IMPLEMENTING THE "INTEGRATED CONTINUUM OF CARE" MODEL for Severely Addicted Addicts: The Key Maine Experience

Process Evaluation Report

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EXECUTIVE SUMMARY

The State of Maine Department of Corrections (MDOC) and the Office of Substance Abuse (OSA) at the Maine Department of Mental Health, Mental Retardation and Substance Abuse Services opened he Key Maine Therapeutic Community (TC) in March 1999 and its Transitional Treatment Program (TTP) in January 2000. Spectrum Behavioral Services, Inc. (SBS) was subcontracted to implement the program that was located at the Maine Correctional Facility in South Windham and the Pre-Release Center in Hallowell. The U.S. Department of Justice Residential Substance Abuse Treatment (RSAT) funded the initiative.

The following report summaries findings from a process evaluation of the program. The specific aims of the evaluation were 1) to describe the program's implementation, including how successful MDOC is in implementing the therapeutic community (TC) model in a prison-setting, how consistent TC staff and inmate attitudes are with the TC perspective and whether or not counselors are utilizing the TC methods; 2) to profile the drug use, treatment, and background characteristics of the inmates in the Maine correctional facilities who are eligible for admission to the Key Maine TC; and 3) to examine treatment process among clients who entered the Key Maine TC during the fifteen months of treatment.

The evaluation was based on 1) quarterly site visits conducted by the principal investigator, 2) a survey of treatment-eligible inmates, client assessment collected from treatment records, and a survey of correctional officers was conducted to examine how they view the drug treatment alternatives for offenders and to collect comparative environmental data on non-TC units at Windham

The Key Maine TC and the TTP Programs

The Key Maine Program opened in March 1999 at the Maine Correctional Center (MCC) in South Windham, Maine with an initial cohort of 30 men. The Transitional Treatment Program (TTP) opened in January 2000 at the Central Maine Pre-Release Center in Hallowell, Maine near Augusta with its first group of seven TC graduates.

The program is loosely modeled after the Key-Crest Program in Delaware. Like the Delaware program, Key Maine TC-TTP seeks to enable offenders to gain control over the addiction in the last 18 months of their incarceration and make a successful transition to the community-at-large. The Key Maine TC is a ten to twelve month program, after which program graduates enter the TTP, which combines work release and drug treatment during the last six months of the inmate's incarceration. As part of TTP treatment, the inmate initiates the process of contacting community-based treatment programs that can address his treatment needs after release from prison. Inmates work on reentry planning with TTP staff and are referred to community providers upon release from prison.

The challenges that were faced during the implementation of the Key Maine TC and the TTP were not atypical of new programs. Staff turnover was high. There were some tensions between MDOC and treatment staff, space and client flow issues. Like all new programs Key Maine encountered situations that required disciplinary action. Assessment of changes in the therapeutic environment indicated program resiliency.

Actions were taken to address problems as they arose, improve staff training and to facilitate better communication between MDOC and treatment staff throughout the first year.

Inmate Profiles

Data from the survey of inmates in Maine Department of Corrections indicates that TC-eligible inmates tend to be white men and 30+ years old. They exhibit extensive lifetime drug use and most report previous treatment attempts. Typical past criminal activities include violent crimes, particularly assault. Approximately ten percent indicated having committed sex crimes.

The TC-eligible inmates bring to treatment variety of issues, including psychiatric histories, childhood abuse, and violence that must be addressed within the context of drug and alcohol treatment. They report high levels of psychiatric disorders. Many have also themselves been victimized, often as young children. In the six months before their incarceration, they engaged in sexual behaviors that may put them at risk for HIV, but concerns about contracting the HIV virus is fairly low.

There were few statistically significant differences among men who entered the program and those who did not. Men in the comparison group were more likely to report previous outpatient and/or treatment from drug and alcohol problems in mental health clinics. Similarly, they were more likely than men in the treatment group to report having psychiatric diagnoses. Men in the treatment group were more likely to report violent victimization against other persons and involvement in drug trafficking. They were also more likely to report being physically and/or sexually abused as children.

Retention and In-Treatment Change

Eighty-five clients entered the program, representing 127 admissions to the TC program. Sixty-two men had a discharge status from the TC at the end of June 2000. Of these 14 (22.6 percent) completed TC treatment. One TC completer did not transfer to the TTP for administrative reasons, but the remaining thirteen entered the TTP program

Most program discharges were administrative discharges for disruptive behavior. The program operated on a "three strikes and you're out" policy and discharges for bad behavior were used as a means of improving compliance. Forty-four percent of the discharges were eventually readmitted to the program.

Data indicated that Key Maine clients experienced statistically significant increases in depression and self-esteem during the first six months of treatment. Motivation and readiness for treatment declined, but internalization of TC principles increased. Among clients who remained in treatment long enough to receive their 12-month assessments, depression appears to decline during the second six months of treatment, with their average depression score only slightly higher than their intake scores. The trend appeared to be the same for levels of motivation and readiness. On the other hand, data suggested that self-esteem and internalization of TC principles continued to increase in the latter half of the first year of treatment.

Limited data on treatment involvement provides evidence that the program is engaging clients in treatment and that clients have supportive working relationships with treatment staff.

Survey of Correctional Officers

A brief survey of correctional officers was conducted in February 2000 to assess support for rank-and-file MDOC staff for the treatment initiative and the gather comparative data on the correctional environments at Maine Correctional Center. Findings indicated general support for treatment alternatives, but many grievances related to Key Maine program itself. On the other hand, correctional officers who worked on the TC unit reported higher job satisfaction and fewer missed workdays than officers who had not worked on the unit in the last month. Few correctional officers who completed the survey indicated having any prior training on drug and alcohol issues and none had participated in the original SBS staff training. These findings point to the need on-going training for corrections officers on issues related to drug and alcohol treatment.

Summary and Recommendations

Programs typically experience a period of adjustment, instability, and change in the initial years of operation. Frequently, programs encounter crises and conflicts of interest that can disrupt the therapeutic environment and undermine the treatment process. How systems respond to crises and the ability of treatment staff to form strong working alliances with correctional staff ultimately determine how successful the program will be in combating recidivism and relapse.

The Key Maine TC and the TTP has encountered obstacles in its implementation phase that could potentially impact the treatment environment. High staff turnover, mandated admission to treatment, and varying degrees of support from MDOC staff has presented problems. However, MDOC and SBS have worked together to overcome crisis situations as they have arisen. As a result, the program has demonstrated resiliency. Admission, discharge, and retention rates are good. In-treatment assessment data, although very preliminary, are also suggestive positive trends.

The report concludes with five basic recommendations that should be seriously considered by MDOC and SBS.

- MDOC should consider the use of positive sanctions to improve voluntary admission to treatment rather than forcing mandated treatment admission.

- There needs to be a flexible set of guidelines that specify how existing MDOC policies are to be modified regarding Key Maine TC and TTP clients and this document needs to be widely distributed to both MDOC and treatment staff.

- An on-going training program for MDOC and treatment staff about TC methods, drug addiction, and current program-related policies is needed for treatment staff, as well as all MDOC staff systemwide.

- Mechanisms to improve information sharing on the medical and psychological information about clients between Key Maine staff and MDOC medical and psychiatric staff must be implemented.

- Finally, MDOC should institute an interagency monitoring and response system that identifies and resolves implementation issues.

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Chapter 1

OVERVIEW

The State of Maine Department of Corrections (MDOC) and the Office of Substance Abuse (OSA) at the Maine Department of Mental Health, Mental Retardation and Substance Abuse have developed a comprehensive plan to address the treatment needs of Maine's prison inmates. The first phase is the founding of the Key Maine Therapeutic Community (Key Maine) with funds from the U.S. Department of Justice Residential Substance Abuse Treatment (RSAT). This report summarizes the process evaluation of the Key Maine Therapeutic Community and the Transitional Treatment Program (TTP). The specific aims of the process evaluation were:

Process Evaluation Research Objectives

1. To describe the program's implementation, including how successful MDOC was in implementing the therapeutic community (TC) model in a prison setting, how consistent TC staff and inmate attitudes were with the TC perspective and whether or not counselors utilized the TC methods.

2. To profile the drug use, treatment, and background characteristics of the inmates in the Maine correctional facilities who were eligible for admission to the Key Maine TC and TTP.

3. To examine treatment process among clients who entered the Key Maine TC and TTP programs during the first year of treatment.

Background

Research has consistently shown that drug treatment reduces drug use and criminal activity (e.g., Wexler et al., 1992; Inciardi, 1995; Anglin & Hser, 1990; Hubbard et al., 1988; Simpson & Savage, 1981-82; Simpson & Sells, 1990). Prison-based drug treatment represents a logical and cost-effective point of intervention for substance-abusing offenders. Studies have shown that in-prison treatment combined with community after care is most cost effective alternative for the most at risk offenders (Griffith, Hiller, Knight, and Simpson, 1999; Lipton, 1995, p. 5, 1989; Payton, 1994).

The link between "time in treatment" and outcomes is well documented (e.g., Lipton, 1995) across treatment modalities and therapeutic community (TC) treatment, in particular, has been shown to be effective in reducing criminal recidivism (Pearson, Lipton, & Cleland, 1996). Research shows that offenders who have undergone TC treatment have the lowest rates of recidivism (Bleiberg, Devlin, Croan, & Briscoe, 1994).

Several client characteristics that are associated with treatment dropout and retention are also related to treatment outcomes. Age, arrest and incarceration history, legal pressure, and minority group status have been associated with relapse and recidivism (e.g., Hiller, et al., 1998; Martin, Butzin, & Inciardi, 1995). Psychiatric disorders (i.e., antisocial personality & attention-deficit/hyperactivity disorder) and the severity of drug

abuse (e.g., Johnson et al., 1985) are associated with lower retention, poorer treatment engagement, and poorer outcomes (e.g., De Leon and Jainchill, 1992; Wexler, 1995).

Increasingly, researchers in the drug treatment field have recognized that recovery involves a complex dynamic between the addict's motivation, treatment history, and treatment process (e.g., Simpson et al., 1998; De Leon, 1995; Hser et al., 1998). The literature underscores the importance of motivational factors (e.g., Knight et al., 1996; De Leon et. al., 1994). Individuals who recognize the negative consequences of their addiction and want to change their lives for the better, tend to stay in treatment, become engaged in the treatment process, and have better treatment outcomes, particularly when they perceive that treatment is necessary for their success (De Leon et al., 1994; Joe, Simpson & Broome, 1998). Higher rates of program participation, is associated through better therapeutic relationships which in turn promote positive behavioral change and better psychosocial functioning during and after treatment (Simpson, et al., 1995; Joe, De Leon, Melnick, & Hawke, 2000).

Growing evidence demonstrates that the effectiveness of corrections-based treatment is enhanced by an "integrated continuum of care" approach to treatment. Inciardi and colleagues (1997, 1999) report the highest significant declines in drug use and arrests among participants in "reentry" work programs. The combination of prison based TC treatment, work release treatment services, and community-based aftercare produce the significant long-term reductions in rates of reincarceration (Wexler, Melnick, Lowe, & Peters, 1999) and parole violations (Lowe, Wexler, & Peters, 1998). They also demonstrate marked reductions in drug use activity and odds of relapse (Knight, Simpson, & Hiller, 1999; Knight et al., 1995).

In sum, the literature supports the claim that treatment improves outcomes among clients who enter corrections-based treatment. Positive improvements in drug use, criminal recidivism, and related outcomes are expected to be greater among inmates who enter treatment, even after taking into account other factors that are known to be correlated with outcomes, such as pre-incarceration levels of drug severity, criminal history, age and other client characteristics. Motivation and readiness for treatment should associated with better treatment profiles among clients in treatment and also should be correlated drug use outcomes. Finally, among inmates who received treatment, outcomes are directly related to "treatment dose" as measured by client retention, engagement in treatment, program completion, and client process while in treatment.

Evaluation Design

To accomplish the aims of the process evaluation, research staff examined both program and client-level data that were collected throughout the first fifteen months of the Key Maine TC's operation, a period that includes the initial start-up period for the TTP.

1) The principal investigator conducted five site visits at three-month intervals. During each site visit, data on the program was gathered through field observation, semi-structured interviews with program staff, focus groups with TC members, and quantitative assessments of the therapeutic environment and the program compliance with the TC model. Semi-structured interviews with treatment staff explored staff attitudes about treatment, working relationships between staff and MDOC, and the daily functioning of the program. Focus groups with inmates addressed their treatment experience, how it differs from experiences in the general population, their drug use, and how they think the TC experience will impact their life once they are in the community-at-large.

2) Evaluation staff conducted interviews with program-eligible inmates to examine client profiles and service needs. Interviews lasted approximately 90 minutes and gathered information across several domains, including past treatment experiences, family and social relations, drugs and alcohol use, criminality, violent behaviors, physical and sexual abuse history, HIV/AIDS risk behaviors, education and training, and employment history. Information was collected for lifetime and the last six months before incarceration.

3) Data from client treatment records were used in the analysis of retention and treatment progress. Treatment staff collected assessment data of clients in treatment at program entry and throughout in treatment. Assessment data measured changes in psychological status, motivation and readiness for treatment, treatment progress and the treatment engagement.

4) Additionally, a brief survey of correctional officers was conducted to examine how they view the drug treatment alternatives for offenders and to collect comparative environmental data on non-TC units at Maine Correctional Center (MCC). In addition to educational and job-related characteristics, officers were asked to complete an environmental scale for the units on which they worked most frequently during the last month. The data was used to compare the characteristics and opinions of correctional officers who did and did not work on the TC unit in the previous month.

Outline of the Report

The remaining chapters report findings subsumed under each of the four primary research tasks. Chapter 2 describes the program and its implementation. Chapter 3 profiles the socio-psychological characteristics of inmates who were eligible to enter the program. Chapter 3 also reports on the statistical comparison of the profiles of the men who entered the Key Maine TC program to those of a comparison group who did not enter treatment to investigate whether there were any systematic biases in the selection of inmates for admission to treatment. Chapter 4 presents an analysis of client retention and treatment progress during the first year of TC treatment and Chapter 5 reports the results of the survey of correctional officers. The final chapter presents an overview and discussion of the findings in light of the current literature on corrections-based treatment.

Chapter 2

PROGRAM DESCRIPTION

Research conducted for the Maine Office of Substance Abuse (OSA) and the Maine Department of Corrections (MDOC) indicates that much of the Maine's adult inmate population of approximately 1,650 adult inmates has problems with drug addiction and that their drug use is closely tied to their involvement in criminal activities. As much as one-third of male prison population exhibit drug severity levels that suggest the need for TC treatment. A study by Weeks and associates (1993) determined that 36 percent of the state's inmate population have intermediate to severe levels of drug addiction and that 58 to 87 percent of their criminal activity was linked to substance abuse.

The Key Maine therapeutic community (TC) and Transitional Treatment Program (TTP) represent the first step in the implementation of a comprehensive plan that was developed by OSA and MDOC to address inmate drug treatment needs in a cost-effective manner. The report that was funded by Center for Substance Abuse Treatment (CSAT) entitled, "The Differential Substance Abuse Treatment (DSAT) Model," which was prepared by Jamieson, Beals, Lalonde, and associates (1999) summarizes the State of Maine's drug treatment initiative. The DSAT model combines the use of computerized screening for drug use severity of all inmates entering the prison system, the motivational enhancement therapy (MET), and the use of client-treatment matching. Upon entry into the prison, inmates receive a computerized screening for drug addiction that produces a "treatment level score" that indicates the degree of treatment intensity that would most cost-effectively treat their level of addiction. DSAT identifies five levels of treatment intensity that will be addressed by programs that incorporate educational services, motivational enhancement therapy (MET), outpatient treatment and long-term residential treatment. Treatment approaches include state-of-the-art cognitive behavioral and therapeutic community methods.

Key Maine-TTP treatment is reserved for the most severely addicted inmates and represents the most intense level of prison-based treatment that is part of the DSAT model. Other levels of prison-based treatment are currently in the developmental phase and/or pending funding from the State legislature.

THE "INTEGRATED CONTINUUM OF CARE" MODEL

The combination of the Key Maine TC and TTP programs is loosely modeled after Key-Crest Program in Delaware that combines prison-based TC treatment with work release, and community aftercare services that also incorporate TC principles to extend a continuum of TC-based substance abuse treatment to offenders. This continuum of TC-based treatment has demonstrated significant reductions in relapse and recidivism. Results from a three-year follow-up of program participants indicated that clients who participated in the full continuum of care were the most successful at remaining drug and arrest-free (Martin, Butzin, Saum, and Inciardi, 1999).

The State of Maine contracted with Spectrum Behavioral Services, Inc. (SBS), a division of Correction Medical Services, Inc. (CMS), to implement a TC-based substance

abuse program and develop a transitional treatment program for adult male inmates in its correctional facilities. SBS also has considerable experience of implementing a variety of behavioral health programs in correctional systems throughout the country. SBS is an experienced provider of therapeutic community services, including Key-Crest program in Delaware. As a result of SBS's ability to recruit program staff with TC experience from other SBS-run programs across the country and the readily available curriculum from Delaware's Key Crest Program, SBS was able to implement the integrated corrections-based continuum of care model in Maine as specified by OAS and MDOC quickly.

The Key Maine TC opened in March 1999 at the Maine Correctional Center (MCC) in South Windham, Maine with an initial cohort of 30 men. The Transitional Treatment Program (TTP) opened in January 2000 at the Central Maine Pre-Release Center in Hallowell, Maine with its first group of seven TC completers. In July 2000, the first Key Maine program participant was released into the community. At that time the community aftercare program, a community referral based program, was still in development.

The Key Maine TC and TTP programs provide treatment in three phases. The Orientation and Primary Treatment phases take place in the Key Maine TC. Key Maine participants learn and practice prosocial lifestyles that are consistent with the TC principles during phases one and two. Orientation lasts between one to three months. During orientation, inmates begin learning the TC culture, the program's philosophy and rules. Movement into Primary Treatment requires that clients successful pass a written test on the TC rules, structure and philosophy. Those who fail the Orientation Test remain in Orientation until they can successfully pass the examination. Graduates of the Key Maine TC continue to receive drug and alcohol treatment during the Secondary Treatment phase at the work-release program, known as the TTP. The TTP lasts nine to twelve months. The TTP combines work release with drug treatment services that is meant to reinforce the personal and behavioral changes that were achieved in the Key Maine TC. In this phase of treatment, participants with the help of TTP staff concentrate on relapse prevention, reunification with family and friends, and the improvement of their living skills. Peer groups are used during this phase to reinforce the self-help process.

The Key Maine Therapeutic Community

The Key Maine TC is designed and structured to create an environment for social learning and change to occur. The program's role is to re-socialize the substance-abusing offender to positive values and substance-free lifestyles. The program provides an intensive full-time residential treatment experience during which offenders' behaviors, attitudes, values, and emotions are continually monitored, corrected, and reinforced. Counseling, education, and other treatment activities are intended to be supportive and TC members are expected to actively participate in the program's peer community, serve on work crews, follow and enforce the programs rules and regulations, and to adhere to the principles of *"right living."*

The TC perspective emphasizes the use of the program's structure as the primary therapeutic agent. The community consists of the social environment, peers, and staff who serve as guides in the recovery process and models of personal success. Members are rehabilitated through open communication and confrontation of feelings among community members; a structured regime of daily meetings and seminars; the use of

positive and negative reinforcement in the form of privileges, sanctions, house surveillance, and urine testing: and an emphasis on ritual and ceremony.

Although not originally an element of the TC program, the program has also incorporated the use of motivational enhancement therapy (MET; Brown and Miller, 1992). MET is a brief intervention that is used to help the client identify his need for treatment and thereby improve the client's compliance to and retention in treatment. Inmates who are screened as eligible for TC treatment will receive a pre-admission MET session to enhance the inmate's motivation and readiness for treatment and facilitate better program participation. At the conclusion of the evaluation period, treatment staff were exploring the possibility of utilizing additional MET sessions at critical junctures throughout treatment.

As part of the program's evaluation the *Scale of Essential Elements Questionnaire* (SEEQ) was completed by staff to examine how closely the program operates in accordance with the therapeutic community model. It consists of questions which cover six domains of TC treatment: 1) the treatment perspective (e.g., views of addictive disorders, the addict, recovery, and right living); 2) the approach and structure of the program (e.g., staff roles and functions, members' roles and functions); 3) the use of community as a therapeutic agent (e.g., peers as gatekeepers, mutual help, enhancement of community belonging); 4) the role of educational and work activities in therapy; 5) the characteristics of formal therapeutic elements (e.g., group and counseling techniques); and 6) the stages of treatment. The instrument was developed by the Center for Therapeutic Community Research (CTCR) using a Delphi survey method was used to establish its content validity. Although the number of staff completing the instrument was small, the findings indicated that there was little variance among staff in their perceptions of the program. Scores indicated close adherence to the TC model.

The Transitional Treatment Program

The TTP is housed in the Central Maine Pre-Release Center in Hallowell, which is approximately 62 miles from the MCC. The TTP occupies half of the second floor where residents and share space in the basement area (including the dining hall) with men who are not in the program. The program itself was in its initial months of operation during the evaluation period.

All the available TTP counseling, the Program Director, and the correctional staff at the Central Maine Pre-Release Center participated in an intensive weeklong training on TC methods was conducted in the month prior to opening the TTP. The training was aimed at facilitating positive working relationships between MDOC staff at the Central Maine Pre-Release Center and treatment staff, as well as developing an understanding of TC methods. This training's format was similar to the one that was provided prior to the opening of the Key Maine TC. It required staff to live on premise for week and participate in all aspects of the TC process.

By all accounts the training was successful, the Program Director was optimistic that the management staff at the Central Maine Pre-Release Center understood the aims and procedures of the treatment program and the groundwork for effective working relationships with MDOC staff had been laid. However, shortly after the training, the Pre-Release Center came under new management and the process of establishing

relationships had to be reinitiated. Moreover, much of the Program Director's time during the initial start-up period of the TTP was devoted to administrative duties such as working with MDOC staff to establish procedural practices regarding the TTP program. She became much less involved in counseling activities at the TC and at the TTP (i.e., running groups and seminars).

Many of the counseling staff had not yet been hired at the time of the training and the Program Director was also responsible for providing ongoing training for new TTP staff on program procedures and TC methods. The TTP management and counseling staff, except for the Program Director, had no previous experience in TC programs. Most were in recovery themselves and all had previous job experience in other drug and alcohol programs. Despite the efforts of the Program Director and the first cohort of TTP client to infuse the TTP program with TC practices and principles (e.g., encounter groups), both the TTP startup staff and clients described TTP services in terms of Alcoholics Anonymous meetings, groups that focused on 12-steps and the disease concept, and case management activities.

Program and MDOC staff viewed TTP participation as a privilege that was earned for successful completion of the TC program, however client flow concerns dictated had to be graduated to the TTP program at its inception. Both treatment staff and clients indicated that a number of the initial cohort were not "ready" to graduate from the TC. New privileges afforded to them by the program (i.e., work release, smoking, more free time), the shift in the therapeutic methods and the severing of relationships with peers who were left behind in the TC combined to make the transition to the TTP difficult. Discipline and moral slacked. Program Director instituted a "tune-up" procedure that permitted returning men to the TC as a punishment for rule infractions. At the end of the evaluation period, none of the three men returned for tune-ups had come back to the TTP. One had been released to the community upon completion of his sentence; one remained in the TC, but was due to be released soon; and one chose to return to the general population rather than to continue in TC or TTP treatment.

Community-Based Aftercare

Community-based aftercare was still in development at the conclusion of the evaluation period. However, there are few community-based programs in Maine that incorporate TC principles and the intent of the community-based aftercare is to link inmates to local treatment providers upon release from prison, rather than establishing a new program based on TC principles. Therefore, the continuum of care that is provided is continuum of participation in some form of drug treatment and related services, not a continuum of TC-based drug treatment. Moreover, since most of the men leaving the prison system in Maine do not go on parole, there are few existing mechanisms to enforce compliance to treatment upon release to the community.

ISSUES OF IMPLEMENTATION

As with all new programs, the first year of the Key Maine TC and TTP was a period of change and adjustment. Several issues that are described below emerged during the implementation. The issues are classified as those related to treatment staff, the spatial or

physical environment of the program, client flow, and the relationship between MDOC and treatment staff.

Staffing Issues

Staffing for the Key Maine TC includes one program director, a clinical treatment director, three drug treatment counselors, including one that specializes in family issues, and a full-time secretary. Staff-to-client caseloads vary between eight to ten clients per counselor. The TTP has a clinical director and two counselors. Custodial staff is assigned to the TC unit on a regular basis.

The TC start-up staff included the program director and four counselors. Two counselors were recruited from Maine and had no background in therapeutic community treatment. Two transferred from other SBS programs and had previous work experience in TC programs. The program director was a young woman with extensive non-management experience in the Delaware Key-Crest program. At least three of the four counselors were themselves in recovery. Additional counselors were added over the course of the first year of program to replace counselors who left and meet additional treatment needs as the emerged (e.g., family counseling and the opening of the TTP program). New staff had extensive drug treatment experience, including their own recovery. However, most did not have previous job experience in TC methods.

At start-up, all TC treatment and custodial staff received special training from CMS. MDOC management was also invited to participate in TC training. Training consists an intensive week of group sessions that cover the principles of therapeutic community treatment, addiction and recovery issues and the structure of the Key Maine TC and TTP programs. Some treatment staff also visited the Key-Crest Program in Delaware. Two additional weeklong trainings were conducted during the first year for select MDOC and treatment staff in response to the need to improve the flow of information about the TC to MDOC staff and the opening of the TTP. The program director provided additional training for new staff that joined the program after start-up.

Treatment staff turnover has been high; as of August 2000 the program has had 100 percent turnover since its inception. The first counselor left one month after the program opened. Three had left by the sixth month. In August 2000, the program director, a new TC clinical director, and a screening counselor with MET training were new. The TTP also lost one of the original counselors during its first six months. Shortly after the evaluation period ended, the TTP clinical director and screening counselor were removed.

Spatial Issues

The Key Maine TC occupies a three-floor unit in Maine's largest prison, the Maine Central Correctional Facility (MCC). MCC has beds for over 400 inmates and like many of the State's facilities is often over capacity. The TC members spatially segregated from the general population. The use of the MCC library and gym have been scheduled to minimize contact between program participants and inmates from the general population. The first floor of the TC unit contains the inmate's cells, bathrooms, and the laundry facilities. Staff offices and the kitchen and eating areas are on the second floor as well as a meeting room that is often used for peer groups. The third floor has a large meeting

room that is used for house meetings and other large group activities. This floor also has two smaller rooms that can be used for peer or caseload groups.

The TTP is located the town of Hallowell outside of Augusta, which is about one and a half hours drive from Windham. Inmates in the drug treatment program share the residential work-release facility with non-participants. Half of the building is designated for the TTP and half for the general population. At the TTP, there is considerably more contact between program participants and non-participants given the small size the unit, inmate's more flexible schedules, and the shared common areas (e.g., kitchen).

Space has been a defining issue during the first year of the TC's operation. The program has lacked many of the resources and amenities that foster successful therapeutic environments (see De Leon, 2000). Although rooms were bright and clean, program's environment was still sparse, although there have been continuing efforts by TC staff to obtain approval from MDOC for supplies to improve the physical environment. For the first seven months, the program did not have access to space on the second floor. This space included offices for counselors, a bathroom for staff, and the TC kitchen. Counselors had to double up in offices, creating various problems of not having enough privacy and scheduling the use of offices for individual counseling. Female staff, who represented the majority, either used a converted shower stall that lacked privacy as a bathroom or were forced to leave the unit to go to bathrooms. Initially, food for program participants was brought to the unit from the Windham's main kitchen and was prepared by inmates in the general population. However, once the TC gained full use of the second floor of the unit, family members operated their own kitchen, the administrative office housed a private staff bathroom, and counselors offices afforded greater privacy.

Complaints about the physical environment tended to lower client morale and reduce program compliance. The close proximity of the treatment and general inmate populations created problems for ensuring psychological security when disgruntled former TC participants spread rumors about clients and/or staff after returning to the general population or when clients are subjected to verbal attacks shouted from other inmates during recreational periods or while in transit to and from shared facilities.

An additional spatial concern related to the distance between the TC program and TTP. The potential for men who transfer to the TTP to act as senior peers for other family members in the TC program has been diminished by the physical distance between the two programs. Although some contact between TTP and TC family members is permitted through letter writing, the ability to transport TTP members back to the TC for regular group activities has been prohibited by MDOC regulations.

Client Flow Issues

MDOC instituted mandatory drug and alcohol screening of all inmates in its facilities upon admission to prison. The screening battery includes the Michigan Alcohol Screening Test, and the Drug Abuse Screening Test to measure alcohol and drug consequences while the short Alcohol Dependence Data and the Severity of Dependence Scale measure physical dependence to alcohol and drug respectively. Using a procedure that is based on standardized scores on these instruments, inmates are categorized into one five levels of treatment need. Scores of 4 and 5 indicate a need for intensive intervention to treat intermediate and severe drug and alcohol dependence problems. All

Level 4 and 5 inmates are eligible for the Key Maine TC and TTP programs. A further criteria is that they must have 18 months remaining on their sentences, which would allot sufficient time to complete the program just prior to release from prison. The first 30 program participants were voluntary admissions—MDOC distributed information to the entire inmate population about the new program and encouraged men to volunteer by indicating that they would receive additional privileges for participation. In particular, they were promised to have first consideration for furloughs and work release.

One of the first challenges that the program faced was that inmates were resistant to voluntary participation in treatment. Inmates were generally suspicious of all efforts by MDOC to provide services. Inmates in focus groups and among those interviewed as part of the process evaluation indicated that they did not believe that MDOC would follow through on their promises, citing a history of MDOC policy changes.

During the first year, MDOC went ahead with its plan to make treatment mandatory. A memo was distributed to the general population that specified that all inmates who MDOC identified as in need of TC treatment must enter the Key Maine program. Failure to do so would result in denial of work release and/or furloughs, and the loss of other privileges.

Non-voluntary program participants were very resentful of the new policy. Some felt that they lost privileges that they had already earned as a result of the decision to put them in the Key Maine program. For example, one inmate stated that he had earned the right to be housed at a facility near his home, which would permit his wife and child to visit him. Despite past good behavior, obtaining various training certificates while in prison, he was moved to Windham, where his family cannot visit him.

Regardless of whether they entered treatment voluntarily or not, the men in the TC program believe that they were promised an array of privileges aside from furloughs and work release (e.g., more recreational time, the ability to wear their own clothes). Treatment and MDOC staff concur that the men have been promised more than they have received. This perception creates anger among current clients, and undermines the credibility of MDOC and the Key Maine program among non-clients.
Inmates, who enter the program against their wills, know that they can be discharged for creating behavioral disturbances, particularly violence. As a result the majority of program's discharges are for disruptive behavior.

The program operates on a "three strikes and you're out" policy and discharges for bad behavior are used as a means of improving compliance. Forty-four percent of the discharges were eventually readmitted to the program (see Chapter 4). Discharged inmates are placed in segregation for a period up to 30 days, after which they may elect to return to the program with the treatment staff's consent. In most cases staff want the client to return to treatment.

Support from MDOC

Conflicts between correctional and treatment staff are inevitable when establishing a treatment program in a correctional setting. Territorial issues have to be worked out. Correctional staff has to be sensitized to a new way of viewing the inmate. Especially in therapeutic communities that emphasize mutual self-help, the treatment philosophy may differ significantly from the way that correctional staff view inmates. As

a result, correctional staff may think that treatment staff is "too liberal" and treatment is being a privilege that offenders do not deserve. The emotionality and empowerment that is intrinsic in TC treatment may be difficult for correctional staff, especially those unfamiliar with TC principles, to accept.

Key Maine TC and TTP programs have received support from top management in MDOC. However, the relationship acceptance among lower level MDOC staff that works most directly with the program (i.e., middle and lower management, administrative workers, and correctional officers) has been more problematic. As a result, the program staff complained of delays processing required paperwork required to move inmates into the program, issues about enforcing MDOC rules on the TC unit, getting approvals from MDOC regarding TC issues, and working with medical and classification staff on problems concerning program participants.

MDOC staff has varying opinions and exposure to the Key Maine TC and TTP programs. While there is general support for corrections-based drug treatment, counselors, classification personnel, and correctional officers at MDOC vary in their support and knowledgeable of the Key Maine TC and TTP programs. Some correctional staff has expressed frustration regarding policy changes involving the program and the lack of a forum through which their input from can be taken into consideration.

Information about the program and MDOC policies regarding drug treatment has mostly been distributed to correctional staff mostly in memo form. Special training on TC methods was given to some MDOC staff (i.e., classification officers and correctional officers assigned to the unit), but not to many of the lower level correctional staff that work with the program. Written guidelines that specify how MDOC rules and procedures should be modified regarding inmates in the program are not readily available to MDOC staff. As a result, correctional staff attempts to apply existing procedures even when they may conflict with treatment efforts. For example, there is no formal mechanism to share information about the clients' medical and psychiatric statuses; therefore, Key Maine TC and TTP counselors primarily rely on the clients to divulge this information about their medical treatment. Attempts to get information from medical or psychiatric correctional staff varies in success depending on the informal relationship that the program staff who requests the information and the MDOC staff who has access to it. As a result, rank and file staff often perceives MDOC policies regarding inmates in the program as inconsistent and partisan.

Throughout the course of the first year, relationships with MDOC staff improved with the consorted efforts of both the TC staff and MDOC upper management. The program director now attends regular MDOC staff meetings and program staff participates in special MDOC staff events (i.e., a bagged lunch day). Both the TC staff and MDOC upper management have made special efforts to improve the integration the treatment staff in facility-wide activities. A special task force has been convened to investigate how to improve the dissemination of information about the Key Maine TC and TTP programs and to facilitate better working relationships among treatment staff and MDOC staff throughout the prison system.

ASSESSING THE IMPLEMENTATION

The *Correctional Institutions Environment Scale* (CIES; Moos, 1974, 1987) was administered to Key Maine staff and clients throughout the evaluation period to provide a quantitative measure of the therapeutic environment and to examine change over the course of the program's implementation.

CIES was used to assess the program milieu. The CIES (Finney & Moos, 1984; Moos & Finney, 1988) contains 100 items that are answered true or false. It is easily administered to staff as well as to clients. The items are collapsed into 9 subscales that represent distinct dimensions: involvement, support, expressiveness (relationship dimensions), autonomy, practical orientation, personal problem orientation (personal growth or goal orientation), order and organization, program clarity, and staff control (system maintenance dimensions). Previous research (Wexler & Lostlen, 1979; others) demonstrates the utility of CIES for describing a prison treatment environment that is distinct from the typical prison environment. The CIES measures the therapeutic environment along three dimensions:

a) The Relationships Dimension: how active inmates are in the day-to-day functioning of the unit (Involvement), the extent to which residents/inmates are encouraged to support each other (Support), and how much the staff encourage open expression of feelings by residents and staff;

b) The Personal Growth Dimension: the extent to which inmates are encouraged to understand their personal problems and feelings (Personal Problem Orientation), learn practical skills to prepare them for release (Practical Orientation), and the degree to which inmates are encouraged to take initiative in planning activities; and

c) The System Maintenance Dimension: how important order and organization are on the unit (Order and Organization), the extent to which residents know what to expect from the daily routine and the rules and regulations that govern the unit (Clarity), and the degree to which staff employ measures to keep inmates under control (Staff Control).

Table 2.2 summarizes data collected from TC peers during the first, fifth, eleventh, and fifteenth months of the program. During each of the administrations approximately 30 clients completed the instrument. Inmates understood that completion was voluntary, still over 90 percent of the program participants completed the instrument at each administration. Very similar scores were observed on all CIES dimensions except for Month 5. During month five inmates indicated that there was less order in the program and more confusion over the rules and regulations. They also suggested that TC staff were not encouraging peer development in ways that would be more in line with TC principles.

These figures illustrate the programs first major crisis and the ability of program and MDOC staff to take corrective action and restore the program's stability. In the sixth month of the program MDOC and SBS conducted an intensive investigation the

behavioral issues that were impacting the program's morale. At the conclusion of this investigation, several clients were discharged from the program and two staff members resigned. While the details of the investigation provided fodder for system-wide rumors and lingering inmate complaints, the data in Table 2.2 attests to the resiliency of the program. In focus groups, inmates identified several minor "crises" that had the potential to impact family moral throughout the first 15 months of the Key Maine program. Loss of family members through staff turnover or client discharge and changes in MDOC or TC policies (e.g., becoming drug-free) did not appear to have the same impact on therapeutic community as measured by the CIES scores.

At the 11 and 15 months site visits, CIES data was also collected from TTP clients. Although few in number, the TTP members scored secondary treatment with CIES dimension scores that were very similar to how TC members scored primary treatment. The only difference was that TTP members gave their program higher average scores on personal problem orientation. This finding may reflect the TTP's focus on helping inmates' prepare for reentry. Only four men were available during the 15-month site visit to complete the CIES due to their work schedules, however, their scores suggest that there was little change in the TTP's therapeutic environment during the first five months of its operation.

SUMMARY

As part of the larger prison-based drug treatment initiative, the State of Maine contracted with Spectrum Behavioral Services to implement a therapeutic community program at the Windham Correctional Facility and a transitional treatment program (TTP) at the Hallowell Pre-Release Center near Augusta. The program is loosely modeled after the Key-Crest Program in Delaware. Like the Delaware program, Key Maine TC and TTP programs seek to enable offenders to gain control over the addiction in the last 18 months of their incarceration and make a successful transition to the community-at-large. The Key Maine TC is a ten to twelve month program, after which program completers enter the TTP, which combines work release and drug treatment during the last six months of the inmate's incarceration. As part of TTP treatment, the inmate initiates the process of contacting community-based treatment programs that can address his treatment needs after release from prison. Inmates work on reentry planning with TTP staff and are referred to community providers upon release from prison.

The challenges that were faced during the implementation of the Key Maine TC and TTP were not atypical of new programs. Staff turnover was high. There were some tensions between MDOC and treatment staff, space and client flow issues. Like all new programs Key Maine encountered situations that required disciplinary action. Assessment of changes in the therapeutic environment indicated program resiliency. Actions were taken to address problems as they arose, improve staff training and to facilitate better communication between MDOC and treatment staff throughout the first year.

Table 2.2
Comparison of Average Correctional Institutions Environment Scale Scores
as Rated by TC Peers at Various Months after Program Inception.

	Month 1 (N=28)	Month 5 (N=31)	Month 11 (N=28)	Month 15 (N=32)	Total (N=119)	F Statistic
RELATIONSHIPS						
Involvement	2.25 (1.40)	1.75 (1.40)	3.61 (0.73)	3.16 (1.14)	2.71 (1.39)	14.03**
Support	2.61 (1.23)	1.84 (1.27)	2.96 (1.17)	2.81 (1.18)	2.55 (1.27)	5.18*
Expressiveness	2.5 0 (1.23)	2.45 (1.12)	3.11 (0.99)	2.72 (0.99)	2.69 (1.10)	
PERSONAL GROWTH						
Autonomy	3.14 (0.93)	2.77 (1.02)	3.64 (0.68)	3.56 (0.72)	3.28 (0.91)	2.17
Practical Orientation	2.61 (0.99)	2.58 (0.72)	2.64 (0.68)	2.84 (0.63)	2.67 (0.76)	0.77
Personal Problem Orientation	2.43 (1.14)	2.52 (1.09)	2.82 (1.16)	2.94 (1.01)	2.68 (1.10)	1.46
SYSTEMS MAINTENANCE						
Order and Organization	2.75 (1.10)	2.10 (1.35)	3.21 (1.07)	3.13 (1.01)	2.80 (1.21)	5.75**
Clarity of Rules and Regulations	3.29 (0.81)	2.93 (0.77)	3.64 (0.56)	3.47 (0.67)	3.32 (0.75)	5.45*
Staff Control	3.00 (0.77)	2.73 (0.94)	3.00 (0.47)	3.12 (0.71)	2.97 (0.75)	1.50

Chapter 3

INMATE PROFILES

This chapter presents findings from 140 interviews TC-eligible inmates that were conducted between August 1999 and May 2000 to determine the treatment needs of the inmates and to examine whether there are any among inmates who enter the Key Maine program and those that do not. Inmate profiles are described in terms of demographic characteristics, socioeconomic status, criminal behaviors, and drug use before incarceration.

THE SURVEY OF TC-ELIGIBLE INMATES

Due to the relatively small number of inmates in Maine's prison system and the fairly stringent criteria for program admission, all inmates who were screened as program-eligible who were due to be released by August 2001 were asked to participate in the study. According to MDOC guidelines, inmates who receive drug use severity scores of 4 or 5 on the computerized screening that was administered either upon the inmate's entry to prison or during the system-wide screening that was conducted before the initiation of the computerized assessment are eligible for Key Maine TC and TTP treatment when they have approximately 18 months remaining on their sentences. Some of the inmates who were interviewed as part of the inmate survey were technically ineligible for TC treatment because they did not have enough time remaining on their sentences to complete the program.

After the survey was completed, Key Maine TC admission data was used to define the treatment and comparison groups. The treatment group consisted of 58 inmates who were admitted to treatment during the between March 9, 1999 and June 30, 2000 who volunteered to participate in the survey. The comparison group consisted 82 inmates who did not enter the Key Maine TC. Although it was the intention of the evaluator to collect 6- and 12-month follow-up data on both groups, the logistics of arranging for the data collection on inmates who were not in the Key Maine TC proved prohibitive.

Participation in the survey was voluntary. Evaluation staff who were not affiliated with MDOC met with inmates to request participation and conducted the inmate interviews.

Interviews lasted approximately 90 minutes and collected data across several domains, including past treatment experiences, family and social relations, drugs and alcohol use, criminal and violent behaviors, childhood abuse history, HIV/AIDS risk behaviors, education and employment history. The interview focused on two time periods for most questions: lifetime prior to entering treatment and the six months before incarceration.

Analysis of differences in the characteristics of inmates in the treatment and comparison groups was conducted using bivariate methods such as comparison of means using analysis of variance and crosstabulation using chi square statistics. The sample size

(N_{tx}=58, N_{exp}=82, & N_{total}=140) was sufficient to detect moderate to large effect sizes using a significance level of .05 using these statistical techniques with levels of statistical power of .80 or above.

Demographic Characteristics

Table 2.1 summarizes the socio-demographic characteristics of inmates eligible for TC treatment. There were no statistically significant differences between the group of men who entered the Key Maine program and the comparison group. The average age of respondents in the sample was 33.99 years (sd=10.07). Ten percent of the sample was less than 22 years of age and about seven percent were over 50 years old. Most (80.7 percent) were Caucasians and the majority was currently unmarried. Approximately, two-thirds had high school or equivalent educational levels. About sixty percent worked in the six months before incarceration, generally (over 90 percent) in blue-collar jobs. About ten percent were homeless before incarceration, although the majority of the sample was living with their families (n=67, 47.9 percent) or sex partners (n=35, 35.0 percent).

Drug Use and Treatment Histories

Tables 3.2 through 3.4 present information about the inmate's drug use history and previous experience in drug and alcohol treatment. Men in the two groups indicated similar drug use histories. Most of the men used alcohol and marijuana, however lifetime prevalence rates indicate experimentation with a variety of drugs, particularly cocaine, amphetamines, hallucinogens, opiates and tranquilizers. About half of the sample indicated cocaine use in the six months before incarceration, usually in the form of crack. Twenty percent used tranquilizers recreationally and 22 percent reported use of hallucinogens in the six months before incarceration. Seventeen percent used opiates.

The majority also indicated that they had been in treatment for drug or alcohol addiction at sometime in the lives. Residential treatment was the most frequently modality. This figure does not include previous experience in therapeutic communities. Since Key Maine is the first TC in the state, the minority who had previous experience had been in treatment in other states (e.g., in New York, Massachusetts, and Texas). There were a few statistically significant differences in the drug and alcohol treatment histories of men in the treatment and comparison groups. Men in the comparison group reported higher rates of drug-free outpatient treatment (chi square=4.93, df=1, $p<.05$) and treatment from mental health clinics (chi square=6.35, df=1, $p<.05$). They were also were more likely to have had sessions from a private therapist to treat addiction (chi sq=5.60, df=1, $p<.05$).

Criminal and Violent Behaviors

As indicated in Table 3.5, the inmates also exhibited extensive criminal histories. On average, they reported 26.88 (sd=28.12) previous arrests. The most frequently reported types of illegal activities were alcohol and drug offenses, burglary and theft, and assault. The only statistically significant differences in the criminal history profiles of the

two groups were that men in the treatment group reported higher rates of participation in drug sales (chi sq=6.06, df=1, p<.05) and gambling activities (chi sq=5.13, df=1, p<.05).

When asked about their violent and abusive behaviors, 48.6 percent indicated that they had physically victimized another person and 9.3 percent indicated having raped or molested another person. Men in the treatment group were more likely to report violent victimization against other persons (chi sq=11.38, df=1, p<.001).

Psychiatric Diagnoses

Respondents were asked whether they had ever been told by a medical professional that they had a psychiatric disorder. Of those who provided information on psychiatric diagnoses, 73.9 percent (N=82) indicated that they had been diagnosed with a psychiatric disorder. However, inmates in the comparison group who provided psychiatric histories were more also likely to indicate having a psychiatric diagnosis (chi sq=6.05, df=1, p<.05); 32 or 62.7 percent of the treatment group and 50 or 83.3 percent of the comparison group. Twenty-nine inmates (20.7 percent) who were interviewed chose not to answer this question; therefore, the actual rates may be higher than this. Key Maine participants were significantly more likely to answer the question than men in the comparison group (chi sq=4.51, df=1, p<.05).

Among those who reported having psychiatric disorders, there were no statistically significant differences in the types of diagnoses reported or the overall number of psychiatric diagnoses (see Table 3.4). Clinical depression (38 inmates or 46.8 percent) and attention deficit/attention deficit hyperactivity disorder (36 inmates or 43.9 percent) were the most frequently reported diagnoses. However, more than one third of the sample reported having post-traumatic stress. Similar, prevalence rates were observed for antisocial personality and learning disorders. Inmates also identified various other disorders that were not specifically addressed in the interview, including schizophrenia, dissociation, homicidal ideation, and sleep disorders.

Childhood Abuse Histories

Over half the sample reported histories of childhood physical abuse and one-fifth reported childhood sexual abuse. Prevalence rates of both physical and sexual abuse were higher among men in the treatment group (chi sq=10.82, df=1, p=.001 and chi sq=7.55, df=1, p=.05 respectively). Among those reporting abuse, the majority indicated that experienced abuse when they were six to twelve years of age, one-third reported abuse between ages 13 and 18 years and almost one-third reported abuse before the age of six years. About half reported abusive acts by family members and half reported abuse by non-relatives. Men in the comparison group with abuse histories were more likely to indicate abusive experiences during middle childhood (chi sq=6.13, df=1, p<.05).

HIV Risk Behavior

Tables 3.8 and 3.9 summarize information on HIV risk behaviors and attitudes from the survey of inmates. Data indicates that 40 to 45 percent of the TC-eligible inmates report lifetime prevalence of injection drug use and 17 percent injected drugs in the six months before incarceration. The majority reported multiple sex partners in the same six-month period, although few reported engaging in anal intercourse. Prevalence

of unprotected sexual activity was also high. Although not statistically significant, men who entered the Key Maine program were more likely to report frequent condom use.

The majority also believes that they know how to protect themselves from getting HIV and most report having changed their behaviors to prevent contracting the virus. However, 45 percent indicate that they worry about getting it and about 20 percent believe that they have a 50/50 chance of contraction.

SUMMARY

In general, data from the survey suggests a great deal of uniformity TC-eligible inmates and that there is little difference between the inmates who entered the treatment program and those that did not. Potential Key Maine clients tend to be white men and 30+ years old. They exhibit extensive lifetime drug use and most report previous treatment attempts. Typical past criminal activities include violent crimes, particularly assault. Approximately ten percent indicated having committed sex crimes.

The TC-eligible inmates bring to treatment variety of issues, including psychiatric histories, childhood abuse, and violence that must be addressed within the context of drug and alcohol treatment. They report high levels of psychiatric disorders. Many have also themselves been victimized, often as young children. In the six months before their incarceration, they engaged in sexual behaviors that may put them at risk for HIV, but concerns about contracting the HIV virus is fairly low.

There were few statistically significant differences among men who entered the program and those who did not. Men in the comparison group were more likely to report previous outpatient and/or treatment from drug and alcohol problems in mental health clinics. Similarly, they were more likely than men in the treatment group to report having psychiatric diagnoses. Men in the treatment group were more likely to report violent victimization against other persons and involvement in drug trafficking. They were also more likely to report being physically and/or sexually abused as children.

Some of the observed differences between the treatment and comparison group may have resulted from the treatment process. Although some inmates in the Key Maine program reported having been diagnosed with severe psychiatric problems (e.g., bipolar disorder or schizophrenia), pre-admission screening aims at identifying clients whose behavioral or psychiatric problems made them inappropriate for the program. This may explain the higher incidence of psychiatric diagnoses among the comparison group. Also, during treatment issues like childhood abuse and aggression were topics addressed. Clients who were in treatment at the time of the interview may have been more willing to report these sensitive issues to evaluation staff.

The findings from the survey of inmates underscores the need for treatment staff to not only have expertise in drug treatment and addiction, but also specialized training and treatment resources to enable them to deal with other treatment needs that clients bring with them to the program. Cooperation and coordinated service efforts between Key Maine and MDOC staff can facilitate the process of engaging clients in treatment, monitoring their progress, and producing the desired treatment effects.

Table 3.1
Socio-demographic Characteristics of TC-Eligible Inmates,
Key Maine Treatment and Comparison Groups

Characteristic	Treatment Group N=58 (%)	Comparison Group N=82 (%)	Total Sample N=140 (%)
Age			
≤ 21 yrs.	6 (10.3)	9 (11.0)	15 (10.7)
22-29 yrs.	16 (27.6)	19 (23.2)	35 (25.0)
30-39 yrs.	22 (15.7)	31 (37.8)	53 (37.9)
40-49 yrs.	10 (17.2)	17 (20.7)	27 (19.3)
≥ 50 yrs.	4 (6.9)	6 (7.3)	10 (7.1)
Ethnicity			
Caucasian	48 (82.8)	65 (79.3)	113 (80.7)
African-American	5 (8.6)	4 (4.9)	9 (6.4)
Hispanic	2 (3.4)	1 (1.2)	3 (2.1)
American Indian	3 (5.1)	12 (14.6)	15 (10.7)
Current Marital Status			
Married	7 (12.5)	17 (21.0)	24 (17.5)
Separated	3 (5.4)	5 (6.2)	8 (5.8)
Divorced	21 (37.5)	22 (27.2)	43 (31.4)
Never Married	25 (44.6)	37 (45.7)	62 (45.3)
Educational Level			
< 8th Grade	6(10.3)	4 (4.9)	10 (7.1)
9th to 12th Grade	11 (19.0)	18 (22.0)	29 (20.7)
High School or Equivalent	35 (60.3)	53 (64.8)	88 (62.9)
> High School	6 (10.3)	7 (8.5)	13 (9.3)
Employed in 6 Months Before Prison	40 (69.0)	47 (59.5)	87 (63.5)
Homeless in 6 Months Before Prison	6 (10.9)	11 (13.4)	17 (12.1)

$p \leq .05$

Table 3.2
Lifetime Drug Use by Type of Drug,
Key Maine Treatment and Comparison Groups

Ever Used	Treatment Group N=58 (%)	Comparison Group N=82 (%)	Total Sample N=140 (%)
Alcohol	58 (100.0)	82 (100.0)	140 (100.0)
Marijuana	54 (93.1)	79 (96.3)	133 (95.0)
Hallucinogens	43 (74.1)	66 (80.5)	109 (77.9)
Cocaine (incl. Crack)	50 (86.2)	73 (89.0)	123 (87.9)
--Crack	36 (62.1)	48 (58.5)	84 (60.0)
Amphetamines	38 (65.5)	54 (64.6)	89 (63.6)
Opiates (incl. Heroin)	36 (62.1)	53 (64.6)	89 (63.6)
--Heroin	25 (43.1)	40 (48.8)	65 (46.4)
Tranquilizers	35 (60.3)	52 (63.4)	87 (62.1)
Barbiturates	31 (53.4)	35 (42.7)	66 (47.1)
Inhalants	19 (32.8)	37 (45.1)	56 (40.0)

Table 3.3
Drug Use in the Six Months before Incarceration by Type of Drug,
Key Maine Treatment and Comparison Groups

Ever Used	Treatment Group N=58 (%)	Comparison Group N=82 (%)	Total Sample N=140 (%)
Alcohol	49 (84.5)	71 (87.7)	120 (86.3)
Marijuana	40 (70.2)	55 (67.9)	95 (68.8)
Hallucinogens	12 (20.7)	19 (23.5)	31 (22.3)
Cocaine (incl. Crack)	31 (53.4)	34 (42.0)	65 (46.8)
--Crack	21 (36.2)	22 (27.2)	43 (30.9)
Amphetamines	15 (25.9)	19 (23.2)	34 (24.3)
Opiates (incl. Heroin)	8 (13.8)	16 (19.8)	24 (17.3)
--Heroin	8 (13.8)	16 (19.8)	24 (17.3)
Tranquilizers	13 (22.4)	15 (18.5)	28 (20.1)
Barbiturates	10 (17.2)	8 (9.9)	18 (12.9)
Inhalants	2 (3.5)	3 (3.8)	5 (3.7)

Table 3.4
Prior Drug and Alcohol Treatment Episodes,
Key Maine Treatment and Comparison Groups[+]

	Treatment Group N=58 (%)	Comparison Group N=82 (%)	Total Sample N=140 (%)	
Ever In Treatment	47 (81.0)	63 (77.8)	110 (79.1)	
Residential Treatment	37 (63.8)	48 (58.5)	85 (60.7)	
Outpatient Drug-Free	9 (15.5)	26 (32.1)	35 (25.2)	*
Detoxification	5 (8.6)	16 (19.5)	21 (15.0)	
Mental Health Clinic	2 (3.4)	14 (17.3)	16 (11.5)	*
Methadone Maintenance	1 (1.7)	3 (3.7)	4 (2.9)	
Private Therapist	8 (13.8)	23 (28.4)	31 (22.3)	*
Average Times in Treatment	2.41 (1.89)	4.13 (4.63)	3.40(3.81)	*

[+] Significance test for average times in treatment is f-tests. Averages are given with standard deviations in parentheses.

* $p \leq .05$

Table 3.5
Lifetime Self-Reported Criminal Activity,
Key Maine Treatment and Comparison Groups[+]

	Treatment Group N=58 (%)	Comparison Group N=82 (%)	Total Sample N=140 (%)	
Alcohol Offenses (e.g., DUI)	49 (84.5)	66 (80.5)	115 (82.1)	
Drug Possession	51 (87.9)	69 (80.5)	120 (85.7)	
Drug Sales	43 (74.1)	44 (53.7)	87 (62.1)	*
Forgery or Fraud	31 (53.4)	40 (48.8)	71 (50.7)	
Fencing	38 (65.5)	40 (49.4)	78 (56.1)	
Gambling or Running Numbers	22 (37.9)	16 (19.5)	38 (27.1)	*
Prostitution	11 (19.0)	14 (17.1)	25 (17.9)	
Weapons Offenses	32 (55.2)	37 (45.1)	69 (49.3)	
Robbery	22 (37.9)	26 (32.1)	48 (34.5)	
Burglary	41 (70.7)	60 (73.2)	101 (72.1)	
Other Theft	38 (65.5)	57 (69.5)	94 (67.1)	
Rape	7 (12.1)	11 (13.4)	18 (12.9)	
Assault	39 (67.2)	58 (70.7)	97 (69.3)	
Murder	5 (8.8)	9 (11.0)	14 (10.1)	
Avg. Lifetime Number of Arrests (Self-reported)	29.55 (24.66)	24.95 (32.53)	26.88 (28.12)	
Violent Behaviors (Regardless of Arrest)				
Ever Beat, Burned or Used Weapon Against Someone	38 (65.5)	30 (36.6)	68 (48.6)	**
Ever Raped or Molested Someone	8 (13.8)	5 (6.1)	13 (9.3)	

[+] Significance test for the average number of arrests is f-tests. Averages are given with standard deviations in parentheses.

* $p \leq .05$

Table 3.6
Childhood Abuse Histories,
Key Maine Treatment and Comparison Groups [+]

	Treatment Group N=58 (%)	Comparison Group N=82 (%)	Total Sample N=140 (%)	
Any Self-Reported Abuse				
--Physical Abuse	39 (67.2)	32 (39.0)	71 (50.7)	**
--Sexual Abuse	19 (32.8)	11 (13.4)	30 (21.4)	*
Age Abused				
--5 years or younger	11 (28.9)	10 (28.6)	21 (28.8)	
--6 to 12 years of age	26 (68.4)	25 (71.4)	51 (69.9)	
--13 to 18 years of age	8 (21.1)	17 (48.6)	25 (34.2)	*
Perpetrators				
Relative(s)	24 (63.2)	22 (53.7)	46 (52.2)	
Non-relative(s)	19 (50.0)	16 (44.4)	35 (47.3)	

[+] Categories are not mutually exclusive due to the potential of multiple abusive experiences which may vary by type, age at the time of occurrence and perpetrator.

* $p \leq .05$
** $p < .001$

Table 3.7
Psychiatric Histories,
Key Maine Treatment and Comparison Groups [+]

	Treatment Group N=51 (%)	Comparison Group N=60 (%)	Total Sample N=111 (%)	
Any Psychiatric Diagnosis	32 (62.7)	50 (83.3)	82 (73.9)	*
Learning Disorder	11 (34.4)	18 (36.0)	29 (35.4)	
Attention Deficit-Hyperactivity	13 (40.6)	(23 (46.0)	36 (43.9)	
Post-traumatic Stress Disorder	12 (37.5)	15 (30.0)	27 (32.9)	
Clinical Depression	15 (46.9)	23 (46.0)	38 (46.3)	
Antisocial Personality Disorder	12 (37.5)	18 (36.8)	30 (36.6)	
Avg. Number of Diagnoses	2.19 (1.23)	2.22 (1.53)	2.21 (1.41)	

[+] Significance test for the average number of diagnoses is f-tests. Averages are given with standard deviations in parentheses.

Table 3.8
HIV Risk Behaviors in Last Six Months Before Prison,
Key Maine Treatment and Comparison Groups +

	Treatment Group N=58 (%)	Comparison Group N=82 (%)	Total Sample N=140 (%)
Any Lifetime Injection Drug Use	23 (40.4)	40 (49.4)	63 (45.7)
Injection Drug Use in Last 6 Months	10 (17.5)	14 (17.3)	24 (17.4)
Sex Partners in Last 6 Months			
None	0 (0.0)	3 (4.0)	3 (2.3)
One	19 (35.2)	27 (36.0)	46 (35.7)
Two to Five	27 (50.0)	30 (40.0)	57 (44.2)
Six to Ten	5 (9.3)	7 (9.3)	12 (9.3)
More than Ten	3 (5.6)	8 (10.7)	1 (8.5)
Anal Intercourse in Last 6 Months			
Never or Seldom	43 (79.6)	66 (85.7)	109 (83.2)
Sometimes	9 (16.7)	10 (13.0)	19 (14.5)
Often	2 (3.7)	1 (1.3)	3 (2.3)
Unprotected Sex in Last 6 Months			
Never or Seldom	46 (62.2)	66 (85.7)	109 (83.2)
Sometimes	9 (16.7)	10 (13.0)	19 (14.5)
Often	24 (32.4)	8 (14.8)	32 (25.0)

* $p \leq .05$
** $p < .001$

Table 3.9
HIV Risk Attitudes,
Key Maine Treatment and Comparison Groups +

	Treatment Group N=58 (%)	Comparison Group N=82 (%)	Total Sample N=140 (%)	
Believe that they know how to keep from getting HIV.	55 (96.5)	79 (97.5)	134 (97.1)	
Worry about contracting the HIV.	26 (44.8)	35 (44.9)	61 (44.9)	
Would want to know if I had HIV.	56 (96.6)	77 (95.1)	133 (95.7)	
Changed their behaviors to prevent getting HIV.	44 (81.5)	65 (80.2)	109 (80.7)	
Believe that they likely than other people to contract HIV.	27 (48.2)	54 (69.2)	81 (60.4)	*
Believes they have 50/50+ chances of contracting HIV.	13 (23.6)	15 (18.8)	28 (20.7)	

* $p \leq .05$

Chapter 4

RETENTION AND TREATMENT PROGESS

The following chapter presents findings on Key Maine's program retention, as well as a comparative analysis of the client characteristics of program dropouts and completers, the reasons for dropout, and how clients change while in treatment. The purpose is to identify trends that may suggest problems with implementation of the TC model or its effectiveness and to explore whether positive changes in inmates' behaviors and attitudes are related to being in treatment.

Specific research questions that are addressed include:

1) What were the short and long-term retention rates of the first cohort clients who entered the Key Maine Program?

2) What was the psychological and motivational status of Key Maine clients at entry to treatment and did clients who completed treatment differ in terms of these characteristics than clients who did not complete treatment?

3) Did clients who remained in treatment experience changes in attitudes indicative of successful rehabilitation?

METHODS

All data on clients were collected by program staff and obtained from client treatment records, including dates of admission, discharge status, and assessments. Assessment instruments addressed the clients motivational and readiness for treatment, depression, self-esteem, internalization of TC principles, and treatment engagement. They were administered during the first, sixth and twelfth months of treatment with the exception of the treatment engagement measures were collected at six and 12 months only. Due to the small sample size (N=85, N=29, and N=15), particularly at follow-up, analyses are limited to univariate statistics that describe the clients' statuses at entry to treatment and Wilcoxon Ranked Signs tests to examine statistically significant changes in between first admission to treatment and in-treatment follow-up intervals.

Psychological and motivational statuses at entry to treatment were assessed using the *Beck Depression Inventory* (BDI; Beck et al., 1966), *the Rosenberg Self-Esteem Scale* (RSE; Rosenberg, 1965), *and The Motivation, and Readiness Scale* (MR; De Leon, 1997). A modified version of the Texas Christian University's Self and Treatment Instrument (STX; Simpson & Knight, 1998) was used to measure psychological status and motivation during treatment, as well as treatment involvement. Complementary instruments were completed by clients and staff to measure the clients progress, the *Therapeutic Community Client Assessment Scale(CAS)* and the *Therapeutic Community Staff Assessment Scale (SAS)* that were developed by Kressel (1998) to measure the complexity of individual change in accordance with the therapeutic community view of treatment.

The BDI measures the severity of depression in psychiatrically diagnosed patients. The maximum score is 63, indicating the highest severity of depression. Scores in the 0 to 9 range are considered asymptomatic; scores from 10 to 18 indicate mild depression; scores above 19 indicate severe depression. A six-item version was developed and administered at in-treatment follow-up to reduce the burden of completing in-treatment assessments on clients and staff. The Cronbach's alpha of reliability for both versions was adequate (.86 for the full version and .73 for the short version). The correlation between the two scores was .88 (p=.000) at treatment entry.

The RSE produces scores range from a low of 10 to a high of 40. Higher scores indicate greater levels of self-esteem. A brief 6-item version was administered at in-treatment follow-up. The Cronbach alphas for the two versions were .88 and .70, respectively. The correlation between the short and long versions was .96 (p=.000).

The MR is a 12-item measure that assesses the dynamic factors that contribute to seeking and remaining in treatment. It has a demonstrated high reliability among adult treatment-seeking and criminal justice populations. Motivational items assess internal reasons for personal change, such as guilt, despair, and the desire for a new lifestyle, healthier relationships, or personal growth, while readiness items measure the individual's perceived need for treatment compared to non-treatment alternatives. Scores on the MR total scale range from 12 to 60. Higher scores indicate greater motivation and readiness for treatment. (De Leon, 1994). The Cronbach's alpha for the MR was .94 at treatment entry, suggesting high reliability.

The SAS and CAS measure the complexity of individual change in accordance with the TC view of treatment. Both scales contain 14 likert items, each of which corresponds to a behavioral, attitudinal or cognitive domain of individual change. Scores range from 14 to 70 for each instrument. Higher scores indicate more internalization of TC principals and the correspondence between client and staff scores (the CAS score minus the SAS score) can be a tool for treatment planning.

RETENTION IN TREATMENT

Table 4.1 presents the monthly census for the program. The Key Maine's program capacity permits treatment for 38 men. The program averaged 38 participants per month throughout 1999 and 31 participants per month in the first half of 2000. Therefore, the program operated at near or full capacity for most of the evaluation period. In January 2000, the TTP opened and 11 men graduated from the TC. Between January and June 2000, 19 men had completed TC treatment (39.6 percent of the TC discharges for 2000).

Eighty-five clients entered the program, representing 127 admissions to the TC program. Sixty-two men had a discharge status from the TC at the end of June 2000. Of these 14 (22.6 percent) completed TC treatment. One TC completer did not transfer to the TTP for administrative reasons, but the remaining thirteen entered the TTP program

Most program discharges were administrative discharges for disruptive behavior. The program operated on a "three strikes and you're out" policy and discharges for bad behavior were used as a means of improving compliance. Forty-four percent of the discharges were eventually readmitted to the program. Readmissions included 32 second admissions and 9 third admissions. One client was admitted to the TC program four

Table 4.1

Monthly Admissions and Discharges,
Key Maine Therapeutic Community Drug Treatment Program,
(March 9, 1999-June 30, 2000)

1999	Clients In Key Maine TC and TTP	Number of Admissions	Discharges	
	Number	Number	Number	% Behavioral Problems
March	36	36	6	33.3
April	32	2	6	100.0
May	33	7	3	66.7
June	36	6	7	100.0
July	36	7	1	100.0
August	35	0	10	90.0
September	31	6	6	83.3
October	33	8	4	100.0
November	37	8	4	100.0
December	37	4	1	100.0
Total for 1999	Avg=29	84	48	83.3
2000				
January	40	4	13	7.7
February	35	8	10	40.0
March	36	10	3	66.7
April	40	8	9	33.3
May	35	4	2	100.0
June	42	9	11	36.4
Total as of 6/30/00	Avg=38	43	48	29.2
Total 3/9/99-6/30/00	Avg=31	127	96	42.5

times, however, the fourth admission was a brief return from the TTP for medical reasons.

Excluding the readmission for medical reasons, the average cumulative length of stay for men who were discharged from the Key Maine program was 184.27 days (n=62, sd=139.08). The retention ratio, the average cumulative days in treatment compared to the minimum planned duration of stay (10 months), was .61.

Table 4.2 shows the patterns of retention at Key Maine as of June 30, 2000. Retention is shown in terms of the retention potential. The retention rate based on the retention potential refers to the number of clients that actually stayed in treatment to the end of a given time interval relative to the number of clients who could have potentially stayed in treatment to the end of that interval (De Leon, 1988). For example, 80 men who were admitted to Key Maine could have stayed in treatment at least 30 days. Of these 80 men, 65 actually did stay 30 days or more. Therefore, the 30-day retention rate at Key Maine based on cumulative days in treatment was 81.3 percent of 65 divided by 80. The 90-day retention rate was 77.6 percent; the 180-day retention rate 61.4 percent. Retention rates for men at Key Maine were consistent with retention rates for men in other prison-based therapeutic communities (De Leon, 1994).

ASSESSING CLIENT PERFORMANCE

Client in-treatment assessments were due within the two weeks into treatment and at 6 and 12 months of continuous treatment. Clients who left the program and were readmitted began a new assessment cycle. Some clients left treatment before first month assessments were completed and assessments were not always completed on time. Twelve-month assessments were given at either graduation from the TC or at 12-months of treatment. As a result, approximately 12 percent of the intake assessment data were not completed. Missing data from 6- and 12-month was less problematic. Additionally, some instruments were unscoreable because clients did not answer all the questions.

Completers vs. Non-Completers

Data from the intake assessments indicated that clients entered the Key Maine TC with moderate levels of self-esteem, moderately low motivation and readiness for treatment and high levels of depression. The average intake RSE score was 23.59 (sd=6.77). MR and BDI scores averaged 47.73 (sd=11.48) and 21.85 (sd=9.96) respectively. Almost half (48.8 percent, n=39) of clients who had scoreable BDI instruments from admission (n=64) had scores indicating severe depression.

No statistically significant differences were found between program completers and those that were discharged without completing treatment in the intake scores on any of the assessment scales. Similarly, there were no differences in any differences in levels of depression, self-esteem or motivation and readiness for treatment between clients who entered treatment only once and those who were readmitted.

Table 4.2
30-, 90-, and 180-Day Retention Rates,
Key Maine Therapeutic Community Drug Treatment Program, 3/9/99-6/30/00

	30 Days	90 Days	180 Days
All Admissions, Including Readmits (N=127)			
Actual Number Retained	93	65	29
Number with the Retention Potential	118	106	84
Percent of Potential Retained	78.8	61.2	34.5
First Admission Only (N=85)			
Actual Number Retained	60	44	12
Number with the Retention Potential	80	76	45
Percent of Potential Retained	75.0	57.9	26.1
Second Admission Only (N=32)			
Actual Number Retained	26	15	3
Number with the Retention Potential	29	24	21
Percent of Potential Retained	89.6	62.5	14.3
Third Admission Only (N=9)			
Actual Number Retained	7	6	3
Number with the Retention Potential	9	6	6
Percent of Potential Retained	77.8	100.0	50.0
Cumulative Days for All Clients (N=85)			
Actual Number Retained	65	59	35
Number with the Retention Potential	80	76	57
Percent of Potential Retained	81.3	77.6	61.4

In-Treatment Change

Table 4.3 summarizes change in psychological status among clients who stayed long enough to receive their mid-treatment assessments. Because the number of clients who received in-treatment assessments at 6 and 12 months was small, the results should be interpreted cautiously. Data indicated that Key Maine clients experienced statistically significant increases in depression and self-esteem during the first six months of treatment. Motivation and readiness for treatment declined, but internalization of TC principles increased. Among clients who remained in treatment long enough to receive their 12-month assessments, depression appears to decline during the second six months of treatment, with their average depression score only slightly higher than their intake scores. The trend appeared to be the same for levels of motivation and readiness. On the

other hand, data suggested that self-esteem and internalization of TC principles continued to increase in the latter half of the first year of treatment.

Treatment Involvement

Self-report data on treatment involvement was collected at 6 and 12 months in treatment using the counselor competence, counselor rapport and treatment engagement scales from the TCU Self and Treatment Scale (Simpson & Knight, 1998). The counselor competence scale contains questions about how easy it is to talk to counselors, whether they respect clients' opinions and whether clients trust them. The average counselor competence score based on reports of clients who were in treatment for six months suggested high levels of perceived counselor competence. Of a possible fifteen points, the average counselor competence score was 13.10 (sd=2.21). Counselor rapport and treatment engagement scores were also moderately high. The averages were 29.30 (sd=4.49) and 29.53 (sd=4.70) respectively. Similar levels on all three treatment involvement scales were observed at 12 months in treatment (n~14). Wilcoxon sign tests suggested stability the levels of counselor competence (mean=12.92, sd=2.94 at 6 months and mean=12.67, sd=2.67 at 12 months), counselor rapport (mean=27.85, sd=4.54 at 6 months and mean=28.77, sd=5.16 at 12 months), or treatment engagement (mean=29.54, sd=4.52 at 6 months and mean=29.23, sd=4.44 at 12 months) between 6 and 12 months in treatment.

SUMMARY

Statistics on program admissions, client retention, and treatment involvement indicate successful attempts to engage clients in treatment. Eighty-five clients entered the program between March 1999 and June 2000. Of these 22.6 percent (n=14) completed treatment. Most discharges were for disruptive behaviors. The average cumulative length of stay for men who were discharged from the Key Maine program was 184.27 days (n=62, sd=139.08). The retention ratio, the average cumulative days in treatment compared to the minimum planned duration of stay (10 months), was .61.

The short-term retention rates for the program were moderately high, although 180-day retention was poor. The retention was 75 percent for 30 days and 57.9 percent for 90 days for first time admissions. The 180-day retention rate was 26.1 percent.

Findings on in-treatment change were mixed. Assessment data indicated increases in depression, self-esteem, and internalization of TC principles during the first six months of treatment, but decreases in motivation and readiness for treatment. For clients who remained in treatment long enough to receive their 12-month assessments, levels of depression and motivation for treatment appeared to return intake levels, while self-esteem and internalization of TC principles continued to increase in the latter half of the first year of treatment.

Because the number of clients on which the analysis is based is small, these findings have to be interpreted with caution. The sample of clients on which the analysis was based are those that remained in treatment at least six months. The apparent deterioration of their psychological status may reflect reactions to program changes (e.g., staff turnover, policy changes). For example, as the end of their sentences approached clients began to express concerns that the TTP would open in time for them to enter the

work release program. These fears were unfounded, however, it is likely that they had an effect on the clients psychological outlook that are reflected in the depression and motivation scores. Increases in self-esteem and internalization of TC principles suggests that program experiences have had some impact how the client feels about himself and his drug use. Moreover, the limited data on treatment involvement provides evidence that the program is engaging clients in treatment and that clients have supportive working relationships with treatment staff.

Table 4.3
6- and 12-Month In-Treatment Assessments
Key Maine Therapeutic Community Drug Treatment Program

Scale	N	Average	Standard Deviation	Z	Sig.
Depression Score					
Intake	28	11.61	5.92	-3.87	*
~6 Months in Treatment	28	14.21	5.53		
Self-Esteem					
Intake	28	17.63	5.07	-2.38	*
~6 Months in Treatment	28	21.62	5.21		
Motivation-Readiness					
Intake	26	51.58	9.84	-3.19	**
~6 Months in Treatment	26	43.19	8.02		
Internalization of TC Principles					
Intake	23	44.91	7.51	-3.87	**
~6 Months in Treatment	23	54.43	7.81		
Depression Score					
~6 Months in Treatment	13	14.43	6.25	-1.07	
~12 Months in Treatment	13	12.57	5.53		
Self-Esteem					
~6 Months in Treatment	13	20.71	6.01	-0.78	
~12 Months in Treatment	13	22.21	5.65		
Motivation-Readiness					
~6 Months in Treatment	15	40.93	8.05	-1.15	
~12 Months in Treatment	15	42.40	5.55		
Internalization of TC Principles					
~6 Months in Treatment	14	53.78	7.51		
~12 Months in Treatment	14	56.14	7.43		

* $p \leq .05$
** $p \leq .001$

Chapter 5

SURVEY OF CORRECTIONAL OFFICERS

The following chapter summarizes the findings for the Survey of Corrections Officers that was conducted at the Windham facility in February 2000. The purpose of the survey was to collect information to augment the on-going evaluation of the Key Maine Therapeutic Community and Transitional Treatment Facility. The survey addressed three key questions:

1) What are the demographic characteristics of the correctional officers who work at the Windham facility?;

2) How do correctional officers who work on the TC unit compare to correctional officers who do not in terms of key job-related indicators (e.g., job satisfaction, missed workdays, and job experience?; and

3) How does the correctional environment of the TC unit compare to the environments of other correctional units at Windham?.

METHODS

The first two questions are answered directly by the data collected from the survey instrument. The third question is answered using data collected from the survey in conjunction with similar data collected from program staff and participants (peers).

The Correctional Officers Survey collected information on background characteristics of the correctional officer and on the units in which he or she worked during the previous six months. The second half of the survey was the completion of the Correctional Institutions Environment Scale (CIES; Moos, 1987) for the unit in which the correctional officer worked most in the last 30 days. This information permits the comparison of the unit environment of the Key Maine Therapeutic Community to other units in the Windham facility.

Maine Department of Corrections staff distributed the instrument to first and second shift correctional officers. Correctional officers completed the survey, sealed it in an unmarked envelope to ensure confidentiality, and returned to research staff at the Center for Therapeutic Community Research at the National Development and Research Institutes, Inc. in New York City. Participation was voluntary.

CORRECTIONAL OFFICER CHARACTERISTICS

Table 5.1 summarizes the demographic characteristics of all the correctional officers who completed the Survey of Correctional Officers. Thirty-five instruments were returned. Most of the officers who completed the questionnaire were over 35 years of age, white, and male. More than half reported that they had attended college and 25.7% reported that they had earned a college degree.

Table 5.1
Demographic Characteristics of Correctional Officers Who Completed the Survey of Correctional Officers (N=35), February 2000.

Characteristics [#]	Number	Percent
Age		
≤35 Yrs.	6	17.1
36-50 Yrs.	11	31.4
> 51 Yrs.	11	31.4
Caucasian	33	94.3
Male	28	80.0
Education Level		
High School	13	37.1
Some College	12	34.3
College Degree	9	25.7
Worked in TC Unit during Previous 6 Months	9	25.7

[#] One case (2.9%) had missing data on all the demographic characteristics, except race and seven cases (20%) had missing data on age.

Nine correctional officers (25.7%) indicated that they had worked in the Key Maine TC unit at sometime during the previous six months. Two (5.7%) did not provide information about the units on which they worked and, therefore, had to be excluded from further analyses.

Table 5.2 compares correctional officers who worked in the TC unit in the previous six months to those that did not work on the TC unit in terms of basic job-related indicators (i.e., days missed from work, correctional experience, job satisfaction, and beliefs about corrections-based drug and alcohol treatment). The sample size is small and the results must be interpreted carefully.

Table 5.2
Comparison of Correctional Officers Who Worked on the Key Maine TC Unit during the Previous Six Months to Those Who Did Not, February 2000

	TC (N=9)	Non-TC (N=24)
Avg Work Days Missed in Last 6 Months	5.9	13.5
Avg. Sick Days Taken in Last 6 Months	2.3	3.5
Avg. Vacation Days Taken in Last 6 Months	2.4	5.4
Avg. Months of Correctional Experience	73.1	115.8
Avg. Months as Correctional Officer	73.1	111.3
Avg. Months at Windham Facility	73.1	106.3
Avg. Units Worked On In Previous 6 Months	9.8	4.2
Percent Satisfied with Job	77.8	69.6
Percent In Favor of Corrections-based Drug & Alcohol Tx	100.0	87.5
Percent With Special Drug/Alcohol Training	11.1	20.8

On average, correctional officers who worked on the TC unit in the previous six months reported taking less time off from work and more job satisfaction than non-TC correctional officers. Missed workdays included days missed from work due to illness, vacation, as well as other possible reasons (e.g., worker's compensation and days without pay). Correctional officers from the TC unit reported an average of 5.9 missed workdays and 2.3 sick days in the previous six months compared to the average of 13.5 missed days and 3.5 sick days for correctional officers who did not work on the TC unit.

On average correctional officers who worked on the TC unit during the previous six months reported less correctional experience (73 months compared to 116 months for non-TC unit correctional officers). They also reported having worked on a wider range of units (9.8 units out of 17) than did correctional officers who did not work on the TC unit (4.2 units out of 17). Eleven percent indicated that they had special training on drug and alcohol abuse/treatment compared to 20.8 percent of correctional officers who did not work on the TC unit.

When asked how satisfied they are with their current job (i.e., very satisfied, somewhat satisfied, somewhat dissatisfied, very dissatisfied), a slightly higher percentage of correctional officers with had worked on the TC unit reported being satisfied with their jobs. However, job satisfaction was moderately high for all correctional officers surveyed.

Similarly, support for corrections-based drug and alcohol treatment was high. One hundred percent of correctional officers who worked in the TC and 87.5 percent of non-TC correctional officers said that they favored providing drug and alcohol treatment within the prison.

Although special training was provided by MDOC and CMS to correctional officers who would work on the TC unit, only 11.1 percent e officers who reported having worked on the TC unit in the last six months and 20.8 percent of the non-TC correctional officers indicated having specialized training on drug and alcohol abuse or treatment. As true of any self-report survey, it is possible that some officers failed to report certain types of training (i.e., CMS training). However, the types of training that were identified by correctional officers included the CMS training, military training, and MDOC training to identify inmates with addiction problems.

CORRECTIONAL ENVIRONMENTS AT MCC

Table 5.3 summarizes data from the Correctional Institutions Environment Scale (CIES) was developed by Rudolf Moos (1974, 1987) to describe the social climates of correctional programs. The CIES data was scored and compared to CIES data collected from TC staff and peers. Two correctional officers filled the CIES instrument out for the TC unit. Their responses were summarized with the TC staff. Thirty correctional officers filled the CIES out for non-TC units. All non-TC units CIES data is summarized together as reported by Non-TC Staff (see Table 5.3).

The CIES describes three primary dimensions of treatment environments. The Relationships Dimension identifies how much inmates actively participate in the day-to-day functioning of the unit (Involvement), the extent to which residents/inmates are encouraged to support each other (Support), and how much the treatment staff encourage open expression of feelings. The Personal Growth Dimension depicts the extent to which inmates are encouraged to understand their personal problems and feelings (Personal Problem Orientation), learn practical skills to prepare them for release (Practical Orientation), and the degree to which inmates are encouraged to take initiative in planning activities. Finally, System Maintenance Dimension measures how important order and organization are on the unit (Order and Organization), the extent to which residents know what to expect from the daily routine and the rules and regulations that govern the unit (Clarity), and the degree to which staff employ measures to keep inmates under control (Staff Control). The first two dimensions directly tap the "therapeutic quality" of the environment, while the system maintenance dimension addresses the ability of the unit to maintain control in a more traditional correctional sense.

The data indicate that the reported average CIES scores on the Relationships and Personal Growth dimensions are significantly higher for the TC unit as evidenced by the both TC staff and peer scores compared to non-TC staff scores. In the Systems Maintenance dimension, the TC staff, TC peers, and non-TC staff scores indicate comparable levels of order and organization and staff control on the TC unit and on non-TC units. However, correctional officers from non-TC units reported significantly less clarity of rules and regulations on those units than TC staff and peers reported in the TC unit.

In sum, the data in Table 5.3 indicates that the TC unit successfully provides a treatment-oriented environment, while maintaining levels of organization and staff control that is characteristic of correctional environments.

SUMMARY

The Correctional Officers Survey provides a snapshot of the correctional environments at Windham. The instrument was brief (less than three pages) and could not really flesh out details about the opinions and background characteristics of correctional officers at MCC. However, the findings highlighted some important issues. First, higher job satisfaction and fewer missed workdays may be unexpected by-products of corrections-based treatment. These findings may suggest that personnel indicators may be one of the first indicators to show the positive impact of establishing prison-based TC on the correctional system. Second, the findings point to the need on-going training of corrections officers on issues related to drug and alcohol treatment. Few correctional officers who completed the survey indicated having any prior training on drug and alcohol issues. Such training provides a means of increasing the understanding/awareness of therapeutic perspective and MDOC policies regarding treatment among correctional officers who do and do not work on the unit, as well as to maintain a pool of correctional officers who are qualified to work on the unit. Finally, the CIES findings document the success of the Key Maine and MDOC staff in establishing a therapeutic environment and balancing system maintenance needs of the correctional setting.

Table 5.3
Comparison of Average Correctional Institutions Environment Scale Scores of TC Staff, TC Peers and Non-TC Staff, February 2000.

	TC Staff (N=8)	TC Peers (N=37)	Non-TC Staff (N=30)	Total Sample (N=75)	F Statistic
RELATIONSHIPS					
Involvement	3.75 (0.46)	3.64 (0.68)	1.03 (1.40)	2.61 (1.64)	60.03***
Support	3.01 (1.07)	3.08 (1.12)	1.67 (1.18)	2.51 (1.32)	13.61***
Expressiveness	3.00 (0.93)	3.22 (0.95)	1.47 (1.11)	2.49 (1.31)	25.88***
PERSONAL GROWTH					
Autonomy	3.00 (0.35)	3.68 (0.67)	1.20 (1.00)	2.71 (1.47)	89.45***
Practical Orientation	3.00 (0.00)	2.65 (0.68)	1.67 (0.84)	2.29 (0.88)	19.84***
Personal Problem Orientation	3.63 (0.52)	3.05 (1.10)	1.17 (1.05)	2.36 (1.43)	33.88***
SYSTEMS MAINTENANCE					
Order and Organization	3.50 (0.75)	3.22 (0.98)	2.67 (1.32)	3.02 (1.14)	2.84
Clarity of Rules and Regulations	4.00 (0.00)	3.70 (0.52)	3.03 (0.85)	3.47 (0.74)	11.69***
Staff Control	3.13 (0.99)	2.97 (0.50)	2.93 (0.90)	2.97 (0.73)	.21

Chapter 6

RECOMMENDATIONS

The first three years of any program's operation are generally characterized by period of adjustment, instability, and change. Frequently, programs encounter crises and conflicts of interest that can disrupt the therapeutic environment and undermine the treatment process. How systems respond to crises and the ability of treatment staff to form strong working alliances with correctional staff ultimately determine how successful the program will be in combating recidivism and relapse.

The Department of Corrections in Maine has contracted with an experienced provider who implemented a treatment program that represents best practices. Recent cost-effectiveness studies indicate that prison treatment is most cost effectively for the most at-risk offenders (Griffith, Hiller, Knight, and Simpson, 1999). Although the present study does not look at outcomes, the literature supports the effectiveness of the continuum of care of care model, especially for severely addicted offenders (Pearson and Lipton, 1999; Martin, Butzin, Saum, & Inciardi, 1999; Wexler, Melnick, Lowe, & Peters, 1999; Knight, Simpson, & Hiller, 1999).

Despite the some signs of instability, the Key Maine TC and TTP have demonstrated a degree of resiliency. Program data indicates that program adheres to the TC model and that the therapeutic environment is good. Admission, discharge, and retention rates indicate that the program moving toward greater effectiveness. The following recommendations are suggested in order to facilitate this process:

1. MDOC should consider effective positive sanctions to encourage treatment compliance.

Clients generally feel that they are being forced into treatment. They often complain that they have lost privileges that they have earned previously because they were forced into treatment. Although initially inmates were told that they would receive preferential treatment when it came to getting furloughs, work release, and other privileges if the entered the treatment program, delays in fulfilling these promises lead to greater distrust in MDOC and treatment staff. MDOC might consider other alternatives for inducing voluntary participation that have been used elsewhere (Weinman & Dignam, in press). For example, inmates could be offered the chance to reduce the length of their sentences (e.g., the ability to earn a reduction of up to 18 months for successful treatment completion). Inmates could begin to accrue reductions at a slower pace at treatment entry, with the bulk of the reduction accrued at the end of treatment. Failure to complete treatment could result in the restoration of the sentence to the original status. Aside from being a major impetus for treatment compliance, this strategy would also have the benefit of widening the pool of eligible clients, since inmates in the last three years of their sentences would now be eligible for program entry. The major advantage of this strategy is that it is an incentive for *successful participation* in treatment as defined by the treatment staff. Because this strategy would widen the pool of eligible inmates, MDOC be able to restore voluntary admission to treatment.

2. Produce and widely distribute a new set of policies that pertains to how MDOC procedures are to be modified regarding Key Maine clients and staff.

MDOC policies and regulations shape the context in which treatment is provided and as such impact ability of treatment to produce successful outcomes. Both MDOC and treatment staff have expressed frustration of the lack of clarity regarding how MDOC rules and regulations apply to Key Maine clients. With the implementation of any new program within the prison system requires some modification of existing DOC policies. The procedures need to address what kinds of information will be shared, how information (files) will be transported, and how inmates are to be notified status changes (e.g., transfer to the TTP). It's important that both security and treatment concerns are balanced and that inmates see that MDOC and treatment staff maintain a supportive relationship.

3. Develop ongoing staff training activities that are open to both treatment and MDOC staff at all management levels and across facilities.

Although there has been training of both MDOC and treatment staff regarding TC principles and the Key Maine program, a need for continuous system-wide training regarding both TC principles in general and the Key Maine TC and TTP/MDOC structure and policies is still evident. High staff turnover rates, staff schedule changes, and the need to keep MDOC staff in other facilities up-to-date on the program suggests that the management of the treatment program can benefit from providing structured and on-going training that is open to treatment and MDOC staff throughout the prison system. Many of the new TC-TTP staff and most of the MDOC staff are unfamiliar with TC methods. Most of corrections officers who completed the survey of correctional officers indicated that they had no special training on drug abuse treatment and TC methods. MDOC staff in facilities other than Windham with varying opinions and knowledge the Key Maine TC and TTP programs.

An ongoing system-wide training that includes MDOC staff at all custodial levels and at all MDOC facilities (i.e., a regular newsletter, regular periodic seminars) can facilitate better communication between MDOC and treatment staff, clarify rules and procedures regarding Key Maine TC and TTP, and assist in developing better rapport through the inclusion of a wider range of MDOC staff.

Additionally, since most of the new treatment staff has little or no background in TC methods, more intensive ongoing staff training may be warranted. The Therapeutic Communities of America (TCA) have produced prison-based TC standards to provide quality assurance of therapeutic community programming in prison settings. in an effort to ensure maintaining quality assurance and best practices in TCs across the country, guiding staff training, and guiding program evaluation (Office of National Drug Control Policy, 1999). This curriculum would complement the SBS training and prepare for eventual program accreditation.

Similarly, there is a need for staff who have specific expertise in conditions that are frequently comorbid with drug abuse and highly prevalent in the incarcerated population (e.g., sexual abuse, psychiatric disorders). Clients with comorbid conditions may differ in pattern or response to drug treatment compared to other clients. They may require specialized treatment services clients and behaviors that are often associated with the comorbid condition (e.g., aggression, control issues, hypersexuality) can disrupt the treatment environment and impede the client's progress, as well as that of others in the program.

4. Improve information sharing regarding clients' medical and psychiatric status between treatment and other MDOC medical and psychiatric staff.

Improved sharing of medical and psychiatric information about inmates in the program can greatly enhance the treatment process. During the program's first year, Key Maine staff was not informed when inmates stop taking prescribed medications on a regular basis or had changes in their medications. Key Maine staff relied primarily on the inmates about their medical and psychiatric statuses. Cooperation between Key Maine and MDOC psychiatric/medical staff was not formalized and as a result sharing of information has been incomplete and sometimes not possible.

TC-eligible inmates reported high rates of exposure to traumatic events (e.g., severe child abuse, alcoholism in the family) and high prevalence of psychiatric disorders (e.g., ADD, PTSD, depression) that can impact their ability to participate successfully in treatment.

The diversity of Key Maine clients' psychiatric and medical needs represent a challenge for treatment staff. Changes in medications can affect clients' behaviors and can impact the treatment environment in adverse ways. Without complete information about the clients' medical status, Key Maine staff can misread behavioral changes as noncompliance with treatment. Moreover, disruptive behaviors may lead to unnecessary discharges and integration into the general population, rather than needed treatment. Key Maine staff can provide feedback to medical and psychiatric staff about client's behaviors and/or reactions to medications.

5. Finally, MDOC should institute an interagency monitoring and response system that identifies and resolves implementation issues.

This systems should include 1) an on-going management group that includes representatives from MDOC, SBS, as well as an independent evaluator and 2) a computerized system to routinely collect and evaluate data on Key Maine TC and TTP clients for the purpose of monitoring program performance. Steady monitoring of program performance and early identification of problems related to program implementation and/or policy changes will facilitate problem resolution and inform future policy initiatives. Although prison programs should be given time to develop and stabilize before being subjected to outcome evaluations, implementing a computerized tracking of Key Maine program participants that electronically obtains key data on arrest data from MDOC files and the Department of Public Safety and merges it with select program information on clients (i.e., days in treatment, reason for discharge) can be informative.

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