM component variables, which have been found to be particularly relevant to the motivational change status, were found to support the latter stage affiliation.

The intake TTM change profiles of the treatment group and the comparison group were found to be significantly different on all 10 of the TTM variables measured except for the *maintenance* scale. The treatment groups profile was indicative of a group with greater motivation or "readiness to change". Reflective of the level of motivation, the treatment group's *precontemplation* mean score was lower, *contemplation* higher, and *action* higher. Also, the mean *cons* for the addictive behavior were greater and the mean *pros* for the addictive behavior were significantly lower. In addition, the treatment group reported more *process use* (experiential and behavioral) and indicated higher levels of *confidence* to abstain and lower levels of *temptation* to use (See Figure 1).

In spite of a well-advanced intake profile, a profile analysis indicated that the treatment group's TTM change profile overall was significantly different from intake to 45-days ($p<=.0001$). Supporting the profile change was an increase in the *confidence* to abstain ($p<=.006$), a decrease in the *temptation* to use ($p<=.0001$), and an increase in the *experiential* ($p<=.01$) and *behavioral* ($p<=.0001$) process use (See Figure 2). Research has indicated that the processes are differentially important during the various stages and that shifting process activity as individuals move through the stages is related to successful change (DiClemente & Prochaska, 1982; Perz, DiClemente, & Carbonari, 1992). In addition, the mean for the *maintenance* subscale ($p<=.04$) of the URICA was significantly less at 45-days than at intake. We did not find significant change on the

other URICA subscales (*precontemplation, contemplation,* and *action*) over the 45-day period nor did we find the decrease in the *pros* or the increase in the *cons* of the addictive behavior to be significant. It should be noted that the intake URICA mean scores for the treatment group were indicative of a participation profile. The mean scores were found to be at the scale extremes not leaving sufficient room for significant positive change.

Due to difficulties in identifying and recruiting long-term general population (GP) clients with substance abuse, we ended up with only 22 valid 45-day assessments for the GP comparison group. We performed similar profile analysis on the GP group but given the limited numbers caution should be taken in interpreting the findings. The analysis revealed a significant overall change in the group driven by a decrease in *temptation* ($p<=.003$), a decrease in the *pros* ($p<=..04$) of the addictive behavior, and an increase in the *cons* ($p<=.001$) of the behavior. We did not find significant change on any of the four URICA stage of change subscales (although there was more room for improvement than in the treatment group profile), confidence to abstain, or process use.

Discussion

During treatment assessment of the New Choices treatment group's TTM profile indicated significant positive change. It is believed that an effective program would be one that facilitated a client's movement through the Stages of Change. To this end, the program would promote an increase in process activity, an increase of the client's "cons" of the addictive behavior over the "pros" for that behavior, an increased self-efficacy confidence and a decrease in temptation. The treatment group within the first 45 days of treatment satisfied some of these criteria. Although significant change was not found on the URICA subscales, the overall TTM profile change was significant. Given the extreme

scale scores at intake for this group on the URICA variables, significant change would not be expected. In addition, although not significant, the group mean score on the pros subscale at 45 days was lower than the intake mean score and the cons group mean was higher than the intake mean.

It should be noted that there was an overall change in the TTM profile in the comparison group as well. However, the individual subscale group mean changes that support the profile change for the comparison group were limited to a decrease in temptation, and an increase in the pros and decrease in the cons of the substance use behavior. The motivational readiness as measured by the URICA subscales was not significantly different from the intake level even though, unlike for the treatment group, there was adequate room for movement. The processes of change, which are the mechanisms that move individuals through the stages, were also unchanged at 45-days. It is plausible that although untreated, just being incarcerated in a safe and controlled environment may influence one's sense of confidence to abstain and temptation to use, as well as provide time to reflect on the importance of substance use in one's life.

Conclusion

Despite major obstacles, the New Choices program has successfully implemented a treatment program for the "sentenced" inmates of the Harris County jail with substance abuse or dependence. Issues of jail policy, jail setting and allotted treatment space, as well as the relationship with the sentencing courts, affected the recruitment of staff, the initial easing of time-in-treatment requirement, and the TC programming. By the end of the evaluation data collection process, however, the unit was fully staffed, full term clients made up 52% of the males' treatment program (up from 11% 12 months earlier)

and the courts were sentencing offenders with much greater frequency to full terms. Even as the program developed and the treatment staff worked through the implementation obstacles, indications are that the clients were positively affected. The evaluation found through an analysis of the treatment group's TTM profiles, significant change between the intake and 45 day group mean scores.

Since there are few treatment programs in jails and even fewer evaluations of the programs that do exist, we do not have a tested "blueprint" for effective programming in these settings. The New Choices program has served to shed some light on factors unique to a jail setting that could affect treatment implementation and programming in similar settings.

Both the program and the field of substance abuse treatment in jails would benefit substantially from a long-term outcome study. This study was limited in producing strong during-treatment impact data by a small number of comparison group participants completing the 45-day assessment, significant group differences on criminal history and drug of choice, and the brief time between assessments. The current recruitment efforts of the program should result in a waiting list for the program which would provide a comparison group of non-treated clients with similar histories and longer terms of stay.

Figure 1: TTM Intake Profile – Treatment x Comparison

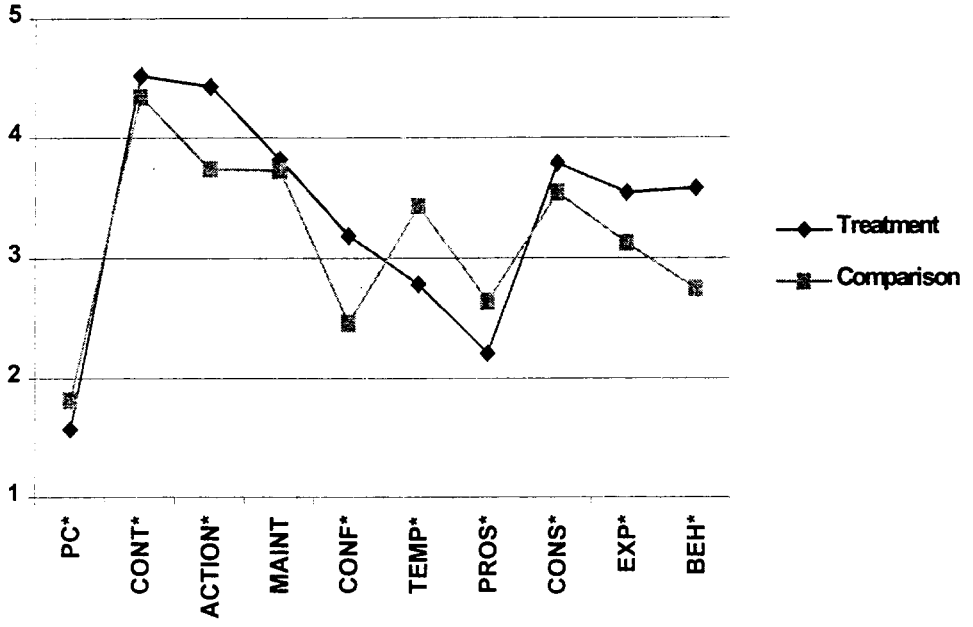
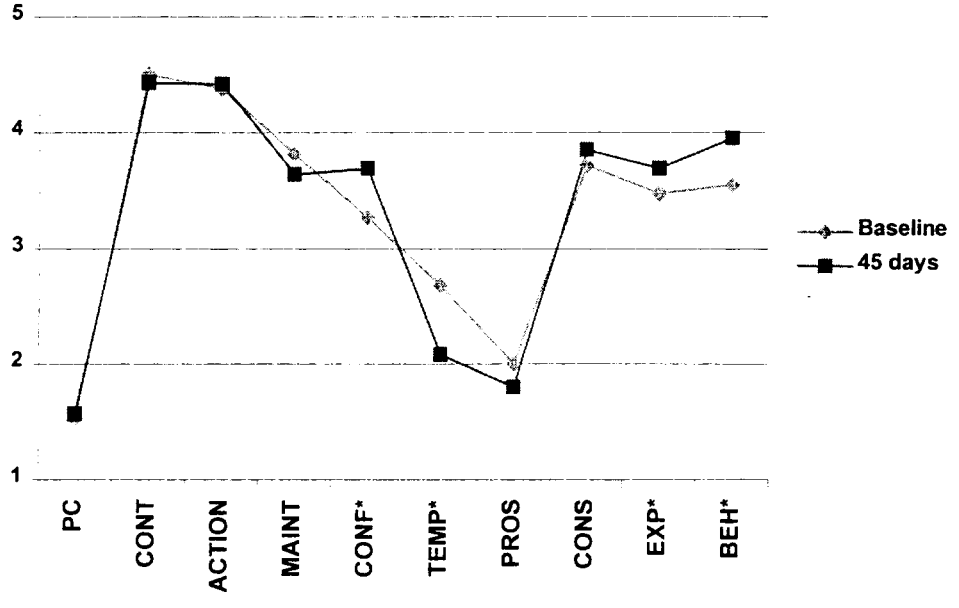


Figure 2: TTM Treatment Group Profile - Intake x 45-days



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PROJECT CARE

Project CARE (**C**hange **A**ssessment **R**esearch **E**valuation), the evaluation of the Harris County Sheriff's Department "New Choices" substance abuse treatment program, was funded on November 1, 1997 through the National Institute of Justice RSAT award number 97-RT-VX-K010. The evaluation was conducted by the Change Assessment Research Project at the University of Houston. The following report represents the Final Report and includes the project's activities, data collection and data analysis procedures, implementation problems encountered, and findings. The findings are composed of a general description of the program, which includes the qualifications and job descriptions of the staff, the characteristics of the program's clients, and programmatic issues of implementation, documentation, policy, and treatment delivery. In addition, the findings from an impact evaluation of during treatment client change examined within and between differences for the treatment client group and a comparison group from the general population.

Background

There has been a marked increase in the number of prisoners incarcerated for drug related offenses in the last two decades (Gilliard & Beck, 1997). It has been shown that local jail populations are increasing at a rate of 4.2% per year. The increase is in part due to a larger percentage of drug law violators. In addition, the rate of re-offending and subsequent re-incarceration is extremely high for those who abuse alcohol and drugs. Indeed, the increase in the Nation's incarcerated is in large part due to the fact that more than 80% of this population are recidivists (Lipton, 1995; Perkins, Stephan, & Beck, 1995). Finally, there are greater numbers of arrests in general and many substance abusing felons are being sentenced directly to our local jails.

The need to treat the substance abusing criminal to affect jail overcrowding, recidivism to crime and re-incarceration was recognized by the 1994 legislature, the National Institute of Justice, Texas justice authorities, and local jail operators like the Harris County Sheriff's Department (HCSD). The National Institute of Justice in response to the Crime Act of 1994 is addressing substance abuse treatment in our local jails, through its Residential Substance Abuse Treatment (RSAT) for State Prisoners Formula Grant program. Recognizing the need for a substance abuse treatment program for the Harris County Jail offender population, the HCSD submitted a proposal to the Criminal Justice Division, Office of the Governor to establish through the RSAT funding mechanism a program to treat 400 of their substance abuse inmates yearly. "New Choices" was funded on March 1, 1997 and began admitting clients for substance abuse treatment in June of that year.

Substance Abuse Treatment in Criminal Justice Settings

Substance abuse treatment in criminal justice settings has had a checkered past but over the last decade great strides have been made in treatment programming and evaluation (Lipton, 1995). Several meta-analyses have revealed post treatment reductions in recidivism to crime and incarceration for offenders having received intensive and

comprehensive in-prison treatment followed by aftercare (Gendrau, 1996; Pearson and Lipton, 1999). By far the therapeutic community treatment approach (TC), which has been most widely used, has been shown to be the most consistent for the reduction of recidivism (Lipton, 1996). The classic reported examples of treatment effectiveness for the prison TC have been the Stay' N Out TC programs (Wexler et al., 1990), the Cornerstone program (Field 1989) and the Key Crest program (Inciardi et al., 1997; Martin et al., 1999). Long term outcomes in more recent studies have shown significant reductions in recidivism for TC clients as well. California's Amity TC (Wexler et al., 1999), an In Prison TC (ITC) in Texas (Knight, Simpson and Hiller, 1999) and several treatment programs in the Federal Bureau of Prisons (Pelissier et al., 1998) to name a few.

Treatment programming in jail settings is much less prevalent and the percentage of jail inmates receiving any treatment is low. In addition, only 7% of those inmates are receiving treatment that can be considered comprehensive (Swartz, Lurigio, Slomka, 1996). As such, there is much less empirical evidence of the effectiveness of jail based programs. Tunis et al. (1996) conducted a thorough examination of several in-jail treatment programs in California and New York. Although the programs experienced various levels of treatment delivery and implementation problems, overall they did show modest reductions in recidivism. Results from the IMPACT treatment program in the Cook County Jail, Chicago, indicated that a comprehensive jail program was effective in reducing recidivism and rearrest rates. Importantly, it was found that the rate of reduction was directly related to time in treatment up to about 150 days, beyond which there were diminishing results (Swartz, Lurigio, Slomka, 1996).

Although treatment generally has been shown to be effective, Gendrau (1996) cautions that effective treatments are intensive and have a behavioral component and several studies (Inciardi et al., 1997; Wexler et al., 1999; Hiller, Knight & Simpson, 1999) emphasize the transition from correctional to community settings. More process evaluations are needed to explicate the problems associated with implementing comprehensive programs in unique jail settings and to determine what programming works, as well as, subsequent long term outcome studies of intensive programs successfully implemented.

Setting

The Harris County Central Jail is a maximum-security jail in Houston, Texas operated by the Harris County Sheriff's Department (HCSD). The Harris County Jail is the fourth largest jail in the United States with an inmate capacity of approximately 8,500. The average daily population for the past five years has ranged from 7,140 to 10,282, with a current average around 7,300. Of the approximately 100,000 persons confined in the Harris County Jail annually, the majority are: individuals being held awaiting trial, conviction, or sentencing; individuals being housed for State, Federal or other authorities awaiting transfer; and individuals serving sentences of generally one year or less. It has been estimated that 30-40% of the inmates are incarcerated for alcohol or drug related offenses or approximately 3600 inmates on any given day.

The RSAT "New Choices" substance abuse treatment program operates within the Medical Services Bureau/HIV Project of the Harris County Jail. The program is

isolated from the general population on a dedicated floor in the Harris County Jail facility at 1301 Franklin. The program clients are housed in "quads" containing individual cells. These quads hold between 6-8 clients with individual cells for each client flanking a common area with tables for socializing or holding groups, as well as for security purposes such as head count at scheduled times throughout the day. The inmate capacity of the floor is 200.

The New Choices substance abuse treatment program, as proposed, is a 6-12 month "quasi-Therapeutic Community which has as its stated goal, "to help the inmates develop a drug and/or alcohol free lifestyle by supporting changes in their attitude and behavior".

"Descriptive" Component

Description of the Overall Treatment Effort

The data collection for the process evaluation was completed by February, 1999. *Record reviews* included a review of the program materials (i.e. policy manuals, recruitment materials, training materials) treatment materials (i.e. treatment manuals, educational materials, curriculum, screening and assessment tools) and schedules. A selection of client files was chosen for review at different points in time to monitor progress in the record keeping efforts of the staff. The client files were examined for consistency and thoroughness of the recording efforts. The client files were reviewed for inclusion of:

- recruitment, screening, and assessment instruments and documentation;
- periodic process notes, treatment progress documentation, and treatment plan;
- infraction and disciplinary documentation;
- discharge plan and discharge outcome documentation

The *observations* of the assessment interviews, treatment components, support services operations, and discharge procedures were conducted on a weekly basis. The evaluation staff was on the unit weekly conducting interviews and observing program activities. Observations were completed by the end of February 1999.

The *interviews and the pencil and paper questionnaires* for the treatment staff, corrections staff, and the administration were combined to allow for the greatest participation and depth of inquiry for each allotted period of time. A total of 15 staff members were interviewed and/or administered questionnaires.

The New Choices Program

The 9th floor, which was dedicated to the treatment program, required remodeling, utility repairs and painting prior to client assignment to the floor. In June 1997 when the first New Choices' clients were admitted to the unit, the refurbishing was approximately half completed. In January 1998 when evaluation data collection began, the unit was approximately three-quarters complete. The male side in January had a daily census of approximately 80 clients and the female side had a census of approximately 30 clients. By September 1998, the floor was complete and the male daily census had increased to 120 and the female census increased to approximately 40. It should be noted that in

October 1998, the Harris County Sheriff's Department (HCSD) designated a section of the 9th floor to be used to house male inmates discharging from the medical detoxification unit. The new assignment of space on the 9th floor reduced the capacity of the New Choices program to approximately 160 beds (120 males and 40 females). The subsequent ratio of male beds to female beds is more reflective of the gender ratio of the Harris County jail facility than the 50-50 split originally proposed. In addition, long-term women clients have been difficult to recruit in large part because the courts are much less willing to impose long-term sentences on women.

As proposed, the treatment program would be staffed with a program director, a male unit supervisor, a female unit supervisor, two counselors each for the male and the female units, and one clerk The treatment staff for the program in June 1997 consisted of a male supervisor, a female supervisor, and a unit clerk. HCSD deputies and correctional staff as with all floors in the jail handled security. By January 1998 when the evaluation data collection began, 2 counselors had been hired; 1 for the female side and 1 for the male side. A second counselor was hired for the female side in the summer of 1998.

Client Selection Process

During the evaluation period, clients admitted to the "New Choices" program came from the current inmate population of the jail on a voluntary basis or were directly sentenced to the program by a county court.

There are three primary methods of entry into the New Choices program for new admissions. The most common method has been self-referral (65%) followed by referral from medical (21%) and court mandates (14%). The self-referred clients have primarily been generated through flyers, promotional visits to the general inmate floors by New Choices treatment supervisors, and by word of mouth. Individuals who go through medical detox upon admission to the jail are systematically referred to the program. Once the New Choices unit supervisors received a request for admission from an inmate, a referral from the medical department, or an order of sentence from the courts, a screening interview would take place with the New Choices supervisor and the potential client. Due to staff and time constraints, the screening of potential clients often took place after the inmate was transferred to the 9th floor. The screening included an interview and administration of the Substance Abuse Subtle Screening Inventory (SASSI) to determine eligibility. Inclusion criteria, keeping in mind that this is a volunteer program, included:

- the client having a minimum of an Alcohol or Drug abuse problem
- the client having an "acceptable" length of stay
- the client accepting the rules and policies of the program
- the client being sufficiently motivated
- the clients being mentally stable

Following the screening, any clients eligible for the New Choices program were given an intake assessment in which the History and Current versions of the ASI were administered. In addition, Mental Health and Mental Retardation Association was engaged in the process if requested by the client or upon detection of florid symptoms or

psychological distress by the interviewer (unit supervisor). Also, all inmates at the jail are given a complete physical after 14 days of incarceration and are offered HIV testing.

Time in Treatment

Between June 1997 and July 1998 when the participant recruitment ended for the evaluation, there were 531 inmates admitted to the unit for assessment and of those 426 clients remained on the unit. The time in treatment for those New Choices clients ranged from 15 days to 396 days with the average stay being 77 days. There were 48 clients during that time (11%) that had 180 or more days on the unit. (It should be noted that as of April 1999, the percentage of male clients remanded to the unit directly by the courts for a minimum of 180 days has increased the rate to 52%).

The New Choices program, although a 6-month program by design, has been affected in its recruitment of long term clients by several factors: the short term of incarceration for the majority of the jail inmates; the policy of the jail administration requiring full occupancy on the dedicated floor; the lengthy process of engaging the courts.

- The Harris County Jail primarily houses three types of inmates and the status of these inmates may change over time. About half of the inmates in the jail at any given time are sentenced to the jail for terms not to exceed 12 months. About ¼ of the inmates are individuals awaiting trial, hearing or sentencing and about ¼ are individuals being held for state, federal or other authorities awaiting transfer. During the term of the evaluation clients for the New Choices program were admitted from any one of the three types of inmate groups. For those clients awaiting a trial or hearing, their time in the program was variable, dependent on both the expediency and the outcome of their trial or hearing. In many cases these clients had short-term stays and therefore, did not complete the treatment program. Similarly, for those clients who were sentenced and awaiting transfer to another criminal justice facility, their time in the program was variable and often of short duration. Clients who were sentenced directly to the Harris County Jail generally had stays of 3-12 months. This group made up the majority of the longer-term clients and program completers.
- The policy at the Harris County jail has been that the "New Choices" program is afforded the use of a dedicated floor providing the unit utilize the available bed space. In order to justify the dedicated floor of the jail that the treatment program occupies, it has been necessary to accept clients into the "New Choices" program from all three groups of inmates. This has frequently resulted in the easing of the inclusion criteria "acceptable length of stay".
- Engaging the county courts, which have the ability to mandate clients to the New Choices treatment program for 6-12 months, has been a long process. The courts first had to be educated on the treatment program being offered at the Harris County jail, a level of trust then had to be forged, and finally the waters had to be tested. The enlistment of cooperation from the courts was pursued diligently by the program director and the male unit supervisor during the period of the evaluation.

Many of the first mandated clients were sentenced for less than 6 months. These clients were accepted into the program as a means of introducing the program to the

courts. There was an initial hesitancy by many of the courts due to an experience in the recent past in Harris County where a treatment facility operated by the county was closed under some public accusations that the inmates were not being treated. Several hundred inmates then had to be released into the community. Therefore, building trust and allowing the courts to "test the waters' was a necessary and as it turned out productive step.

For the women's side of the program, enlistment of court mandated clients continues to be an ineffective means of admitting long-term clients. The courts in general do not like to sentence women for more than 90 days to the jail due to the rationale that many of the women are single moms with families that depend on them. The majority of the women in the county jail have been sentenced for 90 days or less.

As stated previously, in an effort to increase the number of long term clients (6-12 months), the treatment program administration and staff have actively sought the cooperation of the courts. In an ongoing process of education and negotiation, the treatment staff have introduced the courts to the New Choices program. The process has taken the form of printed materials describing the program and several face to face meetings with judges, clerks and other court personnel. Initial reactions were very positive and more offenders are being mandated directly to the program for terms of 6 months and longer. In some instances, the program has accepted clients with 90-day mandated sentences from judges wanting to "test" the program while getting their courts specific needs met. Each judge and court act autonomously and therefore the process requires an ongoing effort to formalize a process that is beneficial to both the program and the courts. In addition, internally the treatment staff are continuing efforts to identify and enroll inmates from the general population that have long-term sentences. As of December 1998, the program has only admitted jail inmates from the general population who have already been tried and sentenced. The restriction of recruitment to post-sentenced jail inmates has effectively eliminated the uncertainty of length of stay associated with inmates not yet tried and/or sentenced.

Substance Abuse Treatment

The treatment delivered to the New Choices clients has been primarily an education and skills based treatment. The core program is based on the Hazelden substance abuse treatment module for the criminal offender. The Hazelden curriculum is composed of several components designed for delivery through didactic instruction and written exercise. The curriculum addresses issues associated with 3 steps of the treatment process, orientation and education, substance abuse treatment, and relapse prevention, as well as, issues specific to criminal behavior and criminal thinking. The "Substance Abuse Education Component" serves to educate the client on the chemicals (drugs) and how they affect the body and the mind, the health risks associated with abuse, the association of drugs and criminality, and how drugs alter awareness. The "Substance Abuse Treatment Component" is heavily based on the 12-steps of Alcoholics Anonymous. The many treatment units of this component are designed to facilitate the movement through the first 7 steps. The "Aftercare Component" introduces the client to the remaining steps and prepares the client for life after incarceration through instruction and exercises addressing relapse prevention, teaching survival skills, and immediate post-release plans and strategies. In addition, there are special components that address issues of power and

control, criminal thinking and decision making, and directions for change. Finally, there are educational materials and skills training exercises specific to the male offender and the female offender. These materials are presented to the male and the female units, respectively, in two education groups scheduled each weekday. There are assignments to be completed during designated times of the day related to these education groups.

Other treatment delivery methods integral to both the female and the male units are a morning motivational group that involves all of the clients (divided into two groups on the male unit due to space limitations), small peer led groups that are held in the individual "quads" and AA/NA groups. Pro-active regular individual counseling is planned for as the units become fully staffed, but at the time of this report, has been limited to re-active problem solving sessions. Current ancillary program components include required recreation on weekends and spiritual groups and bible study, which are optional. In addition, GED classes are offered and jobs available for those that have sufficient time in treatment and have demonstrated sufficient progress in the treatment program.

Therapeutic Community Concept

Therapeutic Community (TC) programs although they differ in size, intensity, and treatment components share certain common attributes (Luger, 1991). TCs in criminal justice settings, which evolved out of community programs, are generally modified to fit the unique physical environments of jails or prisons, as well as, the somewhat contrary philosophies of rehabilitation and punishment. The TC is a complex model, the implementation of which requires the greatest degree of commitment from the administration and the staff.

The "New Choices" treatment program is still very much in a formative stage. Of the components believed to be inherent to a TC:

1) some are apparent in the New Choices program;
   a) inmates with similar needs and goals
   b) inmates taking personal responsibility for their recovery
   c) separation of the treatment community from the general population of the jail
2) some have not been completely incorporated but are in progress or planned for the program;
   a) community as therapist versus the "medical model"
   b) formation of cohorts of clients
   c) client mentors
3) some do not lend themselves well to the unique environment of a county jail and definitively support the designation "quasi-therapeutic community".
   a) family hierarchy
   b) internal job structure
   c) behavioral confrontation by peer groups

1. In traditional TCs, individuals with similar needs and goals provide mutual support to one another within a community that operates in a dedicated environment isolated and protected from the influence of others. Therapeutic communities like twelve-step groups have singularity of purpose, however unlike Alcoholics Anonymous they are

not limited primarily to alcoholics. In a therapeutic community, the recovering individual is supported and encouraged to take responsibility for her/his substance abuse through a personal change in attitudes, values and conduct associated with a socially accepted drug-free lifestyle (De Leon, 1984). The New Choices clients are a diverse group of criminal offenders with substance abuse or dependence, not limited to alcoholics, with a common goal of overcoming their addiction, changing their criminal thinking and behavior, and addressing issues of re-socialization.

TCs are primarily implemented in residential settings. In the case of an incarcerated population it can be critical to the process of change to provide a safe environment where one can develop a sense of belonging (Wexler, 1994). Inmate cultures promote values that are often incompatible with rehabilitation and change, glamorizing drugs and crime and providing an atmosphere of negativism and isolation (Field, 1989). New Choices has a dedicated floor of the jail facility, separate from the floors that house the general population. Separation is maintained with the exception of clinic visits (medical), law library weekly privileges, and recreation. In addition, those with jobs and those receiving GED education have additional exposure to the general population (The unit director is currently negotiating for GED classes to be held on the 9th floor for New Choices clients.).

2. The therapeutic community, as defined in the literature, is a movement away from the traditional "medical model" dichotomy, where the client is actively treated by a professional toward a more active participation by the clients in his/her emotional, physical and intellectual work that is required for the process of change to occur (Wexler, 1994). In the traditional TC, the residents take responsibility for their own recovery process, while the treatment staff (generally including ex-offenders) act as role models providing support and guidance. A primary function of the treatment staff is the monitoring of the health of the community overall, allowing for a treatment experience that promotes peer support, safety and communication (Wexler, 1994; von Sternberg & Carbonari, 1997). In the process of sharing living quarters, participating in groups and learning and studying together the client's learn appropriate behavior, self-reliance and responsibility (Wexler, 1994). The New Choices treatment staff and corrections staff act as role models and provide support and guidance for the individual client. In addition, the staff works to insure a safe environment conducive to open communication between peers and staff. However, the overall sense of community has been difficult to attain on the unit. Factors affecting a sense of community include:

- *jail policy*
  Many substance abuse counselors have a history of substance abuse and often criminal involvement. Traditional TCs generally include in their staff, substance abusers and ex-offenders as role models. Policy at the jail excludes the hiring of anyone with a previous felony conviction or a misdemeanor that involves drugs.

- *a lack of staff*
  Due to the policy restrictions mentioned above, relatively low pay, and the jail setting hiring a sufficient number of qualified counselors has been difficult. The counselor to client ratio during the time of this evaluation was as high as 1 to 20 for

the female side and 1 to 40 for the male side. Due to the enormous workload, staff have had difficulty tending to the health of the community effectively.

- *the design of the treatment*
  The treatment offered is strongly based on the Hazelden substance abuse treatment module for criminal offender populations. The Hazelden model is based primarily on education with several components of substance abuse education and education targeting criminal behavior and criminal thinking. The treatment choice itself is in part an artifact of the lack of staff. Support groups, process groups, and peer confrontation groups are labor intensive. Opportunities for community building are limited to the 2 education sessions each day the morning motivation meetings and AA/NA groups. Other activities involve smaller subsets of the community.

- *physical constraints of the jail*
  The floor as stated earlier is divided into quads and clients for a part of each day (including meals, which are served in the quads) are limited to small groups not allowing for an optimum amount of community interaction. However, as more long-term clients are being admitted, the program supervisors are placing groups of new admissions into "quads" together forming cohorts of clients. In each quad, along with the new clients, there is an elder(s) who acts as a model and mentor through the orientation period.

3. In the traditional TC, the staff operates in a collaborative style in which the individual counseling input is secondary to the creation of a safe environment where therapy takes place via the social milieu (Wexler, 1994). A system of incentives and sanctions form the core of treatment interventions for a therapeutic community. Key to the TC approach is the belief that appropriate and consistent responses to behavior are critical in teaching new behavior skills and promoting responsibility for one's actions. Thus, ensuring that rules, structure and discipline are maintained is a primary focus of the staff. Positive behavior in the TC is generally rewarded through peer recognition and advancement in the hierarchy. Negative behaviors are confronted in a variety of formal and informal means related to the severity and longevity of the behavior. These may range anywhere from the simplest form of a comment from one peer member to another to a resolution through a formal community hearing. For the New Choices program, the physical structure of the jail acts to limit the clients' interaction to between 6-8 clients for a substantial portion of each day. In addition, the emphasis of the larger group functions is on didactic treatment delivery, which restricts the ability of the clients to exhibit behavior that would solicit either positive or negative recognition. Moreover, jail policy will not allow inmate government, hierarchy, or confrontation under any structure. Therefore, it is not possible to create a peer led entity for infraction resolution.

A job structure involving an increasing set of responsibilities is common to therapeutic communities and can be effective in teaching concepts of personal responsibility and social reward to the client and in facilitating increased self-esteem and self-confidence (Wexler, 1994). There is not the availability of a job structure internal to the New Choices program that can provide the clients a simulation of work procurement and advancement. Recognition of good citizenship and taking personal responsibility for

ones recovery must be provided in more subtle ways such as group affirmations rather than advancement through a community hierarchy. There are, however, jobs throughout the jail available to the New Choices clients. Positive behavior and time in treatment are major factors in the selection of candidates for those jobs.

The New Choices treatment staff and the corrections staff are responsible for the formal reaction to negative behavior on the unit. The peers do not formally get involved. As previously stated, there is not a confrontational process involving clients by which negative behavior is addressed and consequences of infractions applied. During the time of the evaluation, the formal function of addressing client behavior was carried out by the treatment staff and the corrections staff. The approach to confronting behavior for the treatment staff and the corrections staff was often disparate. By December 1998, however, the staff jointly created rules and infraction policies, which included documentation of specific consequences to be given for specific infractions, and has contributed to a more consistent and unified approach.

Treatment File Review

Large numbers of admissions and limited treatment staff hampered early efforts at adequate client record keeping. In addition, concentration of staff efforts in the first months of operation were necessarily directed at assessment development, treatment development, policy development, staff training and development of recruitment procedures. As the staff size increased and start-up procedures were developed, client records were well maintained and each file included:

- Chart Summary Checklist
- Client intake form
- Consent for the release of Confidential Information
- Clinic notes
- Copy of consent for Urinalysis
- Copy of Urinalysis Screening
- Copy of SASSI and results
- Copy of the ASI-History and ASI-Current
- Copy of referrals
- Correspondence from the court
- Correspondence from the client
- Checklist of Hazelden components completed
- Client assignments from Hazelden materials
- Treatment plan

Evaluation of Treatment

The first process measure, the Evaluation of Treatment (see Appendix C), was a two-part combination of items from the DATAR Monthly Client Evaluation of Treatment and from the Working Alliance Inventory. The first section was based upon the DATAR form which was developed by Texas Christian University in a NIDA-funded evaluation study and was adapted to measure client satisfaction with treatment staff and specific services of the program (NIDA, 1993). The second section, the Working Alliance Inventory (Horvath & Greenberg, 1986), was used to measure three areas of the client-therapist relationship, and will be addressed further.

Evaluation of Treatment: Treatment Ratings.

The Treatment Ratings section was divided into three sub-sections, namely: Staff, Treatment Components, and ratings of the Program Overall. Each item was rated using a 5 point Likert-type scale ranging from one to five, one being the lowest rating and five being the highest. In the first section, the choices ranged from "Never" (1) to "Always" (5) on nine characteristics which completed the statement "In general, the staff was ...". As shown in Table 1, the percent response per item has been calculated for each rating category; thus, 33.0% of the clients completing this section reported that the staff, in general, was "Always easy to talk to", and so on.

For the *client responses* (n=97), it can be seen by combining the two responses with the highest ratings per item - "Often" (4) and "Always" (5) - that the clients responded the most positively about how "Knowledgeable" (79.4%) the staff was as well as how "Helpful" (65.0%) and "Honest and Sincere" (65.0%). In like manner, by combining the 2 lowest ratings ("Never" and "Rarely"), it can be seen that the two items which yielded the lowest ratings by the clients of the staff were "Dependable" (19.6%) and "Well-organized" (20.6%). It should be noted, however, that even on those items the majority of the clients still endorsed one of the two stronger responses as opposed to the weaker ratings.

Table 1 - Client Ratings of the Staff (n=95)

IN GENERAL THE STAFF WAS	NEVER (1)	RARELY (2)	SOMETIMES (3)	OFTEN (4)	ALWAYS (5)	TOTAL (4) + (5)
1. Easy to talk to	4.1%	6.2%	29.9%	26.8%	33.0%	59.8%
2. Warm and caring	1.0%	7.2%	37.2%	30.9%	23.7%	54.6%
3. Honest and sincere	1.0%	6.2%	27.8%	29.9%	35.1%	65.0%
4. Understanding	1.0%	7.2%	29.9%	32.0%	29.9%	61.9%
5. Dependable	4.1%	15.5%	21.6%	38.1%	20.6%	58.7%
6. Well-organized	7.2%	13.4%	14.4%	37.1%	27.8%	64.9%
7. Persuasive	2.1%	7.2%	25.8%	38.1%	26.8%	64.9%
8. Helpful	0%	7.2%	27.8%	33.0%	32.0%	65.0%
9. Knowledgeable	1.0%	6.2%	13.4%	35.1%	44.3%	79.4%

The scale in the second section, Treatment Components, included choices, which ranged from "Terrible" (1) to "Great" (5) or "Does Not Apply" (9). As can be seen in Table 2, clients responding to items in this section were asked "How would you rate the usefulness of each of the following components of treatments?" The percent response per item has been calculated for each category and is reported in Table 2. As can be seen, the most strongly endorsed treatment component was *Group Counseling*, with 78.4% of the clients indicating "Good" or "Great". *Group Counseling* was also the only endorsement in which all of the clients agreed that the treatment component applied to

this program. *Relapse Prevention Training* (54.6%), *AIDS Prevention Training* (46.4%) and *Networking* (45.3%) which includes familiarization with aftercare and Alcoholics/Narcotics Anonymous, all received the highest two rankings from a large proportion of the respondents.

Individual counseling was mainly by request or employed in crisis management situations. It is therefore, understandable that while one-third (33.0%) of the clients endorsed *the usefulness of the individual counseling* as "Good" or "Great", over one-quarter (28.9%) responded "Terrible" or "Poor" and one-quarter responded that the category "Does Not Apply". "Family Counseling" was endorsed "Does Not Apply" by 58.8% of the clients. Again, as with the individual counseling, family counseling is not a formal treatment component but rather engaged in on a case by case basis.

Table 2 - Client ratings of the Treatment Components (n=95)

How would you rate the usefulness of each of the following components of treatments?	TERRIBLE (1)	POOR (2)	OKAY (3)	GOOD (4)	GREAT (5)	TOTAL (4) + (5)	DOES NOT APPLY
a. Individual Counseling	16.5%	12.4%	11.3%	19.6%	13.4%	33.0%	25.8%
b. Group Counseling	0.0%	3.1%	17.5%	28.9%	49.5%	78.4%	0.0%
c. Family Counseling	13.4%	6.2%	9.3%	7.2%	3.1%	10.3%	58.8%
d. AIDS Prevention Training	8.2%	7.2%	16.5%	18.6%	27.8%	46.4%	20.6%
e. Relapse Prevention Training	3.1%	13.4%	20.6%	17.5%	37.1%	54.6%	6.2%
f. Networking (Familiarization with aftercare resources such as AA, NA.)	8.2%	9.3%	21.6%	17.5%	27.8%	45.3%	12.4%

Finally, in the third section of ratings, clients were asked to rate the Program Overall using ten different items covering a broad spectrum of criteria. The same Likert-type choices were given as in the previous section, ranging from "Terrible" (1) to "Great" (5), and the percent response per item for each category is reported in Table 3. The most positively endorsed items when combining the two the highest ratings - "Often" (4) and "Always" (5), were "Your progress in making changes in your life" (91.8%), closely followed by "The treatment program in helping you make changes in your life" (86.6%) and "Helpfulness of other clients in your counseling group" (81.5%). The three weakest rated items receiving the greatest number of "Terrible" and "Poor" endorsements were "Helpfulness of the individual counseling"(31.9%), "The treatment program in meeting all your needs" (13.4%) and the "Helpfulness of counseling for your other problems" (13.4%). Again it should be noted that although these were the three items rated the lowest, over half of the clients responding indicated a rating of either "Good" or "Great".

Table 3 - Client Ratings of the Program Overall (n=95)

How do you rate.....	TERRIBLE (1)	POOR (2)	OKAY (3)	GOOD (4)	GREAT (5)	TOTAL (4) + (5)	DOES NOT APPLY
1. Friendliness of program staff	3.1%	5.2%	26.8%	35.1%	29.9%	65.0%	0.0%
2. Helpfulness of individual counseling sessions	14.4%	17.5%	11.3%	15.5%	19.6%	35.1%	21.6%
3. Helpfulness of group counseling sessions	0.0%	2.1%	17.5%	36.1%	44.3%	80.4%	0.0%
4. Your similarity (or likeness) to other clients who were in the program with you?	0.0%	4.1%	18.6%	49.5%	27.8%	77.3%	0.0%
5. Helpfulness of other clients in your counseling groups	0.0%	4.1%	14.4%	45.4%	36.1%	81.5%	0.0%
6. Helpfulness of counseling for your substance use	0.0%	0.0%	18.6%	34.0%	47.4%	81.4%	0.0%
7. Helpfulness of counseling for your other problems.	3.1%	10.3%	19.6%	35.1%	30.9%	66.0%	0.0%
8. Your progress in making changes in your life	0.0%	3.1%	5.2%	33.0%	58.8%	91.8%	0.0%
9. The treatment program in meeting all of your needs	3.1%	10.3%	33.0%	32.0%	21.6%	53.6%	0.0%
10. The treatment program in helping you make changes in your life	2.1%	2.1%	9.3%	38.1%	48.5%	86.6%	0.0%

Evaluation of Treatment: Working Alliance Inventory.

As mentioned above, the second section of the Evaluation of Treatment Measure is based upon the Working Alliance Inventory (Horvath & Greenberg, 1986), and focuses upon the relationship between the counselor and the client. The significance of this "therapeutic alliance" has been found to be effective in predicting outcomes from psychotherapy among general psychiatric populations as well as substance abusing populations (Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985). Selected items from the Working Alliance Inventory (WAI) were administered to the clients in the treatment group at 45 days in order to examine the clients' perceptions of the therapeutic relationship.

The questions in this section fall into three main categories as defined by the WAI: agreement on goals, the extent of agreement on tasks to be completed, and the establishment of bonds between the primary counselor and the client. Each item is rated using a seven point Likert-type scale ranging from "Never" (1) to "Always" (7). The group mean response and standard deviation for each scale has been calculated for the clients and is presented in Table 4. It can be seen that each of the mean responses from

the treatment client cohort fall between 5 ("Often") and 6 ("Very Often"). Thus, on the average, the clients reported having achieved a sense of bonding with their primary counselor in between "Often" and "Very Often". Similarly, the clients reported agreeing on both goals and tasks with their primary counselor between "Often" and "Very Often".

Table 4 – Group Ratings of the Working Alliance by Client (n=95)

Client Response		Mean Response scale 1-7	Standard Deviation (N=139)
	BONDING	5.47	1.20
	GOALS	5.34	1.14
	TASK	5.53	0.85

Community Oriented Program Environmental Scale (COPES).

The COPES examines key dimensions of various programs that could be related to outcome (Moos, 1988). The reported psychometric characteristics of the COPES and other research findings indicate that the measure should be useful to investigators evaluating treatment effects and to program staff assessing their own treatment environments. The COPES was normed from a sample of 54 community programs that included rehabilitation workshops, partial hospitalizations, halfway houses, Veteran's Administration psychiatric and general hospitals and private hospitals. Most relevant to this evaluation, some of these programs operated as classic Therapeutic Communities (Moos, 1990). The COPES - Form S is the brief version of the Form R, which was administered in this study to both clients and staff in consideration of the overall time and effort required of the study participants and for its acceptable psychometric properties.

The COPES is composed of three primary dimensions: Relationship; Treatment Program; and, System Maintenance

- Relationship assesses an overall engagement of the clients and the staff in the treatment program. This dimension is defined by its sub-scales: the *Involvement* of the client and staff in the program; the *Support* of the clients to each other and the staff to the clients; and the extent to which clients feel free to express themselves and to act with *Spontaneity.*
- The Treatment Program Dimension focuses on the treatment in relation to the extent that perceived personal needs and practical experience are being addressed for the client. This component is best conceptualized as the personal development dimension, and is comprised of four sub-scales. *Autonomy,* the first, stresses the extent to which a client is encouraged to be self-sufficient and responsible in decision making and relationships. *Practical Orientation* and *Personal Problem Orientation* address the extent to which a client receives education about his problems and enlightenment and practical tools for preparing himself for leaving the program. Finally, *Anger and Aggression* measures the extent to which clients are allowed or encouraged to display aggressive behavior in their process of self-awareness.

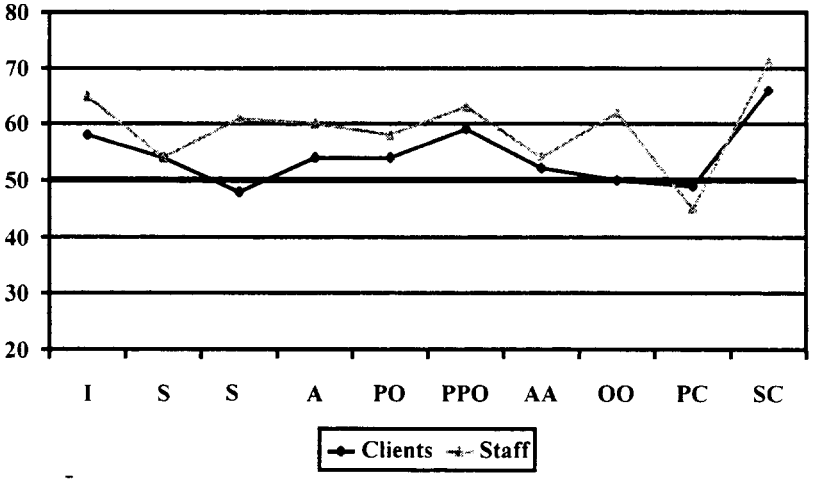
- System Maintenance addresses the systemic relationship. The program is assessed through the client and staff perception of such fundamentals as *Order and Organization* and *Program Clarity*. These address the extent that a program is clear and consistent in its rules and procedures. Finally, *Staff Control* assesses the relationship of the client and the staff in light of the enforcement of those rules.

COPES - Client Results.

The COPES data was collected during the 45-day Assessment Interview from the treatment client participants (n = 97). Any client with a single missing data point was eliminated from this analysis. When comparing staff and client results on the COPES, the developers suggest using the norms for the client. The COPES subscale scores portrayed in Figure 1 for both the client and the staff, therefore, are compared to program client norms (y = 50).

Results from the client version indicate a strong endorsement of major program dimensions. The evaluators examined the clients' subscale means for the Relationship Dimension and found *Involvement* to be significantly above the mean for the norm. The *Support* and *Spontaneity* subscales for the clients were both found to be statistically equivalent to the norm mean. The Treatment Program Dimension subscales were all endorsed positively by the client. Two of the dimension subscales *Practical Orientation* and *Personal Problem Orientation* were found to be significantly greater than the norm mean. Finally, two of the subscales of the System Maintenance Dimension were found for the clients to be equivalent to the norm and *Staff Control* was found to have significantly greater endorsement than the norm mean.

Figure 1: COPES Standard Score Profile



I - involvement
S - support
SP - spontaneity
A - autonomy
PO - practical orientation
PPO - personal problem orientation
AA - anger and aggression
OO - order and organization
PC - program clarity
SC - staff control

COPES - Staff Results

The evaluators examined the subscales for the Relationship Dimension and found *Involvement* and *Spontaneity* for the staff to be significantly above the mean for the norm and endorsed more strongly than by the clients. The *Support* subscale was found to be statistically equivalent to the norm mean and to the client response. The Treatment Program Dimension subscales were all endorsed positively by the staff as with the client. Two of the dimension subscales *Practical Orientation* and *Personal Problem Orientation* were found to be significantly greater than the norm mean. *Anger and Aggression* as with the client response was found to be equivalent to the norm mean. Finally, two of the subscales of the System Maintenance Dimension *Order and Organization* and *Staff Control* were found to be significantly above the mean while *Program Clarity* was endorsed at the norm mean level by the staff.

All of the programs that were used to create the norm for this instrument were programs found in the community. It is reasonable to assume that the jail environment would be characterized by the client as more restrictive and less accepting of spontaneity, however, the treatment group scored near the mean on the *Spontaneity* scale and the staff had a significantly stronger endorsement of spontaneity than the norm. The high *Staff Control* mean for both clients and staff presents evidence that the unit is perceived as more restrictive or controlling than the community programs. Staff Control measures the extent to which the staff (in this case inclusive of the security officers) uses measures to keep the client under necessary control. This endorsement is reasonable given the treatment program is housed in a county jail facility and clients are subject to strict supervision and security measures consistent with a maximum security facility.

Qualitative Client and Staff Data

The clients and the staff were given open-ended questions about the program's strengths and weaknesses, as well as, what they would like to see added to the program in an ideal world. The clients felt the strengths of the program were found in: the quality of the treatment groups (20%) and the focus on "real issues, solutions, and tools"; the client community and environment (18%) where one has the "freedom to speak honestly without the fear of reprisal" one has a sense of "togetherness, confidentiality, and honesty" in an environment of "client helping client"; the treatment staff (12%) who are "knowledgeable", "understanding and caring", and "honest and sincere". The clients when asked about weaknesses of the program most frequently commented on: the security staff (32%) stating that as a group they were "negative", and had bad attitudes; the clients themselves (20%), remarking that some clients did not want to participate; the need for more treatment staff (16%); the need for more individual counseling (36%); the need for more recreation and free time (10%). Finally when the clients were asked what they would like to see in the program, 36% said more individual counseling, 20% said more treatment staff, and 12% wanted family counseling.

The staff felt the strengths of the program lay in the counselors and in the clients themselves and in the mere fact that a treatment program exists for so many of the inmates who are in need of help in understanding that they are "somebody" and that they have "options" in their lives. The staff felt the program could use improvement in that ("weaknesses of the program") the program needs "more counselors", better screening to insure that clients accepted into the program really care about changing, more individual

time for clients allowing for in depth attention to client issues, more attention to aftercare issues, and more formalized "communication between treatment staff and corrections". (NOTE: Percentages of staff responses were not given due to the limited number of respondents [n=12]. Ideas were presented if mentioned by two or more of the respondents).

During-Treatment Impact Component

The during-treatment impact evaluation was designed to provide during-treatment data on program participants (Treatment Group) and contrast findings with data from a group of substance abusing offenders from the general jail population (Comparison Group). The "during-treatment impact" component data collection was completed in January 1999. As proposed, the evaluation activities were to begin in November 1997 with staff meetings and subject recruitment. The staff meetings began in November as scheduled. There were five meetings in November and December 1997: two with the program director, and three meetings with the two unit supervisors. The purpose of these meetings was to introduce the evaluators to the unit staff, to familiarize the "New Choices" staff with the purpose and the plan of the proposed evaluation and to finalize the logistics of the data collection plan for the evaluation.

Treatment Group Recruitment

The evaluation funding beginning on November 1, 1997. The months of November and December were used to finalize the design and production of the intake assessment instruments, hire evaluation staff, and finalize arrangements at the Harris County Jail. Arrangements at the jail included admittance to the facility (i.e. background checks of evaluation staff), acquisition of office space for confidential client interviews, and access to potential subjects and records.

Any and all clients admitted to the New Choices program between October 1, 1997 and July 31, 1998 were to be eligible for inclusion in the Treatment Group. It was projected that during this 9-month period, the evaluators would interview 240 clients at intake to the unit. The recruitment procedures and data collection for the during-treatment impact evaluation actually began on January 8, 1998. Recruitment for the treatment cohort was completed in August 1998. Between January, 1998 and August 1998, 208 clients of the New Choices program had been interviewed. Of those interviewed, 195 (93.8%) agreed to participate in the study and 13 (6.2%) opted to not participate. As proposed, clients were interviewed within thirty days of being admitted into the treatment program with the average time between program admittance and evaluation intake interview being 22 days. After March 15, 1998, clients with less than 30 days remaining in the Harris County jail facility were excluded from participation in the evaluation study.

Administration of the post-intake "during-treatment" assessment, as proposed, was to occur at 90-days post-intake and at discharge. In an effort to collect post-intake data on clients whose stay was less than 90 days, a 45-day assessment was added to the assessment schedule. For the treatment client study participants, there are 195 completed intake assessments, 103 completed 45-day assessments, and 53 completed 90-day assessments.

Discharge interviews were difficult for the clients who did not complete the program because of transfer to another facility or early release as a result of a trial or hearing. For security reasons, no more than 24 hours notice is given anytime a client "pulls chain" (moves to a Texas Department of Criminal Justice prison facility). Discharge interviews were scheduled for full-term clients only. Due to the limited number of Discharge assessment interviews administered (n=13), that data was not analyzed.

Comparison Group Recruitment

The comparison group enlistment began in March 1998 and was originally intended to be comprised of clients on the "wait" list for admission to the New Choices program. However, the wait list for the "New Choices" program proved insufficient for comparison group enlistment. This was due to a shortage of staff available to work on recruitment and screening, the gradual and cautious approach of the courts to sentencing clients directly to treatment, and a frequent turn-over of beds from early discharges due either to insufficient time in treatment and return to the general inmate population, or jail discharge. Given the lack of a sufficient number of clients on a waiting list, the enlistment was postponed in mid-April and necessary adjustments were made to the method of enlistment of comparison group clients for the evaluation. An alternative approach to create a pool of potential comparison subjects began in mid-June 1998. The alternative involved selection from all of the Harris County inmates who were processed into the medical detoxification unit upon jail admission. Inmates were randomly selected for participation in the comparison group from the clients who discharged weekly from the detoxification unit by applying a SAS generated random number list to the weekly detoxification discharges.

Between January 8, 1998 and December, 1998, the evaluators interviewed 119 inmates from the general population who had entered the jail through the medical detoxification unit. Of those interviewed, 96 (81%) agreed to participate in the study and 23 (19%) opted to not participate. In addition, inmates from the general population were not recruited if they: were leaving within a week; were scheduled to enter the "New Choices" program within the next week; or were previously clients of the "New Choices" program. The comparison group intake-assessment interview was administered within two weeks of the inmate's discharge from the detoxification unit. The evaluators collected 101 completed intake assessments and 28 completed 45-day assessments.

Participant Group Comparisons

The sample of clients enlisted in the during treatment impact study (n=195) was 58.5% male and 41.5% female with a median age of 31 ranging from 17 years to 56 years (See Table 6). Three-quarters of the client study participants were self-referred to the unit, the medical unit or other internal source referred 8%, and 14% were mandated by the courts. The type of current offense for the participants was varied but over half of the study participants were incarcerated for probation violation (29%) or drug charges (28%). The remaining offenses resulting in the current incarceration ranged from prostitution to homicide (see Table 7).

The treatment group (T) and the comparison group (C) were similar on several characteristics such as gender, residence at time of incarceration, and employment pattern

(See Table 7). Each group consisted of approximately 40% females [T(41.5%); C(39.1%)] and 60% males [T(58.5%); C(60.9%)]. Although a larger percentage of the treatment group had either a 12th grade education or had received a GED (65%) than in the comparison group (59%), the difference was not significant. The current residence at the time of incarceration for the two groups was again without significant difference although a larger percentage of the treatment group was "living with others" (not paying rent) [T(35.4%); C(28.3%)] and a larger percentage of the comparison group was homeless [C(15.2%); T(9.7%)].

Table 6: Group Demographics

	Treatment Group	Comparison Group
Mean Age*	30.1	33.5
	% of Group	**% of Group**
Gender		
Males	58.5	60.9
Females	41.5	39.1
Education	65.5	59.1
Race*		
White	47.7	62.4
Hispanic	15.4	19.4
Black	34.4	14.0
Residence		
Homeless	9.7	15.2
Rent/Own	50.7	55.4
Living w/others	35.4	28.3
Driver's License	47.2	36.6
Employment Pattern		
Full Time	55.4	43.0
Unemployed	12.4	20.4

*p<.001

When asked about drug of choice, the comparison group named alcohol and heroin significantly more often than the treatment group. The treatment group by contrast endorsed crack cocaine at a much higher rate. Interestingly, when asked about actual drug use for the 90 days prior to incarceration, the two groups endorsed the same frequency of use (number of days of any use) for crack cocaine. The comparison group did have more days of alcohol and opiate use, which was consistent with the drug of choice reported.

The comparison group also differed significantly on several criminal background variables with more prior drug arrests, more prior convictions for any offense, more lifetime incarceration, and more DWI arrests. The two groups were very similar, however, on current offense. Over 1/4th of each of the groups [T(28.6%); C(26.9%)] were incarcerated on drug charges. Another one-quarter of each group was incarcerated on charges of burglary, robbery, or assault [T(24.4%); C(24.8%)]. DWI was the current charge for 5.3% of the treatment group and 6.5% of the comparison group.

The two current offense categories in which the groups differed significantly were probation violations [T(29.1%); C(19.5%)] and the "other" category [T(12.6%); C(22.0%)]. These differences may be related to the "acceptable" length of stay inclusion criteria. The "other' category includes social disorder crimes such as public intoxication, vagrancy, and prostitution. The social disorder crimes are associated with relatively short terms of incarceration. Probation violations on the other hand generate a "motion to revoke" process which entails incarceration prior to a hearing and if revoked time served in the county jail or time awaiting transfer to a TDCJ prison facility.

Table 7: Current Offense

Current Charge	Treatment Group n=195	Comparison Group n=96
Probation Violation	29%	19%
Drug Charge	28%	27%
Burglary	9%	14%
Robbery	8%	7%
Assault	7%	4%
DWI	5%	7%
Other: Prostitution Homicide Forgery Weapons Offense Shoplifting	14%	22%

Measures

The *Client Intake Interview* was developed from several sections of the Addiction Severity Index and included demographic questions, and questions addressing current (pre-incarceration) and lifetime domains of medical, employment, legal, family,-social functioning, psychological status, and HIV/AIDS risk behavior.

The 53-item *Brief Symptom Inventory* (BSI; Derogatis, 1993) was used to measure psychiatric severity. The BSI is a 53-item self-report short form of the 90-item Hopkins Symptom Checklist-Revised (SCL-90-R). The BSI is appropriate in clinical situations where debilitation results in reduced attention and endurance, and where testing procedures demand brevity. The BSI measures nine primary psychological symptom patterns and provides global indices of psychological distress. The nine subscales and the General Severity Index (GSI) were used in this study. The GSI communicates in a single score the level or depth of symptomatic distress currently experienced by the patient. To calculate the GSI, the sums for the nine symptom dimensions are added together and then divided by the total number of responses. In this study, comparisons were made with adult psychiatric outpatients and adult non-patients using the gender norms.

The *University of Rhode Island Change Assessment Scale* (URICA) (see Appendix) questionnaire is a self-report measure based on Prochaska and DiClemente's Transtheoretical Model (1984a) that was used to assess the participants' stage, or "readiness" to abstain from drinking and using drugs . This instrument has four subscales:

precontemplation, contemplation, action, and maintenance. The URICA consists of 24-items (six items per subscale). Past research has yielded Coefficient Alphas for internal consistency ranging from .88 to .89 for each stage subscale (DiClemente & Hughes, 1990.) A single Readiness to Change scale can also be computed from this measure (Carbonari, DiClemente & Zweben, 1994).

A 20-item version of the *Processes of Change Questionnaire* (see Appendix) for substance abuse (PCQ-SA) was used to assesses how frequently an individual uses the processes of change identified in the Transtheoretical Model. The original smoking cessation PCQ was developed by Prochaska, et al. (1988). Items are divided into Experiential Processes (e.g. Social Liberation, Self-Reevaluation) and Behavioral Processes (e.g. Helping Relations, Stimulus Control). The internal consistency has been found to be quite good (Alpha Coefficients ranged from .57 to .89 for the ten different processes (O'Connor, Carbonari, & DiClemente, 1994). The shorter version is highly correlated with the longer version and has demonstrated sound psychometric qualities (DiClemente, Carbonari, Addy & Velasquez, 1996).

The *Abstinence Self-Efficacy* (see Appendix) for substance abuse (ASE-SA) scale is a 20-item self-report measure that assesses confidence to abstain and temptation to drink or use drugs under various conditions. The ASE-SA is a brief, easily usable and psychometrically sound measure of an individual's self-efficacy to abstain from drinking and drug use. Reliability and validity estimates for this scale have demonstrated high internal consistency and a substantial negative correlation (-.58) between the temptation and confidence subscales (DiClemente, et al, 1994).

The *Decisional Balance Scale* (see Appendix) for substance abuse measures subjects' pros and cons of drinking and drug use. This measure is helpful in understanding clients' cognitive and motivational aspects of decision making. Decisional Balance considerations (Janis & Mann, 1977) have been important indicators of early Stage status and movement through these early Stages of Change (DiClemente, 1981; DiClemente, Prochaska, Gibertini, 1985; Prochaska & DiClemente, 1992a; Velicer, DiClemente, Rossi & Prochaska, 1990).When applied to alcohol abuse, both the Pros and Cons scales have demonstrated a high level of internal consistency (Alphas = .85 and .88, respectively; King & DiClemente, 1993).

During-Treatment Impact – Results

Transtheoretical Model (TTM)

The Transtheoretical Model which originated approximately fifteen years ago (Prochaska & DiClemente, 1982) posits a mechanism by which people make purposive behavior change. The major dimensions of the model, *Stages of Change, Processes of Change, Self-Efficacy* and *Decisional Balance* have proven to be important constructs in understanding and explaining the process of intentional change of problem behaviors. The model has shown consistency, predictability and explanatory power across a large number of behaviors and populations.

The *Stages of Change* are the temporal, motivational aspects of the change process which provide a rising continuum of a readiness to change. The stages consist of: *Precontemplation* in which individuals are unconvinced that they have a problem or are unwilling to consider change; *Contemplation* in which individuals are actively considering

change; *Preparation* in which individuals have a more proximal goal to change and make commitments and initial plans to change the behavior; *Action* in which individuals change the behavior and adopt strategies to prevent relapse; and *Maintenance* in which the individuals consolidate the change and integrate it into their lifestyle.

The *Processes of Change* are the strategies and behavioral mechanisms that move individuals through these stages. (DiClemente, 1993; Prochaska & DiClemente, 1984, 1992a; Prochaska, DiClemente, & Norcross, 1992). These Processes seem to be differentially important during the various stages (DiClemente & Prochaska, 1982). Research indicates that shifting process activity as individuals move through the stages is related to successful change (Perz, DiClemente, & Carbonari, 1996).

Within the Transtheoretical Model, *Self-Efficacy* is conceptualized as both the confidence to abstain from a behavior and the ability to resist temptation to engage in that behavior across four different situations (negative affect, social pressure, and resisting urges, and physical and other concerns,). The four situations were derived from Marlatt and Gordon (1985) relapse categories. DiClemente & Hughes (1990) assessed patients' abstinence *self-efficacy* in the context of exploring the stages of change in an outpatient alcoholism treatment program. Two hundred and twenty-four clients entering treatment were classified by stage and their temptation to drink and confidence to abstain from drinking were assessed across the different life situations. Stage-based groups differed significantly on both the temptation and the confidence scales with participants closer to action demonstrating lower temptation to drink and higher confidence to abstain.

Decisional balance considerations have been integrated into the Transtheoretical Model from the beginning of the research (DiClemente, 1981). *Decisional Balance* is an index of the individual's assessment of the positives or "pros" and the negatives or "cons" of engaging in a specific behavior (i.e. substance use). The decisional balance construct has been usefully allied with the Transtheoretical Model in studying the pattern of cognitive and motivational shifts across the stages. In studies researchers have found that individuals in the early stages of change for various behaviors rated the pros of the behavior higher than they rated the cons and participants in the later stages of change rated the cons f the behavior higher than pros (King & DiClemente, 1993; Prochaska, et al. 1994).

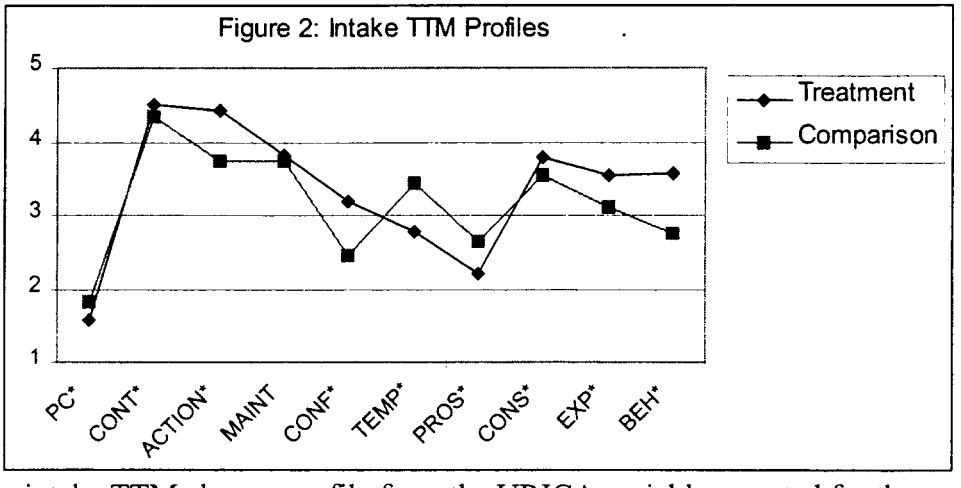
The Transtheoretical Model constructs have been shown to capture an individual's shift in attitude and behavior in both amount and kind as a function of treatment or at least during treatment. It is believed that an effective program would be one that facilitated a client's movement through the Stages of Change. To this end, the program would promote an increase in process activity, an increase of the client's "cons" of the addictive behavior over the "pros" for that behavior, increased confidence and decreased temptation. The Transtheoretical Model measures were administered at intake, 45 days, and 3 months.

TTM Change Profiles

A change profile was created employing each of the subscales from the TTM measures previously discussed (see Appendix). The group mean score was calculated for both the treatment and comparison groups and were then plotted providing a visual picture of each group's current change status. The TTM change profiles were created to examine the group differences at intake and 45 days between the treatment group and the

comparison group. In addition, group profiles were created to examine the during treatment within group change. A profile analysis was conducted to test for any significant change in the level and/or degree of change in the TTM profile between intake and 45 days. Finally, intake TTM change profiles were created for groups based on individual characteristics (i.e. gender) demographic variables (i.e. marital status and type of residence), and historical variables (i.e. prior substance abuse treatment, lifetime incarceration) to test the effect of individual differences on change status at intake.

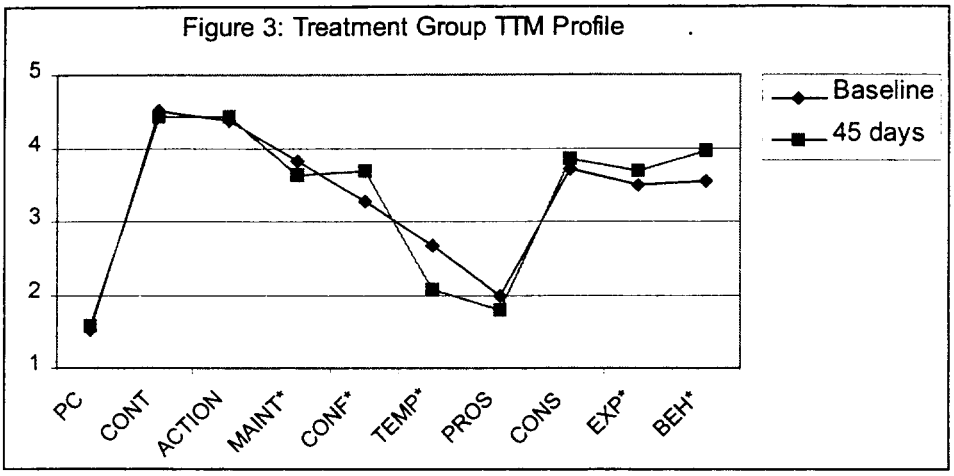
The intake TTM change profile for the treatment group (n=195) was indicative of a group well advanced in the change process. A stage of change profile created for the treatment group by plotting the means of the four subscales of the URICA, mapped on to the DiClemente and Hughes (1990) "participation" profile, indicating that as a group, the treatment clients were motivated to change their drinking and drug use behavior. The other TTM component variables, which have been found to be particularly relevant to the motivational change status were found to support the latter stage affiliation.



The intake TTM change profile from the URICA variables created for the comparison group (n=93), although also reflective of a participation profile, was significantly different on all of the individual subscales except maintenance. Comparisons of the intake TTM change profiles for the treatment group and the comparison group were found to be significantly different on nine of the 10 TTM variables measured. The treatment groups profile was indicative of a group with greater motivation or "readiness to change". Reflective of the level of motivation, the treatment group's *precontemplation* mean score was lower, *contemplation* higher, and *action* higher. Also, the mean *cons* for the addictive behavior were greater and the mean *pros* for the addictive behavior were significantly lower. In addition, the treatment group reported more *process use* (experiential and behavioral) and indicated higher levels of *confidence* to abstain and lower levels of *temptation* to use (See Figure 2).

A profile analysis indicated that the treatment groups' TTM change profile overall was significantly different from intake to 45-days (n=95; p<=.0001) on both level and structure. As can be seen in Figure 3, supporting the profile change was an increase in the *confidence* to abstain (p<=.006), a decrease in the *temptation* to use (p<=.0001), and an increase in the *experiential* (p<=.01) and *behavioral* (p<=.0001) process use. In addition, the mean for the *maintenance* subscale (p<=.04)of the URICA was significantly less at

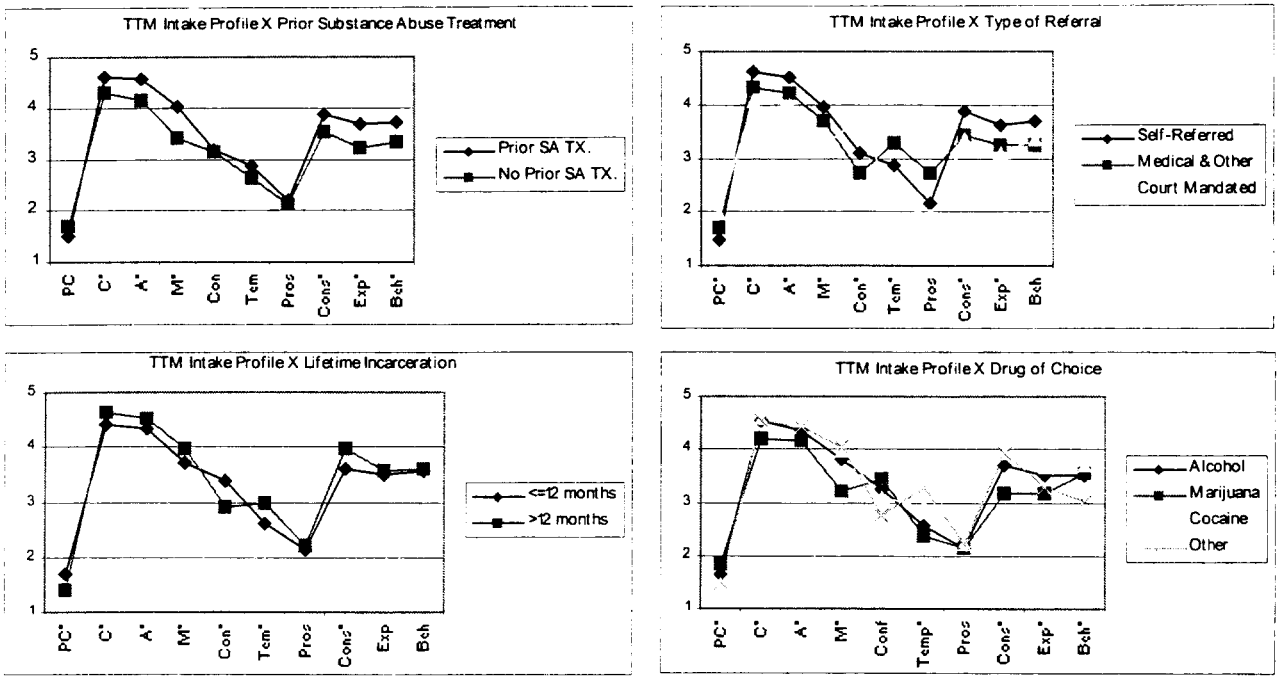
45-days than at intake. We did not find significant change on the other URICA subscales (*precontemplation, contemplation,* and *action*) over the 45-day period nor did we find the decrease in the *pros* of the addictive behavior to be significant. It should be noted that on the intake URICA (Likert 1-5 scale) the *precontemplation* mean score for the



treatment group was quite low (M=1.53) and the *contemplation* and *action* mean scores were quite high (M=4.50; M=4.38 respectively) which meant there was a very restricted range for stronger endorsement or room for positive change.

We had only 22 valid 45-day observations for the GP comparison group. With the limited numbers caution should be taken in interpreting the findings of the profile analysis. The analysis revealed a significant overall change in the group driven by a decrease in *temptation* ($p<=.003$), a decrease in the *pros* ($p<=..04$) of the addictive behavior, and an increase in the *cons* ($p<=.001$) of the behavior. We did not find significant change on any of the four URICA subscales, confidence to abstain, or process use. It should be noted that on the intake URICA (Likert 1-5 scale) the *precontemplation* mean score for the comparison group (M=1.82) although moderately low had ample range on the scale for a significantly lower endorsement. Likewise, the *action* subscale mean for the comparison group (M=3.74) although moderately high had room for positive change. There was also ample range for significantly improved change through increases in confidence and experiential and behavioral process use.

Figure 4: TTM Intake Profile by Individual Characteristics



Also of interest, through the profile analysis of the treatment group (N=179) intake data we found differential TTM profiles across individual characteristics and historical variables. The individual variables with the most significant interaction with the TTM profile were prior substance abuse treatment ($p<.0082$); lifetime incarceration ($p<.0001$); how referred ($p<.0001$); drug of choice ($p<.0003$). The profiles across these client variables were found to be significantly different in terms of level as well as structure (See Figure 4).

For those clients with prior substance abuse treatment, the profile interaction effect was driven by differences in several of the TTM variables. Those clients with prior treatment placed significantly more importance on the cons for the behavior ($p<.032$) than did those clients without prior substance abuse treatment. Their contemplation, action, and maintenance mean scores were all significantly greater (.0001) as was the mean scores for their process use (exp: $p<.0001$; beh: $p<.003$) than for those without prior substance abuse treatment.

Similarly, those with greater than 12 months of lifetime incarceration had a more action oriented profile with significant mean differences on the URICA subscales than those with 12 months or less lifetime incarceration. Those having spent more than 12 months incarcerated had a lower mean score on precontemplation ($p<.0018$), higher mean scores on contemplation ($p<.0037$) and action ($p<.0475$) and lower mean score on maintenance ($p<.0300$). Significantly greater confidence ($p <.004$) and lower temptation ($p <.016$) was also endorsed by those having spent more than 12 months incarcerated in their lifetime.

With "type of referral", it was found that those who were self-referred had a more advanced change profile than those who were court-mandated. All of the TTM subscale

mean scores were found to be significantly different ($p<=.05$) for those self-referred versus those court mandated, with the exception of *behavioral process use*. The self-referred clients had significantly lower *precontemplation* and higher *contemplation, action* and *maintenance* on the URICA than did those mandated to treatment. In addition, the self-referred clients placed more importance on the *cons* of the substance use behavior and less on the *pros* of the behavior and endorsed more *experiential process use* than those who had been court mandated. Interestingly, however, the court mandated clients endorsed more *confidence* and less *temptation* than those who were self-referred.

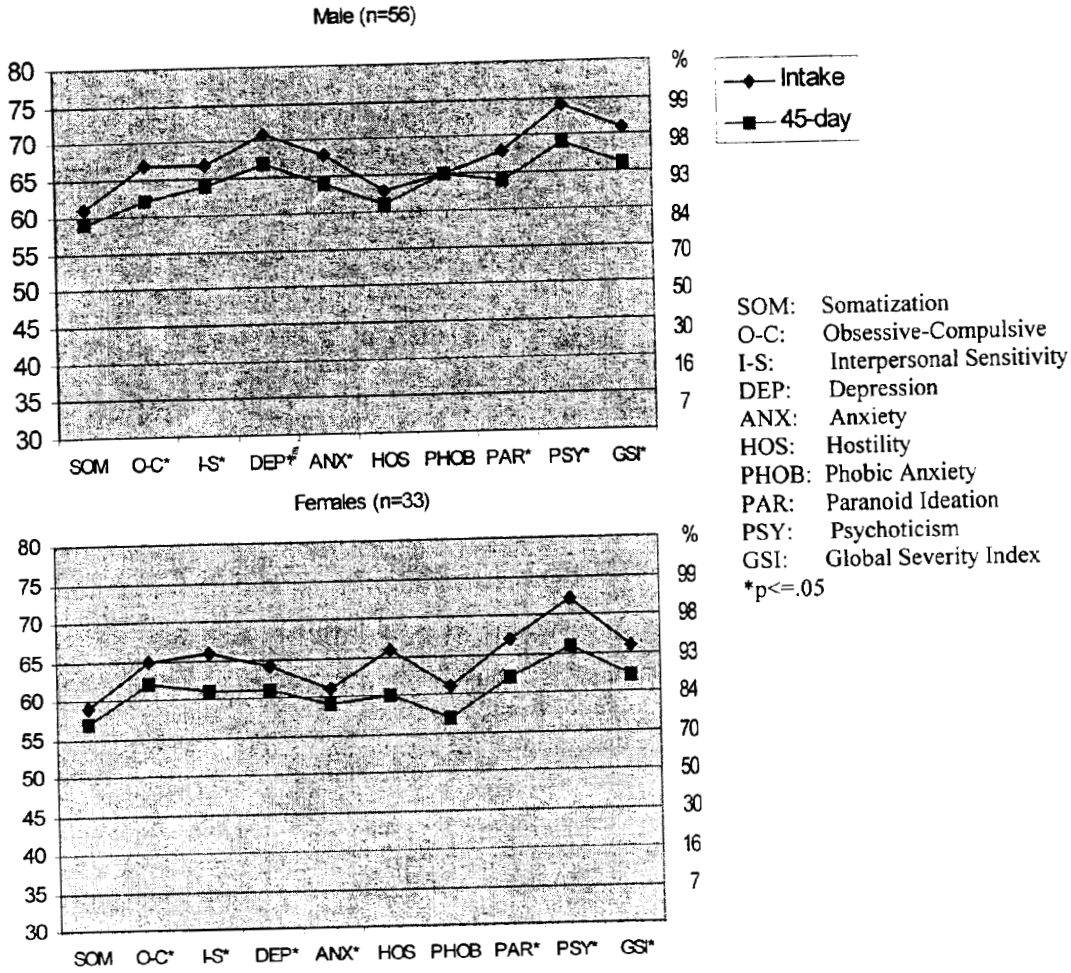
Finally we found that the most motivated to change in relation to their endorsed "drug of choice" were the clients who preferred cocaine and the least motivated were those who preferred marijuana. We found significant differences ($p<=.05$) on the TTM subscale mean scores for these two groups with those endorsing alcohol or other drugs falling in between.

Psychological Distress

The *Brief Symptom Inventory* as stated previously has been used to determine a point prevalence level of psychological distress, as well as, to examine an individual's change in distress level over time. The BSI was administered at all assessment points (intake, 45 day, and 90 day) in order to look at changes in the treatment clients' psychological distress during treatment. The BSI norms are gender specific and therefore the females and males were examined independently (See Figure 5).

On the intake BSI, both the males and females Global Severity Index (GSI) score, which measures the overall level of symptomatic distress, was significantly above the mean for the non-patient norms ($p<.0001$). The females scored above the 93rd percentile and the males scored above the 98th percentile for the norm group. The males high distress level was primarily driven by the subscales of depression ($t=71$), anxiety ($t=68$), and psychoticism ($t=74$), while the females most strongly endorsed hostlity ($t=66$), paranoid ideation ($t=67$), and psychoticism ($t=72$).

During treatment, between the intake assessment and the 45 day assessment, both the females ($p<.0001$) and the males ($p<=.05$) had a significant drop on the GSI. Most of the symptom dimensions of the BSI for both the females and the males were found to have significantly decreased levels of distress during treatment. The only BSI symptom dimensions for the females that were not found to have significantly decreased levels of distress were anxiety and phobic anxiety. For the males, all of the BSI symptom dimensions were found to have significantly dropped during treatment except for somatization, hostility, and phobic anxiety.



Outcome Evaluation

Participant Group for A Potential Future Outcome Evaluation:

Preparation for a future Outcome Evaluation took the form of building relationships with the administration at the jail and the staff of the New Choices program. Subject recruitment did not take place formally with the administration of an informed consent for post-treatment follow-up since there were no plans for an outcome evaluation to be carried out in the reasonable future. Clients who were asked informally if they would be willing to participate in a follow-up study responded positively.

Discussion

It should be noted at the onset that the New Choices substance abuse treatment program was in its first 18 months of operation when the evaluation data was collected. In addition, substance abuse treatment in large urban jails is still quite unique and blueprints for success are not currently available. The most challenging obstacles for the NC program in its early operation have been: the recruitment of a sufficient number of

qualified staff; the occupancy requirements of the Harris County jail, the early reluctance of the courts to mandate clients to treatment.

The delay in hiring qualified staff affected all aspects of the treatment program including: recruitment procedures; treatment delivery; and aftercare negotiating. Being under-staffed meant also there were limitations in systemic programming areas that affected staff communication and the ability to hold regular meetings, as well as, program development and record keeping. The unit is now fully staffed and the program is in the process of incorporating individual counseling and staff facilitated small client groups. In addition, new discharge procedures have been developed and contractual arrangements have been made for aftercare client placement.

The Harris County jail requirement that the treatment program utilize the beds afforded it, necessitated the easing of the 6-month minimum term requirement. Continuity of treatment was difficult to accomplish given the large variability in the term of treatment of the clients. However, the number of full term (minimum 180 days) clients that are currently (as of April 1999) enrolled in the program has increased 500% since July 1998. Since the staff to client ratio increased, more energy has been directed at the recruitment of long-term clients through more efficient internal jail screening methods and continued development of relationships with the courts. Given the cooperation of the courts and the new strategies for enlistment of long-term inmates, an 80% completion rate based on the full term minimum is certainly attainable in the near future.

The clients when asked about weaknesses of the program and additions to the program that they would like to see responded to the lack of staff and issues plausibly related to the staff to client ratio such as, dependability of staff and more individual counseling. One-third of the clients, however, saw the attitude of the corrections staff as problematic. One of the most difficult goals to accomplish in providing treatment in criminal justice settings is to involve the security staff in the treatment process or community while maintaining the corrections goal of security and safety. It is difficult for corrections staff to play a dual role and requires a large amount of training, specific guidelines provided for clear direction, and constant open communication between the treatment staff and the corrections staff. The New Choices staff has ongoing cross training and is continually developing the staff protocol and guidelines. Formal communication has been lacking, however, in that staff meetings, a primary vehicle for inter-staff communication, have been too infrequent to be productive. Regular and frequent staff meetings are required to ensure a unified treatment effort.

The process evaluation data indicates that in spite of the start-up difficulties, the quality of the programming is quite good. The clients are for the most part satisfied with the treatment and the staff of the New Choices program. The clients endorsed as most helpful the group counseling and felt that the staff was knowledgeable, honest and sincere, and along with the other clients on the unit, were helpful in the clients' progression in the recovery process and in making changes in their life. The clients' responses did indicate that they felt there was room for improvement in the staffs' dependability and in the program's organization and clarity. The latter are understandable given the small staff to client ratio during the evaluation period. In addition, the clients believed that their therapeutic relationship with the staff was positive. The clients felt they had effectively bonded with the staff and that there was strong agreement on both their goals and tasks of treatment.

What may be most revealing is the strong endorsement of the COPES subscales, by both the clients and the staff, especially those of the Treatment Program Dimension. These positive endorsements were made despite the perceived high level of staff control seen by both clients and staff. The evidence of the treatment program profile generated by the client and the staff responses on the COPES is that given the inherent restrictive nature of a treatment program in a jail setting, the clients and staff still strongly endorsed all of the program descriptors. Indications are that clients, in spite of their incarceration feel that they are encouraged to: make their own decisions and to take responsibility for themselves (Autonomy); to be concerned with their problems and to seek understanding of those problems (Personal Problem Orientation); and, even to express their anger and aggression. This may be evidence that the clients assess that the "New Choices" treatment program is meeting their treatment needs (on a personal and practical level). In addition, the high endorsement of the Treatment Program Dimension for the staff indicates they also feel the program is meeting the treatment needs of the client.

The Transtheoretical Model change profiles indicated that the treatment group overall was more motivated for changing drinking and drug use than the comparison group of substance abusers from the general population. Indeed, for the treatment group, all of the TTM variables, which combine to form the change profile, were indicative of a group in the action stage of change. It could be argued that strong external factors, such as the experience of being incarcerated, could strongly influence an individual's motivation to change and rush one to action. However, if a URICA stage profile were inflated by extreme outside pressures, we would expect other indications of stage status such as process use and decisional balance to be reflective of an individual in the earlier stages of change. For example another study where strong "dramatic relief" may have "rushed" the respondents to action was a smoking cessation study in a sample of pregnant women. The pregnancy motivated 85% of the women smokers into action for quitting smoking, but on closer examination, these pregnant quitters process use was more indicative of women in pre- contemplation or contemplation (Stotts, DiClemente, Carbonari, & Mullen, 1996). This was not the case in the profiles examined for the jail participants. Although there was strong external motivation that could act to rush an individual into action, we did not find the other TTM variables to be out of balance with their stage status. The comparison group on the other hand, although less dramatic, also had a "participation" profile, from the URICA variables, at the intake assessment. For the comparison group, however, the confidence was low, temptation was high, and the process use was below the mean, all of which may indicate an earlier stage affiliation.

When we examined change within groups from intake to 45-days, the treatment group even with the advanced change profile at the intake assessment, exhibited positive movement in the change process during-treatment. Not surprisingly, we did not see significant change on three of the four URICA subscales (*precontemplation, contemplation* or *action*) since the intake scores were too extreme to allow for much movement. We did see a significant drop in the *Maintenance* mean score, which is common in the latter stages and may reflect a decreased struggle on the part of the client. Several of the other TTM indicators of positive change in a profile status were also significantly different from intake to 45-days. The treatment group had a significant increase in *confidence*, a significant decrease in *temptation*, and a significant increase in *process use*. The *pros* and *cons* of the behavior did not change significantly during

treatment but as with the URICA subscales, these constructs were strongly endorsed at intake.

For the comparison group significant change also occurred for the overall profile and the change was driven by a significant decrease in *temptation* and the *cons* of the behavior, and a significant increase in the *pros* of the behavior. In the case of the comparison group it is plausible that incarceration would naturally affect one's decisional balance as one has time to reflect on what is important to him/her. In addition it is believed that being in a secure environment may serve to reduce one's sense of temptation to use drugs and alcohol. None of the URICA subscale mean scores changed significantly for the comparison group from intake to 45-days and they remained significantly lower than the treatment groups' mean URICA subscale scores.

The change during treatment of the TTM treatment group profiles are believed to be indicative of a positive treatment experience, but it is possible that there are factors indigenous to the setting that may cause distortions in the measurement of an individuals TTM scores. Being incarcerated in a safe and controlled environment may influence one's sense of confidence to abstain and temptation to use. Being out of harm's way and sober for a significant period of time may act to inflate one's confidence and minimize one's temptation. Also strong endorsement of some of the behavioral processes may be affected by the therapeutic, secure environment. Indeed "...staying away from places generally associate with my alcohol or drug use" is temporarily forced on all inmates. The use of contingency management, helping relationships, and stimulus control processes is likely to be facilitated by the controlled environment, as well.

In addition, it should be noted that there was a significant limitation in the during-treatment outcome evaluation involving the recruitment of an adequate comparison group. The proposed comparison recruitment was to come from a waiting list generated for the treatment program. The waiting list never materialized and an alternate plan was initiated in which inmates who entered the jail through the detoxification unit were screened for substance abuse and asked to participate. This alternate group, although similar on many characteristics in addition to being incarcerated substance abusers (gender, education level, residence and employment), had some noteworthy dissimilarity to the treatment group. The comparison group from the general population had a more severe criminal history overall (lifetime incarcerations, convictions, drug arrests, and more DWIs) and preferred alcohol and heroin, whereas the treatment group preferred crack. The comparison group was also lower on motivation to change their substance use. Given that the New Choices program recruited volunteers from the jail inmates the discrepancy in motivation is to be expected. It cannot be determined to what extent the differential change in during-treatment profiles was a result of the treatment program. The different level of motivation for each of the groups and/or of the severity of the criminal and substance use histories of the groups could be responsible for a proportion of the differential change.

Finally, the BSI indicated that the treatment clients during treatment experienced a significant drop in their overall psychological distress as indicated by the General Severity Index. Although as a causal path can not be established, the decreased distress level reported by the clients during-treatment is a positive intermediary outcome of their time in treatment.

Conclusion

HCSD and the New Choices staff have successfully implemented a substance abuse treatment program in the Harris County Central Jail. The New Choices substance abuse program in its first 18 months of operation has made great strides toward accomplishing all of its proposed programming goals. As indicated by the evaluation data, New Choices is a developing program that is currently positively affecting, through its substance abuse treatment, the Harris County jail inmate substance abuser and has set the stage for increased effectiveness and future success. Armed with a clearer understanding of the challenges of providing substance abuse treatment in a large urban jail, that has come through trial and error, the dedicated and aggressive Director and Program Supervisors and their staff plan to continue to implement change and develop an even more effective program. The program has overcome formidable obstacles in the areas of staffing and recruitment and is now poised to address program limitations.

Now fully staffed and with effective recruitment procedures and court participation that yield sufficient long term clients, the concentration of the staff is focused on programmatic issues such as:

- restricting admission to offenders with a minimum of 6 months in order to affect a completion rate of no less than 80% of enrollment;
- expanding treatment to include individual counseling on a minimum of 1 session per month for each client;
- expanding treatment to include staff facilitated small groups on a regular basis;
- increasing the frequency of the inter-staff (treatment and corrections) meetings;
- development of structured aftercare for all program completers.

Finally, New Choices is a promising program. Both the program and the field of substance abuse treatment in jails would benefit substantially from a long-term outcome study. This study was limited in producing strong during-treatment impact data by a small number of comparison group participants completing the 45-day assessment, significant group differences on criminal history and drug of choice, and the brief time between assessments. The current recruitment efforts of the program should result in a waiting list for the program which would provide a comparison group of non-treated clients with similar histories and longer terms of stay.

Acknowledgments

The Evaluators of Change Assessment Research at the University of Houston want to thank the Harris County Sheriff's Department, the Medical Services Bureau/HIV Project, Raul Carvahal, Director, Duane Boyd, Supervisor, Michelle Bovis, Supervisor, Blanca Lopez, Clerk, all of the New Choices treatment and corrections staff, and the program clients for all of their support and cooperation in making this evaluation effort possible. The evaluators are dedicated to ensuring that their efforts will serve to benefit the program, NIJ, and other treatment providers.

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APPENDIX

TREATMENT GROUP: INTAKE / 45-DAYS

Variable	N	Intake Mean	Intake Std. Dev.	45-day Mean	45-day Std. Dev.	t / Sig.
URICA						
Precontemplation	94	1.55	.6440	1.57	.6619	.186 / .853
Contemplation	94	4.49	.5559	4.45	.6275	-.744 / .459
Action	94	4.40	.6403	4.44	.6081	.628 / .532
Maintenance	94	3.80	.7647	3.65	.7616	-2.096 / .039
Abstinence Self-efficacy						
Confidence	91	3.24	1.0920	3.64	1.0637	3.061/ .003
Temptation	91	2.69	1.0122	2.08	.8779	- 6.497/ .000
Decisional Balance						
Pros	88	2.03	.9795	1.82	.9333	-1.888/ .062
Cons	88	3.69	.9932	3.86	1.0925	1.750/ .084
Processes of Change						
Experiential Processes	93	3.51	.8044	3.70	.6459	2.633/ .010
Behvaioral Processes	93	3.55	.8597	3.95	.6798	5.083/ .000

COMPARISON GROUP: INTAKE / 45-DAYS

Variable	N	Intake Mean	Intake Std. Dev.	45-day Mean	45-day Std. Dev.	t / Sig.
URICA						
Precontemplation	24	1.78	.6663	1.65	.5961	-.871/ .392
Contemplation	24	4.56	.4279	4.37	.8718	-1.105/ .281
Action	24	3.87	.8969	3.76	1.010	-.476/ .638
Maintenance	24	3.75	.5740	3.73	.7891	-.076/ .940
Abstinence Self-efficacy						
Confidence	28	2.79	.9860	2.83	1.260	.154 / .880
Temptation	28	3.35	.9375	2.87	1.096	-3.104/ .004
Decisional Balance						
Pros	27	2.40	.8656	2.11	.8313	-1.838/ .078
Cons	27	3.59	.7032	4.17	.7388	3.282/ .003
Processes of Change						
Experiential Processes	28	3.30	.6669	3.38	.6958	.606/ .550
Behvaioral Processes	28	2.87	.8584	3.24	.9515	1.949/ .062

NOTE: The statistics quoted in the above tables were calculated using the individual TTM measures. Therefore, any study participant that had complete data at both time points for a particular measure was included. This may differ slightly from the data as reported in the text because the profile analysis described in the report included only those participants who had complete data on **all** of the TTM measures.

THE TRANSTHEORETICAL MODEL

Stages of Change - the temporal, motivational, and stability aspects of change

* ***precontemplation***	person is not considering or does not want to change a particular behavior
* ***contemplation***	person is certainly thinking about changing a behavior
* ***preparation***	person is seriously considering and has made a commitment to change a particular behavior
* ***action***	person is actively doing things to change or modify behavior
* ***maintenance***	person continues to modify behavior until it becomes permanent

Processes of Change - the mechanisms of change; coping activities

Cognitive/Experiential

consciousness-raising	Increasing awareness of a problem and its potential solutions
dramatic relief	Intense emotional reactions to problem-related events and information
self-reevaluation	Changing appraisals of self and problem
social reevaluation	Changing appraisals of problem's impact on others
social liberation	Creating new alternatives in the environment

Behavioral

self-liberation	Increasing commitment and creating new alternatives for self
counterconditioning	Changing one's reaction to stimuli
stimulus control	Changing environments to minimize occurrence of stimuli
contingency management	Changing reinforcers and contingencies for a behavior
helping relationship	Positive, supportive relationship that facilitates change

Abstinence Self-Efficacy

Confidence – involves the client's confidence in his or her ability to abstain from drinking or using drugs in various high-risk situations

Temptation – involves the client's level of temptation to drink or use drugs in various high-risk situations

Decisional Balance – the "*Pros*" and *Cons*" of the addictive behavior

Stages of Change

Based upon Prochaska and DiClemente's Transtheoretical Model (1984), the URICA was designed to assess an individual's stage of readiness to change. The subscales of the University of Rhode Island Change Assessment Scale (URICA) are Precontemplation, Contemplation, Action, and Maintenance. Originally, the URICA was comprised of 32 items, which posed questions regarding the changing of a generic "problem" (McConnaughy, Prochaska, & Velicer, 1983). In 1996,Carbonari, DiClemente, Addy, and Pollak created two 12-item "short forms" of the URICA specific to alcohol abuse, which can also be combined into one 24-item measure. The 24-item measure has demonstrated a Cronbach's alpha of .89. The following 24-item measure has been modified for use in treatment programs in criminal justice settings to include alcohol and drug use.

University of Rhode Island Change Assessment Scale (URICA) - *Alcohol and Drug Use*
INSTRUCTIONS: Please indicate how strongly you agree or disagree with each of the following statements. *(All items are answered on the following scale : strongly disagree, disagree, undecided, agree, strongly agree)*

Precontemplation :
Trying to change is pretty much a waste of time for me because the problem doesn't have to do with me.
I guess I have faults, but there's nothing that I really need to change.
I may be part of the problem, but I don't really think so.
I'm not the problem one. It doesn't make much sense for me to be here.
All this talk about changing is boring. Why can't people just forget about their problems?
I have worries but so does the next guy. Why spend time thinking about them?

Contemplation :
I have a substance use problem and I really think I should work on it.
I'm hoping that I will be able to understand myself better.
Maybe the treatment program will help me.
I've been thinking that I might want to change something about myself.
I wish I had more ideas on how to solve my substance use problem
I hope that someone will have some good advice for me.

Action :
I am really working hard to change.
Anyone can talk about changing; I'm actually doing something about it.
I am actively working on my substance use problem.
I am finally doing some work on my substance use problem.
At times my substance use problem is difficult, but I'm working on it.
Even though I'm not always successful in changing, I am at least working on my substance use problem.

Maintenance :
I'm struggling to prevent myself from having a relapse of my substance use problem.
I thought once I had resolved the substance use problem I would be free of it, but sometimes I still find myself struggling with it.
It is frustrating, but I feel I might be having a recurrence of a substance use problem I thought I had resolved.
After all I have done to try and change my substance use problem, every now and again it comes back to haunt me.
I may need some encouragement right now to help me maintain the changes I've already made.
I'm here to prevent myself from having a relapse of my substance use problem.

Processes of Change

The Processes of Change Questionnaire was developed by Prochaska, Velicer, DiClemente and Fava (1988) originally to measure the processes of change used in smoking cessation. However, a 65-item alcohol-specific PCQ was developed for Project MATCH which focused upon 13 processes; since that time, three of these processes have been eliminated, as they were not supported by research (DiClemente, Carbonari, Addy, & Velasquez, 1996). The remaining ten processes can be divided into two major components : cognitive/experiential and behavioral. In 1996, DiClemente, Carbonari, Addy, and Velasquez empirically examined the 65-item PCQ that was used in Project MATCH. As a result, two 20-item alternate forms were created (based upon 10 processes) which were designed to measure only the two larger categories (cognitive/experiential versus behavioral processes). By combining the two alternate forms into one 40-item measure, it is possible to measure each process individually. The 20-item alternate versions have demonstrated good internal validity with Cronbach's alphas of .82 and .83 for the Cognitive/Experiential scale and .86 and .81 for the Behavioral scale (DiClemente, Carbonari, Addy, & Velasquez, 1996). The following 20-item measure has been modified for use in treatment programs in criminal justice settings to include alcohol and drug use.

PROCESSES OF CHANGE QUESTIONNAIRE - *Alcohol and Drug Use*

INSTRUCTIONS: Choose the response that best describes how often you make use of the particular situation or thought to help you **not drink alcohol or use drugs.** *(All items are answered using the following scale : never, seldom, occasionally, frequently, or repeatedly.)*

Experiential Processes :

I get upset when I think about illnesses caused by alcohol or drug use.
I am considering the idea that people around me would be better off without my problem alcohol or drug use.
I seek out groups of people who can increase my awareness about the problems of drinking or drug use.
I find society changing in ways that make it easier for me to overcome my alcohol or drug problem.
I consider that feeling good about myself includes changing my drinking or drug use behavior.
I look for information related to problem alcohol or drug use.
Stories about alcohol or drugs and their effects upset me.
I stop and think that my alcohol or drug use is causing problems for other people.
I think about the type of person I will be if I control my drinking or drug use.
I see advertisements on television about how society is trying to help people not use alcohol or drugs.

Behavioral Processes :

I do something nice for myself for making efforts to change.
I have someone to talk with who understands my problem with alcohol or drugs.
I try to think about other things when I begin to think about using alcohol or drugs.
I use reminders to help me not to use alcohol or drugs.
I have someone whom I can count on to help me when I'm having problems with alcohol or drug use.
I tell myself that if I try hard enough I can keep from using alcohol or drugs.
I stay away from places generally associated with my alcohol or drug use.
I calm myself when I get the urge to drink or use drugs.
I spend time with people who reward me for not using alcohol or drugs.
I make commitments to myself not to use alcohol or drugs.

Abstinence Self-Efficacy

The original Alcohol Abstinence Self-Efficacy Scale measure was designed by DiClemente, Gordon, and Gibertini (1983) to address an individual's *confidence and temptation* to refrain from drinking in various high-risk situations. In 1994, nine items were dropped from the measure and the resulting 40-item measure (20 items for confidence, 20 for temptation) has remained in the literature unrevised since that time. The AASE has demonstrated good *construct validity and reliability* with Cronbach's alphas ranging from .82 to .92 for the subscales (DiClemente, Carbonari, Montgomery, & Hughes, 1994). The following 20-item measure has been modified for use in treatment programs in criminal justice settings to include alcohol and drug use.

ABSTINENCE SELF-EFFICACY SCALE - *Alcohol and Drug Use*

INSTRUCTIONS:

Confidence: At the present time, how confident are you that you would not drink or use drugs in each of these situations?

Temptation: At the present time, how tempted would you be to drink or use drugs in each of these situations?

(All items were answered on the following scale : not at all, not very, moderately, very, or extremely)

Negative affect :

When I am feeling angry inside.
When I sense everything is going wrong for me.
When I am feeling depressed.
When I feel like blowing up because of frustration.
When I am very worried.

Social/Positive :

When I see others drinking or using drugs at a bar or a party.
When I am exited or celebrating with others.
When I am on vacation and want to relax.
When people I used to drink or use drugs with encourage me to drink or use drugs.
When I am being offered a drink or a drug in a social situation.

Physical and other concerns :

When I have a headache.
When I am physically tired.
When I am concerned about someone.
When I am experiencing physical pain or injury.
When I dream about taking a drink or using a drug.

Withdrawal and urges :

When I am in agony because of stopping or withdrawing from alcohol or drug use.
When I have the urge just to try one drink or use a drug to see what happens.
When I am feeling a physical need or craving for alcohol or drugs.
When I want to test my willpower over drinking or using drugs.
When I experience an urge or impulse to take a drink or a drug that catches me unprepared.

Decisional Balance

The Alcohol Decisional Balance Scale was developed in 1993 by King and DiClemente in order to assess the decision-making process in terms of the *positive and negative aspects of alcohol use*. Originally with 42-items, this measure was shortened to 20 items (10 for the Pros subscale and 10 for the Cons) as those items were deemed to be the strongest. The AASE has demonstrated internal consistency ranging from .85 for the Pros subscale and .88 for the Cons (King & DiClemente, 1993). The following 20-item measure has been modified for use in treatment programs in criminal justice settings to include alcohol and drug use.

DECISIONAL BALANCE SCALE-*Alcohol and Drug Use*

INSTRUCTIONS:
The following statements may play a part in your making a decision about drinking alcohol or using drugs. We would like to know *how important* each statement is to you at the present time in relation to your making a decision about drinking or using drugs. *(All items are answered using the following scale : Not; Slightly;- Moderately;- Very; Extremely)*

Pros
I like myself better when I am drinking or using drugs.
Drinking or using drugs helps me deal with problems.
Drinking or using drugs helps me to have fun and socialize.
Drinking or using drugs makes me more of a fun person.
Drinking or using drugs helps me to loosen up and express myself.
Not drinking or using drugs at a social gathering would make me feel too different.
Drinking or drug use helps give me energy and keep me going.
I am more sure of myself when I am drinking or using drugs.
Without alcohol or drugs life would be boring and dull.
People seem to like me better when I'm drinking or using drugs.

Cons
Some people try to avoid me when I drink or use drugs.
If I continue to drink or use drugs some people will think I lack the character to quit.
Having to lie to others about my drinking or drug use bothers me.
My drinking or drug use causes problems with others.
Drinking or using drugs interferes with my functioning at home and/or at work.
Some people close to me are disappointed in me when I drink or use drugs.
I seem to get myself into trouble when drinking or using drugs.
I could accidentally hurt someone when I drink or use drugs.
I lose the trust and respect of my co-workers and/or spouse when I drink or use drugs.
I am setting a bad example for others when I drink or use drugs.

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