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Date: 5/17/00

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Residential Substance Abuse Treatment (RSAT) in Jail: Comparison of Six Sites in Virginia

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(Revised)

Table of Contents

Tables

Tables

Virginia Residential Substance Abuse Treatment Program (VARSAT)

Executive Summary

In 1994, the Crime Control Act authorized Residential Substance Abuse Treatment (RSAT) block grants to expand the availability of substance abuse therapeutic community programs in prison. The block grants were premised on using the findings from recent research on effective programs to provide substance abuse programs that are 6 to 12 months in duration, that have a separate living facility, and that provide treatment towards the end of the inmate's stay in prison/jail (Wexler & Williams, 1986; Lipton, 1995). Drug testing was also mandated requirement for jurisdictions to receive other federal funds. Although the federal funds could not be used to support continuing treatment services in the community, the RSAT program guidelines encouraged jurisdictions to provide aftercare in the community as a means of continuing client involvement in treatment and in order to maintain the results achieved during prison-based treatment (Taxman, 1998; Lipton, 1995; Wexler, Falkin, & Lipton, 1999). Jurisdictions were also encouraged to use graduated sanctions to address problems of non-compliance in substance abuse treatment services.

The State of Virginia elected to use their RSAT block grant funds to expand or to establish therapeutic communities within the jail or regional jail environment because the state already had one of the largest therapeutic community prisons (Indian Creek) in the world. Since many of the local and regional jails did not offer comprehensive treatment services to offenders, the funds were used to provide for more extensive therapeutic services while the offenders were detained in the jail. The state Department of Criminal Justice and Department of Mental Health, Mental Retardation and Substance Abuse selected six jails to expand treatment services with the following specific goals: 1) to establish a therapeutic community setting with inmates involved in the program for six to 12 months of care provided in a living area set apart from the general population; 2) to offer services that focus on substance abuse problems and on the issues that affect the risk of relapse, particularly services that develop the inmates cognitive, behavioral, social, vocational, and other skills; 3) to drug test a minimum of 5 percent of the participants; and, 4) to demonstrate the ability to provide a plan of aftercare treatment services specific to the offenders needs. Virginia provided the first national test of applying the RSAT conditions within the context of a jail environment.

This process evaluation examined the implementation of the RSAT program in each site by observing the therapeutic community program in the jail, conducting structured interviews with treatment, correctional, and administrative staff members, and tracking client progress through both the treatment and criminal justice systems. This evaluation provides the opportunity to understand how the jail based-RSAT-TC was implemented in "jail" settings. The evaluation features observations of the treatment programs in the jail setting to understand the nature of the substance abuse services offered and how the programs address the inmates' cognitive, behavioral, social, and vocational skill development.

A. Overview of the Treatment Program

The state of Virginia has aggressively adopted cognitive behavioral treatment for their offender populations based on recent research demonstrating the efficacy of these intervention strategies (Andrews and Bonta, 1996; Gendreau, 1996; MacKenzie, 1997; Gottfredson, 1997). Training in cognitive behavioral models has been on going for the last several years as the state has sought to improve the quality of treatment services provided to all offender populations. The RSAT-TC model was adopted with the intent of using a modified therapeutic community model that also emphasized these cognitive behavioral strategies in order to teach offenders new skills to recognize substance abuse patterns, develop corrective actions, and maintain abstinence.

The state implemented the RSAT program through a series of collaborative interagency efforts involving state agencies (Department of Criminal Justice and Department of Mental Health, Mental Retardation, and Substance Abuse Services) and local Community Service Board (the quasi-governmental agencies). DMHMRSAS is responsible for dispensing the grants and overseeing the RSAT sites. Representatives from the agency meet quarterly with the site directors of the six RSAT programs. These meetings facilitate the sharing of information about the progress in the RSAT programs and to reinforce evaluation efforts.

Each of the six RSAT programs implemented the treatment services to accommodate the socio-political environment of the local detention center and to adapt to state prison policies regarding transfers of inmates to the institution. The program was implemented to complement the existing jail system and to expand treatment services. In many instances the RSAT funds were used to expand existing treatment services offered in local jails where the community service board had offered counseling or outpatient type services for several years. In other jails, the program was new or newly expanded to a new population, such as women or the dually diagnosed.

Findings on Program Structure, Services, and Implementation. The RSAT model encompasses the need to develop a seamless system of care between the jail and the community treatment programs. The underlying premise is that the treatment provider, jail, and probation/parole agencies would work together to develop a coordinated service delivery system to implement the RSAT model. RSAT, although appearing simplistic in concept, organizationally requires alignment in both policy and operational practice to implement lengthy drug treatment services in jail with continued involvement in treatment after release from the facility. The integration of drug testing and sanctions also requires the jail and probation/parole services to be partners in the treatment services. In Virginia, the local community service boards, which provide drug treatment services in the community, were responsible for jail-based services.

Separate Facility/Housing Area. Each of the six RSAT-TC programs was successful in securing a separate living area apart from the general population, however, several of these separate facilities also housed non-program inmates. This mixing of program and non-program inmates appeared to affect the ability of the offenders in treatment to form a community. In any case, the use of these separate living areas resulted in the programs being relatively small due to the size of the cell unit (usually around 15 inmates). In a jail environment, however, even the

use of a fully separate living area does not preclude offenders from being exposed to the normal operations of the jail. Offenders are exposed to noises from the jail (e.g. through the intercom, surrounding cells, or correctional staff) and interruption with normal operations (e.g. delivery of clean clothes and mail, etc.) that may interfere with group sessions or the therapeutic milieu.

Staffing. Most of the RSAT-TC programs had small staffs usually with 2 to 2.5 staff, including the program manager. While small in number, these staffing levels may be seen as comparatively large relative to the small number of offenders being served by these programs. For example, three full time clinical staff and a part time psychiatrist staffed the smallest program, serving a total of 8 male and female clients. For the most part, the staff members have at least a bachelor's degree, with some training in cognitive behavioral skills. About one third of the staff had had personal experiences with substance abuse. Clinical staff members are also often responsible for program management, with one of the positions serving both as a clinician and a manager. Most of the programs were designed to have one staff position designated for case management and discharge planning services. In many instances however, these positions were not filled or the jurisdiction did not receive approval from the local legislative body to fill the position. Staff tended to be contractual employees from the community service board, working in the RSAT program on a part-time status to reduce personnel costs. The reliance on contractual staff affects the program in a number of areas. Specific difficulties presented by the reliance on contractual staff include high staff turnover, restricted involvement with program issues (because the program does not compensate the employee for a number of program development issues), and limited staff involvement in developing formalized relationship with other agencies (e.g. probation and parole, local treatment providers, vocational education, etc.) to foster interagency approaches to treatment for the offender.

Components of the Treatment Program. For the most part, the programs can be most accurately classified as "modified" therapeutic communities, with an emphasis on developing the cognitive and social skills of the offender as a tool to obtain and retain recovery. The programs used the basic framework of the therapeutic community—housing units segregated from the general population—to create a community of peers focused on clients learning how to manage their addiction and to develop prosocial values. Other aspects of the TC model were less well developed, with the apparent emphasis placed on an implicit social learning model of behavior change, rather than one of social control or positive peer association. The observations revealed that the program emphasis (measuring the program's primary focus in terms of the etiology of drug addiction and treatment approach) most commonly rated as "highly used" were "self-work" ("the client must be vigilant and work on him/herself every moment of every day"), "spirituality" ("reliance on a higher power will help control the addiction"), and "change" ("the client should focus on contemplating what his/her life would be like if s/he made changes to his/her lifestyle").

The most widely used treatment topics were cognitive and emotional skills (these tended not to be delivered via pre-packaged or structured skills curricula), while the most widely relied upon treatment activities were peer encounter and awareness building activities. The most widely used treatment styles were formal (scheduled, planned meetings) and interactive-types of treatment approach. Finally, the most widely used view of the residential community (i.e. how does the program make use of the group itself) was collective formats (using group formats as a basis for treatment activities), "Open Community" (use of open, free communication) and participants (allowing group members to participate in, or direct treatment activities).

Table A summarizes the results from the different sites. The observations revealed that the treatment intervention focused more on internalizing the change process at the individual level; little emphasis was placed on building a community or support group or emphasis on prosocial values. Overall, the treatment components were designed to focus on substance abuse problems of the inmates, although many of the issues related to contemplation of changing behavior and motivation to retain a substance free lifestyle were not given sufficient attention. In terms of the services offered by these programs, many did in fact appear to be focusing on several aspects of cognitive behavioral treatments and substance abuse issues, sometimes to the exclusion of other treatment approaches and topics. While emotional and cognitive skill development were emphasized at many sites (typically not via structured skills curricula), often the programs failed to consistently address issues around the development of an effective sense of community and a set of prosocial values. Similarly, factors typically related to the effective functioning of TC groups (e.g., issues such as psychological and physical safety in the program) were often used less frequently.

Quantity of Services. The observed programs had fairly extensive schedules intended to provide relatively intensive treatment experiences, offering several treatment activities per day. These activities included community groups, and therapeutic and educational activities related to drug addiction and recovery. Clinical staff was generally available during the weekday hours and ran approximately two groups a day. Many were on-site at the jail for several hours to meet with the inmates and provide consultations. However, due commonly to perceived under-staffing issues, programs did not commonly offer structured evening or weekend activities. These schedules allowed for some community-run activities during off-hours. However, the observations revealed that the community-run activities tended to be less structured; many of the communities were not well developed and did not appear able to adequately or consistently run the intended community sessions. More clinical time would have enhanced the community-run activities by providing more structure and discipline to address community organization and prosocial value issues.

Drug Testing. The individual treatment programs did not drug test the offenders because each jail had its own drug testing policy, as such testing was conducted by the jail, but frequently the program staff reported having no access to the results. The amount of drug testing varied by program depending on the jail's drug testing practices, ranging from 12 percent in one site to 92 percent in another site. It appears that each jail targeted the offenders in the drug treatment program to be drug tested. However, drug testing was solely administered by the jail while the treatment programs were not involved in the drug testing practice. Very few of the offenders tested positive during their involvement in the RSAT program.

Aftercare or Continuing Care. By design, a case manager position was included in each RSAT program. However, very few of the programs actually had a full-time case manager. Many of the programs relied on clinical staff or the jail staff for case management. Despite few formal linkages to community treatment (e.g. designated treatment slots), the treatment staff did however provide the offender, upon release, with a referral to the appropriate community service board in the area where the offender resided. Offenders referred to the local CSB typically had to have an additional CSB assessment before being placed into a community treatment program. The percentage of offenders that entered community treatment ranged from 1 to 10 percent.

Table A:
Comparison of the Most Highly Used Items at each Site for each Observation Category

Category	Site One	Site Two	Site Three	Site Four	Site Five	Site Six
Program Emphasis	Disease, Spirituality	Self Work, Spirituality	Action Plan, Change, Maintenance, RP, Self Work	Disease, Aftercare, RP, Self Work	Spirituality, Change	Change, Self Work
Treatment Topics	Cognitive Skills, Emotional Skills	Cognitive Skills, Socialization	Psychological Development, Social Relatedness	Emotional Skills, Cognitive Skills, Social Relatedness, Subjective Learning	Cognitive Skills, Emotional Skills	Emotional Skills, Nurturance, Socialization, Social Relatedness
Treatment Activities	Awareness, Peer Encounter	Awareness, Peer Encounter, Therapeutic Education	Awareness, Peer Encounter, Therapeutic Education	Emotional Growth, Peer Encounter	Emotional Growth, Sharing Experiences	Awareness, Emotional Growth, Peer Encounter
Treatment Style	Community Members, Formal, Interactive	Formal, Interactive, Introspective	Community, Formal, Interactive, Introspective	Formal, Introspective	Introspective, Formal, Interactive	Formal, Interactive, Introspective
View of the Residential Community	Collective Formats, Participants	Collective Formats, Membership Feedback, Structured Systems	Collective Formats, Open Community, Participants, Structured Systems	Open Community, Collective Formats	Collective Formats, Open Community, Individual Relationships	Collective Formats, Membership Feedback, Participants

Since federal funds from RSAT were not authorized for community treatment, the systems did not expand community treatment resources to accommodate RSAT clients. Aftercare, which historically has been a difficult process; was hindered by the inability to use federal RSAT funds for community treatment, the lack of operational practices focused on community placement by designating treatment slots in the community or securing a treatment placement before discharge from jail, and the lack of policies to ensure that jail based treatment services are considered the first phase of treatment for some community treatment programs. More policy development is needed in this area to ensure that an appropriate continuum of care is implemented.

Supervision Services After Release. The RSAT model assumes an inter-organizational strategy for ensuring that offenders in jail based drug treatment services continue drug treatment in the community to support recovery and abstinence. In each of the jurisdictions, RSAT was not used to develop an inter-organizational approach or seamless system of care that transcends organizational boundaries. Instead the RSAT programs were administered by the local CSB in cooperation with the local jail facility and mainly focused on providing clinical services "behind the walls." Although many RSAT programs reported attempts to coordinate with probation and parole agencies, these efforts did not result in any formalized agreements to support continued involvement in treatment after release from jail, continued drug testing of offenders in the community, or adapting probation/parole supervision plans to reinforce the principles underscoring RSAT.

Client Participation Results. Each jail program had a small program capacity that was usually determined by the size of the housing unit. The number of offenders served ranged from 32 to 74 during the 14-month evaluation period. Many of the programs selected offenders from the pool of "available" offenders at the jail that may include pretrial offenders with relatively shorter stays in jail. Other inmates selected for these programs were facing subsequent prison time and as such were not likely to be released from custody following RSAT participation.

Participants Characteristics. Participants in the program were fairly similar in age and criminal histories. Overall, the offenders were in their mid-30's and had fairly lengthy criminal histories with multiple arrests and convictions. Many of the offenders were pretrial detainees waiting for final disposition of their case. Crack/cocaine was the favorite drug of choice. Many of the offenders had prior treatment experiences, usually with involvement with self-help (e.g. AA, NA, CA, etc.) groups. The actual client varied by jurisdiction depending on how the local jail was used.

Length of Stay in Treatment/Completion from Treatment. The length of time in treatment varied across the six sites ranging from a low of 49 days to a high of 118 days. Most of the offenders did not complete the six-month RSAT program, as noted in Table A. Generally, the offenders were discharged from treatment before completion of the program due to early discharge from the program or because the offender dropped out of the program. During the evaluation period, the prison system changed their admissions practices and started accepting offenders from local facilities with a sentence of nine months or less. This policy change resulted in an average of 10 to 35 percent of the offenders leaving the program for prison or another jail, rather than being released to the community following RSAT participation, as was the original program design. The unexpected release from jail reduced the average length of stay

in treatment. This also hampered the jail and RSAT staff from beginning a discharge planning process, which would have entailed working with the offender to make a continued commitment to treatment in the community.

Program Compliance/Graduated Sanctions. Overall the programs reported few serious infractions for the offenders involved in the treatment programs. Few of the offenders actually had disciplinary problems in the programs. The largest single category of infractions was for the use of inappropriate language. The tendency was for the program to use sanctions involving therapeutic tasks or to restrict some privileges.

B. Lessons Learned from Implementing RSAT in Jail Environment

Jails present challenging environments in which to implement programs for offenders. Even more than prisons, the population is constantly changing and jail operations (e.g. delivery of meals, recreation time, classification, etc.) often impede or interfere with the provision of services. Each RSAT program had to make certain compromises in the delivery of program services in order to accommodate the socio-political environment of the jail. Further attention is needed to the following issues to ensure that the RSAT model and effective therapeutic community services are provided to offenders.

Theoretical Conflict. Therapeutic communities are one specific intervention strategy based on a model emphasizing the development of prosocial values and the use of the peer community as an agent of change. TCs differ from other residential treatment programs and outpatient programs in their theoretical model of recovery. Modified therapeutic community programs have evolved to incorporate social learning models, using some of the advanced cognitive behavioral strategies (to promote self-change) and socialization techniques (attempting to develop a set of prosocial values). In some cases, it appeared that these programs encountered difficulties effectively integrating these two disparate therapeutic approaches. Program staff appeared to struggle with reconciling these two approaches, one which emphasizes the role of the group in running its own treatment activities, and the other which emphasizes the need for skilled counselors to provide highly structured training in various cognitive-behavioral skills. Given the time restrictions inherent in jail-based programs, from which clients are prone to leave with nearly no notice, this theoretical conflict may be exacerbated by the pressure to produce noticeable, practical changes in thoughts and behaviors (using cognitive behavioral training). Attempting to make practical, important changes in longstanding drug-addicted behavior patterns, while also attempting to build the sense of community and set of prosocial values (cornerstones of the TC model) may be more than a short-term, jail-based treatment program can feasibly be expected to accomplish.

Table B: Characteristics of Offenders in RSAT Programs

Component	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6
Number of Clients Served (in the RSAT)	49	57	63	32	64	48
Average Age	35	34	34	38	35	34
% African American	49%	45.6%	15.9%	34.4%	69%	51%
% Caucasian	25%	45.6%	69.8%	65.6%	28%	44%
Mean No. Arrests	14.5	11.6	13.9	15.5	9.1	10.5
Mean No. Convictions	10.7	6.7	8.0	8.3	6.1	8.4
Primary Drug	Crack/ Cocaine	Crack Cocaine	Crack Cocaine	Alcohol	Unk	Crack Cocaine
% Prior Treatment	59	75	51	84	61	74
Average Length of Time in Jail Program	77 days	77 days	118 days	49 days	71 days	85 days
Clients Successfully Completed Program	10 (20.4%)	10 (17.5%)	13 (20.6%)	3 (9.4%)	9 (14%)	6 (12.5%)
Clients Continued Treatment-Community[1]	2 (5.7%)	11 (45.8%)	4 (10.3%)	3 (13%)	0 (0%)	1 (0%)
Clients Transferred to Prison or Other Jail	5 (10.2%)	22 (38.6%)	22 (34.9%)	6 (18.8%)	12 (18.8%)	15 (31.2%)
% Drug Tested	76%	51%	33%	68%	92%	12%
%Graduated Sanctions Applied	47.5%	57%	0%	19.4%	0%	82%

Targeting and Client Selection. Target selection affects the operation of any program. Most of the RSAT sites attempted to select offenders that were likely to be in jail for six months, however in some sites, this was not part of the selection criteria. While the program evaluation was designed to include information gathered from the use of the Addictions Severity Index (to be completed for each RSAT client), the program staff forwarded few of these forms to the evaluation staff. As such, information on specific assessments used by the program staff to determine program eligibility was poorly recorded. The intention of most of these programs was to provide a six-month period of residential TC-style drug treatment, then to work to transition these clients to appropriate follow-up care in the community, through the use of the CSB system. Changes in criteria regarding admissions to prison from jail and the small number of offenders with six months or more sentenced time in the jail presented obstacles to finding a population that meets the criteria underlying RSAT. Many program staff reported that clients left treatment early because of changes in policy regarding the prisons' acceptance of inmates with less than one-year sentences. Results from these sites suggest that while a comparatively small proportion of program inmates (between 10% and 38%) were in fact removed to serve their time in other prisons or jails, this did not account for most of the RSAT inmates who did not complete their

[1] This percentage represents the number of clients who went on to receive drug treatment in the community divided by the total number of clients. Clients who were sent on to another prison or jail were not included in the calculation.

program. All of the programs observed averaged less than six months treatment duration. While jail inmates are prone to movement out of the facility, often with little advance notice, for whatever reason, the short duration of treatment received by most clients is likely to reduce the effectiveness of any treatment received. While the short duration of treatment reduces the effectiveness of treatment received by any individual client, it also has impacts on the development of a sense of trust and community among clients within the program, as they have little time to come to know one another.

Open Groups. The short treatment duration and constant flow of clients within the jail resulted in most of the programs using an "open" format where new offenders were admitted to the program when bed space was available. Difficulties in selecting clients with enough time to participate in treatment also created the need for these programs to use "open" groups, in which members enter and leave the programs unpredictably. This also likely has impacts on the development of a strong sense of community among clients. Groups containing a mixture of clients, with differing levels of program experience, also means that the staff must balance the need to teach introductory material with the need to examine more complicated, sensitive, advanced issues. This balancing act may also reduce the quality and effectiveness of the treatment experience for both types of inmate/client. A closed format would enhance the community atmosphere and milieu of the treatment experience.

Lack of Aftercare. Federal funding does not allow the RSAT funds to be used for community treatment, although the program requirements encourage the use of aftercare to continue the offender's involvement in treatment and improve long-term outcomes. Virginia requested that each site have a case manager to assist with transition issues. During the first round of development, few offenders entered treatment programs after release from jail. Many of the sites had difficulty getting permission to hire the case manager; in some cases local county governments required the programs to hire part-time positions. Although the grant did not require designated slots for offenders in the community, the programs did not develop any mechanisms to provide offenders with ready slots. Despite anecdotal claims to the contrary from program staff, no formal policies were developed to ensure that the local CSB's consistently provided treatment services to released RSAT participants.

Correctional Culture Conflicts. The conflict between correctional and treatment goals is not unique to these six sites, nor does its existence suggest particular failings on the part of the treatment staff. Nonetheless, several instances were observed in which correctional staff members acted in a manner that either undermined the effectiveness of the treatment program, or was blatantly disrespectful to the treatment staff members or treatment clients. Based on information provided during structured interviews, it appears that even the correctional administrators at these sites were not immune from what were perceived as actions intended to make treatment staff members uncomfortable, or to make treatment clients' experience difficult. (As an example, in one site paid treatment staff members were required to wear ID badges typically given to religious volunteers. Correctly or not, treatment staff perceived this as an attempt to distinguish them as "different" or somehow of lower status within the facility hierarchy.) While many correctional officers interviewed in the current study indicated the need for correctional drug treatment, many of them also openly admitted that they believed the main benefit of the programs was that they made inmates more "manageable". Few correctional staff

revealed close dealings with either the programs or the treatment staff, and fewer seemed to exhibit any depth of understanding about what the programs were attempting to accomplish or how they attempted to do so.

Building Effective Systems through Operations. These RSAT grants were provided to the CSBs for the delivery of treatment services in the jail, intended to conform to RSAT criteria developed by the state agencies. Implicit in the RSAT model is the need to develop an infrastructure that allows for a seamless system of care among treatment and criminal justice agencies. In each of the six sites, the treatment, correctional, and probation/parole agencies did not consider this to be part of their mandate. Instead RSAT was perceived as another funding source for treatment "behind the jail walls." Yet, the RSAT model of treatment, testing, and sanctions requires more formalized systems that focus on the difficult issues of target population, transition into community care, drug testing during the period of incarcerated and community treatment, and adequate attention to non-compliance issues. Building these systems would assist with some of the noted problems of short duration of treatment, high discharge rates without the offender completing the jail program, and low rates of offenders participating in community treatment. Dealing with these issues will serve the long-term benefit of using treatment as a tool to change offender behavior and improve community safety.

Each jurisdiction has a standing memorandum of understanding and has a long-working relationship with the local probation and parole agency. This provides a solid foundation for developing essential RSAT systems. More focus needs to be placed on operational issues, such as the transition of jail offenders into community treatment programs and the placement of offenders in actual programs in the community. Boundary spanning and organizational approaches are needed to ensure that the appropriate offenders receive treatment and supervision services focused on long-term changes in behavior. Specifically changes need to occur in operational practice such as:

- *Joint Assessment/Placement.* Treatment and criminal justice (jail, probation/parole, and prison) staff should jointly determine the type of offenders eligible for the treatment services and assess these potential participants using appropriate diagnostic instruments such as the Addictions Severity Index. Involvement in jail treatment should be premised on the ability expected length of stay and willingness to continue treatment in the community.

- *Share Information Between Agencies.* Criminal history and substance abuse information should be shared to ensure that the appropriate offenders are placed in treatment. Substance abuse staff can use the information to be better acquainted with their clients, particularly their criminal histories.

- *Specialized Probation/Parole Agents.* The probation/parole staff was passive players in the RSAT programs. They did not participate in the case management of the offender or assist with securing treatment slots for the offender after release. Designating special probation and/or parole agents to the RSAT program would allow the agents to develop discharge plans and establish a behavioral contract before release from jail. It should also provide a consistent message that treatment is a critical part of the supervision plan.

- *Designated Treatment Slots in the Community.* Participants in the RSAT program were typically referred to the treatment system in the community. Many of the offenders had to be reassessed and the jail records did not accompany the offender. Often the programs were not selected on a "match" between the jail environment and community programs.

- *Focus on Precontemplation and Readiness to Change.* Recent research has found that treatment approaches focusing on contemplation (e.g. preparing to change one's behavior) or motivation to change behavior is infrequently provided in many treatment programs. Readiness-to-Change curriculums are especially useful as the first stage of treatment or for treatment programs of short duration (under 60 days).

- *Focus on Treatment Programs with Phases that allow for Community Development.* Most RSAT programs do not have a curriculum underlying the treatment program. This often contributes to inconsistent goals for the treatment sessions. Program phases are useful tools to structure the treatment program along a continuum consistent with the different stages of recovery. Phases are useful in a correctional setting because they can be geared to the expected length of time of the program.

- *Assign Specific Correctional Officers to the Program/Establish the Correctional Officers as Role Models.* Long-term success of the RSAT program in jail will require addressing the security-treatment cultural issues. Assigning a correctional officer to the program with a defined role in the treatment process is an effective tool for bridging these cultural issues. In some jail programs, correctional officers are often used as a role model (e.g. work ethic, pride, responsibility associated with the job).

Building Effective Operations through Policy Formation. An interagency policy and monitoring system would be useful to ensure that implementation and policy issues are adequately addressed. A coordinated effort is needed between the state DMHMRSAS (treatment agency) and Department of Corrections (DOC) to ensure the long-term success of the RSAT programs. A full commitment is needed from state agencies to ensure that the RSAT process (e.g. treatment behind the walls, treatment in the community, quality supervision and sanctions, and drug testing) is supported through major policy decisions. This will alleviate some issues that occurred during the implementation of the RSAT programs, such as the transferring of offenders to prison before they have completed the jail based program or the lack of involvement of the supervision agencies in transitional planning. State agencies can set the standards for the RSAT model, which should foster support among the local agencies.

Chapter 1 - Introduction

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

The state of Virginia, prior to the development of RSAT funding, had one of the largest therapeutic community prisons in the country. Indian Creek is a 1500 bed facility in southern Virginia that serves the state prison system. The facility is operated by the Department of Corrections. Since Virginia already had a large residential treatment facility, the state sought and received permission from OJP/CPO to use the RSAT funds in local jails and regional detention centers. Six sites were selected to receive RSAT funds to implement therapeutic community programs.

The following evaluation is designed to assess the implementation of the RSAT model in local jail and detention centers. Working with the six jails and the state agencies, the University of Maryland, College Park implemented a process evaluation. The evaluation consists of: 1) interviews with key program staff and administrators; 2) observations of the therapeutic community program in the jail; and 3) tracking of client progression through the treatment and criminal justice system. The purpose of the evaluation was to assess how the RSAT model was implemented in a jail setting.

Related to this general evaluation purpose was the use of a methodology to measure the therapeutic integrity of the services offered in TC-style programs, using this data to describe and evaluate the effectiveness of a set of six small corrections-based TC's in Virginia. This methodology examines how treatment services are provided, using a systematic observation technique. In addition, this methodology allows us to examine the extent to which these services are focused on the use and development of prosocial values and a positive peer culture-- two central goals of the TC model. This structured observational method is intended as a means of moving away from what are commonly generic, superficial program descriptions provided in outcome evaluations, by quantifying the nature and extent of the specific treatment services offered.

A. What is a Therapeutic Community?

The therapeutic community (TC) is currently the predominant long-term residential treatment program for substance abusers (Etheridge, Hubbard, Anderson, Craddock, & Flynn, 1997) and offenders (DeLeon, 1994; Lipton, 1995). The therapeutic community is well supported by research literature demonstrating its value in reducing both recidivism and substance abuse (Martin, et al., 1995; Wexler, Graham, Koronowski, & Lowe, 1995; Hiller, Knight, Devereux, & Hathcoat, 1996; Nemes, Wish, & Messina, 1998). Yet, despite their apparent success, very little is known about the nature of the services provided in the contemporary therapeutic community program.

The therapeutic community (TC) is designed as a total milieu therapy approach, which promotes the development of prosocial values, attitudes and behaviors through the use of a positive peer culture. Typically, TC participants live together in a separate community environment and, over the course of several months, help one another to recognize, confront and change the negative values and behaviors that have lead them to both substance abuse and criminal behavior. Confrontational interventions are traditionally considered the main tool used in TC programs to address the addict's commitment to recovery, as well as to confront the personality and character deficits that impede therapeutic progress.

Beginning in the 1960's and 1970's TC programs began to emerge as a common treatment approach for substance abusing populations, with the Synanon and Phoenix House programs among the first to be developed. Many programs disappeared in the 1980's as the emphasis in the criminal justice system and wider society moved away from treatment, toward the punishment and deterrence of drug use (Lockwood, Inciardi, & Hooper, 1996). However, evaluations of the Stay 'n Out (Wexler & Williams, 1986) and Key/Crest (Inciardi, 1995) programs continued to demonstrate the effectiveness of TC programs for reducing recidivism among offenders with substance abuse problems. In 1994, federal legislation was passed in support of the use of in-prison TC programs as a means of treating the substance-abusing offender.

B. The TC View of the Offender

The TC model itself is characterized by services that focus on holistic change in the offender. According to Etheridge, et al. (1997), the TC model:

> view addiction as a dysfunction of lifestyle and character development requiring long-term treatment in a total community milieu of peer counselors and fellow addicts. Treatment is designed to confront and replace denial and other psychological defenses and dysfunctional behavior with prosocial values and behaviors (p. 251).

DeLeon (1994), the grandfather of the TC model, suggests that this view of the person emphasizes progressive change along the two dimensions of psychological and social functioning, rather than simply focusing on the individual's particular pattern of drug abuse. In this way the individual's specific social and personal strengths and weaknesses are brought to the forefront, where the addict can use them to begin making appropriate lifestyle and individual

changes. In fact, drug use itself is seen, not as the sole dysfunction, but rather as the result of a disorder affecting the entire person.

DeLeon (1994) proposes that TC interventions must be organized around a developmental view of individual change, in order to facilitate the offender's movement through the stages of the recovery process. He outlines a prototypical, three-stage treatment process for the TC model including Induction, Primary Treatment, and Re-entry (into the community) phases. In the Induction phase, members are introduced to the concepts involved in the TC process itself, while staff conducts assessment of the individual's treatment needs. In the primary treatment phase the individual becomes more fully involved in the group therapeutic process and focuses on internalizing new, positive, peer value systems. During the re-entry stage (which DeLeon divides into early and late re-entry) group members work to reintegrate themselves into the wider community. According to DeLeon then, the TC model ideally is organized such that learning at each developmental stage helps the individual prepare for, and progress to, the next stage of recovery.

An example of the program stages described by DeLeon can be seen in the Key/Crest program (Lockwood, Inciardi, & Surratt, 1996). The Key/Crest program employs three phases, determined primarily by the client's position within the correctional system. Phase 1 is provided in prison and is devoted to changing the individual's deviant lifestyle and antisocial behavior patterns. The TC provides the opportunity to learn positive values and skills from the staff and peers. The program initially employs behavioral strategies, such as modeling and redirection to assist members in recognizing and changing negative behaviors. The use of confrontational strategies is minimized, while an increased focus on role modeling is used to demonstrate alternative behaviors to TC members. Negative behavior by new members is handled through role modeling, instead of through the demeaning, confrontational methods traditionally employed in TC's. After this initial modeling stage, the process of cognitive restructuring can begin, during which time new members learn to identify and modify their antisocial, substance abuse promoting behaviors, feelings, and thoughts.

The work-release phase (Phase 2) involves prosocial skill development, which occurs as individuals begin to integrate themselves into wider society. This phase also includes a maintenance component devoted to refinement of prosocial skills. While under parole supervision, (Phase 3) the member continues to engage in action planning and maintenance activities as part of the change process. While this particular program has been evaluated in terms of its effectiveness in reducing drug use and criminal recidivism, (Martin, et al., 1995) the specific impact of the program's use of these stages of change remains unknown.

C. The TC as a Different Residential Treatment Program

Typically, therapeutic community services have emphasized the use confrontational techniques as a means of promoting recovery. For example, either the professional staff members, or preferably other group members were responsible for recognizing, and then forcefully, verbally confronting inappropriate thoughts, statements, or behaviors. Often this "therapeutic" confrontation took the forms of yelling, profanity, and other "in your face" type activities, followed then by some attempt to reintegrate the individual, after having condemned

his behavior. Since the inception of the TC program in 1960's, the therapeutic community model has evolved away from the traditional reliance on confrontation, incorporating many new therapeutic services, especially social learning based approaches to treatment. These modified therapeutic communities have continued to have success at moderating their clients' various substance abuse-related needs and have also shortened the planned length of stay to less than one year (DeLeon, 1994 as cited in Etheridge, et al., 1997). Despite some recent modifications, at its core the TC model of substance abuse treatment retains two main components: a prosocial value orientation and a reliance on the peer group.

Value Orientation. The emphasis on prosocial values is a key component of the TC model, unlike other psychoanalytic or behavioral therapies. The clarification of values has been seen as an important tool of the TC, as it emphasizes integrating the substance-abusing offender back into conventional society through the adoption of mainstream values. However, the model recognizes that the client must work to acquire these new values, as they may initially be foreign to the addicted individual. DeLeon (1994) in particular, describes how some clients have already developed and subsequently given up these prosocial values, while others may have experienced life circumstances where they were never socialized toward these conventional values. The moral component (re-socialization to positive values) is a substantial aspect of what is thought of as the TC model.

The use of the community itself as an agent of change reflects this TC goal as well. Since negative peer influences are often associated with the development of substance abuse problems, the positive peer culture developed among the community itself is seen as an integral part of the re-socialization of appropriate values and behaviors. This is one way in which the TC model differs from other forms of social learning drug treatments, which may place lesser emphasis on changing morals or values, while concentrating more exclusively on cognitive or behavioral change. Despite the conceptual importance assigned to this aspect of TC programs by DeLeon, little empirical work has examined the impact of this program component. In fact, none of the outcome evaluations reviewed below attempt to assess the impact of this TC component.

Peer Group. The positive peer culture, developed with guidance from experienced, committed members and program counselors, is expected to influence not only the internalization of prosocial values, but is also the mechanism relied on for all types of individual change. The peer group is expected to monitor and confront one another on antisocial values, but also on inappropriate and counter-productive behaviors, thoughts, feelings and beliefs. Group members are seen as especially important in monitoring and detecting the defensive mechanisms and "game playing" that addicts typically engage in to minimize or dismiss their drug using, as well as other negative behaviors and thoughts which facilitate drug abuse.

In addition, the peer group is essential in monitoring behavior and maintaining the therapeutic environment while professional staff is absent. Many of the therapeutic activities conducted in TC programs are run by group members who serve various leadership, administrative and paraprofessional roles within the group. In fact, the TC approach generally sees the professional staff member's role as limited to facilitation and the provision of technical information. Ideally, the majority of other therapeutic activities are run by the group itself. As is the case with DeLeon's concept of "value orientation", the impact of the positive peer group has not been specifically evaluated.

Separate Facility. Another essential component of the TC approach is use of a separate living unit, which not only promotes the development of a sense of community, but also insulates TC members from various antisocial influences typically present in the wider correctional environment (Lipton, 1995; RSAT, 1994; Wexler & Williams, 1986). A separate living environment is seen as crucial to the development of a sense of community. TC living units typically demonstrate this sense of community in the form of various program materials displayed on the walls. Commonly displayed items include a list of each members' role (and their responsibilities) within the group, materials from the Alcoholics Anonymous/Narcotics Anonymous programs, the Serenity Prayer, and members' artwork depicting various motivational themes. These items are expected to help develop and perpetuate a sense of belonging to the group, as well as to reinforce the notion that all members share the common goal of recovery.

D. Effectiveness of TC Program Components

Few evaluations have specifically investigated the effectiveness of various aspects of the TC program as conceptualized by DeLeon (1994). The cornerstones of this model, according to DeLeon, are the prosocial value orientation, use of a peer group, and a separate facility. In attempting to reduce both substance abuse and criminality, TC programs attempt to isolate participants from the negative prison environment and utilize positive peer pressure to facilitate individual change. In a recent review of correctional interventions, Chanhatasilpa and his colleagues (Chanhatasila, MacKenzie, and Hickman 1998) categorized in prison therapeutic communities with aftercare as an effective intervention. However, their review, like many others, does not adequately describe the characteristics of the therapeutic interventions being evaluated.

Three studies dominate the TC literature on effectiveness. One recent study compared two community-based residential TC programs in Washington, D.C. In the standard TC condition, clients received 10 months of inpatient treatment at a residential facility, along with two months of community aftercare services. In the "enhanced" TC, clients received six months of inpatient treatment and six months of aftercare (Nemes, et al. 1998). In the "enhanced" group, clients received more intensive treatment during the aftercare phase than did the standard group. According to both official and self-report data, after 6 months of follow-up, standard TC participants were significantly less likely than enhanced clients to be arrested. Standard TC participants also had significantly longer average time until first arrest, after discharge, than the enhanced clients. The authors concluded that longer inpatient treatment duration had more of an impact on recidivism than did the program that emphasized more intense aftercare services. While Nemes et al. (1998) do not evaluate in-prison TC programs, the findings suggest that more intense in-patient treatment may be more important to program success than more substantial emphasis on community aftercare. Similarly, the apparent effectiveness of the program's emphasis on in-patient treatment at least suggests the importance of the use of a separate residential facility and the development of a positive peer group.

Chanhatasilpa, et al. (1998) also review an evaluation by Martin, Butzin, and Inciardi (1995), who examined the multi-stage Key-Crest TC program in Delaware, which included both an in-prison component and an intensive "transitional", community aftercare component. These

authors found that participants in the combined Key-Crest program (both residential and community aftercare services) were less likely to be rearrested than those who participated in the prison-only phase, the outpatient-only phase, or those who did not participate in the TC program at all. However, the only statistically significant finding was the difference between those who received the Key-Crest treatment and those who received no treatment. In addition to the findings regarding the impact of combined in-prison and community aftercare components, the Key-Crest program evaluation supports the impact of the use of a separate residential facility in TC programs.

Finally, Chanhatasilpa, et al. (1998) review an evaluation by Prendergast, Wellisch, and Wong (1996) who also examined the combination of an in-prison TC (with a separate living facility for program participants) and community-based aftercare. These authors also found that the combination of in-prison and community-based aftercare was associated with lower recidivism among a sample of female offenders. Overall, then there seems to be a relatively consistent body of research supporting the effectiveness of combined in-prison TC treatment and aftercare services. In addition, this research suggests, although only indirectly, that the TC model's reliance on a separate living facility may be an effective program component. The effectiveness of the two central components of the TC model (i.e. use of the peer group and prosocial value orientation) has not been thoroughly examined.

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

As DeLeon (1994) points out, the proliferation of programs calling themselves TC's confounds program evaluation results, as some of these programs are no doubt substantially different (including many additional services and program components) from the traditionally conceptualized TC model. While evaluations of TC's commonly provide superficial descriptions of the program "on paper", few attempts have been made to quantify what actually occurs in these programs. Nor have attempts been made to examine how the use of these various TC components (as well as the more recent program additions) relate to various positive program outcomes.

Chapter 2 – Data Collection Methods

This process evaluation of the Virginia Residential Substance Abuse Treatment (RSAT) employs uses systematic social observation (SSO) and traditional data collection to examine the implementation of the program. The systematic social observations provide an understanding of the nature of services delivered in the program whereas the empirical data yields an understanding of basic implementation of the programs. Together the two provide a picture of the implementation of the RSAT program in the jails and regional jails in the state of Virginia. This chapter describes the research methods used in this study. The first section details the SSO methodology. Section two summarizes the client level data collected as part of this evaluation.

A. Systematic Social Observation

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

> The main procedures for SSO....include selection of problems for investigation, preliminary investigation by direct observation (optional), definition of the universe to be observed, sampling for observation, development of instruments to collect and record observations systematically, provision of measuring error, pretesting instruments, organization for direct field observations, processing observations, and quantitative analysis (p.3).

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

The initial step in SSO is to determine, and explore the area under observation. Mastrofski suggests, particularly for policing studies that early, unguided observation of police work helped define for researchers those areas of exploration, which would be of interest. For example, the exercise of informal police discretion has been a widely researched topic in the policing literature (see Reiss, 1971; Smith, 1986 as examples), however this issue might not have been considered important had early ethnographic studies of police behavior revealed that the practice was common. Fortunately, in the field of correctional substance abuse treatment the areas for observational study have been well defined by prior evaluation research and theoretical

work describing the proposed internal and external mechanisms contributing to recovery and rehabilitation. Thus the current study was able to use prior research as a base from which to begin defining the scope and content of the issues to be studied through systematic observation (See the introduction for a sample of the specific studies.)

In discussing the application of SSO to the study of police behavior, Mastrofski and colleagues (1998) review the advantages and disadvantages of SSO over other traditional survey or archival data methods. In particular, they note that SSO data is gathered independent of any influence of the subject's under study. For instance, when using archival data on police behavior, such as arrest data or complaints filed against officers, the recording processes of officers themselves is allowed to influence the quality and reliability of the data which is stored and eventually analyzed. In SSO, the officers' behavior is observed firsthand and the effects of such official filtering are diminished. Similarly, SSO allows for the study of subjects, and their behavior, in the natural setting, rather than asking about hypothetical situations or using artificial laboratory simulations. Finally, researchers using the SSO method can make and record their observations using systematized procedures, which other scientists could replicate. In this way many researchers could ideally be employed to study the same phenomenon, and their results could be assumed to be comparable and reliable, rather than a single observer having to conduct all the observations.

Regarding potential disadvantages of the SSO method, at least regarding police behavior, Mastrofski and colleagues suggest that subject's reactivity (to being observed) may potentially invalidate the observational data. The researchers, however, report that from their own experience police officers generally acclimate to being observed relatively quickly. As support for this claim, they cite incidents in which police officers have been observed to commit minor, and in some instances, major acts of misconduct while accompanied by a trained observer. This same issue is obviously a potential problem for evaluations of correctional environments as well, as both clients and staff may be expected to have motivations to present themselves or their programs in certain, biased ways. Mastrofski, et al. (1998) suggests that assurances of and conspicuous adherence, to standards of confidentiality are effective ways to reduce potential reactivity biases.

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

Aside from the extensive work by authors such as Mastrofski (1998), Reiss (1971), and others in the field of policing, several other noteworthy attempts have been made to apply SSO techniques to the study of other criminological issues. In one of the earliest attempts to quantify characteristics of the social environment in correctional setting, Moos (1968) developed the Moos Social Climate Scale. This (paper-and-pencil) survey was developed after trained observers first rated various characteristics of several different types of correctional institutions. Scale items were derived from these structured observations (as well as interviews with residents and staff, and prior empirical work on the functioning of these units) and were eventually administered to both facility residents and staff. This scale was found able to effectively differentiate several types of correctional institution (e.g. boys' training schools from juvenile detention halls), based on several important characteristics commonly associated with the social environment in each type of facility.

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

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

Overall, while several attempts have been made to utilize systematic social observation techniques in criminology, the use of this technique could easily be described as in its infancy. The technique has been infrequently used basically due its newness and cost. Similarly, Mastrofski et al (1998) suggest several policy-relevant applications for this type of technique,

particularly in regards to the study of police behavior. To the extent that traditional correctional treatment program outcome evaluations have made little use of structured observational techniques, particularly in assessing the relationship between specific program characteristics and recidivism/substance abuse outcomes, they may have missed a potentially invaluable source of data. Indeed, the prior review of drug abuse treatment outcome studies (see Chapter One) revealed that few of these evaluations provided detailed, objective descriptions of the day-to-day activities incorporated into these programs. The current study then reports on the development and implementation of one such methodology for objectively quantifying characteristics of these correctional programs.

B. Observation Instrument

After reviewing the literature on the purpose and intent of a Therapeutic Community (TC) for the treatment of drug-involved offenders (as discussed in Chapter One) an observation coding sheet was developed which tapped the critical components of the theoretical model of the TC. Theoretically a TC has the goal of using the peer community to assist offenders/addicts in acquiring prosocial values. The instrument was developed to tap into areas of programming that are designed to achieve this goal: Program Emphasis, Treatment Topics, Treatment Activities, Treatment Style, and View of the Residential Community. (See Table 1 for a description of the areas included on the instrument). Within each area, several items were selected which reflect the specific category. (See Appendix A for a copy of the instrument and Appendix B for a copy of the definitions of each item).

Table 1. Five Components of the Structured Observation Instrument

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

Coding of Variables. Items from the five scales on the instrument were rated on three dimensions: use, consistency, and effectiveness (each on five point Likert scales)[1]. The "use" dimension refers to the degree to which a particular program component was used in a given treatment session, where a score of "1" indicates the item was used only briefly, while a rating of "5" indicates the item was used heavily throughout the meeting. These observation dimensions are designed to assess both the frequency of use, as well as provide a qualitative assessment of how well each item achieves the intended purpose of a TC. Thus, we hope to address the question of whether certain aspects of the TC are presented, as well as whether their presentation fulfilled the goals of the theoretical TC program. A key concern here is the assessing, first hand the emphasis on the traditional goals of the TC and the extent to which information and program

[1] Results from the "use" ratings only are presented in the current paper. These ratings were considered more readily interpretable and more reliable relative to the other two dimensions, especially given the previously untested implementation of this observational methodology. Consistency was defined as whether the item was implemented in a manner consistent with the goals of the TC, specifically was the item implemented in a way that emphasized the peer group and the development of prosocial values. Effectiveness was defined as whether the item was implemented in a manner judged to be thorough and productive.

materials are thoroughly processed during treatment activities. While other instruments have been developed in attempts to assess the therapeutic integrity of correctional treatment programs, most notably the Corrections Program Assessment Inventory (CPAI), these other instruments do not make use of on-site observations, but only interviews with staff. The current methodology, though still not perfect, was preferable to these previous methods since it relied heavily on structured observations of the programs, while still employing a staff interview component. This methodology (both observational and interview-based) was also designed specifically for use with residential therapeutic community style programs, rather than correctional treatment programs more generally. In fact, the interview component of this methodology included items specifically related to aspects of these programs outlined in the funding guidelines, thus overall the assessment techniques employed in this evaluation were uniquely suited to their purpose.

C. Procedures Undertaken to Observe Programs

Structured Interviews. Interviews were conducted with security, treatment and administrative staff. At all sites at least one clinician and the treatment program administrator were interviewed. Similarly, at least one security staff person was interviewed at each site, and where possible a security administrator was also interviewed. All staff level interviewees were asked the same set of questions from the staff interview form, while a special program staff interview was used for the treatment program administrator. In general, the interview asked subjects about their impressions of the purpose of the jail and the TC within the jail setting. In addition, general information about the size of the program, the average length of stay, the types of activities used, whether the subject felt any changes could be made to the program and so on was solicited during the interview. Similarly, subjects were asked to relate any problems that were encountered in setting up or running the program, as well as information regarding the cooperation and relationship between the security and treatment program staffs.

Observations. Raters attended meetings involving program participants and recorded their observations in each of the five areas (plus counselor style) on the observation code sheet. Observers sat in treatment sessions, but did not participate in the meetings themselves. At the first meeting the observers introduced themselves to the group members, who in all cases had been informed that their meetings would be observed beforehand. Introductions informed the TC participants that the observers were there to observe the program to understand how a TC program operates. In addition, the members were assured that the observers would observe strict rules of confidentiality and that neither they as individuals, nor their specific facility would be identified by name.

Most sites were observed for four consecutive days[2]. Program schedules were obtained prior to each site visit and observers attended as many meetings as were possible each day. In addition, interviews were conducted with a member of the treatment staff at each location, the TC program administrator, representatives of the security staff and where available a security administrator. In addition to the observational and interview data obtained on each site, the observers wrote field notes, upon their return from each visit (based on their interviews,

[2] Site One was observed for five days.

structured observations, as well as their general impressions of the program, the treatment and jail environments and so on).

Jail scheduling conflicts at times interfered with the observation of planned meetings. For instance, some facilities would not allow observers on the living unit without staff supervision, thus evening meetings could not be observed in several locations (evening meeting tended to be community-run, not staff facilitated meetings). Similarly, day-to-day changes in the program schedule, often due to delays in various jail-wide activities (such as a unit going outside for recreation or being served lunch later than scheduled) disrupted planned observations. While disruptive to our planned observation schedule, these types of disruptions to the program themselves provide useful information about the environment in which these programs operate. In general, each site was able to provide access to at least one scheduled treatment activity per day. Thus, while it was not possible in most locations to observe every scheduled treatment activity over the entire four-day period, the length of each site visit itself helped ensure that at least an example of each type of meeting (e.g. educational, clinical, community-run) offered by the program was observed.

Multiple Observations. By nature, the ratings of how much a topic or activity is "used" are likely to be more reliable across raters, as they require less potentially biased, individual judgement, relative to ratings of "consistency" and "effectiveness". Reliability analyses were computed in the few instances where multiple raters of the same meetings were used. However, the majority of observations included in the final data set were observed and rated by Rater A, either alone or in conjunction with Rater B. A small number of meetings at five of the sites were rated solely by Rater B, typically because they involved female-only meetings, which occurred on women's living units, where neither male staff nor visitors were allowed. Similarly, Site #5 was a female-only program, which Rater B alone observed. Issues regarding inter-rater reliability are discussed further in the Results section that follows.

Inter-Rater Reliability. Sites 1, 2, 3, and 4 had several meetings rated by more than one observer. Reliability analyses were conducted on these multiple ratings to assess the reliability of the method. It is important to note that while both the raters involved in this project had been specially trained in the use of this measure, there were substantial differences in the raters' previous clinical experience. Specifically, one of the raters had an advanced degree in clinical psychology and had previously worked for several years with incarcerated populations providing both treatment and assessment services. In addition, this rater had previously worked with social observational techniques for measuring aspects of the correctional environment and their relation to various program outcomes. The other rater had not yet earned an advanced degree and had no prior experience with either correctional treatments or observational techniques. These factors are important to consider since, some of the difference in ratings (and subsequently the relatively poor reliabilities) may be the result of differing levels of experience in general between these two raters, not necessarily the result of problems with the reliability of the technique itself.

Table 2 displays a measure of the inter-rater reliabilities associated with each set of "Use" ratings. To create this measure of reliability, each item in the five subject areas was compared across raters. The percentages associated with each subject area represent how often the two observers' ratings agreed. The criteria for agreement was set at one Likert scale-point, with the

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

Comparisons of topic areas show that there is relatively wide variation in the level of agreement achieved within an area. For instance, the two sets of ratings agreed in only 70% of the Treatment Style variables. The Treatment Style category may have included items, which were more subjective, leading to less inter-rater agreement than on other scales. Raters may have differed in how they interpreted the meaning of some of the items from this category, despite extensive training. This appears to be the case in regards to the "informal", "check-in", and "listening post" items, which apparently needed more clear operational definitions in order to achieve higher levels of inter-rater agreement. In any event, most of the categories were relatively reliable (though the reliability of these categories does appear to vary, suggesting that more initial training may be necessary to reduce potential observer bias). On the other hand, there was 100% agreement in the View of the Residential Community variables' ratings.

Table 2. Percent of Scale Items Rated within 1 Scale Point by Both Raters

Scale Name	Number of Items	Percent in Agreement
Program Emphasis	11	90.9%
Topics	18	77.8%
Treatment Activities	18	72.2%
Treatment Style	10	70%
View of Residential Community	9	100%

Analysis of Observational Data. The frequency with which each of the variables rated by the observers was used to a high degree (a rating of more than "3") and the frequency with which each variable was rated as not having been used at all were computed for each site. The percent of meetings in which the variables were rated as highly used, relative to the number of meetings observed was calculated, as were the same type of percentages for meetings in which the variables were rated as "not used." Examining the pattern of results allows us to begin to understand the types of activities and treatment topics employed at each site. While there are some patterns in these results, suggesting that the programs share some common elements, there are also substantial differences noted between programs. The relevant results for each site are reviewed separately in the appendices to this report (letters C through H) as a means of describing each individual program. In addition, information gathered from the structured interviews, along with that reported by each site, regarding characteristics of the offenders (recidivism rates, length of stay in treatment, etc) is included in each appendix to further describe the characteristics of each program site. Similarly, the Summary (Chapter Three) compares the sites to one another, while Chapter Four (Discussion), attempts to reach conclusions regarding these types of modified TC programs as a group.

D. Data Collection Methods

The researchers also used traditional data collection methods to examine the implementation of the RSAT programs in each jail. Each program submitted monthly information on each client participating in the RSAT program. The monthly forms were designed to measure the different aspects of the program. Data collection began January 1998 and continued until June 18, 1999.

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

From this data, the researchers will calculate the length of time in the program and continuum of care rate. The continuum of care rate reflects the unique aspects of RSAT, which is designed to begin the treatment process in jail and continue in the community after release from the facility. In addition, the researchers collected information on incarceration and arrests. The incarceration information includes the date of entrance and discharge from the jail. Arrest information contains the date of the arrest and nature of the arrest.

Chapter 3 – Overview of Six Modified TC Programs

This chapter synthesizes the specific observational and client data presented in the appendices to this report regarding various program characteristics and aspects of the therapeutic intervention at these six corrections-based, modified therapeutic communities for drug involved offenders. In addition to general themes arising from the comparison of these sites, the overall strengths and areas of improvement among these programs are also discussed.

Each of the sites had operational treatment programs, which is a credit to the agencies delivering services. With a few important exceptions, the sites were able to implement programs generally in line with their own original intentions and consistent with the guidelines set out by the various state and federal funding agencies. Even with obstacles to overcome, such as staff turnover and acquiring physical space for the program within the jails, each site managed to implement a program and deliver substance abuse services that generally incorporated treatment techniques of proven effectiveness (e.g. cognitive-behavioral techniques). Staff, for the most part were able to work within the jail environment and recognized the need to be flexible when delivering substance abuse services within these jail environments. The programs tended to follow a format that was consistent in some respects with a modified TC model, (e.g. having mostly separate living space for offenders participating in the programs) and also included relevant aspects borrowed from cognitive behavioral approaches.

A. Observational Categories

Program Emphasis. Despite these qualified successes in basic program implementation, the structured observation methodology revealed that the majority of these programs were not guided by a single program emphasis (i.e. a treatment philosophy and set of specific program goals) regarding the provision of services to offenders. In fact, only Sites Two and Six were rated as using more than one of the possible program emphases to a high degree in more than two-thirds of their meetings. Site Two was rated as frequently using a focus on Self-work and Spirituality to a high degree. Site Six frequently emphasized the Contemplation of Change and Self-work to a high degree in their meetings. Sites Three and Five were rated as using a single program emphasis (Action Planning and Spirituality, respectively) to a high degree in two-thirds of their meetings. No other programs were observed to frequently use any of the program emphases categories to a high degree.

Perhaps more importantly, a large number of programs were rated as frequently "not using" a particular program emphasis category. For example, no program used Motivation-building in more than one-third of their meetings. These findings are particularly important as they suggest that the programs may need to improve their attempts at articulating a clear set of goals or organizing principles to the offender. It also suggests that the programs may need to more clearly communicate a well-defined idea of how, and through what steps, program participants need to progress in order to achieve their goals of recovery. Anecdotal impressions from the observers would support this conclusion, as they often felt that the programs were in need of more structure, frequently lacking specific, formalized curricula or distinct program

phases. While these treatment components are not required by the projects' various funding agencies, prior research on drug treatment effectiveness would suggest that improvements of this kind could improve the functioning of these programs and the success of their clients.

Again, while not specifically required by the funding agencies, the structured (and anecdotal) observations revealed that these programs did not typically follow a specifically delineated series of program phases. While some programs purported to have an "orientation" phase, followed by other stages of treatment, when clinical staff was interviewed about the specific phase of treatment that a given group was in, the answer was frequently that each client was at a different point in the treatment program. As has previously been discussed, some of this is likely the result of these programs' difficulties forming and maintaining "closed" groups. Apparently because the length of stay is considerably shorter than it would be in comparable prison-based TC's, and because clients can enter and leave these jail facilities with little or no advance notice to treatment providers, it is extremely difficult to implement closed groups.

In addition to the short, often unpredictable length of stay, most of these programs required the use of various scarce jail resources (meeting rooms, separate housing units, etc). Thus, when potentially eligible inmates enter the jail it is likely difficult for program staff to block or delay their admission to the program. Since jail administrators devote scarce space resources to a TC program, they may be unlikely to support withholding the program from new "eligible" admissions. Apparently then for several possible reasons, these jail-based TC programs are often unable to maintain closed groups. The use of closed groups may more likely promote the development of trust and a sense of community central to the workings of a milieu-based, TC model. Without closed groups then, it is apparently impracticable to require clients to progress through distinct program phases, as part of a coherent group. As such it would appear that the closed groups issue must be addressed before the "program phase" issue can likely be resolved.

Treatment Topics. During the treatment meetings, several topical areas were commonly discussed at a high level at most sites. For instance, every site was rated as discussing emotional skills (an example of a cognitive behavioral training (CBT) technique) to a high degree in more than two-thirds of their meetings. Five of the six sites were also observed to have used cognitive skills (another CBT-type technique) and social relatedness (potentially representing the community aspects of a TC model) to a high degree in more than two-thirds of their meetings. While the sites did tend to discuss these CBT-type issues, the evaluation staff noted that often these topics were not covered in a structured manner, such as through the use of any pre-designed social skills curricula. Similarly, four of the six sites were rated as frequently discussing psychological development (CBT-type) issues in more than two-thirds of their meetings. On the other hand, every program showed a tendency not to use diaries, while five seemed not to use letters or to review past street experiences. Four of the sites were rated as frequently not using recent TC issues, subjective learning experiences, healing experiences, aftercare and issues regarding physical or psychological safety in the program. The results for the use of physical and psychological safety issues, in particular, suggest that more emphasis could be placed on the use of the community itself as an agent of change (as outlined in a TC model).

From these structured observation results, it appears that these programs are succeeding in implementing some type of unstructured cognitive behavioral change strategies, while they appear to place less emphasis on addressing issues related to the development and functioning of the group itself (TC components). Aside from the generally high ratings of "social relatedness" most of the variables representing the development of a sense of community are frequently not highly used. Similarly, the type of issues being underutilized (e.g. physical and psychological safety) would seem to be those partly related to building a "safe" community, capable of fostering self-disclosure and self-change. Thus, to the extent that these programs attempt to implement a hybrid TC/CBT model, they must recognize the need to consistently emphasize aspects of both treatment approaches.

Treatment Activities. The pattern of results for treatment activities supports the suggestions made above regarding the apparent focus of these programs on CBT-style, individual change, with an additional emphasis (to a somewhat lesser degree) on building a strong and effective sense of community. For instance, awareness training, emotional growth training, and peer encounter techniques were frequently used to a high degree, though again these were not delivered using highly structured or pre-designed skills techniques. While peer encounter training suggests activities that would build community cohesion, the other two most commonly used activities suggest a focus on individual, as opposed to group work. Finally, sharing experiences and therapeutic education were used to a high degree in three of the six sites. Reliance on this type of activity again suggests a focus on individual self-disclosure and therapeutic work. Again, these sites may wish to consider placing more equal emphasis on the use of treatment concepts derived from both the TC and CBT approaches, specifically in terms of developing group cohesion and pro-social values (basic TC concepts).

In fact, consistent with the suggestion that these programs underutilized the community itself as a therapeutic tool, community management and community enhancement activities were frequently not used in five of the six sites. In addition, discussion of the goals of the program and the criteria for positive or negative program discharge were largely unused at five sites. Neither were vocational education, parenting skills, vocabulary meanings, or relapse prevention activities frequently dealt with at many of these sites. The lack of discussion of program goals and criteria for discharge is consistent with the results presented above regarding the typical lack of a single program emphasis. The low frequency of parent training, vocational education, and relapse prevention activities suggests that these programs may typically be focused more exclusively on "drug use" issues, without considering the entire interplay of factors related to these clients' life problems (of which drug abuse and crime are typically only a part). It is especially important for these programs to make improvements in targeting these underutilized treatment topics, in light of the requirements from the State of Virginia that these programs focus on clients' multiple social, economic, familial and personal problems, beyond substance abuse.

Treatment Style. Every site was rated as relying heavily on formal (i.e. scheduled) group meetings, however difficulties were frequently encountered in attempting to observe inmates in their living units during extended periods of "unscheduled", free time. In light of these difficulties these results may be somewhat biased toward finding a reliance on formal activities. However, anecdotal evidence (e.g. comments heard during group sessions) suggests that informal (i.e. unscheduled, inmate-initiated) meetings were relatively rare. In fact, in some

sites where inmates were supposed to conduct pre-scheduled, group-run meetings after-hours on their living units, it was revealed that even these informal, yet scheduled meetings were not held. This may suggest that these programs should make more consistent efforts to monitor these "informal" activities to ensure compliance with these important aspects of the therapeutic milieu. If clients do not consistently engage in therapeutic activities, outside of their scheduled, counselor-run treatment sessions, the program may likely come to more closely resemble outpatient treatment, rather than a residential TC-style treatment program. Those aspects of the milieu-based TC model that have been demonstrated to be effective in reducing recidivism and subsequent drug use will likely lose their effectiveness if they are not utilized by the clients in the course of their daily routine. Programs may wish to consider what the inconsistent use of these client-run activities suggests regarding client motivation and their internalization of therapeutic goals, as well.

Most sites were rated as relying heavily on introspective meetings (e.g. that members' input and self-disclosure was highly emphasized). Similarly, sessions at five of the six sites were characterized as highly interactive (allowing clients and staff to interact with one another). All of the sites were characterized as infrequently using informal meetings, check-ins, "listening-post" activities (in which a member must passively listen to feedback from others), punishment or reward meetings, or staged client presentations. In general, these results suggest that these six programs tend to allow clients to interact with one another and with staff and typically provide services in manner that promotes clients' self-examination. Specialized types of treatment meetings (punishment/reward meetings and specific structured activities) were relatively rarely used in these programs.

View of the Residential Community. In terms of the view of the residential community categories, every site was characterized as frequently using collective formats (services tended to be delivered in a group format, rather than individually) and open communication. Five of the sites were also described as frequently using high levels of membership feedback and member participation. In general these programs seem to provide most treatment in a group format, to allows clients to actively participate in their own treatment, and to promote open communication among members. Only three sites were characterized as frequently using highly structured systems (e.g. requiring members to provide answers in a routinized format, raise hands to make comments, and so on). The relatively infrequent use of structured systems seems consistent with the general findings that these programs did not well resemble traditional TC programs, which would commonly make widespread use of this type of regimented treatment interaction. The infrequent use of structured systems also supports the conclusion that CBT-type activities and topics (discussed above), though relatively common, were not implemented in structured formats.

Four of the six sites relied somewhat less heavily (more than 50% of meetings) on the use of role models and individual relationships within the group. The relatively high number of sites using individual relationships within the group is potentially troublesome, in terms of the TC model. As discussed above, members should ideally come to see the whole group as the agent of change, rather than seeking help from relationships with certain individuals within the group. The finding that only two sites frequently did not use individual relationships supports this ascertain. Again, some of the difficulty encountered in these programs around the reliance on

individual relationships may also stem from the use of the hybrid TC/CBT model. In a strict TC model, this type of interaction would be specifically contraindicated, however the theoretical conflicts involved in blending treatment approaches may contribute to this problem. These programs may wish to consider how to best deal with this issue in light of their specific program goals and philosophies.

B. Comparison of Program Outputs

Having considered the results from the structured observation of these six programs, the remainder of this chapter focuses on a comparison of the sites in terms of several program and client characteristics, as reported by the sites themselves. Table 3.1 compares these six sites in terms of several characteristics. In terms of the number of clients served these six sites ranged from 32 clients to 64 clients served during the 14-month study period. Site four served the fewest clients during this period, likely because site four's residential units housed only 4 inmates at one time. Site four also served clients with both substance abuse disorders and diagnosed mental illnesses. On the other hand, site six served a relatively large number of clients and was housed within one of the larger overall jail facilities observed in this study.

In terms of the average length of treatment stay in the jail program itself these six sites ranged from 49 days to 118 days (approximately 4 months). Site four clients spent the shortest amount of time in jail-based treatment. Again, this result may be due to the unique nature of site four's program (serving dually diagnosed clients). In any event, all of the observed programs' clients averaged substantially less than the six to twelve months of jail-based treatment required by the Virginia Department of Criminal Justice.

The Virginia Department of Criminal Justice also required these six sites to provide urine testing to clients. Specifically, 5% of clients were to be tested bi-weekly. Results for drug testing provided by these six sites suggest that they fared much better in terms of meeting these criteria. The sites ranged from 12% of clients being drug tested over the 14-month study period, to a high of 92% of clients tested. Drug testing policies varied by site, although it appeared in some sites that the treatment staff was unaware of the drug testing policy.

These six programs successfully graduate relatively few clients, ranging from three to thirteen clients successfully completing the program. Many of the sites experienced problems with the clients being transferred to other facilities. Again, site four (a small program for dually diagnosed clients) reported one of the lowest successful graduation rates. This low rate may reflect both the small overall size of the program, and possibly the added difficulty in making substantial progress with dually diagnosed clients. Site three, which also had the longest length of stay, (and served a relatively large number of clients) not surprisingly produced the highest rate of successful graduates. As numerous drug treatment evaluations have consistently found, the length of stay in treatment again seems related to client success.

Programs also varied in the percent of clients leaving the first phase of treatment who then continued to a second phase of treatment (in the community). These six sites ranged from 2.9% continuing treatment in the community to 45.8% continuing treatment. While the factors that directly contributed to these varying rates of community treatment among the sites are

unknown, many sites reported the lack of a designated case management staff person to arrange aftercare services. Many of these programs also reported that the counselors themselves conducted transitional planning. Another important factor that likely contributed to this low rate of community placement is the widespread finding that community treatment agencies (CSB's) did not have designated treatment slots for clients leaving these jail-based services.

In terms of the frequency of infractions while participating in jail-based treatment, results reported by these six sites suggest that there were relatively few infractions committed by these clients, nor were the types of infractions of a relatively severe variety. In fact, these six sites ranged from a rate of 0.02 infractions per client to 3.7 infractions per client (over the 14-month study period). These six sites were also relatively consistent in the use of various graduated sanctions in response to these infractions, ranging from 138% of the infractions sanctioned (more than one sanction per infraction) to 89% of the infractions sanctioned.

Finally, this evaluation effort found that some program staff was operating without the benefit of thorough background information on their clients, particularly regarding their primary drugs of choice and criminal histories. It is common that treatment staff do not have access to official criminal records or that in a jail setting the offenders may not be willing to discuss prior drug use. Typically, program staff reported to the evaluation staff that this information was not available for an average of 25% of their clients (some sites did not have this data on as many as 75% of their clients). It would seem prudent for the counselors to have access to, and make use of this information in designing individual treatment and aftercare plans.

Table 3. Comparison of Program Characteristics

Component	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6
Number of Clients Served (in the RSAT)	49	57	63	32	64	73
Average Age	35	34	34	38	35	34
% African American	49%	45.6%	15.9%	34.4%	69%	51%
% Caucasian	25%	45.6%	69.8%	65.6%	28%	44%
Mean No. Prior Arrests	14.5	11.6	13.9	15.5	9.1	10.5
Mean No. Prior Convictions	10.7	6.7	8.0	8.3	6.1	8.4
Primary Drug Choice	Crack/ Cocaine	Crack Cocaine	Crack Cocaine	Alcohol	Unk	Crack Cocaine
% Prior Treatment	59	75	51	84	61	74
Average Length of Time in Jail Program	77 days	77 days	118 days	49 days	71 days	85 days
Clients Successfully Completed Program	10 (20.4%)	10 (17.5%)	13 (20.6%)	3 (9.4%)	9 (14%)	6 (12.5%)
Clients Continued Treatment in the Community[1]	2 (5.7%)	11 (45.8%)	4 (10.3%)	3 (13%)	2 (3.9%)	1 (2.9%)
Clients Transferred to Prison or Other Jail	5 (10.2%)	22 (38.6%)	22 (34.9%)	6 (18.8%)	12 (18.8%)	15 (31.2)
% Drug Tested	76%	51%	33%	68%	92%	12%
%Graduated Sanctions Applied	47%	57.0%	0%	19.4%	0%	82%

Having presented some general trends in the observational data and program-reported characteristics collected from these six sites, Chapter 4 presents several important issues related to the operation of these corrections-based modified TC/CBT programs.

1 This reflects the percentage of discharges that were eligible for the community thereby excluding those that are transferred to prison or jail.

Chapter 4 - Next Steps for Modified TC's in Jail Settings

Results from this evaluation reveal that while delivering treatment services within a correctional facility is feasible, there are many practical realities about the impact of the services provided to the client that must be overcome. As Pogrebin (1978) noted over 20 years ago, if the correctional facility's administrative staff endorse the goal of rehabilitation or behavioral change as part of the overall mission of the correctional facility, then the correctional and civilian staff will be more comfortable with this goal. This is still an important issue in the delivery of contemporary correctional treatment programs. An environment in which the correctional leadership provides support for programs then enhances the delivery of services provided to offenders. In the six jails evaluated in this project the treatment staff often found it necessary to modify the provision of treatment services to "fit" the correctional environment. To some extent, these modifications appear to affect the delivery of services to the offender population. Below we discuss these issues.

Use of Open Groups. As mentioned previously, each site used open groups in their treatment program. Open group sessions allow new participants to enter the treatment program at any time, regardless of the stage of the rest of the program members. While the open group is suitable to educationally oriented programs, designed to build awareness of issues among program participants, within the context of a clinical intervention the entrance of new members makes it difficult to build trust and a sense of community within the group. The use of open groups also seemed to make it more difficult to follow a proscribed curriculum of program phases.

The decision to use open groups was apparently made to accommodate the jail environment and to ensure that the bed space allocated to these TC programs was efficiently used. Members of these groups were prone to leave the program at any time, either to be released back to the community, or to serve a prison sentence at another facility. As a result, most programs contained members who were at different stages in the treatment process. As an example, in one case nearly the entire group was reviewing introductory drug treatment material they had first been presented with six months earlier (and were now dealing with relatively advanced issues related to relapse prevention and maintenance of therapeutic gains) to accommodate the newly arrived member. This member was learning this material for the first time (and presumably gaining very little from watching the other members work through more advanced treatment and maintenance issues).

Not only does the use of open groups affect the ability of new members to learn basic, introductory material as described above, but it may be responsible for the difficulties many of these programs appeared to have in developing and utilizing a strong sense of community. Individuals in open groups will always have newer members present when they are discussing potentially sensitive personal issues. The likely result of this mixing of old and new members is less trust and potentially less self-disclosure within the group. Despite the open nature of these programs, specific criteria for entering or exiting the group were not made clear to the evaluators (consistent with the general lack of structured activities), nor were these treatment criteria commonly discussed in the course of treatment activities.

Use of the Peer Group as an Agent of Change. Related to the open groups issue is the difficulty presented by failing to make use of the entire peer group as an agent of change. The TC model is premised on the concept of the community—the development of prosocial values from the development of a strong peer group that challenges and assists each member in the acceptance of mainstream values. As previously mentioned, many of these programs appeared to make use, either intentionally or by failing to confront the issue, of individual relationships within the treatment community. While the support of a close and trusted "friend" is no doubt a valuable aid when an individual is faced with a personal difficulty, the reliance on these individual relationships as a means of substance abuse recovery has been identified as counter-productive. For instance, one reason that those in drug treatment might choose to rely on this type of one-on-one relationship is that it allows the members of the dyad to support each other in continued, negative thoughts and behaviors. Recovery issues dealt with in the presence of entire group would be less likely to result in such mutual defensive action and would ideally be more susceptible to scrutiny, confrontation and eventual change.

The underlying assumption that effective treatment involves the use of positive peer pressure, applied by those who know the "games" addicts will play (i.e. fellow addicts), may be undermined when individual relationships are allowed to supplant the role of the entire group in facilitating recovery. In the traditional TC model, (which overall has been shown to be effective in reducing drug use and crime) the peer group takes an active, in fact leading role in the day-to-day operation of the group, including the monitoring and confrontation of one another's thinking patterns and behavior. To the extent that the programs observed in this evaluation seem to both allow individual relationships to flourish, and to inadequately cultivate, implement and maintain a positive, safe, effective sense of community they may be missing a potentially invaluable tool for promoting recovery and conventional lifestyles.

Focus on a Prosocial Value Orientation. As previously mentioned, these programs seemed to under-utilize the development, or re-socialization of a prosocial value orientation in their members. While many of these programs appeared to devote a large proportion of their treatment interventions on building individual cognitive and emotional skills, promoting self-awareness and psychological development, few of them seemed to consistently focus their therapeutic efforts on either confronting or replacing antisocial value systems. While the role of antisocial values in these members' lifestyles was frequently mentioned (members would commonly describe their lives on the street, hustling for drugs, using any type of drug they could "score", avoiding familial and economic responsibilities, and so on), these antisocial values were infrequently confronted, either by staff or other members. (As mentioned, confrontation was relatively less consistently used, in general). Nor was the need for developing prosocial values, in general the topic of many treatment sessions. On the contrary, many treatment activities did appear to focus on the development of specific, concrete, cognitive, emotional, or behavioral skills.

Selection of Clients and the Impact of Average Length of Treatment. The determination of selection criteria for clients to participate in these RSAT programs was left to each individual site. Information regarding the specific assessment instruments used in this selection process was not collected from each site. Instead the selection of appropriate assessment measures was left to the discretion of each site. The evaluation staff did attempt to

gather information from the Addictions Severity Index for each client, however, the sites varied in the completion and return rates for this instrument. Specific details regarding the type of client intended to participate in each program were unclear, though all sites originally attempted to provide services to inmates with at least six months remaining on their jail sentence that would then be released directly to the community. In some instances, due to changes in their policy regarding minimum length of sentence, the Department of Corrections apparently took custody of some RSAT participants with less than the customary one-year sentence needed for serving time in prison, thus prematurely terminating these clients' treatment participation. Finally, while information regarding the use of individual treatment plans was not collected as part of this evaluation, anecdotal impressions from the observers suggest they were not commonly implemented as guides to treatment progress. Given the lack of background information frequently available to treatment staff, it is unlikely that individual treatment plans could have been, or were effectively developed.

According to the data regarding the length of treatment for the average client, reported by the programs themselves, it is apparent that many of these clients receive less than 6 months of residential treatment in these modified TC programs. In fact, some of these programs averaged less than 2 months of residential treatment. Apparently it is not uncommon for clients to be removed from these programs without the prior knowledge of, or input from treatment staff. On the other hand, the selection of appropriate clients based on accurately predicted length of stay in the facility would allow the scarce resources of these programs to be focused on those who are most likely able to complete some substantial portion of the program.

Not only would the appropriate selection of those clients most likely to absorb a meaningful amount of treatment lead to longer treatment stays, (a factor that is commonly associated with better outcomes) but the adherence to some reasonable length of stay criteria (e.g. six months) might also help promote the use of closed groups. Closed groups then would be more likely to facilitate the development of trust and a stronger sense of community among program participants, which would also be expected to improve treatment efficacy. Appropriate selection of clients would also allow clients to receive enough treatment to begin working on the multiple issues they face.

Conflict with the Correctional Environment and Culture. Several instances, at several sites were observed in which correctional staff members acted in a manner that either undermined the effectiveness of the treatment program, or was blatantly disrespectful to treatment staff members or clients. Even the correctional administrations of these sites were not immune from what were at least perceived as actions intended to make treatment staff members uncomfortable or to make treatment clients' experiences difficult. At one site, female clients were almost never allowed off their living unit, effectively denying them privileges afforded to male inmates within the facility. At another site paid treatment staff were required to wear ID badges typically given to religious volunteers. Correctly or not, treatment staff perceived this as an attempt to distinguish them as somehow "different" or of lower status within the facility hierarchy. In yet another site, correctional officers were so disruptive as to make treatment meetings extremely difficult to conduct. In many sites inflexible and inconsistent jail schedules meant that several treatment meetings simply could not be held, and in another site officers failed

to inform a counselor that treatment clients would be half an hour late in arriving at their classroom.

While many correctional officers interviewed in the current study indicated the need for correctional drug treatment, many of them also reported that in their eyes the main benefit of the programs was that they made inmates more "manageable". Several suggested that the strict monitoring and imposition of punishment exemplified by the correctional environment would somehow motivate group members to "abstain" from, or choose to avoid drug use and crime. Few revealed close dealings with either the programs or the treatment staff, and fewer seemed to exhibit any depth of understanding about what the programs were attempting to accomplish or how they attempted to do so.

More generally, correctional and municipal administrations were commonly found to be unwilling or unable to provide adequate meeting facilities or separate living units (which are essential to the development of a therapeutic milieu, typically seen as a crucial aspect of a TC program). Some facilities had placed restrictions on the interaction of counselors and clients of different genders (reportedly because of prior improprieties committed by correctional staff). Other jurisdictions have been slow to fully fund the treatment or case management positions needed to run programs that have been, at least partially funded by federal grants under the assumption that they would employ specific numbers of treatment staff.

While none of these political, budgetary, or "correctional culture" conflicts are unique to this group of six treatment sites, (such stories are common among clinicians who have worked in correctional environments) they present no less serious obstacles to the provision of effective treatment merely because they are common occurrences. To say that correctional treatment programs are dependent on smooth relations with (and to a great degree are at the mercy of) correctional staff members and administrators is to restate the obvious. These individuals and the "corporate cultures" they work within are commonly serious and potent impediments to the delivery of effective correctional treatments. One particular difficulty is presented by the comparatively small size of most of these RSAT programs, relative to the jail population as a whole. Their small size likely makes it relatively easy for jail, and other agency administrators to overlook any problems encountered (client selection and drop out, treatment staff turnover, or lack of transitional planning or released participants) by the RSAT programs. However damaging the problems may be for the program itself, given their narrow scope it is possible that other officials who could have acted to alleviate them may have easily put these concerns aside. For this reason, in particular the involved agencies must make concerted and specific attempts to coordinate the planning and implementation of both residential and community-based RSAT services.

Implementing the RSAT Model in Jails. Federal legislation calls for RSAT programs to follow the prescribed process of effective TC programs for offenders with the provision of quality treatment services in a correctional environment, followed by aftercare in the community. These correctional and community-based treatment programs are to be supplemented with drug testing and the use of graduated sanctions to ensure compliance with treatment program conditions. The programs' philosophy is that involvement in treatment services for a longer period of time should reduce recidivism and the consumption of illicit drugs.

The RSAT model requires the delivery of treatment services to offenders through the efforts of multiple agencies. The RSAT model involves the following treatment aspects: 1) select offenders who will benefit from six months of treatment in a local jail; 2) transition the offender to suitable treatment services in the community; 3) monitor participation in treatment in the community; 4) drug test the offender during involvement in the RSAT program; and 5) use graduated sanctions and incentives to improve compliance with the treatment program in the jail and the community. In Virginia, the relevant agencies include the jail or correctional facility, the local community service boards (CSB), the local probation and parole office, and the state Department of Correction as well as the local county/city governments.

Each agency has a role to play in making decisions about the value and importance of the RSAT program model. Several important inter-agency decisions must be made. First, the Department of Corrections, local jail, and CSB must agree upon the selection criteria for program participants (to ensure that offenders have sufficient time to complete the treatment program). Second, the local jail and CSB must provide adequate and supportive staff for the treatment program. This includes correctional officers that will work with treatment staff to ensure that attendance at treatment sessions is not only ensured, but is portrayed to the client as an important goal of both the correctional and treatment staff. Third, the local probation and parole office and CSB must make a commitment to the aftercare component of the RSAT model by providing necessary discharge planning services to ensure that offenders can acquire a treatment slot after release from the facility. Finally, drug testing and the use of graduated sanctions must be integrated into the services provided by all of the different agencies throughout the RSAT model. Each agency also must contribute resources to effectively implement this seamless system of care.

This evaluation found that the jail-based component of the treatment program was developed and implemented, though typically with some significant difficulties and limitations. Each of the sites delivered a modified TC as previously described, with each program making concessions to exist within the jail environment. Discharge planning, transitional services and aftercare were the main components of the RSAT model appearing to require more consistent implementation. Few of the sites had case management or designated probation and parole agents to assist with discharge planning and transitional services. Ultimately few of the clients participating in the jail program were placed in the treatment program in the community. The low involvement of the probation and parole staff in the overall program illustrates how the organizational boundaries to the integration of treatment throughout the correctional process remain. Few of the CSB's had designated treatment slots for offenders released from the TC program, partially due to the lack of funding and the inability to use the federally provided RSAT funds for the provision of community-based services. Further, few of the probation and parole agents perceived that they have a substantial role in the RSAT model.

The effective implementation of the RSAT model will require a partnership among the various local and state agencies, which transcends previous efforts. The partnership must be developed at both the policy-development and offender-management levels. Policy-makers must make a commitment to the RSAT process that requires specific resources. First and foremost policy-makers must recognize that the goal of these systems must be to use treatment as a crime

reduction strategy. Realization of this goal, in and of itself will assist jail and correctional administrators to visualize how RSAT fits within the mission of their agency. Following the acquisition of this new goal, policy-makers must also recognize that resources must be devoted, and staff organized to implement both the jail-based, and particularly the community/aftercare components of the program.

One essential difficulty associated with the delivery of aftercare services for these programs was the lack of dedicated funding for the planning and implementation of appropriate community-based drug treatment services. While the RSAT grants involved in these programs provided funding for the CSB's to implement jail-based drug treatment services these grants specifically prohibited the use of RSAT funds for the provision of aftercare services. This prohibition existed despite the fact that prior research has shown aftercare to be an effective component of residential drug treatment services. Without the funding necessary to provide aftercare treatment slots specifically for released RSAT participants (and in some cases even to hire case managers) it was apparent that few of these clients were successfully transitioned to appropriate community services. The potential for this lack of aftercare to undermine any therapeutic gains made during the residential portion of the RSAT programs is great.

Next, policy decisions must focus on the selection of target populations suitable for the RSAT process. If the goal is to reduce recidivism, it is an inefficient use of scarce treatment and correctional resources to begin offenders in a treatment program, only to transition them to another jail or correctional facility or release the offender after only a few days or weeks in the treatment program. The ability to develop sound target policies that transcend organizational barriers is an important part of the effective delivery of treatment services. Better selection of the target population will allow for the jails to offer closed groups which, as previously discussed should improve the nature of the clinical interventions with more focused group work.

A successful integrated treatment/aftercare policy must recognize that aftercare is a critical component of the model. Aftercare services cannot be an afterthought. Given the relatively short-duration of these programs, aftercare components need to be integrated into the model from the beginning, with much of the treatment process in jail being devoted to discharge planning and preparation for continued treatment in the community. In other words, the appropriate jail, probation/parole and treatment staff must have as a goal the placement of the offender in the treatment program in the community. Without this continued involvement in the treatment program in the community, it is likely that the effectiveness of treatment provided in the jail will in fact be undermined.

At the offender-management level, appropriate staff should reinforce the importance of the treatment process. While this did not appear to have taken place in the current programs' design and implementation, the correctional, treatment and probation/parole staff should be focused on providing the offender with correctional and treatment services throughout the sentence period. Among these sites there were no proactive attempts made to coordinate the activities/roles of each agency, especially in reference to transitional planning. The use of a behavioral contract with the offender that involves jail and community treatment participation would reinforce the message regarding the importance of treatment at all stages of the system. It would also facilitate the offender making a long- term commitment to recovery. The use of this

tool from the beginning of the assessment/treatment process will reinforce the message that treatment will be provided in each phase of the correctional process. Another crucial offender-level issue is the ability to get the client into treatment services in the community. With a commitment from the policy-makers, either specialized funding or designated slots for TC program graduates would further the involvement of offenders in these community-based programs.

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Appendix A:

Observation Instrument

Date:_____ Observer:_____

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

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

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

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

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

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

Describe the purpose of the Session: _____

EACH SESSION

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

Each Session

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

Each Session

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

Each Session

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

Each Session

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

Describe the clinical intervention:

_____

_____

_____

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

_____

_____

_____

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

Strengths

Weaknesses

Each Session

Counselor Style

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

Appeared to be professional? Yes/no

Recovering Yes/No

Other characteristics: _____

Each Session

Jail:_____ **Date:** _____

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

Describe the climate:

Offenders

Staff

Materials Distributed

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

Describe Groups (Talkative, Distractive, etc.)

Case Management / Discharge Planning for Offenders

Date:_____ Observer:_____

Time: _____

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

_____

_____

2. What was the focus of the discussions?

_____

_____

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

_____

_____

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

_____

_____

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

_____

_____

6. What was the main goal of the meeting?

_____

_____

7. Was another meeting scheduled? When and how?

_____

_____

Sessions_____
Site:_____

OVERALL PROGRAM—Each Day

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

Sessions_____
Site:_____

OVERALL PROGRAM—Each Day

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

Sessions_____
Site:_____

OVERALL PROGRAM –Each Day

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

ROLES/DEFINITION OF UNIT	Used 1-5	Consistent with across situations

Sessions_____
Site:_____

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

Site:_____

OVERALL PROGRAM—End of Week

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

Site:_____

OVERALL PROGRAM—End of Week

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

Site:_____

OVERALL PROGRAM –End of Week

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

ROLES/DEFINITION OF UNIT	Used 1-5	Consistent across situations

Site:_____

End of Week

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

Appendix B:

Operational Definitions for Structured Observation Items

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

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

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

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

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

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

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

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

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

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

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

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

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

Use of Peer Encounter Groups- The interaction with the community or therapeutic group is used to heighten individual awareness of specific attitudes or behavioral patterns to be modified.

Use of Awareness Training- Teach the client how to be aware of situations that might lead back to drug use. (Early stage of Relapse Prevention)

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

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

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

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

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

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

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

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

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

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

Vocabulary- Teach therapeutic terms and their meanings.

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

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

TREATMENT TOPICS – Topics discussed during the treatment process.

Community Issues- Issues related to anticipated problems in the community.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TREATMENT STYLE - Style of treatment delivery.

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

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

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

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

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

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

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

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

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

Appendix C:

Site One Description

A. Site and Program Design Overview[1]

Site One is a 270-bed facility serving three jurisdictions in southeastern Virginia. The therapeutic community at Site One is designed to house 10 inmates in a separate unit within the facility. This is the only specialized treatment unit within the facility. During on-site interviews treatment staff reported the expected length of treatment at this site at between 6 and 18 months. Program counselors also report that participants in this program are randomly drug tested by the jail itself, however this testing is not conducted specifically as part of the treatment program. The program is designed be staffed by two counselors and a case manager. The Community Service Board (CSB) in this area does not offer priority/reserved treatment slots for persons leaving the jail who are in need of further outpatient drug treatment, but the intent is to have the program match clients to appropriate follow-up services in the community.

The program at this site used a treatment curriculum based on a combination of Hazelton's "Curriculum for Living" and Gorski's Relapse Prevention program, with the staff developing the actual day-to-day curriculum. The program design included 15 treatment meetings each week, with three scheduled program activities each weekday; a morning community meeting, a morning educational meeting, and an afternoon educational meeting. Between 8:00 and 9:00 each morning the inmates conduct a group meeting. This meeting was conducted by clients, without professional staff members present. These morning meetings began with the traditional AA-style check-in. Next, group members typically read selections from Alcoholics or Narcotics Anonymous books. These readings included AA traditions and short stories of other's addiction-related problems. Feedback was solicited from the group on the readings, followed by any "pull-ups" or "push-ups," as members deemed necessary. Finally, members have an opportunity to bring up any new business or issues. This meeting closes with the group joining for the "Serenity Prayer."

The second meeting is designed to run from 9:30 a.m. until 11:00 a.m. each weekday. For the most part, this meeting is run by a staff member (typically counselor A), and includes the presentation of educational material related to various aspects of the recovery process. Topics include spirituality, the importance healthy living in terms of the mind, body, and spirit, or provision of information about drug use and addictions. These topics were commonly presented in an interactive style, mixing lecture and group discussion. The final structured group activity of the day takes place between 1:30 p.m. and 3:00 p.m. each weekday. This meeting is a continuation of the educational activities conducted during the late morning group.

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[1] Site One was observed for five consecutive days in June 1998, approximately nine months after the RSAT funded treatment program had been in operation. The structured observation results describing the treatment program at this site represent the program as it operated at that time. The structure and operation of treatment programs may change over time. Data reported by the sites (e.g. client characteristics, drug testing) represent the entire 14-month period of the evaluation effort.

B. Overview of Program Implementation

Characteristics of the Sample. The Residential Substance Abuse Treatment (RSAT) program at Site One served a total of 49 clients[2] since program inception. The average client is approximately 35 years of age. All clients participating in the modified therapeutic community are male. The majority of clients served in this program are African American (49%), with 24.5% identified as Caucasian. A very small percentage of clients served were employed in the last 30 days prior to participation in the TC (4.1%). (See Table C.1a)

Table C.1a. Demographic Characteristics

N	49
Mean Age	35.1 YRS
Minimum-Maximum	19.1-57.2
Standard Deviation	8.7
%Male	100
%African American	49
%Caucasian	24.5
%Missing Race Data	24.5
%Employed	4.1

Data presented in this section were obtained directly from treatment staff and treatment records. Clients at Site One have quite extensive criminal histories (See Table C.1b), with the average client arrested over 14 times. These arrests resulted in approximately 11 convictions. Treatment staff apparently did not have access to complete data regarding the nature of the instant offense (73.5% was missing) or criminal history (44.9% missing). Among those clients for whom data was submitted, 25% of the clients' instant offenses were drug offenses, with 6.1% being for possession, 6.1% distribution, and 2% for possession with intent to distribute (PWID).

[2] Site One submitted information for more than 49. However, no Client Treatment Movement data was submitted for these clients, or it was submitted too late to be included in this report. With no way to tell if they ever entered the modified therapeutic community, they were not included in this table.

Table C.1b. Criminal History Characteristics

Mean Number Of Adult Arrests	14.5
% Missing Arrest Data	44.9
Mean Number Of Convictions	10.7
% Missing Conviction Data	44.9
Instant Arrest Offense	
% Property Crime	2.0
% CDS Possession	6.1
% PWID CDS	2.0
% CDS Distribution	6.1
% VOP	4.1
% Other	4.0
% Missing	73.5

The primary drug of choice identified by most Site One clients was crack/cocaine (32.7%), followed closely by alcohol (20.4%). Unfortunately, over 26% of the clients' "drug of choice" information was not available, due to the treatment staff not obtaining this information on all of the clients admitted to their program. Many of the clients reported that they had used drugs daily over the past 30 days (32.7%). However, 24.5% of all clients had not used drugs in the past month, probably due to the fact that they have been incarcerated during this time. Participation in this treatment program is likely not the first for most clients, with 59.2% having previously participated in some form of drug treatment.

Table C.1c. Substance Abuse Characteristics

Drugs Of Choice	%
% Alcohol	20.4
% Heroin	8.3
% Crack/Cocaine	32.7
% Marijuana	12.2
% Missing	26.5
Frequency Of Use	
% No past month use	24.5
% 1-3 times in past month	2.0
% 1-2 times per week	10.2
% 3-6 times per week	6.1
% Daily	32.7
% Missing	24.5
% Any Prior Treatment Experience (including self-help groups and education)	59.2

Continuum of Care. Site One served a total of 49 clients within the modified therapeutic community (TC). At the time of this report seven clients were still active in the TC program within the jail. Of the other 42 clients, data was submitted to indicate that 10 were discharged successfully, (completed or transitioned to other treatment) 28 had been discharged unsuccessfully, and five went to another prison or jail before program completion. Of those 35 clients who were discharged from the program (but not sent to another prison or jail), two (5.7% of the 35 who were "eligible"-not sent to another prison or jail) continued treatment in the community. The average length of time (LOT) spent in the first phase of treatment (jail-based) was almost 77 days, but ranged from three to 439 days.

Graduated Sanctions. Of the 49 clients served by Site One in the modified therapeutic community, 28 committed some sort of infraction (47.5%, see Table 3.1d), with the average client committing 1.6 infractions. The most common infractions were negative program behaviors (35%) and non-participation in a group session (23.8%). Program staff responded to instances of non-compliance by issuing a written warning in 26% of these incidents and verbal warnings in 8.5% of these incidents. Responses ranged from verbal warnings to administrative removal/therapeutic discharge.

Drug Testing. Drug testing of RSAT clients was performed, by the jail on a random basis. A total of 37 out of 49 clients were tested, with an average of 2.8 drug tests per client, during their stay in the modified therapeutic community. As such, program participants were tested at a rate of once every 32.9 days. According to the results that were provided, two clients tested positive for marijuana and one for sedatives.

Table C.1d. Graduated Sanctions

Total Number of Clients	49
Number of Clients with Infractions Reported	28(47.5%)
Mean Number of Infraction Events	1.6
Total Number of Infractions Reported	80
Most Serious Infraction(s) Reported	
Negative Behaviors	28(35.0%)
Non-participation in Tx Group	19(23.8%)
Inappropriate Language/Talking	9(11.3%)
Violation of Jail Rules	8(10.0%)
New Felony Arrest	4(5.0%)
FTA (Treatment or Testing)	4(5.0%)
Community Violations	2(2.6%)
New Misdemeanor Arrest	1(1.3%)
Other	5(6.3%)
Total Number of Responses Elicited	82
Most Serious Response(s) Elicited	
Written Warning	21(25.6%)
Verbal Warning	7(8.5%)
Therapeutic Tasks	9(11.1%)
Admin. Removed	5(6.1%)
Increased Supervision	3(3.6%)
Violation Action	2(2.4%)
Meet Supervision Agent	1(1.2%)
Other	34(41.5%)

Table C.1e. Drug Testing

Total Number of Clients	49
% Clients Tested	76%
Mean Number of Drug Tests	2.8
Rate of Drug Testing	1 drug test / 32.9[3] days
Marijuana – Positive	2
Sedatives – Positive	1

[3] This number reflects the rate of drug testing for those clients for whom drug-testing data was submitted. There were several clients for whom no drug testing data was submitted and were, therefore, not included in this calculation.

C. Treatment Program and Observations

Structured Interview & Informal Observation Results. During the observation period the treatment program at Site One was serving nine client/inmates. While the program intended to provide services using three clinical staff (including one case manager) two full time treatment/administrative staff were assigned to the program during the observation program. Originally, the unit was to be staffed by a third counselor (case manager), however at the time of the observations the position was vacant. A search was ongoing to re-fill the position. The primary counselor (counselor A) recently earned a Bachelor's degree in Social Work. The two staff members shared a small office (converted from a supply closet) just outside the clients' living unit. Counselor B split his time between administrative and clinical duties, while Counselor A was more exclusively involved in the provision of clinical services.

Neither the jail, nor the treatment program employed a case manager at the time of the observations, however the treatment staff did report working directly with clients to assess their needs for further treatment services and refer them to such services. In general, according to interviews with both treatment and correctional staff, these two groups seem to work well together.

As intended, the treatment staff appeared to make use of a variety of program materials, from several different pre-packaged social skills and other therapeutic/educational curriculum materials. Most treatment activities took place in the dormitory style living unit. Program participants were allowed off the unit as a group for outdoor recreation, but ate meals, and spent most of their free time on the unit. The inmates were housed on a unit measuring approximately 30 by 20 feet, which included its own, semi-private bathroom facilities. The unit contained one shower, with a curtain, and a single toilet, which was separated from the main area only by two low walls. The unit contained two metal tables, about 15 plastic resin chairs, and five sets of bunk beds, each with a set of built-in drawers for the storage of inmates' clothing, personal items and commissary purchases. The walls of the unit were covered with materials related to the program, such as diagrams of the treatment process, unit and jail rules, lists of common thinking errors, such as "If, then" and other related materials, such as the serenity prayer. These materials were consulted and referenced by the counselors throughout the treatment sessions.

Treatment Activity/Schedule. The treatment program planned to have 15 meetings per week (3 per weekday). During the observation period all of these scheduled meetings were conducted. On Friday afternoon, clients were allowed to watch a movie on videotape rather than participate in a final afternoon educational meeting. Counselors presented this privilege to the group as a reward for a long week of treatment activities. Over the course of the week's observations, the early morning meetings appeared to attempt to build community and refocus clients' commitment to treatment. These meetings are conducted by role models from within the group.

The late morning and afternoon meetings were aimed at providing education to the group members. This was accomplished by means of an interactive style lecture, lead by the counselor. Information provided during the early part of the week of observations centered on spirituality and its role in recovery. Differences between spirituality and religion were discussed at length. The role that faith in a "higher power" can play in recovery was also discussed. The domains of

mental, physical, emotional and spiritual existence were reviewed. The characteristics of a healthy and unhealthy person, in terms of each domain, were identified with the help of member feedback. Similarly, ways to improve deficiencies in each of these areas were developed and made relevant for each member. This part of the week's curriculum also involved two video tape presentations, one based on a traditional AA model of spirituality and another using a combination of AA and Native-American teachings on spirituality and manhood. In all, it seemed that the goal of discussing spirituality was consistent with the AA model, whereby faith in a "higher power" is one of the cornerstones of recovery. It may also serve in a more secular sense to provide members with an alternative activity, i.e. prayer or meditation, to use in the future when faced with a trigger to relapse.

Later in the week, the focus of the educational groups shifted to a review of some of the materials used during the "orientation phase" of the program. About half of the group had not been exposed to these materials, as they had come to the program at various times over the last six months. The counselor's plan for this review was to begin to involve some of the inmates who had already learned this material in teaching the newer members. This plan appeared to work, to a limited extent, in that the counselor solicited details from the notebooks of older members on the materials to be discussed. However, at no time did the inmates who had prior exposure to these concepts actually take over the leadership of the group and 'teach' the materials to the newer members. In general, they simply answered questions from their own notebooks in response to the counselor's questioning.

The topics reviewed during these educational meetings included basic aspects of drug treatment, the attitudes necessary to participate in such treatment, the definition of 'therapeutic community', (not surprisingly this was defined by the members as a "place for members to work on their individual issues in the group") and the assumptions underlying therapy. These topics served to introduce the philosophies and techniques of therapy to the inmates. Some of the newer members, who had not had previous exposure to these concepts, but had nevertheless been participating in the group for at least a month, seemed extremely interested in these topics, as though they had been missing something up to this point.

Several of the late morning and afternoon educational groups began with the group practicing a few basic steps of Tai Chi, as presented on videotape. The purpose of these exercises appeared to create an awareness of the need for physical and mental 'wellness', as well as to build community, as the group learned the different moves together. In fact, the counselors stated that they had been discussing 'wellness' issues prior to our arrival. In addition, the early week's discussion of spirituality and the aspects of mental, emotional, and physical health were framed in terms of 'wellness'. It is not clear whether the videotape presentation of the Tai Chi exercises succeeded in heightening awareness of the need for wellness, or in building community spirit, but the inmates did generally seem to enjoy the activity.

Counselors. At the time of the observations, there were two full time clinical staff members for this program. Counselor B appears to split his time between clinical and administrative duties. He serves as the "program director" and has several years of experience working with inmates and drug addicts, including serving in a program administrative role while in the military. Counselor A is newer to both this program and to providing drug treatment, in

general. He has recently finished his Bachelor's degree in social work and appears genuinely motivated to help addicts with their recovery.

Roles Models and Community Process. At the time of the observations there were three roles or functions for group members in this program: the Coordinator, Assistant Coordinator, and the Expediter. All inmates in the program rotated monthly through these roles, "based on demonstrated acceptance of responsibility," according to the program director. However, there was no "right of passage" associated with the assignment of these roles, nor did the community vote on who will play each role. Instead, there was simply a system whereby each member rotates through each position. The responsibilities of each role did not appear to be clearly defined. However, the Coordinator seemed to run the early morning group, soliciting suggestions on what the group should read aloud, as well as member feedback on those materials. The Assistant Coordinator appeared to take charge of soliciting pull-ups and push-ups from the group, while the Expediter solicited any new business that members wished to discuss. Outside of the early morning group, the three role players seemed to do little in terms of their assigned responsibilities. In general, outside of the early morning group, whether someone participated in the group process, or took on a leadership role appeared to be influenced not by assigned role, but by member's personality style and current mood.

Overall, despite working together during various treatment activities, the community of offenders did not seem particularly close knit or effective in eliciting change in its members. This may be partially due to the fact that only half of the members had had the entire program curriculum and had lived together for roughly six months. As mentioned above, about half of the group had not received the entire curriculum and had been on the unit for one to three months at the time of these observations. Yet, the original members did not display a sense of community either.

In general, the members had the idea that they should ideally work together on their problems, but in the end they resorted to looking out for themselves alone. In fact, late in the week when asked to define a 'therapeutic community' several members offered definitions which emphasized the need to "work on our *individual* problems, in the group", defining the group as a setting for *individual* change only. The members were successful in pointing out each other's problem behaviors, such as one member identifying one member for instigating hostility between two other members who he knew to have had previous problems together. However, they seemed to lack the ability to identify issues that might underlie those problem behaviors. Similarly, the group seemed less interested in developing productive substitute behaviors, than in having the member in question cease the 'irritating' behavior. Nor did the members seem to point out others' behaviors with the intent of helping that member. Instead, they appeared more concerned with getting him to stop something that they perceived as bothersome (not framed as 'unhealthy'), or in pointing out another's foibles for the mere sake of pointing them out. In other words, despite a few vague references to the contrary, there did not seem to be a genuine interest among many members to help their 'fellow man' in his recovery or growth. Overall, some of these community development issues may have been compounded by the short period of time that the program had been operating at the time of the observations.

Structured Observation Results. The overall program emphasis appears to have predominantly focused on the "disease model" of addiction, as well as on spirituality (See Table C.2). Each of these emphasis variables was frequently rated as being "highly used" (61% of the meetings were rated as using these items at a level of "3" or higher) during the observed meetings. A substantial number of meetings (53%) also focused to a large extent on issues of "contemplation of change." The program emphasis employed at this site frequently did not involve action planning (69% of meetings rated as "not used" on this variable), aftercare (92%), maintenance (69%), motivation (69%), motivation readiness (54%), redefining action (100%), or relapse prevention (69%).

Table C.2. Program Emphasis at Site One
(n=13 men's meetings observed)

Variable	High Use	Not Used	Variable	High Use	Not Used
Acceptance/Disease	61%	15%	Motivation Readiness	31%	54%
Action Planning	23%	69%	Redefining Action	0%	100%
Aftercare	8%	92%	Relapse Prevention	23%	69%
Contemplate Change	53%	30%	Self-work	46%	23%
Maintenance	23%	69%	Spirituality	61%	39%
Motivation	23%	69%			

In terms of topics discussed (see Table C.3) during meetings at this site, cognitive (92% high use) and emotional skills (85% high use) dominated the focus, as did issues around psychological development (84% high use), socialization (69% high use), and social relatedness (61% high use). Discussions of diaries, TC issues, aftercare, past street experiences, learning from others in the group, healing experiences, physical safety, recent incidents, and nurturance were also largely unused. In general, an emphasis was placed on topics related to accomplishing tangible present-oriented individual changes, without as thorough consideration of past experiences or issues related to the TC group itself.

Table C.3. Treatment Topics at Site One
(n= 13 men's meetings observed)

Variable	High Use	Not Used	Variable	High Use	Not Used
Aftercare	23%	77%	Past Experiences	39%	46%
Cognitive Skills	92%	8%	Physical Safety	15%	69%
Psychological Development	84%	8%	Psychological Safety	39%	39%
Diary	8%	92%	Emotional Skills	85%	15%
Subjective Learning	0%	69%	Socialization Issues	69%	8%
Incident Review	31%	61%	Social Relatedness	61%	15%
Letters	0%	100%	Street Experiences	15%	69%
Nurturance	31%	54%	Healing	23%	69%
Unit Issues	38%	54%	TC Issues	15%	77%

In terms of treatment activities, awareness training and peer encounter activities (each with ratings of 92% for high use) dominated the meetings, while parenting, vocational education, and discussion of discharge goals were largely unused (see Table C.4). Again, the focus on awareness training may signify a focus on individual level change, while the dominance of peer encounter methods may suggest that this type of activity is taking place with the participation of the entire group. The lack of focus on several other potentially useful treatment activities suggests that many other important aspects of drug related problems (such as poor parenting abilities or lack of vocational skills) might be underutilized.

Table C.4. Treatment Activities at Site One
(n= 13 men's meetings observed)

Variable	High Use	Not Used	Variable	High Use	Not Used
Awareness	92%	8%	Vocabulary	31%	46%
Check-In	15%	62%	Parenting	0%	100%
Community Management	15%	85%	Discussion of Discharge	8%	92%
Emotional Growth	61%	15%	Community Enhancement	8%	85%
Discussion of Goals of Phase	8%	85%	Peer Encounter	92%	8%
Education	53%	39%	Pull-Ups	8%	54%
Relapse Prevention	46%	54%	Trigger Analysis	39%	61%
Pre-release Planning	46%	46%	Sharing Experiences	30%	15%
Vocational Education	0%	100%	Therapeutic Education	61%	15%

Treatment style at this site typically involved formal (100% high use), community-oriented and interactive interventions (each used to a high degree in 92% of meetings). Punishment, reward, and listening post activities were largely unused (see Table C.5). Treatment services in this program appear to be largely delivered in a group setting, to the entire community. All observed meetings were described as "formal," typically meaning they were previously scheduled, rather than spontaneously occurring treatment activities. Finally, most of the meetings were delivered in a manner that allowed for interaction between the counselors and group members or among group members. Specialized meeting styles (listening-post activities or reward/punishment meetings) were infrequently, if ever offered.

Table C.5. Treatment Style at Site One
(n= 13 men's meetings observed)

Variable	High Use	Not Used	Variable	High Use	Not Used
Check-In	15%	62%	Introspective	54%	31%
Community-based	100%	0%	Listening Post	8%	92%
Formal	92%	8%	Punishment	0%	100%
Informal	23%	77%	Reward	8%	92%
Interactive	92%	8%	Staged Presentation	23%	77%

Finally, in terms of the View of the Residential Community (see Table C.6), this site frequently employed collective formats (100% high use), participant involvement (100% high use), membership feedback (92% high use), open communication (85% high use), and structured systems (84% high use). This program focused much less on individual relationships within the group (56% not used) and confrontation (46% not used). Overall, the program appeared to use group formats to provide education, teach various individual skills, and resolve conflicts, rather than focusing on using the community itself to build group cohesion and promote recovery.

Table C.6. View of the Residential Community
(n= 13 men's meetings)

Variable	High Use	Not Used	Variable	High Use	Not Used
Confrontation	46%	46%	Use of Participants	100%	0%
Collective Formats	100%	0%	Individual Relationships	23%	54%
Membership Feedback	92%	8%	Use of Role Models	62%	15%
Collective Norms	38%	31%	Structured Systems	84%	8%
Open Communication	85%	15%			

D. Summary/Discussion

Site One served a total of 49, male clients, most of whom exhibited extensive criminal histories and poor employment records. The most commonly used drugs among these clients were cocaine/crack and alcohol. Of the 49 clients served, 41 were discharged, with 10 being discharged successfully. The average number of days spent in jail-based treatment was 77 days, substantially less than was intended (6-18 months reported by the treatment staff, 6 months required by the state's own criteria). Ten of the 41 (20.2%) discharged clients were transitioned to a second phase of treatment. There were relatively few infractions reported at Site One, with the average client committing 1.6 infractions over the study period. Infractions also tended to be relatively minor, consisting mostly of negative program behaviors or non-participation in treatment sessions. The average client submitted 2.8 drug tests during the study period and only three clients tested positive for drugs (marijuana and sedatives).

The treatment program itself focused on drug addiction from the perspective of the disease model, by emphasizing issues related to spirituality, and to a somewhat lesser extent by focusing on the contemplation of change. Somewhat inconsistently with these program emphases, the program focused on treatment topics more characteristic of an "action planning stage," in which clients work to make concrete changes in their behavior, values, and thinking patterns. For instance, cognitive and emotional skills, as well as psychological development, socialization skills and social relatedness were topics commonly discussed at great length at this site. In addition, awareness-training and peer encounter activities were commonly employed at this site. These treatment activities again seem somewhat inconsistent with the program's apparent emphasis, which appears to focus on spirituality, the disease model (addiction being beyond an individual's control), and merely the contemplation of change (rather than planning or implementing specific changes characteristic of an "action planning stage"). These activities are however relatively more consistent with the type of treatment topics discussed (e.g. socialization and cognitive/emotional skill development). The style in which treatment was delivered tended to be formal, scheduled, and delivered to the entire group in an interactive style. Overall, the primary counselor appeared generally skilled, providing appropriate guidance and information to the group.

Despite the program providing some information on clients' drug use and criminal history it appears, from the large amounts of missing data reported, that the treatment providers were unaware of the background characteristics of many of their clients. Without this information, it may be difficult for the counselors to tailor the program services to the specific needs and characteristics of the individual client.

In addition to the difficulty presented by a lack of complete information on clients, the treatment program suffered from difficulties presented by the use of open groups. While many of the group members had had several months of exposure to the treatment curriculum, there were a few members much newer to the program (one had only been in the program for one month). This mixing of clients with different levels of experience with this drug treatment approach seemed to interfere with both the progress of individual members (some were working on advanced therapeutic concepts, without having learned the underlying basic materials) and with the sense of community developed among the members as a whole. Improved selection of

clients (all of whom should have enough time in jail to complete meaningful portions of the treatment program together) would likely reduce this program implementation problem.

Related to this open groups issue, the community-building goal (particularly of the morning community meetings) seemed inconsistently met. Members used these community meetings to bring up their own issues or point out other member's problem behaviors. However, the group seemed largely unable to resolve any of the issues they raised, even at times with the help of intervention from the counselors. Nor did the group seem consistently able to identify the important underlying issues that relate to the problems they are addressing.

Prosocial value development was not consistently done and the group sessions did not tend to follow through on cognitive processing of issues discussed in treatment sessions. For example, during one morning meeting an African-American group member brought up another (white) member's use of what he perceived as a racial slur in reference to a basketball player. To paraphrase the white group member's comment in his defense: 'you said something about a white player, so I called the black player a name'. The members and the counselors debated back and forth about who decides if a word is considered a racial slur, with the counselor eventually saying to the white group member, "the word you used is considered a racial slur whether you think so or not." The fact that the counselor had to intervene and 'lay down the law' in order to resolve the issue appeared to undermine the community's ability to regulate itself, or learn how to regulate itself.

Both the counselors and the group members seemed to miss what might have been a very enlightening underlying issue, specifically that the members in conflict were operating from a view that "two wrongs make a right". This kind of antisocial thinking, if addressed effectively could have benefited the entire group's therapeutic learning. In general, then it seems that the group may lack not only community cohesion and an investment in working together to help each other, but also seems to be ineffective in following a set of prosocial values, such as respecting each other, that are cornerstones of the TC.

Another example involves the failure to reinstate community rules. During another morning meeting a member brought up the fact that several others had been talking late at night, after lock in, and after having been told to be quiet by a guard. In fact, while a few members mentioned that the core issue was about respecting each other and the need to live together, the end result was a complete failure of the group to acknowledge this need for respect and establish a set of guidelines for the group to live by. The group debated whether or not they needed to respect each other by being quiet during sleeping hours, going so far as to take a vote on the proposed unit rule requiring no talking after 1:30 a.m. The group voted against such a rule, even though doing so apparently contradicted jail rules. From this incident it appeared that the group was unable to agree on a set of rudimentary rules by which to live. Potentially more disruptive to the treatment process, they could not recognize or agree that the issue was one of respecting each other. Again, this appears to point to the lack of community cohesion and investment in prosocial values among the group members.

Overall, Site One was successful in implementing a modified TC drug treatment program meeting several of the standards set out by the various funding agencies (e.g. separate living unit,

drug testing, the use of treatment approaches of proven effectiveness). Like other sites, several difficulties encountered were the use of open groups and the development of the group's ability to work together, rather than merely as a collection of individuals. These two issues are likely at least partly related. The use of closed groups would likely help promote a sense of community and allow members to begin to work more consistently with one another over a relatively long term. Similarly, the treatment techniques used in the program can likely be more effectively targeted at promoting the traditional TC concept of the peer community.

Appendix D:

Site Two Description

A. Site and Program Design Overview[1]

Site Two is a 1,000-bed facility serving southeastern Virginia. The overall TC program at the Site Two included three male TC units and one female TC unit. One male unit and one female unit were observed as part of this evaluation. Each of the male units (and the female's unit) was similar in design to the one observed and described in this chapter. The Therapeutic Community programs, for males and females, were each designed to house 15 inmates in separate units within the facility. The units each consisted of approximately 8 double-bunked cells arranged along a corridor (roughly 20 feet long) which connected the units' locked entrances, to the common rooms at the opposite end of the hallways.

Each common area is approximately 15 by 25 feet, with two large, screened windows approximately 10 feet tall. All treatment activities observed during the week were conducted in these common areas. Each unit contained its own bathroom facilities, including one shower, with a curtain. Each cell also contained a single toilet/sink combination. The common area also contained a television and VCR, which were apparently under the direct control of the inmates and thus could be watched at any time, outside of scheduled program activity periods. The unit was equipped with a video surveillance camera, hung from one corner of the ceiling. The lighting in the common room provided a yellowish-tint to the setting. An intercom speaker was located in the middle of the common room ceiling and jail-wide announcements were made throughout the day (including during treatment activities). Inmates were fed on the unit, with the main door being opened when meal trays arrive.

The walls of the unit were covered with materials related to the program, such as the AA 12 Steps, the Serenity Prayer, unit rules, a list of who has been elected to each of several inmate positions, a schedule showing each inmate's current position within the program curriculum, and various posters made by inmates (either as homework or sanctions for being "pulled-up"). These materials, particularly the 12 steps, were frequently consulted and referenced by the counselor(s) during treatment sessions.

The programs are designed to be run by one full-time counselor each. Program staff reports that drug testing of program inmates is conducted by the jail itself, but not specifically as part of the treatment program. The program does not have an assigned case manager, but the facility itself has a case manager to help coordinate aftercare services for both treatment participants and other inmates within the jail. The facility case manager works with both the treatment providers and the client to develop an appropriate aftercare plan, however jail clients are not given a priority for community treatment slots. Expected treatment length is six months

[1] Site Two was observed for four consecutive days in June, 1998, approximately six months after the RSAT funded treatment program had been in operation. The structured observation results describing the treatment program at this site represent the program as it operated at that time. The structure and operation of treatment programs may change over time. Data reported by the sites (e.g. client characteristics, drug testing) represent the entire 14-month period of the evaluation effort.

for both programs. Treatment staff do not have office space within the jail, however the agency does have a satellite office, located just off the jail grounds.

Women's Program Design. Site Two employed what was called the "S.I.S.T.E.R.S. program," on the women's unit. The women's program was designed to provide several therapeutic activities every weekday, from 8:30am to 9:00pm. One female counselor was to provide services to the women's program. Male staff members were not allowed on the women's living unit at any time. Treatment staff reported that the facility had recently had problems involving inappropriate contact between female inmates and male correctional staff, which lead to the implementation of this rule. All treatment activities provided to the female program participants took place on the living unit. In fact, the women were infrequently allowed off the unit to participate in facility-wide privileges (e.g. for outside recreation), apparently in an effort to avoid further inappropriate contacts. Inmates on the men's TC unit were allowed off their unit for recreation and other jail services.

From 8:30 a.m. until 9:00 p.m., the women's group follows a daily schedule that includes community (with the therapist) and pod (without the therapist) meetings, parenting skill classes and various other individual and spiritual activities. The group also has free time when they are to interact with each other in a pro-social manner. The women's therapeutic community at this site meets with their therapist twice a day, five days a week, for approximately an hour and a half. The scheduled time for the group's meetings varies depending on the overall jail's schedule. For example, there are several other programs offered to the women's unit (i.e., parenting classes and bible classes) that coincide with the therapeutic sessions. Hence, the timing of the group sessions, as well as the groups themselves must be flexible within the correctional facility. The week's observations focused on numerous issues ranging from past personal experiences to skills relating to recovery.

Men's Program Design. The men's unit did not utilize a specific program curriculum, but did appear to follow a relatively "traditional" TC model (e.g. extensive use of member roles, structured systems, a period of junior level status). The TC programs were designed to provide treatment activities three times a day, five days a week. The inmates in this program had three primary program activities each day. First, between 8:00 and 9:00 each morning the inmates conducted a group meeting. The men's community meeting began with an exercise period, which was scheduled to last about 10 minutes. Then, the traditional AA-style check-in was followed by some brief readings selected from either the Alcoholics or Narcotics Anonymous books. These readings included AA "traditions" and short stories of others' addiction-related problems. In addition, feedback was solicited from the group on the readings. Then, any needed "pull-ups" or "push-ups" were solicited. Finally, members were given the opportunity to bring up any new business or issues. During the observed meeting, the members voted on each of the 9 unit positions, including Coordinator, Facilitator, Supply Clerk, Orientation Representative and Education Coordinator. This meeting was then closed with the group joining hands in a circle to recite the "Serenity Prayer."

The second meeting began at 9:00 a.m. and ran until lunch trays were delivered, typically between 10:30 and 11:00 each morning. For the most part, this meeting was run by the counselor, with the focus on group members (who were free to bring up any pertinent issues they

wished to discuss). The final structured group activity of the day took place between 1:00 and 3:00 each afternoon. This activity differed from day to day, with an outside parenting skills provider working with the group twice a week, and the TC staff filling in the remainder of the afternoon meetings, apparently as staff resources allowed.

B. Overview of Program Implementation

Characteristics of the Sample. The Residential Substance Abuse Treatment (RSAT) program at Site Two served a total of 57 female clients[2] since program inception (See Table D.1a). This site reported no data for male members of the TC program because the program is not funded by RSAT. The average female client is approximately 34 years of age. Approximately half of the female clients served by this program were Caucasian (45.6%), with another 45.6% identified as African American. None of these clients were employed in the last 30 days.

Table D.1a. Demographic Characteristics at Site Two

N (females only)	**57**
Mean Age	**33.8**
Minimum-Maximum	**20.0-51.8**
Standard Deviation	**7.2**
%Female	**100.0**
%African American	**45.6**
%Caucasian	**45.6**
%Missing Race Data	**8.8**
%Employed	**0.0**

Site Two female clients have been arrested an average of 11.6 times, resulting in approximately seven convictions (See Table D.1b). The data that was submitted indicates that most of the clients are incarcerated for a violation or probation/parole (26.3%), with another 17.8% incarcerated as a result of a property offense, and 17.7% incarcerated for a miscellaneous offense (e.g., contempt of court, habitual offender, failure to appear, etc.). Nearly 25% of the clients did not have an instant offense reported, suggesting that treatment providers were unaware of the criminal history of a substantial portion of their clients.

[2] Site Two submitted information for more than 57 female clients. However, no Client Treatment Movement data was submitted for these clients, or it was submitted too late to be included in this report. With no way to tell if they ever entered the modified therapeutic community, they were not included in this table. The men's TC program was not specifically funded by the RSAT grant program, thus data was not reported on these male subjects. Observations of the men's program were conducted in order to make programmatic comparisons.

Table D.1b. Criminal History Characteristics at Site Two

Mean Number Of Adult Arrests (females only)	11.6
% of Arrest Data Missing	7.0
Mean Number Of Convictions	6.7
% of Conviction Data Missing	7.0
Instant Arrest Offense	
%Property Crime	17.8
%CDS Possession	10.6
%VOP	26.3
%Prostitution	3.5
% Other	17.7
%Missing	24.6

The primary drug of choice identified by most Site Two female clients was crack/cocaine (43.9%), followed by heroin (21.1%) and alcohol (15.8%). Apparently, treatment providers had better access to clients' drug abuse histories (than they did to criminal history information), as only about 12% of clients had missing data on their primary drug of choice. The overwhelming majority of female clients had not used drugs in the past month (68.4%), probably due to the fact that they have been incarcerated during this time. This almost certainly has not been their first experience in a treatment program, with approximately 75% reporting that they have received some form of prior treatment services.

Table D.1c. Substance Abuse Characteristics

Drugs Of Choice	**(females only)**
%Alcohol	**15.8**
%Heroin	**21.1**
%Crack/Cocaine	**43.9**
%Marijuana	**5.3**
%Methamphetamine	**1.8**
%Missing	**12.3**
Frequency Of Use	
%No past month use	**68.4**
%1-3 times in past month	**1.8**
%1-2 times per week	**5.3**
%3-6 times per week	**0.0**
%Daily	**14.0**
%Missing	**10.5**
% Any Prior Treatment Experience (including self-help groups and education)	**75.4**

Continuum of Care. Site Two served a total of 57 female clients within the modified therapeutic community. Of these 57 female clients, data was submitted to indicate that 14 had been unsuccessfully discharged, 10 had been successfully discharged and 22 had been sent to another prison or jail. Of the 24 who had been discharged, 11 (45.8% of the 24 who were eligible) went on to receive treatment in the community. The average length of time (LOT) spent in the first phase of treatment (jail-based) was almost 77 days, but ranged from five days to 216 days.

Graduated Sanctions. Of the 57 female clients served by Site Two in the modified therapeutic community, 33 committed some sort of infraction (57.9%). In fact, the average client committed 3.7 infractions. The most common infraction was inappropriate language/talking out (31.7%). Infractions ranged from not following the dress code to violence, sex or weapons on site. Program staff responded to instances of non-compliance by restricting privileges (30.8%) and issuing therapeutic tasks (25.8%). Responses ranged from a verbal warning to a violation action.

Table D.1d. Graduated Sanctions at Site Two

Total Number of Clients	57 (females)
Mean Number of Infraction Events	3.7
Number of Clients with Infractions Reported	33(57.9%)
Total Number of Infractions Reported	208
Most Serious Infraction(s) Reported	
Inappropriate Language	66(31.7%)
Negative Behaviors	20(9.6%)
Personal Space Violation	19(9.1%)
Program Non-participation	17(8.2%)
Program Rule Violations	16(7.6%)
Trust Violations	14(6.7%)
Contraband Possession	11(5.3%)
FTA Treatment Session	10(4.7%)
Violation of Jail Rules	6(2.9%)
Area Restrictions	5(2.4%)
Verified Negative Behavior	5(2.4%)
Drug Use	4(1.8%)
New Felony Drug Conviction	1(.5%)
Fail Prior Sanction Condition	1(.5%)
Other	13(6.3%)
Total Number of Responses Elicited	198
Most Serious Response(s) Elicited	
Therapeutic Sanctions	80(40.4%)
Restricted Privileges	61(30.8%)
Verbal Warning	9(4.5%)
30 Day Suspension from Treatment	7(3.5%)
Area Restrictions	5(2.5%)
Admin. Removed	3(1.5%)
Telephone Call	3(1.5%)
Violation Action	1(.5%)
Other	29(14.6%)

Drug Testing. Drug testing results were conducted on 26 clients, 36 percent of the offenders. The average client submitted 2.2 drug tests during their stay in the modified therapeutic community. As such, program participants were tested at a rate of once every 35 days. This rate was calculated as the number of drug tests divided by the length of time (LOT) spent in the treatment. According to the results that were provided, clients tested positive for three different substances (marijuana, cocaine, or heroin).

Table D.1e. Drug Testing at Site Two

Number of Clients Tested	**29**
Mean Number of Drug Tests	2.2
Rate of Drug Testing	1 drug test / 35.0[3] days
Marijuana – Positive	1
Cocaine – Positive	1
Heroin – Positive	1

C. Treatment Program Description

Structured Interview & Informal Observation Results (Both Units). During the observation period the treatment program units at Site Two were serving 14 male clients and 11 female inmates. The program provided services to these two units with two full time counselors. A part-time male intern also provided services to the men's program observed as Site Two. While the RSAT grant requires a case management position be employed in the TC program, no specific staff member was assigned these duties at Site Two. As intended the program appeared to make use of a variety of treatment approaches in dealing with clients. Most treatment activities took place on the separate living units, assigned to the program, as intended by the RSAT and state of Virginia program guidelines.

According to structured interviews with several of the treatment staff, many of the correctional officers did not respect the program or the treatment process. Based on interviews with the correctional staff, most of the correctional officers appeared to know very little about the treatment program. In addition, several instances were observed in which correctional staff openly disrespected the TC clients. In addition, the daily operation of the jail frequently seemed to work against the program's treatment activities. For example, jail staff frequently interrupted group meetings to deliver laundry or lunch trays, and announcements over the intercom continually disrupted meetings.

Treatment Activity/Schedule (Men's Unit). Site Two's treatment program attempted to implement two to three treatment activities per day, including some activities which were provided by outside staff (e.g. parenting skills meetings). For the most part the program was successful in implementing its scheduled number of treatment meetings. The early morning meetings seemed to attempt to build a sense of community and commonly dealt with housekeeping issues and refocusing client commitment to treatment. The fact that the meeting was run by the leaders, from within the group, seemed to help get the community involved in their own treatment. To a certain extent members demonstrated to each other that the work of recovery can be done, and that the group can be supportive in that work. The purpose of this meeting appeared to be partially met, in that members were helped to focus their attention on the treatment activities of the day and could take the opportunity to resolve daily living issues, as well as "push-up" or "pull-up" their peers. However, our observation of the community meeting was the first that the counselor had attended in several weeks and he was notably disappointed by

[3] This number reflects the rate of drug testing for those clients for whom drug testing data was submitted. There were 28 clients for whom no drug testing data was submitted and were, therefore, not included in this calculation.

the failure of the group to conduct the exercise period for as long as it was intended.

The second meeting for the men's program was rather unstructured, as the counselor opened the meeting by soliciting an issue to discuss directly from the clients. Yet during the week of observations the group never failed to come up with a relevant and typically productive topic, from their recent experiences. The counselor typically began the meeting with a solicitation such as "What do we need to work on today?" In response, he himself sometimes had a pre-planned answer, such as the need to have one member recite the 12 steps as a rite of passage in the group, the need to review pull-ups, or the need to discuss a group member's homework assignment (e.g. a letter to his mother). At other times, a group member would bring up an issue to discuss, taking the opportunity to present it to the group.

For example, one member had tried to call his brother, with whom he had a tenuous relationship, the evening before and was told by his brother's wife that the brother did not wish to talk to him. This precipitated a discussion by the group around issues of abandonment by their families, while in jail. This topic proved to be quite a revealing and productive one, as several members of the group appeared to accomplish some very difficult self-exploration, to the point that several were crying over past wrongs they had apparently committed against their families. While this group was typically run in an interactive style, with the counselor directing the group, more than the group directing itself, the group members did participate and offer each other appropriate feedback.

The afternoon meeting did not appear to be as regularly conducted by the TC staff, as was the morning meeting. In fact, for differing reasons, no afternoon group meetings were observed over the course of the week. It was not possible to make arrangements with the parenting skills providers to observe their groups and the TC staff afternoon meetings in some instances conflicted with previously scheduled structured interviews with either correctional or treatment staff.

Nevertheless, the later-morning and afternoon meetings were aimed at providing therapy and/or education to the group members. This was accomplished by means of an interactive discussion, lead primarily by the counselor. Again the structure and topic of these meetings were dependent on the issues relevant to the members on a given day. For example, on Monday the counselor discovered that two members of the group had, over the weekend, cut their hair in very unusual styles. One had cut a lightning-like, "zig-zag", Mohawk pattern into his hair, while the other had cut a "Grateful Dead" skull into the back of his head. The counselor began the conversation saying: "I got to tell you guys something...what the hell is going on with your hair?" This precipitated a discussion among the group members and counselors as to how it was important to present oneself in a socially acceptable manner, particularly if the members want to be taken seriously as "recovering" people. The counselor, along with some of the group members, insightfully noted that the haircuts were the continuation of "drugging" behaviors, such as attention seeking and "looking stylish." The member with the "zig-zag" haircut then offered some admissions of guilt and a desire to present himself in a better light, going so far as to say that he wished he could have the clippers back to get rid of the hair cut immediately. The counselor responded to this that it might be better that he was stuck with it for a few days so he could think about it.

The member with the 'Grateful Dead' haircut, who was newer to the group, but coincidentally has reportedly had several hundred arrests and an extensive history of drug abuse treatment, was nearly silent throughout the discussion, beyond his admission that his hair made a poor statement about him. Unfortunately, this member had an upcoming court hearing regarding delinquent child support payments. The counselor expressed concern for the outcome of that hearing, since the judge would likely perceive the group member as irresponsible and antisocial, due to his appearance. This seemed to depress the member, and he remained silent throughout the remainder of the session. As can be seen from the discussion of this incident, the goal of these education/therapy meetings (later morning and afternoon) seemed to be to promote prosocial values by means of community and counselor discussion.

In addition to reviewing current issues which the counselor or group feels are appropriate, the counselor also used these meetings to review homework assignments with the group. One example of this, from another late-morning meeting, involved a young member who was made to read to the group a letter of apology to his mother that he had been assigned, as homework. Then, after this member had read his letter aloud, the counselor reread the letter, changing the pronouns so as to reflect the mother's perspective. He read this letter aloud in a soft, often halting voice, which seemed to have the effect of 'reaching' many of the group members, as several of them, including the member in question, broke out in tears. A discussion of how this letter made the other members feel and how they may have treated their own families in a similar manner followed. The goal of this particular exercise seemed to have been to build empathy, perspective taking, and acceptance of responsibility for their actions as a means of promoting client motivation for change.

Treatment Activity/Schedule (Women's Unit). The women's program also appeared successful in implementing the intended number of treatment meetings. The women's unit counselor also appeared to be successful in working on several important and productive topics during the week. In addition, the female clients themselves seemed able to make use of time spent in the community-run meetings to address anti-social or negative behaviors that arose during unsupervised sessions or free time activities. The female inmates were taught, and seemed to understand, that the therapeutic community is based on working as a cohesive unit in order to aid one another in their recovery. These formal and informal meetings provided the opportunity for the members to recognize and confront negative behaviors, in order to elicit pro-social behavioral change within a communal environment.

In particular, the group spent several sessions discussing issues surrounding the activities of the jail itself. For instance, topics included the jail-wide announcements frequently sent over the intercom, and the varying arrival of lunch trays, mail delivery, and cell checks that often disrupted group meetings. Several members voiced their opinion about the inability to conduct treatment activities over these distractions. As a result of these jail distractions, conversation among members usually ceased and once the interruption subsided, they often appeared hesitant to resume discussing their thoughts.

Despite the annoyed and distraught behavior that was expressed by the group, the therapist was typically able to bring the women back into focus. In fact, the therapist used the

distractions, quite skillfully, as a therapeutic topic. She informed the group that the distractions they were experiencing within the jail were similar to those that they might experience outside the jail. The therapist continued to say that these distractions/interruptions were nothing to get upset about and that they were just everyday occurrences that needed to be dealt with in a positive manner. The interruptions were bothersome, the therapist continued; however, they were not worth the anguish or the anger that they tended to elicit. The group attentively listened to the therapist and began to continue their group discussion apparently disregarding any negative feelings brought about by the interruptions.

Another issue that the therapist was able to transform into a positive, pro-social learning experience, was the issue of perceived favoritism within the jail facility. The female inmates felt that the male inmates receive privileges in excess of the females. For example, the male inmates were allowed to have a recreational period and exercise in a secured yard, whereas the females were not allowed to leave their unit for recreation. In order to help the group deal with this issue, the therapist suggested that the group not get mad (and feel like a victim) but that they should be constructive and strive for change. The therapist emphasized the fact that for years women have remained silent and in order to make a change, it is necessary to pursue the venture in a positive and pro-social manner. Furthermore, the therapist stated that complaining and crying about how "you" are the victim is not going to make anyone want to listen. The therapist concluded the discussion by stating that actively pursuing change in a positive manner can lend itself to beneficial outcomes.

Roles Models and Community Process (Men's Unit). There were nine roles or functions for group members in the men's program: the Coordinator, Expediter, Facilitator, Secretary, Education Coordinator, Orientation Representative, Supply Clerk, Physical Fitness Leader, and something apparently called "the Creative Energy". All inmates who were eligible, by having completed certain milestones in the program (e.g. memorizing and successfully reciting the 12 AA "traditions") vote on who should hold each of these positions. However, there appeared to be no particular level of achievement necessary to be eligible for any position, beyond being a member in good standing (e.g. having passed certain milestones in the program). The responsibilities of each role appeared to be clearly defined and were listed on a wall in the common room. The "Coordinator" seemed to run the early morning group, soliciting suggestions on what the group should read aloud, as well as member feedback on those materials. The "Facilitator" for this unit was sick and had lost his voice, so a volunteer was selected (by the counselor) to fill his role for the week. The interim "facilitator" was a younger inmate who was relatively new to the program and as a result was not particularly effective, nor vocal over the course of his service. Similarly, the "Expediter" did not appear particularly effective over the course of the week. In addition to the interim facilitator's lack of ability, some of the lack of effectiveness of the facilitator and expediter may be due to the fact that the counselor tends to do much of the soliciting of feedback from group members.

The community of offenders in the men's program seemed to work quite well together and despite the fact that several of them were apparently fairly serious offenders, with extensive histories of crime and violence, they generally seemed to have a genuine concern for each other and their progress in recovery. While there were apparently some 'groups' within the group,

(apparently defined by length of time in the group) overall, the community seemed to be able to work together in a respectful, pro-social manner.

As a group, it appeared that there was a relatively high value placed on recovery, self-improvement, and responsibility for one's actions. The group seemed to function well in terms of being able to live together, following the unit rules and policing each other's behavior. Policing of other member's behavior included both daily-living concerns (e.g. respecting each other), as well as therapeutic concerns, (e.g. participating actively in-group meetings and in the community as a whole).

Roles Models and Community Process (Women's Unit). The women's unit maintained the same set of role models as did the men's unit; including the role of coordinator, expediter, supply clerk, and so on. These roles were assigned to group participants by the counselor and were not voted on, as in the men's unit. The role assignments appeared to be taken very seriously by the female TC participants. Furthermore, if the role leaders were not fulfilling their job requirements it was not uncommon for them to be confronted, either by the group or by the therapist. The members' roles were used to instill a sense of responsibility in the female inmates. The therapist expressed to the group that being a leader is difficult and challenging, but if one can learn how to deal with work relationships in jail, then it will better prepare the inmate for work outside the facility. Over the week's observations, it became clear that the role leaders took their jobs seriously and were determined to make a concerted effort in their leadership positions.

The community of female inmates appeared very pro-social and positive in their behaviors and attitudes. The group was able to openly communicate with each other about their personal experiences and anti-social behaviors. Moreover, the group confronted each other on unit issues as well as issues relating to individual behaviors. For example, one inmate "pulled-up" another inmate on being disrespectful to other members in the group. The confronted inmate was a little uneasy about being challenged, but accepted the feedback and responded to the group by stating that she would "get right on that" negative behavior (the appropriate, TC-model response).

The TC participants, for the most part, were very attentive during community sessions. However, at times certain members engaged in side conversations. These side conversations usually took place when another member was talking about a past personal, or unit experience. The group members involved in these side conversations were usually confronted by the therapist. The therapist requested that the disruptive members share their side conversation with the other community members. The therapist not only confronted the inmates who engaged in side-conversations, but also confronted the other members in the group for not confronting the members themselves. The therapist specifically targeted the community's role leaders whose job is to make sure the participants are conducting themselves in a pro-social manner.

Despite some of the disturbances to the community, overall the group appeared to have established a bond that strengthened their recovery process. The members seemed to be able to support each other without sacrificing the need to confront one another on their negative behaviors and thoughts. Furthermore, while the group participants were relatively new to the TC

style of treatment, it was clear that the participants had the ability to lead one another through the pro-social pathways of recovery.

Structured Observation Results. The program emphasis (see Table D.2) at Site Two was dominated by a focus on "Self-work" (89% of observed meetings rated as using this item at a level of 3 or higher), as well as "Spirituality" (78% rated as High Use). "Acceptance of disease" (56% High Use) and "Contemplation of change" (56% High Use) were also used relatively frequently. Most other possible emphases were unused at this site, such as "Redefining action" (100% of observed meetings rated as Not Used), "Aftercare" (89% Not Used), "Maintenance" (89% Not Used), and "Relapse prevention" (89% Not Used).

Table D.2. Program Emphasis at Site Two
(n = 9 meetings observed, 4 men's & 5 women's meetings)

Variable Name	High Use	Not Used	Variable Name	High Use	Not Used
Acceptance/Disease	56%	33%	Motivation Readiness	33%	67%
Action Planning	44%	56%	Redefining Action	0%	100%
Aftercare	11%	89%	Relapse Prevention	0%	89%
Contemplate Change	56%	33%	Self-work	89%	0%
Maintenance	0%	89%	Spirituality	78%	11%
Motivation	33%	67%			

Treatment topics at this site (see Table D.3.) focused on the use of cognitive skills (89% High Use), socialization issues (89% High Use), emotional skills (78% High Use) and psychological development (78% High Use). Topics given lesser emphasis at this site included diaries (100% Not Used), letters (89% Not Used), and subjective learning (89% Not Used). In general, the reliance on these topics may suggest a focus on promoting individual client gains, over the development of a sense of community.

Table D.3. Treatment Topics at Site Two

(n = 9 meetings observed, 4 men's & 5 women's meetings)

Variable	High Use	Not Used	Variable	High Use	Not Used
Aftercare	33%	67%	Past Experiences	67%	22%
Cognitive Skills	89%	0%	Physical Safety	11%	56%
Psychological Development	78%	11%	Psychological Safety	11%	67%
Diary	0%	100%	Emotional Skills	78%	0%
Subjective Learning	11%	89%	Socialization Issues	89%	0%
Incident Review	44%	56%	Social Relatedness	66%	22%
Letters	0%	89%	Street Experiences	33%	56%
Nurturance	11%	67%	Healing	33%	44%
Unit Issues	11%	67%	TC Issues	22%	56%

Consistent with the results obtained for treatment "topics", treatment activities commonly used to a high degree (see Table D.4) included awareness training (89% High Use), peer encounter activities (89% High Use), therapeutic education (89% High Use), and emotional growth training (78% High Use). Most of these activities would be used to support the development of individual client skills, such as cognitive or behavioral changes, rather than a focus on development of the community or prosocial values. Community management or enhancement activities, parent training, and vocational education were not used in any of the observed meetings (100% Not Used). Discussion of program discharge criteria (89% Not Used), the goals of the program phase (89% Not Used), education (78% Not Used), relapse prevention (78% Not Used), and vocabulary (78% Not Used) were frequently not used.

Table D.4. Treatment Activities at Site Two
(n = 9 meetings observed, 4 men's & 5 women's meetings)

Variable	High Use	Not Used	Variable	High Use	Not Used
Awareness	89%	11%	Vocabulary	0%	78%
Check-In	22%	67%	Parenting	0%	100%
Community Management	0%	100%	Discussion of Discharge	11%	89%
Emotional Growth	78%	11%	Community Enhancement	0%	100%
Discussion of Goals of Phase	11%	89%	Peer Encounter	89%	11%
Education	11%	78%	Pull-Ups	22%	44%
Relapse Prevention	11%	78%	Trigger Analysis	22%	67%
Pre-release Planning	56%	44%	Sharing Experiences	67%	22%
Vocational Education	0%	100%	Therapeutic Education	89%	11%

In terms of treatment style, (see Table D.5) this site frequently employed a formal (100% High Use), interactive (100% High Use), and introspective (100% High Use) manner of conducting treatment. Most other treatment style variables were rated as frequently unused in sessions observed at this site.

Table D.5. Treatment Style at Site Two
(n = 4 men's & 5 women's meetings)

Variable	High Use	Not Used	Variable	High Use	Not Used
Check-In	11%	78%	Introspective	100%	0%
Community-based	56%	44%	Listening Post	0%	100%
Formal	100%	0%	Punishment	11%	89%
Informal	11%	89%	Reward	0%	100%
Interactive	100%	0%	Staged Presentation	0%	89%

In terms of the "View of the Residential Community" items (see Table D.6), this site commonly used collective formats, membership feedback, open communication, participation by members and structured systems (all rated High Use in 100% of the observed meetings) to a high degree. Individual relations between members in the group were frequently (68% of meetings) rated as Not Used. Shared group norms were used to a high degree in 68% of the observed meetings, however confrontation was highly used in only 44% of meetings, and was not used at all in 56% of the observed meetings.

Table D.6. View of the Residential Community at Site Two
(n = 9 meetings observed, 4 men's & 5 women's meetings)

Variable	High Use	Not Used	Variable	High Use	Not Used
Confrontation	44%	56%	Use of Participants	100%	0%
Collective Formats	100%	0%	Individual Relationships	22%	68%
Membership Feedback	100%	0%	Use of Role Models	56%	33%
Collective Norms	67%	33%	Structured Systems	100%	0%
Open Communication	100%	0%			

D. Summary/Discussion

Site Two served a total of 57 female clients, during the study period. No client information was provided by this site on male clients. Most of these women exhibited extensive criminal histories and poor employment records. The most commonly used drugs among this group were cocaine/crack, heroin, and alcohol. Of the 57 female clients served, 47 were discharged, with 10 successfully completing the program. Of the 47 discharged, 12 (25.5%) were placed in a second phase of treatment in the community. The average length of stay in jail-based treatment was 77 days, far short of the 6 months intended by the program design and required by the RSAT program and the responsible state agencies.

Among this group of women there were 33 infractions reported, an average of 3.7 per client. The most common infraction was inappropriate language/talking out of turn during treatment. Consistent with the RSAT program requirement, 26 clients submitted drug tests, an average of 2.2 tests per client. Three clients tested positive for drug use (on each for marijuana, cocaine, and heroin). The program also appeared successful in meeting the state of Virginia's requirement that they make use of techniques proven to be effective by prior research, specifically the frequent use of cognitive-behavioral type interventions, as measured by the treatment activity and treatment topics variables. However, as was seen in other sites, the focus on CBT intervention strategies may have caused a trade-off in terms of the program's ability to focus equally on traditional TC program components, such as the development of a sense of community and a set of prosocial values.

The treatment program itself focused on substance abuse from the perspective of self-work, spirituality, acceptance of disease, and the contemplation of change. Treatment topics focused on cognitive and emotional skills, psychological development, and socialization. Treatment activities commonly included awareness training, peer encounter groups, therapeutic education, and emotional growth training. Treatment activities typically were formally scheduled, introspective and interactive in style. Overall, the counselors at Site Two were rated as skilled, experienced, and not rated as overly lax.

For the most part, this group had been together for several months, and this along with the skill of the counselor in reinforcing treatment and more general pro-social goals, may account for the fairly good community cohesion. Despite generally productive and appropriate work while in the formalized group setting, observations after the late-morning meeting on the second day suggest that the progress seen in group-wide activities, may not have yet generalized to the member's entire lifestyle.

Late morning meetings adjourn when officers arrive on the unit to announce "trays" for lunch, however on the day in question the group was in the middle of a heated discussion at that instant and did not respond to line up at the door quickly, as required. As a result, the officers closed the unit door and went on down the hall delivering "trays". However, the group did cease shortly after that and the inmates lined up at the front door. This observer and the treatment intern waited near the door with the inmates for the officers to return, while the counselor continued with some housekeeping issues with several individuals in the common room. At this time one member whose cell is directly in front of the unit door began to exhibit some veiled

antisocial behaviors. For instance, he approached the front door, looked out the window toward the guards and rattled the door. After this he turned quickly back to the observer saying, "Do you want to get out? Well, you can't!" When the observer failed to respond to the inmate, the inmate then waited a few seconds for the intern to turn his attention back toward him, from another conversation, then repeated the same statement. The intern then responded by saying "That's ok...I get to go home eventually". This appeared to be the response the inmate was looking for, as he laughingly replied, "If we let you, you mean". The intern then responded with comments such as "It's not a fear thing, but when those doors close behind you it does get a little claustrophobic." He did not confront the veiled threat just offered by the inmate.

Interestingly, the inmate in question had asked the counselor, during the previous group meeting, whether he could move into a more desirable cell and bottom bunk, away from the front door of the unit, where apparently it gets quite noisy. The counselor responded that he was not going to get involved in room or bunk assignments, but instead told the unit Coordinator to have the community devise a means of assigning beds, based on some criteria they deemed appropriate. The inmate in question did not appear to take this 'refusal' well and his subsequent behavior in the hallway seems likely motivated by his need for power or control (i.e. to "get back on top of someone" by saying in effect, 'you guys aren't any better than me...you're stuck in here too!'). This issue was not dealt with in any subsequent groups that were observed.

Appendix E:

Site Three Description

A. Site and Program Design Overview[1]

Site three is a 104-bed facility serving central Virginia. The jail housed 160 male and female inmates overall. The TC program at site three was referred to as "SAPPHIRE" (an acronym for Substance Abuse Program Promotes Healthy Incarceration Recovery Environment) and served both male and female inmates. The male therapeutic community observed at Site three was housed in a unit that also housed non-TC inmates. The female TC program was housed in two different housing units, each of which also housed non-TC inmates. All counselor-run therapeutic activities are conducted in a second floor classroom. Inmates' housing units are on a separate floor from where treatment meetings are held. In addition to formal sessions conducted by the staff, clients were expected to hold group meetings on the housing unit. The counselors did not conduct therapeutic activities on the housing units therefore observation of the male and female cellblocks were not possible.

The meeting room on the second floor was the only program space available within the jail. As a result, the room was shared by the religious services program, the GED program, the TC program and other substance abuse services, such as the AA and NA groups offered by the facility. The second floor also contains the facility library, commissary, and several jail-services staff offices. This classroom is triangularly shaped, with concrete walls. The room contained about 20 metal and plastic chairs, a six-foot table, a portable blackboard, a TV and VCR on a cart, several bookshelves containing religious and educational books, a portable podium, and several locked cabinets. The room was typically extremely cold from the air conditioning. In addition to various services conducted in this room, jail staff also held their staff meetings there. In fact, during the Wednesday afternoon men's meeting the TC group had to move to the library area (which was a relatively wide open area) in the middle of their group session.

Treatment meetings were conducted as both same-sex-only and mixed-sex sessions. The program is designed to provide male and female inmates with three counselor-run, group meetings per week, in addition to group-run meetings to be held on the living units after hours. Treatment staff reported that participants were randomly drug-tested as part of the TC program. The program is designed to be run by three full time treatment providers, and this number of staff was currently assigned to the program. The counselors (two male and one female) provided services to both male and female inmates. One of these counselors also functions as the case manager. This case manager meets with each client near his/her release date to plan appropriate aftercare services. The jail itself also has a case manager to serve the transitional needs of the remaining jail inmates. The local CSB does not offer designated treatment slots for clients

[1] Site Three was observed for four consecutive days in July, 1998, approximately nine months after the RSAT funded treatment program had been in operation. The structured observation results describing the treatment program at this site represent the program as it operated at that time. The structure and operation of treatment programs may change over time. Data reported by the sites (e.g. client characteristics, drug testing) represent the entire 14-month period of the evaluation effort.

released from the TC program. The treatment staff members do not have an office within the jail, but their agency has a satellite office across the street from the facility. Treatment staff appears to infrequently visit the inmates' living units and observational staff was not afforded the opportunity to examine these units. Overall, the correctional and treatment staffs appeared to have a positive working relationship, however both staffs felt that cross training could improve upon the current relationship. Correctional officers felt that the inmates participating in treatment were better behaved than the rest of the jail population.

Both male and female inmates in this program participated in one therapist-run program activity each day. The women's group met on Monday, Thursday and Friday for 2 hours each day, while the men's group met on Tuesday, Wednesday and Friday, also for approximately 2 hours each day. In addition, the men's group members were scheduled to conduct a group meeting each evening on the living unit. Since the women did not all live on the same unit, it is unknown whether they have regularly scheduled group-run meetings.

The purpose of each meeting was unclear and apparently was defined from day-to-day. The first female group dealt with the departure of one member and the introduction of another. The purpose of this group then appeared to be to provide closure for the group members around the departure of a member who was being released to the community within the next two days. In addition, a new member arrived in the group and was given information about the procedures and goals of the group. Counselor 'C' ran this group alone.

The purpose of the first men's meeting was primarily to review a previous homework assignment. This homework assignment involved writing a list of where each group member wanted to be "ten years from now". The purpose of this exercise appeared to be to build motivation within the clients. Each member read his homework aloud and was given feedback about the quality of the exercise from the group. Members were then given feedback that seemed to provide support for their ability to reach those goals. In addition, the group was told that the "booking" procedure (written "pull-ups") would soon be implemented, and were given the list of rules and expectations associated with the booking process, as well as details about the process itself. The group was also assigned to review the applicable rules and the process itself during a group-run unit meeting later that night.

The second men's meeting was originally intended to be a review of the booking procedure after the group had discussed the process among themselves during an evening meeting. However, the group did not conduct the meeting it was assigned to, because the group leader apparently became ill that evening. Instead of the planned review of the "booking" procedure, the meeting time was used to read through the rules and expectations which member's were to begin "booking" each other on. In addition, the member's apprehensions, questions, and comments regarding the implementation of this process were solicited by counselor 'B'. Counselor 'A' also participated in this meeting, but was limited to providing information about the booking process and did not 'lead' the group.

The second women's meeting involved a visit from a community program service provider who was specifically asked to attend, in order to provide information about community programs for two pregnant members of the group. This outside service provider gave

information about several community programs, such as transitional housing and an outpatient treatment program providing childcare and transportation for women (with children) who are participating in drug abuse treatment. In addition, the meeting concluded with another closure for a member who was to be leaving the jail program within the week.

While the program apparently tried to make use of group-run meetings on the living units, it is unclear whether they were regularly scheduled meetings, or were conducted only "as-assigned" by the counselors. In any event, the one men's group-run meeting that was assigned by the counselors (to review the booking procedures) was never held, because the group leader did not feel well. Whether these assigned groups are ever consistently held is unknown, but given the failure of the group to follow through on the one assigned during the week in question it seems possible that these meetings may benefit from more thorough monitoring. Similarly, it is unclear whether the women held group-run meetings on their living units, but considering that they were spread over two separate housing units, both of which contain non-program inmates (as did the men's unit), it seems unlikely that they can conduct effective meetings under such conditions.

B. Overview of Program Implementation

Characteristics of the Sample. The Residential Substance Abuse Treatment (RSAT) program at Site Three served a total of 63 clients[2] (38 males, 25 females) since program inception (see Table E.1a). The average client is approximately 33 years of age, with males (33.5 years) being slightly younger than females (34.2 years) on average. The vast majority of clients served in this program are Caucasian (69.8%), with 15.9% identified as African American. None of the clients were employed in the last 30 days.

Table E.1a. Demographic Characteristics at Site Three

	Total	Males	Females
N	63	38	25
Mean Age	33.8	33.5	34.2
Minimum-Maximum	20.6-51.8	20.8-51.8	20.6-47.8
Standard Deviation	7.1	6.7	7.9
%Male	60.3		
%Female	39.7		
%Missing Gender Data	0.0	0.0	0.0
%African American	15.9	15.8	16.0
%Caucasian	69.8	71.1	68.0
%Missing Race Data	12.7	10.5	16.0
%Employed	0.0	0.0	0.0

[2] Site Three submitted information for a total of 76 clients. However, no Client Treatment Movement data was submitted for several of these clients, or it was submitted too late to be included in this report. With no way to tell if they ever entered the modified therapeutic community, they were not included in this table.

Site Three clients have been arrested an average of 13.9 times, resulting in an average of eight convictions (See Table E.1b). The large amount of missing instant offense data precludes drawing any conclusions from these data and suggests that treatment staff do not have adequate information regarding important aspects of their clients' backgrounds.

Table E.1b. Criminal History Characteristics

	Total	Males	Females
Mean Number Of Adult Arrests	13.9	18.2	7.4
% Arrest Data Missing	52.4	52.6	52.0
Mean Number Of Convictions	8.0	10.2	4.0
% Conviction Data Missing	55.6	52.6	60.0
Instant Arrest Offense			
%Property Crime	1.6	0.0	4.0
%CDS Possession	3.2	2.6	4.0
%CDS Distribution	1.6	2.6	0.0
%VOP	4.8	7.9	0.0
%Assault/Battery	1.6	2.6	0.0
% Other	3.2	5.3	0.0
%Missing	84.1	78.9	92.0

As with the instant offense information, much of the prior drug history information was missing (See Table E.1c). This makes drawing conclusions in the evaluation context difficult; however, it suggests an even more important problem for the treatment providers themselves. As was seen in some other sites, treatment providers at Site Three appear to lack a thorough knowledge regarding their clients' specific substance abuse histories. Among those clients whose primary drug of choice was reported, crack/cocaine (17.5%) was the most common, followed by alcohol (14.3%). In terms of those clients for whom data was submitted, most had either used drugs daily (14.3%) or had not used in the past month (7.9%). A slight majority of the clients have previously participated in treatment (50.8%).

Table E.1c. Substance Abuse Characteristics

Drugs Of Choice	Total	Males	Females
%Alcohol	14.3	18.4	8.0
%Crack/Cocaine	17.5	10.5	28.0
%Marijuana	3.2	5.3	0.0
% Other	4.8	5.3	4.0
%Missing	60.3	60.5	60.0
Frequency Of Use			
%No past month use	7.9	2.6	16.0
%1-3 times in past month	1.6	0.0	4.0
%1-2 times per week	4.8	5.3	4.0
%3-6 times per week	6.3	5.3	8.0
%Daily	14.3	23.7	0.0
%Missing	65.1	63.2	68.0
% Any Prior Treatment Experience (including self-help groups and education)	50.8	50.0	52.0

Continuum of Care. Site Three served a total of 63 clients within the modified therapeutic community (TC). Of these 63 clients, data was submitted to indicate that 26 had been discharged unsuccessfully, 13 had been discharged successfully, (completed or transition to other treatment) and 22 were sent to another prison or jail. Of the 39 who had been discharged from the program, four (10.2% of the 39 who were eligible) went on to receive treatment in the community. The average length of time (LOT) spent in the first phase of treatment (jail-based) was almost 118 days, but ranged from 29 days to 263 days.

Graduated Sanctions. Of the 63 clients served by Site Three in the modified therapeutic community, only three committed some sort of infraction (4.8%). In fact, the average client committed only 0.13 infractions. The most common infractions were positive urine tests (62.5%) and report of drug use by friends/family (25.0%). Infractions ranged from failure to appear for a treatment session to report of drug use by friends/family. Program staff responded to instances of non-compliance by holding a meeting with the supervision agent (45.5%), issuing a verbal warning (18.2%), or through a treatment referral (18.2%). Responses ranged from a verbal warning to an arrest warrant.

Table E.1d. Graduated Sanctions at Site Three

Total Number of Clients	63
Number of Clients with Infractions Reported	3 (4.8%)
Mean Number of Infraction Events	.13
Total Number of Infractions Reported	8
Most Serious Infraction(s) Reported	
Positive Urine Test	5 (62.5%)
Report of Drug Use by Friends/Family	2 (25.0%)
FTA Treatment Session	1 (12.5%)
Total Number of Responses Elicited	11
Most Serious Response(s) Elicited	
Meeting w/Supervision Agent	5 (45.5%)
Verbal Warning	2 (18.2%)
Treatment Referral	2 (18.2%)
Arrest Warrant	1 (9.1%)
Violation Action	1 (9.1%)

Drug Testing. Drug testing results were submitted for 21 clients or 36 percent of the clients in the program. The average client submitted 3.6 drug tests during their stay in the modified therapeutic community. As such, program participants were tested at a rate of once every 54.1 days. According to the results that were provided, three clients tested positive for marijuana, one for cocaine, and one for sedatives.

Table E.1e. Drug Testing at Site Three

Number of Clients Tested	21
Mean Number of Drug Tests	3.6
Rate of Drug Testing	1 drug test / 54.1[3] days
Marijuana – Positive	3
Cocaine – Positive	1
Sedatives – Positive	1

C. Treatment Program Description

Structured Interview & Informal Observation Results (Both Units). During the observation period the men and women treatment programs at Site Three each served 10 inmates. As intended three full times clinical staff were assigned to the program, with one serving as the case manager. Also as intended the program delivered approximately 6 hours of

[3] This number reflects the rate of drug testing for those clients for whom drug testing data was submitted. There were several clients for whom no drug testing data was submitted and were, therefore, not included in this calculation.

treatment services to each group each week, in the form of three regularly scheduled meetings of about two hours each. Friday meetings were run with both male and female clients together. Most of the meetings appeared to take a free form, depending on the needs of the group (e.g. a client about to leave the program), while some had specific, pre-planned purposes (e.g. reviewing the newly instituted "booking" procedure). Drug testing was conducted, as required by the responsible agencies and structured observation results (discussed at length below) suggest that several treatment approaches, of empirically demonstrated effectiveness were implemented during treatment sessions. Transitional planning for clients' movement to follow-up community-based treatment was being arranged by the program's case manager despite the local CSB's lack of designated community treatment slots for TC graduates. While both federal RSAT funding guidelines and the state of Virginia's program guidelines required the use of separate living facilities for TC inmates, Site Three did not meet this requirement at the time of observation, as both male and female clients were reportedly being housed on units which contained non-program inmates.

Counselors. There are three full time counselors for this program, who seem to take a team approach to leading both the men's and women's groups. None of the counselors is particularly confrontational. In particular, the group of counselors generally seem to have the skills and experience needed (to varying degrees) to conduct residential drug treatment, they also have chosen (by their own report) not to implement some of the more traditional aspects of the TC model, especially the use of confrontation. In addition to the de-emphasis of some of the TC model's components, the structure of the jail itself (in terms of the lack of a dedicated program living unit and the failure to create closed treatment groups) also impacts the programs ability to implement these aspects of the TC model.

Roles Models and Community Process. There were three roles or functions for male group members in this program; the group leader, coordinator, and a position called a 'sidewinder'. According to the program manual the "group leader" is responsible for being a role model at all times and is responsible for the overall condition and operation of the "family" (group) and its functions. He is also responsible for keeping staff fully informed of all issues. He must also log each member's attendance and punctuality, call the group to order prior to staff's arrival, collect all homework assignments, and arrange the classroom furniture to facilitate the group's functioning. The group leader is chosen by the treatment staff, however the selection criteria were not reported to the observers. The "coordinator" and "sidewinder" roles are not defined by the program manual, nor were the duties of the positions made clear during observations of the group. The coordinator did seem to take a leadership role in reading through the rules and expectations associated with the newly implemented "booking" (written "pull-ups") procedure, and after reading several of them, chose another member to continue reading. The current coordinator was appointed to the position of "sidewinder", serving both positions concurrently. The women's group did not appear to have any formal positions or roles.

Community Process in the Men's Unit. The community of male offenders seemed to work well together, although they did not appear to have developed a strong sense of community. It was difficult to estimate the degree to which they work together prosocially on a daily basis however, without seeing either the living unit or a group-run meeting. There were apparently some friendships within the group, which in some cases were relied upon more

heavily than was the support of the group itself. The existence of these friendships may have promoted the tendency for members to avoid confronting each other. For example, one member, when reading his "ten year goals" homework was given feedback regarding his over-reliance on his "higher power" to the exclusion of the 12-steps of recovery themselves. This member responded by saying things such as all he "needed was faith in god", "if you have strong enough faith in god you won't fail", and "I only need myself". His brother was also a member in the group and he had made the original comments about his over-reliance on the higher power, but failed to confront him on the subsequent comments. None of the other members of the group, nor the counselors, confronted him on these antisocial, unproductive attitudes.

In addition, some member's feedback in response to the reading of the "ten year goals" homework seemed shallow, insincere, and un-insightful. The lack of a separate living unit and the newness of the program overall may have contributed to the apparent lack of community and low investment in therapeutic work and prosocial goals. In addition, due to trips to court, doctor's appointments and so on, the composition of the group at any given day's group meeting changed. While there were ten members at each of the observed men's groups, they were not the same ten men on either day. This also likely makes it difficult to build trust and a sense of community, as well as to do consistent therapeutic work in the groups. In addition, the inability of the program to implement closed groups likely hindered the development of a strong sense of community.

Community Process in the Women's Unit. The women's group was characterized by comparative emotionality, though this may have been an artifact of the group's participating in several closure activities during the observation period. Again, some of the 'goodbye' offerings to those members leaving the group appeared somewhat shallow, insincere and general, rather than specific to the person leaving the group ("you're a good person...you're gonna make it"). Despite this apparent lack of sincerity on the part of some members, at least half were moved to tears during these closure activities. However, as in the men's group, the existence of friendships within the group seems to threaten the integrity of the "community as agent of change" process. Many of the women, during their parting statements said they would see the departing member at groups on the outside and that she had "been a good friend". This appears to run counter to the intention of the TC model, in which the group as a whole is supposed to provide support and encourage change. Instead the women seemed to value certain individuals in the group for their support, at times devaluing other members, often apparently because they did not "get along with" them. In other words, there seemed to be a tendency for individuals to value their relationships with members for whom they had positive feelings, while not valuing those member's with whom they had conflicts. It seems probable however, that the individual's they did not get along with were the ones who confronted them and held them accountable for their behaviors. Thus, the existence of, and reliance on these individual relationships is likely counter-productive in terms of effective progress in treatment.

In general, the parting comments from members during the closure activities were optimistic and positive, such that possible weaknesses and potential pitfalls were not mentioned. While the closure ceremony may not be the place for that type of feedback, such overwhelmingly positive feedback may serve to 'set up' the departing member for unforeseen difficulties in the community. In fact, there was little confrontation or similar feedback observed during any of the

women's activities. For instance, during the orientation of the new member (on the first day) it seemed that the group was portrayed as a universally supportive and positive environment. There was no implicit or explicit message that thought processes or negative behaviors would be identified and challenged, and in fact, this is not what seemed to happen in the group.

Structured Observation Results. Program emphasis at Site Three appeared predominantly focused on "action planning," with many other variables (e.g. motivation, motivation readiness) rated as largely unused. These results together with the results for the treatment topics items discussed below, suggest that the program is highly focused on producing noticeable individual-level changes (typical of CBT approaches) in the group members. This is particularly true in terms of the focus on clients' psychological development, socialization and cognitive and emotional skill development. On the other hand, the program appears somewhat less focused (with the exception of social relatedness topics reviewed below) on using several aspects central to the TC model (the development of an effective sense of community and an emphasis on prosocial value development).

Table E.2. Program Emphasis at Site Three
(n= 2 men's & 2 women's groups)

Variable Name	High Use	Not Used	Variable Name	High Use	Not Used
Acceptance/Disease	25%	50%	Motivation Readiness	25%	75%
Action Planning	75%	25%	Redefining Action	0%	75%
Aftercare	25%	50%	Relapse Prevention	50%	25%
Contemplate Change	50%	50%	Self-work	50%	0%
Maintenance	50%	25%	Spirituality	25%	0%
Motivation	25%	75%			

In terms of treatment topics, (Table E.3) as previously mentioned psychological development, socialization issues and cognitive and emotional skills were frequently used to a high degree in meetings at Site Three. One treatment topic potentially representative of a TC approach, social relatedness was highly used in all meetings, suggesting that the program was successful to some degree in integrating TC and CBT concepts. However, topics related to the effective functioning of the group, especially physical and psychological safety were largely unused at Site Three. Diaries, healing experiences, street experiences, and subjective learning were largely unused at these meetings.

Table E.3. Treatment Topics at Site Three
(n = 2 men's & 2 women's groups)

Variable	High Use	Not Used	Variable	High Use	Not Used
Aftercare	25%	50%	Past Experiences	50%	25%
Cognitive Skills	75%	0%	Physical Safety	25%	0%
Psychological Development	100%	0%	Psychological Safety	0%	25%
Diary	25%	75%	Emotional Skills	75%	0%
Subjective Learning	25%	89%	Socialization Issues	50%	25%
Incident Review	50%	0%	Social Relatedness	100%	0%
Letters	25%	50%	Street Experiences	25%	75%
Nurturance	0%	50%	Healing	0%	75%
Unit Issues	50%	0%	TC Issues	50%	50%

Treatment activity variables (Table E.4.), such as awareness training, discussion of the goals of discharge, education, emotional growth training, peer encounters, and therapeutic education were commonly used at high levels in this program, while other treatment activities, vocational education in particular, were largely unused.

Table E.4. Treatment Activities at Site Three
(n = 2 men's & 2 women's groups)

Variable	High Use	Not Used	Variable	High Use	Not Used
Awareness	100%	0%	Vocabulary	25%	50%
Check-In	25%	50%	Parenting	25%	50%
Community Management	50%	50%	Discussion of Discharge	75%	0%
Emotional Growth	75%	0%	Community Enhancement	0%	50%
Discussion of Goals of Phase	0%	50%	Peer Encounter	100%	0%
Education	75%	0%	Pull-Ups	50%	25%
Relapse Prevention	25%	50%	Trigger Analysis	25%	50%
Pre-release Planning	50%	0%	Sharing Experiences	50%	0%
Vocational Education	0%	100%	Therapeutic Education	100%	0%

Treatment style at Site Three was frequently characterized as formal (used scheduled, staff-directed activities), community oriented (delivered services in a group format), introspective (allowed clients to examine themselves) and interactive (allowed clients to interact with each other and staff). Other treatment styles were largely unused.

Table E.5. Treatment Style at Site Three
(n= 2 men's & 2 women's groups)

Variable	High Use	Not Used	Variable	High Use	Not Used
Check-In	25%	50%	Introspective	100%	0%
Community-based	100%	0%	Listening Post	0%	100%
Formal	100%	0%	Punishment	0%	100%
Informal	0%	100%	Reward	0%	100%
Interactive	100%	0%	Staged Presentation	0%	75%

Finally, in terms of the "View of the Residential Community" items (Table E.5), collective formats, open communication, the use of participants and structured systems were emphasized, as were role models and membership feedback. Other uses of the group itself were less emphasized. Again, the use of several of these aspects of the community does suggest that the program had some degree of success integrating treatment components from both the CBT and TC approaches.

Table E.6. View of the Residential Community at Site Three
(n = 2 men's & 2 women's groups)

Variable	High Use	Not Used	Variable	High Use	Not Used
Confrontation	50%	0%	Use of Participants	100%	0%
Collective Formats	100%	0%	Individual Relationships	50%	0%
Membership Feedback	75%	0%	Use of Role Models	75%	0%
Shared Norms	50%	0%	Structured Systems	100%	0%
Open Communication	100%	0%			

D. Summary/Discussion

Site Three served 63 clients (38 males and 25 females) during the study period. Most of these clients exhibited poor employment records and extensive histories of criminal involvement and drug treatment. The majority of the clients in this site were white (roughly 70%). The most commonly used drugs among this group were cocaine/crack and alcohol. Of the 61 clients discharged, 13 successfully completed the program and four (10.3%) were transitioned to a second phase of treatment. The average length of stay in jail-based treatment was 118 days. The average client at Site Three committed 0.13 infractions (33 overall), with the most common infractions being positive urine tests and report of clients' drug use by family or friends. Drug testing occurred for 36 percent of the clients, with the average client submitting 3.6 tests. Three clients tested positive for marijuana, one for sedatives, and one for cocaine, during the study period.

The treatment program itself focused mostly on action planning as a treatment philosophy. Treatment topics centered on psychological development, cognitive and emotional skills development, and socialization issues. Commonly used treatment activities included awareness training, peer encounter groups, education, discussion of the goals of discharge, emotional growth training, and therapeutic education. Treatment activities tended to be delivered to groups of clients (not individually), in an interactive and introspective style. Overall, the counselors were rated as skilled and experienced, though they generally were not rated as overly confrontational, nor process-oriented.

The inability of the counselors to gain access to the living units suggests that they would not be available to help organize unit meetings and ensure that they are conducted as scheduled. This lack of access not only decreases the ability of the counselors to monitor and support the groups' activities; it may also serve to undermine clients' involvement and subsequent commitment to the treatment process. The lack of supervision produces a less than total milieu may also have helped promote the development of individual relationships discussed in both groups.

APPENDIX F:

Site Four Description

A. Site and Program Design Overview[1]

Site Four is a 540-bed facility serving the northern Virginia area. The jail currently houses approximately 920 male and female inmates. The men's and women's dually diagnosed (mental illness and substance abuse problems) therapeutic community programs are each designed to house four inmates in a separate unit within the facility. The program is designed to have three full time treatment providers, one of who serves as the case manager for treatment clients. The jail itself also has a case manager who provides services to other jail inmates. Both therapists have master's degrees, while the case manager has a Bachelor's degree and is not certified as a therapist. The program case manager meets with each client to develop a discharge plan and the case manager coordinates the referral to appropriate aftercare services. In addition, a psychiatrist consults on the medication issues involved with these dually diagnosed individuals. The staff members have several office spaces within the facility. The program is designed to provide six months of treatment within the jail.

Male and female inmates were housed on units whose overall size was approximately 20 by 10 feet. The units were self-contained, including a shower with curtain, and a single toilet with a low wall separating it from the rest of the small common area. Each unit contained four separate cells, occupied by a single inmate. On other units of similar design within the jail, inmates were "double-bunked" in this same type of cell. The door to each unit opened to the main hallway where an officer was stationed at a desk. There was a pay phone on each unit, as well as a small color television, both of which appeared that inmates could make use of at will. The unit entrance doors had a small window for observation and a locking slot, through which meals were delivered to the unit. Inmates were fed on the unit. Nothing was hung on the walls of the men's unit. The women's program unit was largely similar in physical layout, however there had been, just prior to our visits, some program materials displayed on the walls of the women's unit (which had become an issue for the correctional officer's during our visit, see discussion below).

The RSAT treatment program at Site Four is designed to include a case management stage, followed by three treatment phases: Phase I (intake, orientation, and engagement), Phase II (Treatment Program), Phase III (Relapse Prevention and Re-entry). Phase I of the program included activities such as: learning the rules and regulations of the treatment program, identifying drug and mental health problems, and establishing a relationship with treatment staff and other treatment members. The second phase of the program consisted of guiding new participants, participating in a 12-Step program for dual-diagnosis, alcohol, and drug problems,

[1] Site Four was observed for four consecutive days in July, 1998, approximately six months after the RSAT funded treatment program had been in operation. The structured observation results describing the treatment program at this site represent the program as it operated at that time. The structure and operation of treatment programs may change over time. Data reported by the sites (e.g. client characteristics, drug testing) represent the entire 14-month period of the evaluation effort.

and presenting an autobiography to the group. Phase III of the program had the client focus on preventing relapse and continuing their treatment regime outside in the community.

Upon entry into the treatment program, the inmates were given a manual that outlines all of the phase requirements, as well as information on the group, cardinal rules of the program, and participants' requirements. As new members are accepted into the program, they are assigned to read through the manual and sign a treatment contract. All the clients are on medication during the treatment sessions. The effects of both mental illness and the medications on individual member's ability to comprehend and participate in the TC program are largely unknown, however both anecdotal and structured observation information suggest that these group participants were less active than those observed in other sites.

Treatment activities were conducted either on the units themselves, or when scheduling allowed, in one of several classrooms shared by all facility programs. Treatment meetings are conducted as same-sex-only sessions in this program. Treatment staff reported that program participants are randomly drug-tested twice a month by the jail, but not as a requirement of the treatment program. Some of the individual staff members interviewed felt that there was some tension between the treatment and correctional staff. Some reported individual officers often show disrespect for the treatment process. In particular, on the women's unit, several inmates also reported that they felt that the correctional officer assigned to their unit did not respect their desire for treatment.

B. Overview of Program Implementation

Characteristics of the Sample. The Residential Substance Abuse Treatment (RSAT) program at Site Four served a total of 32 clients[2] since program inception. A slight majority of clients who participated in the modified therapeutic community were male (53.1%). The average client is approximately 38 years of age, with the females (39.4 years) tending to be slightly older than males (35.9 years) on average. Approximately two-thirds of all clients who participated in the RSAT program are Caucasian (65.6%), with 34.4% identified as African American.

[2] The treatment continuum in this site begins with case management and moves into the TC. Since most clients do not move into the TC, the study only included data on clients entering the TC.

Table F.1a. Demographic Characteristics

	Total	Males	Females
N	32	17	15
Mean Age	37.5 Yrs	35.4Yrs	39.4 Yrs
Minimum-Maximum	25.4-55.8	25.4-54.6	25.4-55.8
Standard Deviation	8.3	8.0	8.6
%Male	53.1		
%Female	46.9		
%Missing Gender Data	0.0	0.0	0.0
%African American	34.4	23.5	46.7
%Caucasian	65.6	76.5	53.3
%Missing Race Data	0.0	0.0	0.0
%Employed	0.0	0.0	0.0

Much of the criminal history data was not submitted for those clients who entered the modified therapeutic community (dual diagnosis unit). With such a substantial proportion of data missing, any conclusions that can be drawn would be tenuous, at best, since there is no way to determine if those clients for who data was received are substantively different from those clients for whom no data was sent. As has also been the case with other sites described in this report, this amount of missing information suggests that treatment providers may not have a thorough understanding of the background characteristics of their clients. Among those clients for whom data was submitted, it appears that Site Four clients have a quite extensive criminal history with the average client arrested almost 16 times. These arrests resulted in eight convictions on average. The large amount of missing instant offense data also present problems in attempting to draw valid conclusions, however the data that was submitted indicates that most of the clients are incarcerated for either a property offense (6.2%) or a miscellaneous offense (9.3%) (e.g., stalking, failure to pay fine, failure to obey a police officer, etc).

Table F.1b. Criminal History Characteristics at Site Four

	Total	Males	Females
Mean Number Of Adult Arrests	15.5	19.8	9.0
% of Arrest Data Missing	68.8	64.7	73.3
Mean Number Of Convictions	8.3	7.4	9.7
% of Conviction Data Missing	75.0	70.6	80.0
Instant Arrest Offense			
%Property Crime	6.2	0.0	13.4
%CDS Possession	6.2	5.9	6.7
%Assault/Battery	3.1	5.9	0.0
%Weapons	3.1	5.9	0.0
% Other	9.3	11.8	6.7
%Missing	71.9	70.6	73.3

The primary drug of choice identified by most clients at Site Four was alcohol (25.0%), followed closely by crack/cocaine (21.9%), and heroin and PCP (each 12.5%, See Table 6.1c). Again, over 20% of clients did not have drug of choice information reported, suggesting that in many cases the counselors may not have an accurate picture of their clients drug use history. The majority of clients had not used drugs in the past month (53.1%), probably due to the fact that they have been incarcerated during this time. This almost certainly has not been their first experience in a treatment program, with almost 84.4% reporting that they have received some form of prior treatment services.

Table F.1c. Substance Abuse Characteristics at Site Four

Drugs Of Choice	Total	Males	Females
%Alcohol	25.0	35.3	13.4
%Heroin	12.5	5.9	20.0
%Crack/Cocaine	21.9	11.8	33.3
% Other Opiates	3.1	5.9	0.0
%PCP	12.5	23.5	0.0
%Methamphetamine	3.1	5.9	0.0
%Missing	21.9	11.8	33.3
Frequency Of Use			
%No past month use	53.1	70.6	33.3
%1-3 times in past month	9.4	5.9	13.3
%1-2 times per week	0.0	0.0	0.0
%3-6 times per week	3.1	5.9	0.0
%Daily	3.1	0.0	6.7
%Missing	31.3	17.6	46.7
% Any Prior Treatment Experience (including self-help groups and education)	84.4	82.4	86.7

Continuum of Care. Site Four served a total of 32 clients within the modified therapeutic community (TC). Of these 32 clients, data was submitted to indicate that 20 had been discharged unsuccessfully, three had been discharged successfully, (completed or transitioned to other treatment) and six were sent to another prison or jail. Of the 23 discharged from this program, three (13% of the 23 who were eligible) continued treatment in the community. The average length of time (LOT) spent in the first phase of treatment (jail-based) was 49 days. The length of stay in the jail program ranged from two days to 157 days.

Graduated Sanctions. Of the 32 clients served by Site Four in the modified therapeutic community, five committed some sort of infraction (19.4%). The average client committed only 0.4 infractions. The most common infractions were trust violations (30.8%), negative behavior (15.4%), inappropriate language/talking out (15.4%), and negative community behavior (15.4%). The infractions ranged from not following the dress code to violation of jail rules. Program staff most often responded to instances of non-compliance by either sending the client back to general population for 11-30 days or through an administrative removal/therapeutic discharge (each 20.0%).

Table F.1d. Graduated Sanctions at Site Four

Total Number of Clients	32
Number of Clients with Infractions Reported	5 (15.6%)
Mean Number of Infraction Events	.4
Total Number of Infractions Reported	13
Most Serious Infraction(s) Reported	
Negative Program Behaviors	6 (46.2%)
Trust Violations	4 (30.8%)
Negative Community Behavior	2 (15.4%)
Violation of Jail Rules	1 (7.7%)
Total Number of Responses Elicited	5
Most Serious Response(s) Elicited	
Jail 11 – 30 Days	1 (20.0%)
Administratively Removed/ Therapeutic Discharge	1 (20.0%)
Other	3 (60.0%)

Drug Testing. Clients participating in the RSAT program at Site Four were drug tested as part of both facility and program protocol. Drug testing occurred for 21 clients who participated in the modified therapeutic community. The average client submitted 5.6 drug tests during their stay in the modified therapeutic community. As such, program participants were tested at a rate of once every 18.8 days. According to the data provided, there were no positive drug tests.

Table F.1e. Drug Testing at Site Four

Number of Clients Tested	21
Mean Number of Drug Tests	5.6
Rate of Drug Testing	1 drug test / 18.8[3] days

C. Treatment Program Description

Structured Interview and Informal Observation Results. During the observation period, the treatment program at Site Four was serving four male and four female inmates, as intended. The program was staffed by three full time treatment providers (with one working as a case manager) and a part time psychiatrist. As intended the treatment program made use of a variety of therapeutic techniques, of empirically proven effectiveness, such as various CBT approaches. However, the mental health characteristics of the clients in this program seem to have necessitated a relatively slow, rudimentary pace of treatment, and precluded the use of

[3] This number reflects the rate of drug testing for those clients for whom drug testing data was submitted. There were several clients for whom no drug testing data was submitted and were, therefore, not included in this calculation.

several of the more central aspects of the TC model, such as the large scale use of the community itself as an agent of change. The dually diagnosed clients in this program were simply not high enough in their individual levels of functioning to work together effectively as a unit, as would typically be seen in a TC.

Treatment Activity/Schedule (Men's Unit). Both the male and female inmates in this program had program activities scheduled at various times throughout the week. Both groups received approximately five group treatment sessions throughout the week. Some activities were conducted on the unit, while others were conducted in a classroom on the second floor of the jail. Classroom space was limited at the jail, so that TC activities had to be scheduled between other programs also assigned to use these classrooms. Each meeting typically lasted for an hour. The counselors originally had planned to conduct meetings of an hour and a half, however according to one counselor the inmates were not able to remain productive for that length of time.

The male TC members participated in a "Process" group from 9:30 to 10:30 Monday mornings in the classroom. At 2:30 they had another "Process" group on the unit. On Tuesdays the men had a "Case Management" group meeting on the unit at 9:30 to 10:30. On Wednesday the men had an "Educational" group in the classroom from 12:30 to 1:30. On Thursday the men had no treatment activities scheduled and on Friday they participated in another "Process" group on the unit at 2:30 (These Friday meetings were not observed). There was no group run activities in this program.

The men's "Process" meetings seem to provide members an opportunity to review assignments, such as the "lifeline" (personal history timeline), or to go over educational materials related to mental illness and substance abuse. For example, during one men's process group the member's reviewed a packet of information covering various aspects of depression, including how it could effect daily living or how it may be related to a family history of depression. During this session, each member went through each of several questions about how their depression effects them, whether they can see signs of its family history, how it effected their self-esteem and what factors in their lives may contribute to depression. The purpose here seemed to be to provide both objective information, as well as helping the members become aware of how these factors relate to their own subjective experience of depression.

One additional purpose of the Monday morning process meeting seems to be to provide the inmates an opportunity to discuss relevant medication issues with the psychiatrist. It is unclear whether the psychiatrist conducts any individual therapy or medication monitoring sessions with the group members outside of this group interaction. The imposition of this activity into the process meeting seems to be more a matter of convenience (a way for the doctor to see many patients at once) rather than because it adds anything to the purpose of the rest of this meeting. As mentioned above, the rest of this meeting, at least as observed this week, appeared to be to review assignments and get the members to begin working together on their recovery.

The men's case management group observed on the unit (Tuesday morning) seemed to be aimed at providing the inmates a chance to review with the case management counselor any changes in their current legal status. The counselor asked each member if there were any

changes in their legal status. She made suggestions to each, as necessary in regards to anything they needed to do to prepare for release and also told them what she would be doing on their behalf. Stylistically she provided supportive feedback on each member's current situation or the steps they had been taking to prepare for release with comments such as "that's sounds very promising."

Finally this session ended with a more detailed review of one inmate's pre-release plan for his first few weeks. As mentioned above he had originally planned to take the first week off and go fishing and walking around a nearby lake. After some feedback regarding his need to meet with his probation officer and take steps to find a job, he revised his plan for the first week appropriately. These revisions were made in response to feedback from both the counselor and other members. The other member's feedback, while appropriate and constructive, had to be solicited by the counselor and was not spontaneously given.

The final type of meeting observed was a men's educational group, offered in the second floor classroom. This meeting tried to provide further educational information regarding depression. (Depression was the topic throughout the week). In this meeting the group was shown a video-tape (on the triggers for depression) that was related to the written packet of materials discussed in the "process" group earlier in the week. The group members also reviewed further the information in these packets. While they seemed to have a hard time concentrating on and understanding the videotape, the counselor tried to make the issues discussed there relevant for them, by asking if they could identify with the situations depicted in the tape. She also tried to point out to them the need to identify and change some of their beliefs and values in order to avoid relapsing into both depression and drug abuse.

Treatment Activity/Schedule (Women's Unit). The four women in the treatment program at Site Four met with their therapist once a day, four days a week. Interventions focused not only issues related to the clients' drug addiction, but frequently also focused on their mental illness and other personal situations which triggered negative thought processes. The treatment sessions usually lasted for an hour and fifteen minutes. The scheduled time for the group's meetings varies, depending on the jail's agenda. For example, there were a few times over the course of the observations that the therapist had to wait over thirty minutes before the clients were brought by jail staff to the treatment session in one of the facility classrooms. The treatment staff were well aware of their need to be flexible when working in the correctional environment, however the correctional staff did not seem willing or able to give even an approximate time as to when her clients would be arriving for class. Apparently this type of incident is not rare, suggesting that the correctional officers do not consider the treatment program a priority.

During the first women's session, the women discussed an incident that occurred over the weekend. The inmates apparently had been subjected to a "shakedown", during which the officers tore down all of the women's treatment posters and threw them away. While it is apparently common for officers to take down posters during a shakedown, it is uncommon for them to throw the posters in the trash. The clients also mentioned that the officers took their bibles, apparently throwing one client's bible in the trash. The therapist appeared dismayed at

this behavior, since the hanging of treatment posters had previously been approved by the Lieutenant.

During this meeting most of the clients openly discussed their feelings with the therapist. The clients were most upset with the destructive nature of the correctional officers. They also felt that the officers were "tearing down a part of the members' self-worth". Overall, the clients appeared to feel that the correctional staff or the other inmates do not respect them. (In fact, the inmates with a diagnosed mental illness are required to wear special wristbands, which identify them as an inmate receiving mental health services.) The therapist spent the rest of the session helping the clients' process their feelings through open communication. Towards the end of the session, the inmates were convinced that they were not going to let the officers interfere with their rehabilitation process. Several clients relayed their own emotional and behavioral experience with this incident. Apparently many had demonstrated the ability to contain their anti-social tendencies and act in a controlled manner, reflecting positively on their progress in the treatment program, despite the distraction brought about by the wider jail environment.

During another treatment session, after having watched a video on severe depression, the inmates were asked to relate their own experiences to the lives of the individuals in the movie. The life stories that were discussed in the video focused on how depression negatively affected the individuals' relationships and "normal" functioning. Instead of discussing how depression affected their lives, however the inmates' discussion shifted to focus on their medications. One inmate in particular was very unhappy with the medication that she was given for her depression. She further discussed with the group that she has been very irritable and has been unable to sleep. Another member of group suggested that her irritation and insomnia might be due to the fact that she will be released from the facility within a month. The therapist agreed with that suggestion and asked the irritable inmate to discuss her feelings about leaving the facility. The inmate did admit that some of her irritability had to do with the reality of leaving the jail. The inmate began to process some of her feelings but the therapist did not push the inmate to disclose her feelings. The major portion of the treatment session centered on the medications that the inmates were taking and how they were not satisfied with the medication's effects. However, the counselor did not deal with the potential motive underlying this topic, specifically that the inmates were focusing (again) on drugs, and how they were not working to make them feel better, instead of focusing on the self-exploratory work that was the meeting's apparent original goal.

Counselors. There were three full time clinical staff members assigned to this program. The staff members took turns providing various groups to both the male and female members of this program. A Program Director oversees the treatment staff and appears to have several years of experience working with inmates and drug addicts. In addition, a psychiatrist prescribes and monitors medications for these mentally ill inmates.

Role Models and Community Process (Men's Unit). There are no roles or functions for group members in this program. The members are all suffering from a diagnosed mental disorder. Among the four male TC members, one is diagnosed as a Schizophrenic, two more are diagnosed with Depression, and the fourth is diagnosed with "Anxiety/Depression". None of the male group members could be characterized as high functioning, with most unable to initiate

much in the way of spontaneous conversation.

For the most part the inmates seem to be so low-functioning that there is no real sense of community among them. While this is likely an effect of the isolation common among mental patients, it may also signify a lack of either motivation or understanding of the group process. It appears that it may be some of both, but given that at least some of the members may be higher functioning than they appear, the possibility remains that this is not the outcome of isolation alone. The counselors do not seem to ask much of the members in terms of self-initiated participation in the group, instead dealing with the members as is appropriate for such withdrawn, mentally ill clients, typically asking them specific, simple questions in order to get them to offer each other feedback.

Nor does there seem to be an overt emphasis placed on prosocial values. While this too may be a result of the counselors' attempts to implement the program in a manner appropriate for the mentally ill, it has the effect of watering down this basic aspect of the TC model. This is not to suggest that the counselors promote antisocial values or behavior, it simply seems that they are not focused on specifically reinforcing the need for prosocial values in all aspects of the members' lives. This lack of emphasis on prosocial values may also be the result of the programs need to focus so exclusively on developing and maintaining mental health and abstinence (both of which are generally prosocial values in themselves). The point here being that the counselors have not attempted (at least as far as was observed) to get the members to look at their past or current antisocial values and behaviors, outside of how these issues may relate to substance abuse and mental health.

One example may help to explain. During the case management session on Tuesday morning, the inmate who presented his release plan in detail at one point said he wanted "to get away from people, because it seems like when there's people around there's problems...I have to think about people's feelings, remember my family members' birthdays...it's just easier to live by myself away from people". Here the counselor had conceivably been presented an excellent opportunity to deal with an obvious antisocial belief, (e.g. "if I can only get away from people I won't have any more behavioral/legal problems"). No detailed processing of this statement was observed to take place, and overall it seems that the counselor in this case was willing to facilitate the inmate's holding onto his belief that this strategy would be effective in keeping him out of trouble. At the very least, the counselor's not calling him out on the statement may give passive assent to his statement that "other's can be to blame for my shortcomings".

Role Models and Community Process (Women's Unit). There were four roles assigned to group members in the women's program (based on program seniority) at Site Four, Senior Resident, Resident Facilitator, Cleanliness Monitor, and Telephone Monitor/Schedule Keeper. These roles had only recently been assigned to the group members and as such there seemed to be little use of these new roles by the members. In terms of the overall sense of community, the female inmates were able to discuss their emotions openly with each other, although not in an in-depth manner. The members were also able to confront one another on their negative behaviors, although typically in an unstructured manner. For example, one client pointed out the ingratitude of another inmate, with the confronted member refuting the claims. While eventually she began to accept the accuracy of the comments regarding this negative

attribute, the confrontation session was not conducted in a structured manner. There was a point in the inmates' discussion that their voices became raised and both clients appeared highly agitated. Towards the end of the session, the inmates involved in the confrontation engaged in "horseplay," which the therapist did not attempt to stop. Not only was the confrontation used in this program unstructured in terms of how it was delivered, but it also seemed to be used by members at any time during a treatment session.

There were also times during the treatment sessions when the treatment participants did not seem interested in the therapeutic intervention. However, the lack of motivation and boredom may be due to factors such as the participants' medication, the length of the sessions, or other factors beyond lack of motivation. One factor, which may contribute to their sometimes poor attention, is the tendency of the therapist to deal only with one member at a time, leaving other members relatively uninvolved. In fact, the treatment sessions often had the appearance of individual counseling sessions. The physical layout of the classroom, with members sitting in chairs placed in rows, rather than the traditional group therapy circle may have lead to the sometimes low level of group participation. However, despite occasional lapses the group was relatively interactive and members generally appeared actively involved in their rehabilitation.

Structured Observation Results. No particular program emphasis dominated the meetings at Site Four (Table F.2). In fact, no items were rated as "highly used" in more than 17% of the meetings. A focus on self-work was rated as "not used" in only 33% of the meetings, however all other items were rated "not used" in at least 50% of the sessions. This lack of a specific program emphasis may be the result of the need for the program to deal with both substance abuse and mental health issues simultaneously.

Table F.2. Program Emphasis at Site Four
(n = 6 meetings observed, 4 men's & 2 women's groups)

Variable Name	High Use	Not Used	Variable Name	High Use	Not Used
Acceptance/Disease	17%	50%	Motivation Readiness	0%	83%
Action Planning	0%	100%	Redefining Action	0%	100%
Aftercare	17%	67%	Relapse Prevention	17%	83%
Contemplate Change	0%	83%	Self-work	17%	33%
Maintenance	0%	83%	Spirituality	0%	67%
Motivation	0%	83%			

In terms of treatment topics covered at Site Four (see Table F.3), emotional and cognitive skills, as well as social relatedness and subjective learning dominated these meetings, while discussion of letters and nurturance issues were completely unused. Healing experiences, recent incident reviews, past street experiences, and TC issues were largely unused, as well. The high level of reliance on topics related to cognitive and emotional skills is consistent with a CBT focus, commonly used in both substance abuse and mental health treatments. The use of social relatedness (i.e. how people relate to one another) topics is one component that is consistent with a TC model, which emphasizes the use of the overall community group. Thus, to some extent this program may be integrating treatment components characteristic of both CBT and (to a lesser extent) TC approaches.

Table F.3. Treatment Topics at Site Four

(n = 6 meetings observed, 4 men's & 2 women's groups)

Variable	High Use	Not Used	Variable	High Use	Not Used
Aftercare	33%	50%	Past Experiences	50%	50%
Cognitive Skills	67%	33%	Physical Safety	17%	67%
Psychological Development	50%	50%	Psychological Safety	33%	67%
Diary	33%	67%	Emotional Skills	83%	17%
Subjective Learning	67%	33%	Socialization Issues	33%	33%
Incident Review	17%	83%	Social Relatedness	67%	0%
Letters	0%	100%	Street Experiences	0%	83%
Nurturance	0%	100%	Healing	17%	83%
Unit Issues	33%	50%	TC Issues	17%	50%

As for treatment activities (Table F.4), emotional growth training and peer encounters dominated the activities at these sessions, as did awareness training. Goals of the program phase, parenting, pull-ups, and vocational education were completely unused, while community management, community enhancements, pre-release planning, and vocabulary were used extremely infrequently. Again, the treatment activities commonly used suggest a mixing of CBT and some TC approaches in this program. These activities are also consistent with a program attempting to target mental health issues, as well.

Table F.4. Treatment Activities at Site Four
(n = 6 meetings observed, 4 men's & 2 women's groups)

Variable	High Use	Not Used	Variable	High Use	Not Used
Awareness	67%	33%	Vocabulary	17%	83%
Check-In	33%	33%	Parenting	0%	100%
Community Management	17%	83%	Discussion of Discharge	33%	67%
Emotional Growth	83%	17%	Community Enhancement	17%	83%
Discussion of Goals of Phase	0%	100%	Peer Encounter	83%	0%
Education	33%	50%	Pull-Ups	0%	100%
Relapse Prevention	33%	67%	Trigger Analysis	33%	17%
Pre-release Planning	17%	83%	Sharing Experiences	33%	50%
Vocational Education	0%	100%	Therapeutic Education	50%	50%

Treatment styles at Site Four (Table F.5) were frequently characterized as highly formal, introspective, and somewhat interactive, while the meetings were never classified as reward or punishment sessions. Informal, listening-post and staged presentation styles were infrequently used. Thus, while the treatment meetings were largely scheduled and formalized meetings, they were also characterized as introspective and interactive, allowing inmates to reflect on treatment issues and discuss these with the counselors and one another, at least as much as their level of functioning would permit.

Table F.5. Treatment Style at Site Four
(n = 6 meetings observed, 4 men's & 2 women's groups)

Variable	High Use	Not Used	Variable	High Use	Not Used
Check-In	0%	67%	Introspective	67%	0%
Community-based	33%	50%	Listening Post	17%	83%
Formal	67%	17%	Punishment	0%	100%
Informal	17%	83%	Reward	0%	100%
Interactive	33%	17%	Staged Presentation	17%	83%

As for the "View of the Residential Community" items employed at Site Four (Table F.6), collective formats, open communication, the use of participants, and membership feedback were emphasized, while role models were never used, and shared norms and structured systems were not emphasized. Again, this would suggest that inmates were allowed to discuss treatment issues openly and participate actively in their own treatment, within the groups' treatment activities.

Table F.6. View of the Residential Community at Site Four
(n = 6 meetings observed, 4 men's & 2 women's groups)

Variable	High Use	Not Used	Variable	High Use	Not Used
Confrontation	33%	50%	Use of Participants	83%	0%
Collective Formats	83%	17%	Individual Relationships	50%	33%
Membership Feedback	67%	17%	Use of Role Models	0%	100%
Shared Norms	0%	83%	Structured Systems	0%	83%
Open Communication	100%	0%			

D. Summmary/Discussion

Site Four served 32 clients (17 males and 15 females) during the study period. Most of these clients had prior drug treatment experience (84%) and were also diagnosed with a mental illness, in addition to a substance abuse problem. Most of these clients had poor employment records and extensive criminal histories (average number of arrests = 16). The most commonly used drugs were alcohol, cocaine/crack, heroin, and PCP. Of the 32 clients served, 30 were discharged, with 3 successfully completing the program. Of the clients discharged, 3 (13%) were transitioned to a second phase of treatment. The average length of stay in jail-based treatment was 49 days. The average client committed 0.4 infractions, with 5 total of infractions reported during the study period. The most common infraction was a trust violation. Site Four reported information on 21 clients who were drug tested (an average of 5.6 tests per client), with no positive tests reported.

The treatment program itself could not be categorized as employing any particular program orientation, however this may be due to the unique nature of this program for dually-diagnosed clients. Emotional and cognitive skill development, social relatedness and subjective learning were commonly employed treatment topics at Site Four. Emotional growth training, peer encounter groups, and awareness training were commonly used treatment activities at this site. Most treatment activities were characterized as formal and introspective in terms of their style of delivery. Finally, the counselors at Site Four appeared generally skilled and experienced, though they exhibited relatively low levels of confrontation.

As with many other sites reviewed in this project, the counselors at Site Four lacked thorough background information on their clients. In general, the treatment program met several of the program guidelines, such as the use of separate living units, the use of empirically supported treatment techniques (CBT), and drug testing. As with other sites, it appears that this program was unable to provide a minimum of six months of jail-based treatment. While the program was able to blend several treatment techniques, from both CBT and TC models, the overall use of the community itself seemed to be diminished by the psychiatric condition of the clients served in this program. The clients offered each other relatively little feedback on treatment issues, unless specifically solicited by the counselor, indicating a relatively underdeveloped sense of community. In addition, the program seemed to make relatively little use of treatment issues focused on the development of a prosocial set of values. While the strict use of these TC components was not specifically required by the state of Virginia, the federal funding agencies involved did intend for programs using these RSAT funds to attempt to implement TC treatment components as part of their substance abuse services. In this particular site, given the relatively low level of functioning characteristic of the client population, it remains unclear whether aspects of the traditional TC model can be effectively employed.

Appendix G:

Site Five Description

A. Site and Program Design Overview[1]

The therapeutic community (TC) at Site Five is designed to provide drug abuse services to 12 female inmates at a time. According to the treatment staff, the actual number of treatment participants varies over time, due to the transitory nature of the jail population. Inmates participate in the TC program for approximately six months. Inmates participating in the program were housed in a separate unit within the facility. A religious program block was located in the same section of the correctional facility as the women's TC program.

The women's TC unit consisted of two separate areas: a sleeping area and a common area. The sleeping area consisted of several bunk beds and a few plastic chairs. The sleeping area was somewhat smaller than the common area, however it did not appear overly crowded. The common area contained only two picnic-style tables and a bathroom area, which was not enclosed in any way. In fact, the inmates commonly used towels to cover-up while using the bathroom facilities. There were two showers available for the inmates, each of which had a small curtain. The common area was fairly large and it appeared that this was the area where the inmates spent most of their time. Each wall of the TC unit contained several very narrow windows, which stretched from the ceiling to the floor. The windows were covered in mesh and thus it was difficult to see anything from the cell area.

The TC unit itself was decorated with several posters that stated various rules of the TC program, as well as aspects of the recovery process. These rules were discussed and agreed upon by all the members, and were to be obeyed in order to avoid punitive consequences. In addition to the posters outlining numerous rules for the group, there were several posters emphasizing "womanhood," as well as the "Twelve Steps" of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). In addition, posters created by the treatment members displayed various inspirational sayings celebrating "womanhood".

The program is run by two full time counselors and a program case manager. According to these treatment staff, all group members were randomly drug tested each week by the program itself. The program staff was obliged to report positive drug tests the sheriff's office. However, the treatment staff was not required to inform the sheriff's office about which specific inmate had tested positive, instead they were only required to report that they suspected drugs were present on the unit. Correctional officers would then conduct an investigation and "shake down" the unit.

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[1] Site Five was observed for four consecutive days in August, 1998, approximately nine months after the RSAT funded treatment program had been in operation. The structured observation results describing the treatment program at this site represent the program as it operated at that time. Data reported by the sites (e.g. client characteristics, drug testing) represent the entire 14-month period of the evaluation effort.

Overall, despite some reported tensions, the treatment staff felt that they were able to work effectively and comfortably with the correctional staff, though they did tend to feel that drug treatment was given a relatively low priority within the jail. Treatment staff did have office space located within the jail facility, while the program's director has an office outside the jail. Treatment staff report that participants are matched with appropriate community services by the case manager, prior to being released, however specific treatment slots in the community were not allotted to graduating TC members. Most participants in this program are not placed on parole after their release from the jail.

The therapeutic community program at Site Five included three meetings per weekday. The typical day's schedule called for a morning group therapy session, from 9:30 to 11:00, followed by lunch. From 12:30 to 1:30 members were scheduled to participate in substance abuse education classes, followed from 1:45 to 3:00 by another group therapy session. The scheduled times for the group's meetings varied depending on the wider jail's schedule, e.g. lunch and recreation times. In fact, there were times during the week observed when treatment sessions had to be re-scheduled due to conflicts with recreation and lunch times. Scheduled visitation times (with outside visitors) also affect the treatment schedule. As a result, the counselors and TC participants were forced to be very adaptable to the jail's schedule.

Generally, the treatment schedule required inmates to run the therapeutic meetings, even when counselors were present. However, during the week's observation period this did not consistently take place. Treatment activities largely included substance abuse education meetings and group therapy sessions. No group-run meetings were observed during the week because observation staff was not allowed on the unit without staff escort. There were several group-run community meetings scheduled in the mornings, as well as at different points throughout the day, however through informal observation of these meetings (from outside the unit) it did not appear that the inmates accomplished much at these meetings. In fact, these scheduled community meetings were often not conducted at all.

B. Overview of Program Implementation

Characteristics of the Sample. The Residential Substance Abuse Treatment (RSAT) program at Site Five served 64 female clients since its inception (See Table G.1a). The average client is approximately 35 years of age. All clients served in the modified therapeutic community are female. The majority of clients served in this program are African American (68.8%), with 28.1% identified as Caucasian. None of the clients were employed in the last 30 days.

Table G.1a. Demographic Characteristics

N	64
Mean Age	34.6
Minimum-Maximum	19.5-48.1
Standard Deviation	7.2
%Male	0.0
%Female	100.0
%Missing Gender Data	0.0
%African American	68.8
%Caucasian	28.1
%Missing Race Data	1.6
%Employed	0.0

Site Five clients have been arrested an average of 9.1 times, resulting in approximately six convictions (See Table G.1b). Much of the instant offense information was missing (54.7%), making it difficult to draw conclusions about the background of these inmates. As mentioned throughout this report this lack of information also likely impacts the counselors' knowledge of the specific histories of their clients. In any event, the available data indicates that most of the clients are incarcerated for a violation of probation/parole (18.8%).

Table G.1b. Criminal History Characteristics

Mean Number Of Adult Arrests	9.1
% Arrest Data Missing	56.3
Mean Number Of Convictions	6.1
% Conviction Data Missing	54.7
Instant Arrest Offense	
%Property Crime	4.8
%CDS Possession	6.3
%PWID CDS	4.7
%VOP	18.8
%Assault/Battery	1.6
%Prostitution	4.7
% Other	4.7
%Missing	54.7

As with criminal history data, it appears that much of the prior drug history information was missing, as well (See Table G.1c). With such a substantial proportion of data missing it is difficult to draw firm conclusions about the drug of choice among this group, however it also suggests as mentioned previously that the program staff may not have the necessary background information to deal effectively with their clients. Among those clients for whom data was available, the primary drug of choice appears to be crack/cocaine (10.9%). The largest group of

non-missing subjects suggested that 9.4% had used drugs daily over the past 30 days. This treatment experience is most likely not their first: 60.9% of the clients have previously participated in treatment.

Table G.1c. Substance Abuse Characteristics at Site Five

Drugs Of Choice	
%Alcohol	1.6
%Heroin	1.6
%Crack/Cocaine	10.9
%Missing	85.9
Frequency Of Use	
%No past month use	3.1
%1-3 times in past month	0.0
%1-2 times per week	0.0
%3-6 times per week	1.6
%Daily	9.4
%Missing	85.9
% Any Prior Treatment Experience (including self-help groups and education)	60.9

Continuum of Care. Site Five served a total of 64 clients in the modified therapeutic community (TC). Of these 64 clients, data was submitted to indicate that 29 had been unsuccessfully discharged, nine had been successfully discharged, (completed or transitioned to other treatment) and 12 had been sent to another prison or jail . Of the 38 who had been discharged, 2 or 3.9 % were reported to continue treatment in the community. The average length of time (LOT) spent in the first phase of treatment was almost 71 days, but ranged from two days to 357 days.

Graduated Sanctions. Of the 64 clients served by Site Five in the modified therapeutic community, only one committed an infraction (1.6%). This client reportedly used inappropriate language during a treatment session. Program staff responded by issuing a therapeutic task.

Table G.1d. Graduated Sanctions at Site Five

Total Number of Clients	64
Number of Clients with Infractions Reported	1 (1.6%)
Mean Number of Infraction Events	.02
Total Number of Infractions Reported	1
Most Serious Infraction(s) Reported Inappropriate Language/Talking Out	1 (100.0%)
Total Number of Responses Elicited	1
Most Serious Response(s) Elicited Therapeutic Tasks	1 (100.0%)

Drug Testing. Drug testing results was conducted for 92 percent of the offenders participating in the program. The average client submitted 7.3 drug tests during their stay in the modified therapeutic community. As such, program participants were tested at a rate of once every 7.0 days. According to the results that were provided, there were no positive drug tests.

Table G.1e. Drug Testing at Site Five

Number of Clients Tested	64
Mean Number of Drug Tests	7.3
Rate of Drug Testing	1 drug test / 7.0 days
Positive Tests (All Drugs)	0

C. Treatment Program Description

Structured Interview & Informal Observation Results. During the observation period the treatment program at Site Five was serving 12 female inmates. The program was also delivering services using two full time counselors and a facility case manager, as intended. Both of the program's counselors had earned Master's degrees. The facility case manager worked with the counselors and clients to develop aftercare plans and refer graduating inmates to appropriate community-based drug treatment. However, the local CSB did not utilize designated treatment slots for graduating TC members. As intended, the program made use of a variety of treatment techniques or proven effectiveness (CBT approaches) that are reviewed in more detail below. The program also appeared to meet the requirement to utilize drug testing and a separate living unit for TC members.

Treatment Activity/Schedule. Site Five attempted to implement 15 treatment meetings per week and during the observation period the program was successful in offering most of these meetings. However, some meetings were rescheduled, commonly due to conflicts with the daily operation of the jail itself. Several examples of the type of therapeutic tasks offered and topics discussed in this treatment program are reviewed below. At one point during the week, as part of a substance abuse education group, each counselor took half the group to different areas of the cellblock, conducting the two smaller groups individually. In one of the two groups, the counselor helped two inmates talk through their personal disagreements. While the processing of emotions within this smaller group setting helped strengthen the bonds among the six participants in that group (and hopefully between the two conflicting members), it did not seem to help strengthen an overall sense of community among all members. While this activity may have helped the counselors discuss the inmates' personal issues in a more intimate setting, it did not appear to have benefited the community as a whole.

Another group exercise, as part of a substance abuse education meeting, included eight of the twelve community members. The eight members were instructed to create a skit that focused on the principle "define yourself or be defined." The skit was given to these eight members

because they were caught breaking the community rules. The eight inmates worked together to create a skit that focused on self worth. The inmates chose to model their skit after the "Wizard of Oz." In the skit, the inmates had different personal struggles that they had to focus on in order to get back to the "Bridges to Freedom" treatment program. For example, the inmate who played the part of the "lion" had to get courage from the Wizard of Oz before she could go back to Bridges of Freedom. According to this inmate, if she had courage she would be able to stand-up to negative peer influence and follow the rules. Another example from the skit was the persistence, which the inmates who portrayed Dorothy and Toto had to maintain on their mission back to Bridges to Freedom. Dorothy and Toto's persistence were supposed to be an example of the strength that the inmates need in order to have a successful recovery. As previously mentioned, the skit was intended to help the inmates understand and follow the rules of the treatment program.

At the end of the skit, one of the counselors asked the eight inmates how the skit helped them on their road to recovery. The inmates could not answer the counselor's question with a response that was sufficient. The counselor told the inmates that the assignment should have been more than a "play." Furthermore, the counselor stated that the assignment should have been an opportunity for the participants to analyze how breaking the rules had defined them. The counselor wanted the inmates to see that one's actions influence how people view one another. For example, "when you break the law, people define you as a criminal". In an attempt to help the eight inmates accurately complete the original homework assignment, one of the counselors made the participants make a list of the behaviors that define a person versus those behaviors that are defined by a person.

The skit exercise brought to the surface several issues that were affecting the pro-social functioning of the therapeutic community. For instance, when one of the counselors asked the participants how this exercise helped them in their recovery process, one inmate said that it taught her she cannot "out slick a slicker." The counselor responded that the participants in the program are working under a double standard. According to this counselor, when the counselors are present on the unit the inmates are on their best behavior, but when the counselors leave the unit, the inmates revert back to their street behaviors.

During the third day of observations, one of the counselors conducted an educational session with the treatment participants. The educational session focused on the different stages of addiction. For example, one of the counselors discussed with the treatment participants the "primary," "progressive," "chronic," and "fatal" stages of addiction. The counselors emphasized the fact that the inmates' addiction was a disease rather than the result of environmental pressures. After discussing the stages of addiction, the counselors discussed the different phases of addiction. The first phase was characterized as "euphoric" and an individual's initial drug experience. In the second phase of addiction the individual seeks out situations where one can drink and use drugs. This facet of the treatment curriculum centered on awareness training. The TC participants were given an opportunity to ask the counselors' questions about their addiction. The educational session was used as an attempt to increase drug awareness among the participants, as well as curb future drug abusing behaviors. One problem with this session was that for some of the TC members it was the second time they heard this lecture. The fact that

some of the members had already heard the cycle of addiction lecture may have affected their participation and interest levels.

Other treatment activities included the presentation of one client's life story and another inmate's "good-bye to drug" letter. One difficulty that presented itself during the client's life story presentation was the length of time it took for the inmate to go through her life history (the life story took two days to complete). Finally after two days of presenting, in detail, her life story to the group this client was released. There were certain points during the inmate's life story when she became very emotional and angry about the circumstances in her life. Instead of trying to help the inmate deal with those feelings, the counselors tried to encourage the inmate to delve deeper into her emotional unrest. Little attempt was made in these sessions to diminish the impact of this client's heightened state of vulnerability prior to her being released back to the community.

During another client's "good-bye to drug" letter, the inmate was very unwilling to divulge her personal feelings to the group. The counselors probed the inmate about her street behaviors as well as the negative street situations that enhanced her drug addiction. In the beginning, the inmate denied that there were situations that influenced her decision to continue her drug use. However, eventually the inmate began to openly communicate her emotions with the group. The life story and the "good-bye to drug" letter helped the inmates begin to understand their feelings and enhance the functioning the treatment community. Overall, the program seemed to make use of various types of treatment activities and was able to have both successes and some failings in terms of its ability to effectively uncover and process information related to clients' substance abuse addictions.

In addition to some difficulties encountered with adequately processing clients' life history and drug addiction issues, several of the community/treatment rules appeared to have hindered the development of a positive and effective community environment. For instance, during client presentations the community members were not allowed to give the presenting client any feedback or ask clarifying questions. The community was allowed to give feedback only after the inmate had finished presenting her entire life story. The inmates' inability to provide community members with feedback may have contributed to their boredom and lack of interest. The feedback given to the presenting inmate was primarily through the counselors, who were allowed to continually interact with the inmate throughout her presentation. Unfortunately, the constant interaction between counselors and the presenting inmate left very few questions unanswered, such that by the time the community members had a chance, all of their questions had been asked by one of the two counselors.

As a result of the low level of participation by group members it was difficult to determine whether these members had actually acquired any of the skills needed to identify negative behavioral patterns. If the members had acquired these skills, they appeared unable to share their insight with the other members of the community. Only twice during the week were members observed to actively participate; once during a substance abuse education session, and once during a group encounter session focused on spirituality. A volunteer counselor, not associated with the RSAT program, conducted the spirituality meeting. In these instances, when the inmates were given an opportunity to voice their opinions, the group did seem more cohesive

and productive. The emotional connection experienced by most of the group members during the spirituality session did appear to enhance community cohesion, if only temporarily.

Counselors. Two counselors provided treatment services to the female clients at Site Five. Both therapists have Master's degrees in psychology. The counselors at this site frequently appeared to employ a rather structured group process in the meetings observed. Although different, the therapeutic styles of the two counselors complemented each other. The highly structured approach of one counselor was moderated by the less strict style of the other. In general, the counselors discussed with each other the various homework assignments that they should assign to the community.

Role Models and Community Process. The therapeutic community employed one client role, that of "cell representative". The cell representative's duties included informing the counselors of any pull-ups, talking with the correctional officers, and organizing the members for recreation time. The cell representative was given more responsibility than the other members, however her responsibility was still vastly limited with regard to the situations that arose in the community. Over the week's observations, the cell representative exhibited behaviors suggesting that she did not have a heightened interest in obeying the rules of the community. For example, the cell representative, along with eight other members, disobeyed one of the group rules, and together they were sanctioned accordingly. As a role model for the community, the cell representative frequently did not appear to guide the pro-social behavioral development of the other clients. In fact, the cell representative, at times reinforced the anti-social behaviors of certain members. Her negative behavior may have impacted the way the compliant members of the group viewed her as a role model. It appeared that the other members found it difficult to respect her as a leader when she defies the rules she was supposed to help monitor. In general, during the week's observations, the treatment participants seemed to work more as individuals than as a collective group on their recovery.

Despite being housed in a separate living unit, the TC program was located in close proximity to a religious program. This proximity appeared to adversely affect the functioning of the TC in particular due to the noise produced by the religion program's members. This noise frequently hindered the TC members' ability to listen and participate effectively in their own treatment activities. In addition, the movement of inmates in and out of the cellblock often distracted the treatment community. There were numerous times over the course of the week when TC clients shifted their attention from their treatment activities to those outside the unit.

Additionally, there were several times over the course of the week when a few TC clients left the session and began talking to correctional officers through the bars. The counselors made no attempt to maintain the clients as part of the treatment session. For instance, during the first two days of observation, numerous inmates removed themselves from the group during another client's presentation, to use the bathroom or get a drink from the water fountain. The constant interruptions provided by the group members themselves not only distracted the community as a whole, but also impacted the individual client's ability to present her life story accurately. In fact, as the inmate's story continued it became more elaborate and embellished, apparently in an attempt to keep the other group members' attention.

Overall, the program members appeared to lack a cohesive sense of community. Specifically, several friendships were formed between certain members, which seemed to hinder the cohesiveness of the group. Throughout the week's observations, there were several instances when the attitudes of certain group members negatively impacted the treatment sessions. For example, when one client confronted another about her body language and negative attitude, the confronted inmate quickly became defensive. The confronted inmate then responded with a negative attitude, turning on the first member by pointing out some of her negative attributes. The confronted inmate failed to respond to the original feedback with the appropriate therapeutic statement ("I will get right on that"). Overall, the confronted inmate did not appear to internalize the potentially helpful behavioral suggestions offered during this interchange.

A major component of the TC model is helping participants become aware of their disruptive or antisocial behaviors. An example of the difficulties encountered in this program as it relates to this aspect of the traditional TC model is discussed below. While a group member typically read the group rules at the beginning of each treatment session, and the community rules were posted on the unit wall, in general it appeared that the counselors failed to make a consistent effort to enforce these rules. For example, several inmates were observed either sleeping or not paying attention during some of the treatment sessions. The counselors and group members failed to confront or sanction these inmates on these disruptive, inappropriate behaviors. The lack of rule enforcement seemed to encourage the members to continue their disruptive behaviors without fear of negative consequences.

An even more troubling indicator of the lack of a sense of community among these group members were the several instances during the course of the week in which some participants made faces at, or openly mocked other TC members. Various inmates were observed rolling their eyes or making noises in order to demonstrate their disdain towards certain other members. For example, during one inmate's life story, several inmates laughed or talked to one another about her presentation. The inmate distractions appeared to have impacted the level of seriousness given to the client's presentation and to the treatment session in general. Again, neither the counselors, nor the other group members dealt with this negative behavior.

Structured Observation Results. Site Five, a women-only program, heavily emphasized "spirituality" (used to a high degree in 68% of meetings observed), while nearly all the remaining program emphasis variables were rated as frequently or always unused (see Table G.2). In other words, the program appeared to frequently approach the problem of drug addiction from the perspective of a spiritual issue, consistent with either the AA or NA models of substance abuse treatment.

Table G.2. Program Emphasis at Site Five
(n = 8 women's meetings observed)

Variable Name	High Use	Not Used	Variable Name	High Use	Not Used
Acceptance/Disease	13%	87%	Motivation Readiness	0%	100%
Action Planning	0%	100%	Redefining Action	0%	100%
Aftercare	0%	100%	Relapse Prevention	0%	100%
Contemplate Change	25%	75%	Self-work	25%	50%
Maintenance	13%	87%	Spirituality	68%	25%
Motivation	0%	100%			

Despite the program's spiritual emphasis, treatment topics tended to focus on cognitive and emotional skill development (see Table G.3). These topics were heavily used in every meeting observed at Site Five, while past experiences (75%), psychological development (75%), social relatedness (75%), and socialization issues (63%) were also commonly used at a high level. Aftercare, diaries, nurturance, and physical safety were completely unused topics, while healing experiences, recent incidents, letters, and psychological safety were frequently rated as "not used" in the meetings, observed. Overall, while somewhat inconsistent with an exclusive focus on drug addiction as a spiritual issue, these frequently used treatment topics would suggest that the program is attempting to implement treatment components that prior research has found to be effective (e.g. CBT approaches). The program also seemed to be implementing at least some components consistent with a traditional TC model (e.g. social relatedness), though the low levels of use for physical and psychological safety would suggest that more could be done to promote the development of an effective sense of community and trust.

Table G.3. Treatment Topics at Site Five
(n = 8 women's meetings observed)

Variable	High Use	Not Used	Variable	High Use	Not Used
Aftercare	0%	100%	Past Experiences	75%	0%
Cognitive Skills	100%	0%	Physical Safety	0%	100%
Psychological Development	75%	13%	Psychological Safety	13%	75%
Diary	0%	100%	Emotional Skills	100%	0%
Subjective Learning	13%	63%	Socialization Issues	63%	37%
Incident Review	25%	75%	Social Relatedness	75%	25%
Letters	13%	87%	Street Experiences	13%	75%
Nurturance	0%	100%	Healing	13%	87%
Unit Issues	50%	50%	TC Issues	38%	62%

Treatment activities focused on emotional growth training and sharing experiences, which were used to a high degree in every observed meeting, while awareness training (87%), peer encounters (87%), and therapeutic education (75%) were frequently used at a high level (see Table G.4). Community management, community enhancements, goals of the program phase, relapse prevention and vocational education were unused in these meetings, while discussion of discharge, education, pre-release planning, parenting, trigger analysis, and vocabulary were frequently rated as "not used". Consistent with the results for treatment topics, these results for activities suggest that the development of the community as an effective agent of individual change could be improved with more emphasis on community management and enhancement activities. The other treatment activities widely used appear consistent with the focus on topics related to individual change, such as emotional and cognitive skill development.

Table G.4. Treatment Activities at Site Five
(n = 8 women's meetings observed)

Variable	High Use	Not Used	Variable	High Use	Not Used
Awareness	87%	13%	Vocabulary	13%	87%
Check-In	37%	63%	Parenting	0%	88%
Community Management	0%	100%	Discussion of Discharge	13%	87%
Emotional Growth	100%	0%	Community Enhancement	0%	100%
Discussion of Goals of Phase	0%	100%	Peer Encounter	87%	0%
Education	25%	75%	Pull-Ups	13%	75%
Relapse Prevention	0%	100%	Trigger Analysis	13%	87%
Pre-release Planning	13%	87%	Sharing Experiences	100%	0%
Vocational Education	0%	100%	Therapeutic Education	75%	25%

In terms of treatment style (Table G.5), all of the meetings at this site were rated as highly introspective (100% of meetings rated as highly used), while many were rated as highly formal (88%). Most of the other treatment style variables at this site were frequently rated as "not used." Treatment activities at this site then appeared to be delivered in a regularly scheduled, group-wide manner, which focused on clients' introspection, with less focus being placed on client interaction, either with one another or with treatment staff.

Table G.5. Treatment Style at Site Five
(n = 8 women's meetings observed)

Variable	High Use	Not Used	Variable	High Use	Not Used
Check-In	37%	63%	Introspective	100%	0%
Community-based	0%	100%	Listening Post	25%	75%
Formal	88%	12%	Punishment	0%	100%
Informal	13%	87%	Reward	0%	100%
Interactive	33%	12%	Staged Presentation	37%	63%

The "View of the Residential Community" items reveal a focus on collective formats (100% of meetings rated as highly used), while open communication (87%), individual relationships (87%), confrontation (75%) and structured systems (63%) were frequently rated as highly used (Table G.6). Role models were frequently rated as "not used", as were items measuring membership feedback and shared norms.

Table G.6. View of the Residential Community at Site Five
(n = 8 women's meetings observed)

Variable	High Use	Not Used	Variable	High Use	Not Used
Confrontation	75%	25%	Use of Participants	38%	50%
Collective Formats	100%	0%	Individual Relationships	87%	13%
Membership Feedback	13%	75%	Use of Role Models	0%	88%
Shared Norms	38%	62%	Structured Systems	63%	37%
Open Communication	87%	13%			

D. Summary/Discussion

Site Five served 64 female clients during the study period, the majority of whom (69%) were African American. Most of these women had poor employment histories, extensive criminal involvement and past drug treatment participation. The site did not have information on the substance abuse history of the client except for 10% of the women who reported cocaine/crack as their drug of choice. Of the clients discharged from this site, 9 successfully completed the program. Two clients were transitioned to a second phase of treatment (3.9% of those discharged). The average length of stay in jail-based treatment was 71 days. Only one client was reported to have committed an infraction, inappropriate language.

The treatment program itself focused largely on spirituality as a "program emphasis." Other program emphases were largely unused. Treatment topics focused on components characteristic of CBT interventions, such as cognitive and emotional skill development, socialization, review of past experiences, social relatedness, and psychological development. Consistent with these treatment topics, treatment activities included emotional growth training, awareness training, sharing experiences, and therapeutic education. Less emphasis was placed on activities consistent with the development of the community itself as an agent of change or with the development of a set of prosocial values (traditional TC components). In general the program was able to integrate some aspects of both the TC and CBT models of drug abuse treatment, while maintaining a program emphasis consistent with AA or NA models (i.e. the predominant focus on spirituality). Meetings were generally rated as formally scheduled, and introspective, with less emphasis on interaction and membership feedback (as would be more characteristic of a TC approach). Overall, the counselors were rated as skilled and experienced.

Appendix H:

Site Six Description

A. Site and Program Design Overview[1]

Site Six is a roughly 900-bed facility serving several jurisdictions in southeastern Virginia. The therapeutic community programs at Site Six are designed to serve 12 male and 12 female inmates, with each program housed within separate living units. The expected length of treatment at this site is six months. Treatment staff reports that TC participants in this program are randomly drug tested by the facility. The program is run by two full-time treatment staff (one male, one female) and a program-specific case manager. The jail itself employed a case manager, who typically focuses on inmates in the work release program. A case manager was promised to the TC program, but treatment staff reports that this position has yet to be filled.

The staff members are assigned two small offices just outside the men and women living units. The program curriculum includes both individual, as well as group treatment sessions. The treatment staff work informally with group members to arrange community-based follow-up drug addiction and related social services. The counselors can directly refer clients for follow-up drug treatment (and other supplementary) services in the community, through the local Community Service Board (CSB), of which they are a part. While the CSB in this area does not offer priority/reserved treatment slots for persons leaving the jail who require further outpatient drug treatment, it is possible for TC members to move directly into CSB services, if available.

Both male and female inmates were housed on triangularly shaped, multilevel units measuring approximately 30x30x30 feet. Both units were essentially similar in design. The units included their own private shower facilities (two per unit, each in a separate small room) and each cell had its own toilet-sink combination unit. Each unit contained two metal tables, fixed to the floor, on the level of the main unit doorway, along with several plastic resin chairs. While the 12 individual cells on each unit were not closely examined, the units themselves were decorated with many program-related materials (e.g. posters). Each unit contained only two very narrow, exterior windows that were roughly 6 feet tall, in the corner of the unit. These windows were opaquely shaded so as to provide no view of the outside. Ramps connected the multiple levels of each "pod" unit, allowing handicapped inmates access to all levels of the living unit. Each unit also contained a television. Treatment staff reports that the inmates are allowed to watch TV only during scheduled times, however the inmates appeared to have direct control of, and access to the set. The entire unit could be observed from a control booth, which was located

[1] Site Six was observed for four consecutive days in November, 1998, approximately nine months after the RSAT funded treatment program had been in operation. The treatment staff working at Site Six at the time of the observation had been hired approximately 2 months prior, as the original staff had all left the program after the first few months of operation. The structured observation results describing the treatment program at this site represent the program as it operated at that time. The structure and operation of treatment programs may change over time. Data reported by the sites (e.g. client characteristics, drug testing) represent the entire 14-month period of the evaluation effort.

between all four (2 TC and 2 Segregation) units. The windows between this booth and the living units were tinted, such that inmates could not see the officer stationed inside.

The program curriculum at Site six was derived from a "traditional" TC model, borrowing the use of members in various community roles and the employment of structured systems (e.g. routinized means of group interaction) in some therapeutic activities (most notably during "confrontation groups"). Both male and female inmates in this program were scheduled to begin the day with a group-run, community meeting. They also have several counselor directed program activities throughout the day, which were conducted in one of several classrooms outside the living unit area.

The morning group meeting is typically conducted without the presence of professional staff members. One female, group-run, community meeting was observed and was begun with the traditional AA check-in. Group members then read selections from Alcoholics or Narcotics Anonymous books. These readings included AA traditions and/or short stories of other's addiction-related problems. In addition, feedback was solicited from the group on the readings, followed by any "pull-ups" or "push-ups" which members deemed necessary. Finally, members were given the opportunity to bring up any new business or issues. This meeting was closed with the group joining for the "Serenity Prayer".

Mixed in with the group meetings, the counselors at site six offered each inmate (both male and female) individual treatment sessions once a week. For reasons of confidentiality, these individual sessions were not observed. These individual sessions appeared highly sought after by the group members, judging by their frequent "popping in" to the staff office with inquires about their next session, typically while being moved as a group to some other area of the facility (e.g. for recreation).

Treatment groups at this site were conducted as same-sex only, and as mixed sex groups. Both men's and women's schedules included "process" groups, educational groups, and highly structured "confrontation" groups. On Fridays, the program schedule called for "Coed relapse prevention groups", however these groups were not observed during the four-day site visit. Process groups typically involved discussion of therapeutic topics (e.g. denial, how to handle obstacles to one's plan, procrastination), but could include a general discussion of any pertinent inmate concerns. Educational groups focused on the dissemination of information related to diverse topics, including self- esteem, feelings, drugs, addiction, the "whole body" (mind, body, spirit) approach to recovery, and so on.

Confrontation groups involved the entire group, both males and females, coming together to review "booking slips". During these meetings, group members who had submitted slips regarding other inmate's antisocial behaviors were given a structured opportunity to present that information to the inmate in question. The inmate being "confronted" was required to sit inside the circle of group members, facing the member who had submitted the slip. The confronted inmate was required to sit on his/her hands and was not allowed to respond to the feedback until the end of the confrontation.

B. Overview of Program Implementation

Characteristics of the Sample. According to data provided by the site, this Residential Substance Abuse Treatment (RSAT) program has served a total of 48 clients[2] since program inception. The average client is approximately 34 years of age, with males (34 years) tending to be slightly younger than females (35 years) on average. Most of the clients served are male (58.9%), with 41.4% being female. The population of clients served is roughly equally split between African Americans (50.7%) and Caucasians (43.8%). None of the clients were employed in the last 30 days.

Table H.1a. Demographic Characteristics at Site Six

	Total	Males	Females
N	48	29	19
Mean Age	34.1 Yrs	34.0 Yrs	35.0 Yrs
Minimum-Maximum	20.4-48.6	20.4-44.3	22.5-48.6
Standard Deviation	6.6	6.7	6.5
%Male	58.9		
%Female	41.1		
%Missing Gender Data	0.0	0.0	0.0
%African American	50.7	51.2	50.0
%Caucasian	43.8	46.5	40.0
%Missing Race Data	5.5	2.3	10.0
%Employed	0.0	0.0	0.0

Clients at Site Six have been arrested an average of 10.5 times, resulting in approximately eight convictions (See Table H.1b). Similar to several other sites examined in this report, 37% of the instant offense information was missing for this group of clients, again suggesting that the counselors may need more access to more complete information regarding the background characteristics of their clients. The available data indicates that most of the clients are incarcerated for a commission of a property offense (16.4%), such as burglary, theft or shoplifting, while another 13.9% are incarcerated as a result of miscellaneous offenses (e.g., family offense, failure to appear, etc.). Almost 14% of clients are incarcerated due to a violation of probation/parole.

[2] Site Six indicated that they had 74 clients enter the program but they were only able to document information on 48 clients.

Table H.1b. Criminal History Characteristics

	Total	Males	Females
Mean Number Of Adult Arrests	10.5	10.7	10.1
% Arrest Data Missing	35.6	34.9	36.7
Mean Number Of Convictions	8.4	7.7	9.46
% Conviction Data Missing	35.6	34.9	36.7
Instant Arrest Offense			
%Property Crime	16.4	16.2	16.6
%CDS Possession	5.5	7.0	3.3
%CDS Distribution	2.7	4.7	0.0
%VOP	13.7	9.3	20.0
%Uttering	5.5	4.7	6.7
%Assault/Battery	2.8	4.6	0.0
%Weapons	2.8	4.6	0.0
% Other	13.9	13.9	13.2
%Missing	37.0	34.9	40.0

The primary drug of choice identified by most clients at Site Six was crack/cocaine (46.6%), followed by heroin (15.1%) and alcohol (13.6%, See Table H.1c). Again, as with criminal history information, over 12% of the clients' drug of choice information was not available. Despite the problems presented by the missing data, the vast majority of clients had apparently not used drugs in the past month (79.5%), probably due to the fact that they have been incarcerated during this time. This treatment experience is almost certainly not their first: 74.0% of the clients have previously participated in treatment.

Table H.1c. Substance Abuse Characteristics at Site Six

Drugs Of Choice	Total	Males	Females
%Alcohol	13.6	20.9	3.3
%Heroin	15.1	9.3	23.3
%Crack/Cocaine	46.6	46.5	46.7
%Marijuana	8.2	9.3	6.7
% Other Opiates	1.4	0.0	3.3
% Other	2.7	4.7	0.0
%Missing	12.3	9.3	16.7
Frequency Of Use			
%No past month use	79.5	86.0	70.0
%1-3 times in past month	0.0	0.0	0.0
%1-2 times per week	0.0	0.0	0.0
%3-6 times per week	5.5	7.0	3.3
%Daily	6.8	0.0	16.7
%Missing	8.2	7.0	10.0
% Any Prior Treatment Experience (including self-help groups and education)	74.0	74.4	73.3

Continuum of Care. Site Six served a total of 48 clients within the modified therapeutic community (TC). Of these 48 clients, data was submitted to indicate that 20 had been unsuccessfully discharged, 6 were successfully discharged, (completed or transitioned to other treatment) and 15 were sent to another prison or jail. The others were active in the program at the time of this report. Of those discharged, 1 went on to community-based drug treatment. The average length of time (LOT) spent in the first phase of treatment (jail-based) was 85 days, but ranged from 11 days to 312 days.

Graduated Sanctions. Of the 48 clients served by the modified therapeutic community at Site Six, 39 committed some sort of infraction (82%). In fact, the average client committed 5.5 infractions. The most common infractions were verified negative community behavior (27.1%) and inappropriate language/talking out (13.9%). Based on information provided on standardized treatment tracking forms, by the program itself, infractions ranged from not following the dress code to violence, sex or weapons on site. The program director has since reported that this information, regarding the range of infractions, is inaccurate. Program staff responded to instances of non-compliance by holding an individual session (34.6%), or issuing a therapeutic task (29.8%). Responses ranged from a verbal warning to sending the client to general population for a period of between 6-10 days.

Table H.1d. Graduated Sanctions at Site Six

Total Number of Clients	48
Number of Clients with Infractions Reported	39 (82%)
Mean Number of Infraction Events	5.5
Total Number of Infractions Reported	266
Most Serious Infraction(s) Reported	
Inappropriate Program Behaviors	129(60.7%)
Verified Negative Community Behavior	72(27.1%)
Violation of Jail Rules	31(11.7%)
Special Conditions Violations	13(4.9%)
Trust Violations	4(1.5%)
Failure to Report Police Contact/Arrest	3(1.1%)
Report of Drug Use by Family/Friends	2(1.0%)
Curfew/Area/House Arrest Violations	2(1.0%)
Other	11(4.1%)
Total Number of Responses Elicited	231
Most Serious Response(s) Elicited	
Individual Session	81(35%)
Therapeutic Tasks	69(29.8%)
Verbal Warning	29(12.6%)
Offender Written Daily Program Reports	10(4.3%)
Increase Supervision/Tx Requirements	6(2.6%)
Reprimand of Client by Supervisor	3(1.3%)
Revise Tx Plan/Behavioral Contract	3(1.3%)
Restricted Privileges	3(1.3%)
Violation Action	2(1.0%)
Jail – 6-10 Days	2(1.0%)
Telephone Call to Tx Provider	2(1.0%)
30 Day Suspension from Treatment	1(.4%)
Other	20(8.7%)

Drug Testing. Drug testing results were submitted for nine clients who participated in the modified therapeutic community at Site Six or 18.75 percent of the offenders (See Table H.1e). The average client submitted 0.3 drug tests during their stay in the modified therapeutic community. As such, program participants were tested at a rate of once every 34.3 days. According to the results that were provided, there were no positive drug tests.

Table H.1e. Drug Testing at Site Six

Total Number of Clients	9
Mean Number of Drug Tests	.3
Rate of Drug Testing	1 drug test / 146 days
Positive Drug Tests (All Drugs)	0

C. Treatment Program Description

Structured Interview & Informal Observation Results. During the observation period the treatment programs at Site Six were serving 10 males and 10 females. While the program intended to provide services using two full time counselors and a case manager, the facility had not made arrangements for a program specific case manager. The program did make use of the services of a part-time student intern. As intended the program appeared to make use of several treatment techniques of empirically proven effectiveness, as is discussed below in the "Structured Observation" section. In addition, the program met various funding agency guidelines by employing a separate living unit for each program and by drug testing program participants. The treatment program was also successful in implementing several treatment activities each day, as scheduled.

Interviews with correctional staff suggested that correctional staff have little knowledge of the workings of the TC program; while interviews with the treatment staff suggested that the administrative or correctional staff has not wholeheartedly accepted treatment. The treatment staff seemed to feel that the jail staff had not been overly accommodating in either the development, or implementation of the TC program and relayed several instances to support this view.

Neither correctional, nor treatment staff seemed to think the current units which housed the men's and women's TC programs were adequate to promote a therapeutic milieu. In fact, the TC programs were housed in a section of the jail that also included two units for segregated inmates (typically inmates with disciplinary problems or those in protective custody). Both staff related instances in which treatment participants were treated in a manner similar to that of the segregated inmates, including their being denied certain privileges afforded other inmates of the same custodial status as the TC members. Program participants were allowed off the unit as a group for outdoor recreation and educational and treatment meetings, but ate meals and spent most of their free time on the unit.

Counselors. Site six employed two full time counselors (one male, one female) and a part time intern (female). There were apparently no restrictions regarding cross gender counselor-group interactions, as had been seen at some other TC sites. Both counselors seemed skilled and had several years of experience working with drug addicted populations. Both counselors also appeared very professional, and demonstrated interest and concern for the progress of their clients. Counselor "A" reported that frequent attempts to incorporate cognitive-behavioral strategies into the treatment meetings, in accordance with prior training. Counselor "B" reported enjoying the relatively long-term treatment approach of the TC model, because it

allowed for the development of a better understanding of the client's personalities and needs, and furthered the counselor's own self-understanding.

Roles Models and Community Process (Men's and Women's Units). Both the men's and women's units maintained several inmate roles, including coordinator, assistant coordinator, information coordinator, service coordinator, education coordinator, and expediter. It is unclear how these roles were assigned to various group members, however each position's responsibilities were posted on the units' walls, along with other program materials. Program participant roles seemed most consistently used during the community meeting. For instance, during the women's morning community meeting the coordinator, assistant coordinator, and expediter helped conduct various aspects of the meeting. The role models generally did not seem to play an extensive role during the other, counselor-run meetings.

Overall, the majority of group members in both the men's and women's units seem to have developed a reasonably strong sense of community (with some occasional difficulties, discussed below). They frequently participated actively in program activities, providing each other apparently sincere and appropriate feedback. Generally, the members were able to remain on task. However, there were instances, during a process meeting for example, when some members were carrying on side conversations while the rest of the men's group was reviewing a treatment issue. In addition, there did seem to be some strong individual relationships existing within the group.

Finally, in one instance, during a confrontation group, one member of the community seemed to have submitted slips (for various, apparently legitimate, antisocial behaviors) for nearly everyone in the men's program. After going through the confrontation process with several inmates, the group realized that most of the slips had been about issues raised by one member and questioned why he was "pulling up" everyone. This appeared to be a legitimate issue for the community to deal with, either because no one else was taking the "booking slip" procedure seriously, or because one member was potentially abusing the system. However, the counselors required the rest of the community to reserve comments about this issue until all slips had been formally processed.

Eventually, the group did come back to deal with this issue in a subsequent group, however it does suggest that the apparently well developed sense of community may have been weaker than it appeared on the surface. While this is admittedly only one incident, it may suggest some divisions within the "community" or a less than ideal commitment to the monitoring of each others' behaviors. Conversely, it may suggest that the large number of submissions by one inmate reflects some minor personality conflict between clients. In either case, this incident suggests a potential need to continue to develop the groups' sense of community and/or reinforce the need for group members to work together.

Structured Observation Results. Results for program emphasis items at Site Six revealed a focus on the contemplation of change (67% of meetings rated as high use) and self-work (67% high use), while nearly all other variables were frequently rated as "not used' (see Table H.2). In general this would suggest a program that is focused on helping inmates imagine what they and their lives would be like after they have begun to manage their addictions and

decrease their criminal involvement. A program emphasizing self-work would also tend to stress the need for clients to focus on the day-to-day efforts needed to achieve and maintain progress in these two domains.

Table H.2. Program Emphasis at Site Six
(n= 1 men's, 2 women's, 3 mixed meetings)

Variable Name	High Use	Not Used	Variable Name	High Use	Not Used
Acceptance/Disease	0%	33%	Motivation Readiness	33%	67%
Action Planning	33%	67%	Redefining Action	0%	83%
Aftercare	0%	83%	Relapse Prevention	0%	83%
Contemplate Change	67%	33%	Self-work	67%	17%
Maintenance	17%	83%	Spirituality	33%	50%
Motivation	17%	83%			

Treatment topics used heavily at site six included emotional skills (67% high use), nurturance, socialization issues, and social relatedness (all were commonly rated as "highly used"), while aftercare and diaries were completely unused as topics in these meetings. These topics, with the possible exception of emotional skills development (which is more consistent with an action planning phase) seem largely consistent with the program's emphasis on building motivation for change. Letters, past experiences, physical safety, street experiences, and subjective learning were also frequently rated as "not used" (see Table H.3).

Table H.3. Treatment Topics at Site Six
(n= 1 men's, 2 women's, 3 mixed meetings)

Variable	High Use	Not Used	Variable	High Use	Not Used
Aftercare	0%	100%	Past Experiences	17%	83%
Cognitive Skills	33%	50%	Physical Safety	0%	83%
Psychological Development	33%	67%	Psychological Safety	33%	50%
Diary	0%	100%	Emotional Skills	67%	33%
Subjective Learning	17%	83%	Socialization Issues	67%	33%
Incident Review	33%	67%	Social Relatedness	67%	17%
Letters	0%	83%	Street Experiences	0%	83%
Nurturance	67%	33%	Healing	33%	33%
Unit Issues	33%	50%	TC Issues	33%	67%

Treatment activities focused on awareness training (used highly in all meetings), while emotional growth training, peer encounter groups, and sharing experiences were also commonly used at a high level (see Table H.4). Awareness training in particular seems to be a treatment activity consistent with a program focus on the contemplation of change, as does the widespread use of sharing experiences. Discussion of discharge, goals of the program phase, and vocational education were not used in any meetings, while community management and enhancements, parenting, and vocabulary were frequently rated as "not used." The somewhat lesser emphasis placed on community management and enhancement activities suggests that the program could do more to integrate the building an effective sense of community (a common TC component) into the curriculum, along side the CBT approaches widely implemented in the program.

Table H.4. Treatment Activity at Site Six
(n= 6 meetings observed, 1 men's, 2 women's, 3 mixed)

Variable	High Use	Not Used	Variable	High Use	Not Used
Awareness	100%	0%	Vocabulary	0%	83%
Check-In	17%	67%	Parenting	0%	83%
Community Management	17%	83%	Discussion of Discharge	0%	100%
Emotional Growth	83%	17%	Community Enhancement	0%	67%
Discussion of Goals of Phase	0%	100%	Peer Encounter	83%	100%
Education	33%	67%	Pull-Ups	33%	67%
Relapse Prevention	17%	67%	Trigger Analysis	17%	67%
Pre-release Planning	0%	100%	Sharing Experiences	67%	17%
Vocational Education	0%	100%	Therapeutic Education	50%	50%

In terms of treatment styles, all meetings at this site were rated as highly formal (previously scheduled), while most were rated as highly interactive and introspective (see Table H.5). No meetings were rated as informal, and none involved listening-post, punishment, reward, or staged presentation styles.

Table H.5. Treatment Style at Site Six

(n= 1 men's, 2 women's, 3 mixed meetings)

Variable	High Use	Not Used	Variable	High Use	Not Used
Check-In	0%	83%	Introspective	83%	17%
Community-based	50%	50%	Listening Post	0%	100%
Formal	100%	0%	Punishment	0%	100%
Informal	0%	100%	Reward	0%	100%
Interactive	83%	17%	Staged Presentation	0%	83%

The results for "View of the Residential Community" items suggested that collective formats (all meetings were rated "high use"), membership feedback, and use of participants were all commonly employed. While many meetings were rated high for use of open communication (see Table H.6), only confrontation was rated as "not used" at a relatively high frequency. These results, along with the results for treatment style suggest that the program typically offered services in a group format (although they were one of the few programs observed to also offer individual treatment sessions), allowing clients to focus on self-examination, to participate actively and to interact openly with one another and with the counselors.

Table H.6. View of the Residential Community at Site Six

(n= 1 men's, 2 women's, 3 mixed observed)

Variable	High Use	Not Used	Variable	High Use	Not Used
Confrontation	33%	50%	Use of Participants	100%	0%
Collective Formats	100%	0%	Individual Relationships	50%	33%
Membership Feedback	100%	0%	Use of Role Models	50%	33%
Shared Norms	50%	17%	Structured Systems	50%	0%
Open Communication	83%	17%			

D. Summary/Discussion

Site Five served 48 clients, most of whom had extensive criminal and substance abuse treatment histories, as well as poor employment records. The most commonly used drugs of choice were cocaine/crack, heroin, and alcohol. Of the 48 clients, nine of successfully completed the TC and 15 were transferred to another prison or jail during their treatment time. Of those discharged clients, 1 (2.9%) was transitioned to a second phase of treatment. The average length of stay in jail-based treatment was 85 days. Clients at Site Six committed 39 infractions, an average of 3.6 per client. The most common infractions were negative community behavior and inappropriate language/talking out during treatment sessions. Site Six provided data on nine clients who submitted drug tests. The average client submitted 0.3 drug tests during the study period. No positive drug tests were reported. As with other sites there appeared to be a lack of information available to treatment staff regarding the criminal and drug use histories of some of their clients. This lack of complete information may negatively impact the ability of the treatment staff to offer effective services to their clients.

The treatment program itself focused on the contemplation of change and self-work, as program emphases. Consistent with that focus, emotional skills, nurturance, socialization, and social relatedness were common treatment topics at this site. Common treatment activities consistent with the program's emphasis included awareness training, peer encounter groups, emotional growth training, and sharing experiences. Most treatment meetings were formally scheduled, interactive, and introspective in style. The program made use of the community itself by allowing open communication, membership feedback and by employing clients in several facilitating roles. Finally, the counselors at Site Six were generally rated as skilled and experienced.