Evaluation of Prison Based Drug Treatment in Pennsylvania:

A Research Collaboration Between

The Pennsylvania Department of Corrections and

The Center for Public Policy At Temple University

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Wayne N. Welsh, Ph.D.
Associate Professor, Department of Criminal Justice
5th Floor, Gladfelter Hall (025-02)
1115 West Berks Street
Temple University
Philadelphia, PA 19122

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EXECUTIVE SUMMARY

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Project Goals and Objectives

The time that drug-involved offenders are incarcerated affords a critical opportunity to break the cycle of drug abuse and recidivism by providing effective treatment. An in-prison Therapeutic Community is an intensive, long-term, highly structured, residential treatment modality for hard-core drug users convicted of a criminal offense. TC emphasizes the necessity of the inmate taking responsibility for his/her behavior before, during, and after treatment.

Several evaluations of in-prison TC have produced promising results. However, studies have been criticized for small sample sizes, faulty research designs (e.g., selection and attrition biases), and inadequate attention to interactions between inmate characteristics, treatment process, and treatment outcomes. No studies have examined prison-based TC across multiple sites nor attempted to include programmatic and contextual variations in analyses of outcome. Numerous questions remain about the true impact of prison-based TC, and the potential impacts of unmeasured variations in inmate characteristics, treatment programs, and multiple outcome measures.

In this study, we examine in more detail the individual and programmatic factors associated with effective drug treatment across multiple sites. We examine relationships between inmate characteristics, treatment process, and treatment outcomes, and discuss critical issues in prison based drug treatment programming and policies. We provide recommendations intended to assist

correctional agencies in designing, implementing, and evaluating programs that are responsive to the drug treatment needs of their prison populations.

The current project built upon a collaborative research partnership between Temple University's Center for Public Policy (CPP) and the Pennsylvania Department of Corrections (PA-DOC) that began in 1999. As part of a demonstration project, we conducted a statewide assessment of prison-based Alcohol or Other Drug (AOD) treatment programming, including identification of critical service delivery components and goals, and an intensive on-site process evaluation of AOD programs at two institutions. Results from that project have influenced departmental AOD treatment policies, and led to development of an AOD treatment program database that helped guide the design of the present study.

A Steering Committee consisting of senior executive, research and treatment personnel from the Pennsylvania Department of Corrections and Center for Public Policy researchers was formed to guide research activity and facilitate the department's overall research agenda. This group continues to meet regularly to provide oversight of the research process and consider the larger organizational and policy issues that the research raises. Steering Committee members participated in the entire oversight of this project. Findings were presented and discussed at Steering Committee meetings, and members provided numerous helpful comments on an earlier draft of this report.

Research Design and Methodology

We examined in-treatment measures and multiple post-release outcomes for inmates who participated in TC drug treatment programs (n = 742) or comparison groups (n = 2,029) at five state prisons. Matched comparison groups made up of TC-eligible inmates participating in less intensive forms of treatment (e.g., short-term drug education and outpatient treatment groups) at

the same five institutions were constructed based upon known predictors such as drug dependency, need for treatment and criminal history. Process and outcome measures incorporated a range of institutional, intermediate (e.g., attitudinal and behavioral change, participation in treatment) and post-release measures (e.g., drug relapse, rearrest and reincarceration, employment, levels of parole supervision). At the time of this report, 247 TC inmates and 803 Comparison inmates had been released from prison, with follow-up periods extending up to 18 months (mean = 11 months). We continue to track releases and recidivism for the entire sample[1].

Below we summarize our major findings, recommendations and conclusions. Details of analyses and further discussion are provided in the full Final Report for this project.

Major Findings

- In order to properly account for treatment exposure, researchers need to account for multiple admissions into prison drug treatment programs. In this sample, 2,891 inmates accounted for over 4,500 admissions into various AOD treatment programs.
- Offenders in TC received nearly 20 times the treatment "dose" compared to offenders in less intensive programs.
- We found positive effects of TC treatment, but for successful program graduates only (not failures), and mainly upon reincarceration rates (but not rearrest or drug relapse rates). The TC group had a significantly lower rate of reincarceration (19%) than the Comparison group (26%).

[1] The Pennsylvania Commission on Crime and Delinquency has provided additional funding to track post-release outcomes (Subgrant No. DS-19-11188).

- The positive effects of TC treatment were contingent upon employment following release from prison. Comparison inmates who failed to obtain full-time employment following release were 9.6 times more likely to be reincarcerated.
- The TC group (11%) had a slightly lower rearrest rate than the Comparison group (14%), but this difference was not statistically significant.
- TC inmates (36%) had a slightly lower relapse rate than Comparison inmates (39%), but this difference was not statistically significant.
- Post-release employment strongly reduced (by 50% or more) the likelihood of drug relapse, rearrest, and reincarceration.
- Treatment outcomes were generally invariant across institutions, with one important exception. Significantly higher rates of drug relapse were observed for inmates treated at Cresson (44%) and Houtzdale (46%) compared to Waymart (23%), Huntingdon (31%), and Graterford (32%).
- TC inmates evidenced numerous, positive improvements in psychosocial functioning and involvement in treatment over the first six months of treatment. TC inmates showed significant decreases in *self-esteem, depression*, and *risk-taking behavior,* and significant increases in *therapeutic engagement, personal progress, trust in group, opinions of program staff,* and *perceptions of counselor rapport and counselor competence.*
- The strongest area of consistency across the five TC programs was in the high ratings that inmates gave of counselor rapport and counselor competence. Each unit, while implementing the basic TC philosophy, also exhibited some programmatic variations.
- Two of the five TC units were rather large (100+ inmates). Large units make it difficult to properly implement the TC philosophy, which depends heavily upon positive peer interactions.

- Treatment staff showed a high level of discretion about appropriate thresholds for success and grounds for dismissal. While the overall termination rate for TC (25%) was reasonable, one program (Waymart) was very low (5%); another (Graterford) was very high (71%).
- Significant variation in several measures of psychosocial functioning (*depression, self-efficacy, hostility, risk taking, social conformity, treatment readiness*) was found across the five sites. Generally, Huntingdon inmates showed the greatest improvements in psychosocial functioning over time, Houtzdale and Waymart inmates showed the least improvement, Graterford and Cresson were in between.
- No significant differences in measures of involvement in treatment (e.g., therapeutic engagement) were found across the five sites.

Limitations

- The major limitation was the brevity of the follow-up periods and associated sample sizes available for multivariate analyses so far. As more inmates are released, and as average time at risk increases, we will revisit the analyses and conclusions formulated in this report.
- Our ability to examine post-release outcomes was limited by the unavailability of automated data regarding participation in aftercare treatment. Aftercare may interact with employment and other observed predictors to influence outcomes. Further research should examine ways to better integrate prison-based drug treatment with post-release needs and resources.
- It was difficult to determine the degree to which employment was a cause or an effect. To do so, it would be useful to obtain more detailed information on parolees' type of post-release employment, employee performance, income, etc. To disentangle potential causes, research should also determine how other factors (e.g., intelligence, cognitive abilities, education, in-

prison and pre-prison work history, job training) might interact with drug treatment to influence post-release outcomes (employment, drug relapse, reincarceration and rearrest).

- However, none of the control variables examined in this study (e.g., assessed level of need for drug treatment, prior and current offense severity, age) substantially weakened the observed relationship between employment and reduced recidivism, leaving us with the impression that the effect of post-release employment is quite robust.

Conclusions and Recommendations

Ten recommendations are summarized in Table I, along with the specific findings supporting each. Policies regarding prison-based drug treatment should focus on strengthening and enhancing TC quality and implementation so as to maximize treatment effects. Guidelines formulated by professional associations and informed by both clinical practice and research suggest that the bar could profitably be raised. Where TC is sufficiently intense but supportive, treatment engagement and completion should be intentionally maximized. The benefits of TC, where they exist, appear to be restricted to those who successfully engage, complete and graduate.

The effects of TC were statistically significant and encouraging, although not unqualified. TC significantly lowered the likelihood of reincarceration, but only when successful program graduates were isolated. The effects of TC on rearrest or drug relapse failed to reach statistical significance. Post release employment emerged as the strongest predictor of recidivism.

Further policy-relevant research should continue to explore and evaluate productive strategies in these directions, while at the same time examining more detailed interactions between inmate characteristics, treatment process, and outcomes across multiple sites.

Table I

Policy Issues and Recommendations

Recommendation	Findings Supporting Recommendation
1. Correctional officials, in cooperation with Parole, Probation and privately contracted Community Correctional Facilities (CCF's) should further explore and evaluate strategies to enhance post-release employment prospects.	Of the three major outcomes examined, TC significantly reduced the likelihood of reincarceration alone. Post-release employment was strongly related to a lower likelihood of reincarceration, rearrest, and drug relapse.
2. Correctional administrators, working with researchers, drug treatment specialists, treatment supervisors and program managers, should examine the frequency of different reasons given for program termination at each institution. Examine whether existing procedures aimed at improving inmates' therapeutic engagement and retention in the program can be strengthened. 3. DOC administrators should work with drug treatment specialists, treatment supervisors and correctional program managers to carefully monitor implementation of drug treatment policies and procedures (e.g., selection criteria for TC and other program types).	We found some inconsistencies in inmate selection and termination procedures across the five institutions. Two TC programs tended to recruit older, lower-risk inmates. Attrition rates varied substantially (5 – 71%).
4. Correctional administrators should carefully monitor the implementation of assessment, screening and program placement procedures specified by policies. Verify that AOD staff at each institution understand and properly implement these guidelines. Ensure that programming resources correspond to need/demand.	Many high-need inmates (e.g., high offense gravity scores, high need for drug treatment) were assigned to less intensive Outpatient programs rather than TC.
5. Correctional administrators should regularly review, update and verify critical data fields (data that inform program eligibility, selection and placement decisions) entered into automated information systems. Verify that AOD staff at each institution understand and properly implement selection guidelines.	Considerable variability was observed in time remaining to minimum release date. In contrast to stated policy guidelines, many inmates enrolled in drug treatment programs were already well past their minimum release dates.

Recommendation	Findings Supporting Recommendation
6. Correctional administrators, working with researchers, drug treatment specialists, treatment supervisors and program managers, should identify consistent standards for assessment of inmate psychological needs at each institution, as well as procedures for ensuring that such needs are adequately addressed.	TC inmates may in some cases have psychological needs that are not being fully addressed, as indicated by REST (inmate self-report survey) and CRC (counselor ratings) change scores.
7. While DOC drug treatment policies and procedures now identify consistent standards for each program type, DOC administrators should carefully monitor (e.g., through inmate self-reports, inmate and counselor interviews, and periodic site visits) the implementation of these standards at different institutions. 8. Correctional administrators, working with drug treatment specialists, treatment supervisors and correctional program managers, should identify strategies for on-site quality control in drug treatment programming. Officials should examine whether current resources devoted to program quality assurance are sufficient.	TC programs varied in several respects. Two of the TC programs did not use pull-ups, and individual counseling was provided inconsistently. Therapeutic engagement and inmate satisfaction also varied somewhat.
9. Correctional and Parole officials should ensure that appropriate levels of aftercare treatment are identified and provided to inmates upon release from prison. DOC and PBPP administrators should work together to further develop automated procedures for tracking inmate post-release behavior and compliance with conditions of supervision. **10.** DOC should continue to strongly support the development of offender-based treatment information systems. In response to previous recommendations, DOC recently completed development of a Unit Management System that captures diverse aspects of offender program participation (e.g., inmate's name and number, date of program admission and discharge, and reason for discharge).	At the time of this study, there was a lack of computerized data on several measures (e.g., admissions and discharges from prison-based treatment programs, participation in aftercare treatment) that would have been useful for program evaluation purposes.

I. Overview

Introduction

Like other states, Pennsylvania has experienced rapid growth in its correctional population and capacity since 1980. Like other states, correctional issues in Pennsylvania command greater budget and policy attention than ever before (Welsh, 1993; 1995). Like other states, Pennsylvania lacks the necessary resources to evaluate the wide range of treatment programs offered to thousands of inmates within its institutions. There is an increasing need for evaluative research, to determine which programs work for which offenders under which conditions, to improve programming to reduce recidivism and increase public safety, and to demonstrate accountability. In particular, high numbers of drug-involved offenders are treated annually, but research is sorely needed to determine effective elements of service delivery and overall treatment effectiveness.

The purpose of our current project was to examine multiple treatment process measures and post-release outcomes for 2,981 inmates who participated in TC drug treatment programs or comparison groups at five state prisons. Matched comparison groups made up of TC-eligible inmates participating in less intensive forms of treatment (e.g., short-term drug education and outpatient treatment groups) at the same five institutions were constructed post-hoc based upon known predictors such as drug dependency, need for treatment and criminal history. Process and outcome measures incorporated a range of institutional (e.g., misconducts), intermediate (e.g., attitudinal and behavioral change, participation in treatment) and post-release measures (e.g., drug relapse, rearrest and reincarceration). We also examine critical interactions between client selection, program structure and process, inmate responses to treatment and outcomes.

Background

The Research Partnership Between PA-DOC and Temple University

In 1999, we developed a collaborative research partnership between the Pennsylvania Department of Corrections and Temple University's Center for Public Policy. Our initial project was funded by a one-year grant (Jan. 1- 1999 - Dec. 31, 1999) from the National Institute of Justice. During our first year, we conducted a descriptive assessment and process evaluation of AOD programming offered by the Department of Corrections (Welsh, 2000a, 2000b). A second project, an outcome evaluation of AOD programs at 5 prisons, was funded by the National Institute of Justice (Jan. 1, 2000 - June 30, 2002). A third project, funded by the Pennsylvania Commission on Crime and Delinquency (Oct. 1, 2001 – Dec. 31, 2002), is now tracking post-release outcomes (reincarceration, rearrest, relapse) for 2,891 inmates who participated in either Therapeutic Community or less intensive Education or Outpatient programs at 5 state prisons.

Pennsylvania Department of Corrections

The Pennsylvania Department of Corrections operates 25 State Correctional Institutions, one Motivational Boot Camp, 14 Community Corrections Centers and 43 vendor-run Community Contract Facilities (CCF's). The Department housed 38,195 inmates as of January 31, 2002, with males representing 96% of the state's inmate population (Pennsylvania Department of Corrections, 2002a). Pennsylvania consistently ranks among the ten highest prison populations in the country (Beck and Harrison, 2001). As of January 31, 2002, offenders were housed at 112% of the system's design capacity, with six facilities housing offenders in excess of 130% of design capacity (Pennsylvania Department of Corrections, 2002b). The inmate population consisted of 33.9% Caucasians, 54.5% African Americans, and 10.9% Hispanics, with less than one percent accounted for by other ethnicities or races. The average age of offenders in DOC custody was 35

years old. Offenders were serving an average minimum sentence length of 6.2 years and an average maximum length of 13.9 years.[2] Inmate enrollment in AOD programming increased from 11,824 as of December 31, 1996 to 16,100 as of December 31, 2001, an increase of 36%. By comparison, the total number of offenders under DOC custody increased from 34,537 as of December 31, 1996 to 38,195 as of January 31, 2002, an increase of 11%. The Department of Corrections General Fund Budget for fiscal year 2000-2001 was $1,216,569,000, representing 6 percent of the total state budget. The overall operational cost per inmate for fiscal year July 1, 1999 - June 30, 2000 averaged $28,111 per year or 77.02 per day. As of December 31, 2000, the department employed 14,439 staff.

Alcohol or Other Drug Programs Administered by DOC

The department's approach to alcohol or other drug (AOD) programs is informed by a holistic health model that treats substance abuse as a complex problem with physiological, psychological, emotional, behavioral, spiritual, environmental and sociopolitical dimensions (Pennsylvania Department of Corrections, 2001). Long-term goals are to reduce recidivism, drug dealing and drug use, and increase the prospects for successful reintegration into society. The Department's AOD programming is grouped into four major categories: (1) *Education* programs offered to inmates identified as having a low level of drug and alcohol involvement; (2) *Outpatient Treatment* programs offered to inmates in need of more intensive, intermediate levels of intervention, including individual and group counseling sessions; (3) *Therapeutic Communities* offered to inmates identified as needing intensive, residential substance abuse treatment; and (4)

[2] Averages do not include lifers, capital cases and parole violators. For those interested in more detailed statistical breakdowns of the DOC population, annual statistical reports, current monthly population reports, and current monthly institutional profiles are available online at: www.cor.state.pa.us.statistics.htm

Ancillary Groups, such as self-help, peer counseling and relapse prevention groups, offered to inmates as supplements to other treatment, or when slots are not available in more intensive treatment modalities.

Substance Abuse Education. AOD Education programs provide participants with a fundamental overview of the social, physical and behavioral effects of drug and alcohol/addiction. Participants learn the benefits that result from a drug free life style. Education groups cover the following: the disease concept; pharmacology of drugs; physical, psychological, social and financial impacts of use; self-assessment treatment options; role of self-help groups and relapse prevention. At the time our study began, each institution had the flexibility to determine the length and presentation style for their groups. Program content and structure has since become more standardized, largely as a result of recommendations following the first-year research report produced by the Temple/DOC partnership. Substance Abuse Education groups function as the "entry level" treatment for the general population. The approach and the information presented are intended to motivate inmates to seek continued treatment. The Spanish version of substance abuse education is available to correspond to prison demographics and inmate demand.

Outpatient Treatment. Outpatient treatment provides services to inmates identified as having moderate to severe substance abuse problems. In this phase of treatment, Departmental Drug and Alcohol Treatment Specialists (DATS) work directly and intensively with inmates to help them recognize and address their dependency problems. Treatment offered can include twelve step approaches, individual and group intensive counseling, rational/emotive therapy, cognitive restructuring therapy, and other services rendered by treatment specialists. Where clinically indicated, detoxification services are also offered. These treatment programs are

integrated into the other activities that make up the inmate's day, such as work, education and recreational activities.

Therapeutic Communities. Correctional therapeutic communities place inmates in a residential treatment environment, separate from the general prison population. The Department of Corrections has instituted several therapeutic communities to treat a wide spectrum of substance abusing offenders. The TC model involves a long stay, ranging from 12 to 18 months.[3] The aim of the TC is total life-style change, including abstinence from drugs, elimination of antisocial behavior, and development of prosocial attitudes and values. All therapeutic communities incorporate several treatment models and approaches for the treatment of substance abusing inmates. Individual and group counseling, encounter groups, peer pressure, role models, and a system of incentives and sanctions form the core of treatment interventions. Inmate residents of the TC live together, participate in self-help groups and take responsibility for their own recovery. All TC's have a defined structure and daily activities to reinforce the mission of the TC. The main emphasis of the TC is on healthy, positive development of all aspects of life.

Ancillary Groups. All state correctional institutions have developed various ancillary groups to supplement prescriptive substance abuse programs. Currently, institutions provide a wide range of ancillary services. The ancillary groups include, but are not limited to, peer groups, 12-step groups, advanced codependency groups, assertiveness groups, survivor's groups, transitional services, self-esteem group, aftercare group, breaking barriers group, long term support group, denial group, decision making and coping skills group, lifers group, parole

[3] DOC implemented more standardized guidelines for TC program structure, content and duration (12 months) beginning January 2001. Once again, these policy changes were responsive to recommendations made by researchers in the earlier study of AOD treatment in Pennsylvania prisons (Welsh, 2000a; 2000b).

violators group and pre-release groups. Inmates with moderate to minimum substance abuse problems are provided opportunities to participate in these groups during the time they are waiting to participate in structured AOD programs. Ancillary groups utilize a wide variety of educational and self-help approaches. Lifers and inmates with very low motivation are encouraged to participate in ancillary groups. The goals of the ancillary groups include recovery from addiction, personal growth and self-esteem, integration into the community through readiness and prosocial skills training, and the reduction of recidivism. In addition, ancillary groups help to maintain institutional security, minimizing disciplinary problems, reducing drug dealing and use, and improving relationships between inmates and correctional staff.

Goals and Objectives of this Study

The study of five prison-based Therapeutic Community treatment programs provided by the Pennsylvania Department of Corrections builds upon a systematic, joint agency-university research partnership. This project attempted to more closely examine relationships between program process, inmate characteristics, and treatment outcomes than has previously been the case. The information realized through this endeavor is intended to be of use to correctional managers and researchers alike, as they design, implement and track the effects of prison based drug treatment.

II. Literature Review

Scope of the Problem

Substance dependent offenders are responsible for a high proportion of crime (Ball et al., 1983; Chaiken, 1989; Inciardi, 1979; Lipton, 1995). Many of these drug-abusing offenders are

repeatedly incarcerated, but untreated, with the result that high proportions relapse into drug use and crime after release (Lipton, 1995). The time that drug-involved offenders are incarcerated presents a unique opportunity to provide them with treatment. While there is yet little consensus about what types of treatment work best for what types of offenders in what settings, studies have suggested that in-custody treatment (especially intensive Therapeutic Community programming) can be effective in reducing relapse and recidivism among seriously drug-involved offenders.

The Need for Treatment

The successor to the Drug Use Forecasting program (DUF), the Arrestee Drug Abuse Monitoring (ADAM) program, tracks drug use among booked arrestees in 35 large urban areas. In 1998 the ADAM program conducted interviews and drug tests with more than 30,000 recent arrestees in 35 metropolitan areas (National Institute of Justice, 1999). A total of 20,716 adult males, 6,700 adult females, 3,134 juvenile males, and 434 juvenile females participated in the program during 1998. In 15 sites, about two-thirds of the adult arrestees and more than half of the juvenile males arrestees tested positive for at least one drug. Among adult males, marijuana was the drug most frequently detected in 22 of the 35 sites. Cocaine was the drug most likely to be detected in 11 sites. Among females, cocaine was the drug most frequently detected in 28 of 32 sites. Methamphetamine was the most frequently detected drug in the three sites for females. Among juveniles, marijuana was the most frequently detected drug.

The National Center on Addiction and Substance Abuse (CASA) (1998) reported that 60 to 80% of all prison inmates (federal, state, and county) have been involved with drug use or drug-related crimes in some fashion. Of $38 billion in correctional expenditures in 1996, more than $30 billion was spent incarcerating individuals with a history of drug and/or alcohol abuse. For chronic

users, activities and behaviors surrounding drug acquisition and use pervade their lifestyle (Johnson et al., 1985; Walters, 1992). Drug-using felons are a primary source of failure on parole (Wexler et al., 1988).

Most drug-involved offenders have avoided treatment while in the community, although many have experienced detoxification. More than 70 percent of active street addicts have never been in treatment nor intend to enter treatment for their addiction (Lipton, 1989; Peyton, 1994). The need for expanding drug abuse treatment was recognized in the Violent Crime Control Act of 1994, which for the first time provided substantial drug treatment resources for Federal and State jurisdictions.

In 1979, there were 160 prison treatment programs serving about 10,000 inmates--4 percent of the Nation's prison population (NIDA, 1981). Of 160 programs, 49 programs (32 percent) were based on the TC model and served about 4,200 participants (or 42 percent of all participants). Ten years later, the percentage of inmates in drug treatment programs had risen to an estimated 11 percent (Chaiken, 1989). Although the increase has been sizable, the majority of inmates with substance abuse problems still do not receive any treatment while in prison (Lipton, 1995), and only small portions of high-need inmates receive high-intensity treatment.

About 2 out of 3 inmates admit drug histories, but less than 15% receive any systematic treatment while in prison (Mumola, 1999). In 1997, 9.7% of State prison inmates (101,729) and 9.2% of Federal prison inmates (8,070) reported participation in drug treatment (i.e., residential treatment, professional counseling, detoxification, or use of a maintenance drug) since their admission (Mumola, 1999). Participation in much less intensive drug abuse programs (e.g., self-help, peer group or drug education classes) was more common: 20% of State and 9% of Federal prison inmates reported participation in such programs.

According to a recent report by the Substance Abuse and Mental Health Services Administration (SAMHSA) (2000), 40% of all correctional facilities nationwide (federal and state prisons, local jails, and juvenile facilities) provided some sort of on-site substance abuse treatment (i.e., detoxification, group or individual counseling, rehabilitation, and methadone or other pharmaceutical treatment) to inmates in 1997. However, only about 11% of inmates in these institutions received any treatment, most frequently in a general facility population program. Few of these inmates were treated in specialized treatment units (28%) or hospital or psychiatric inpatient units (2%).

Prison-based TC treatment programs date back to at least the 1960's. In general, TC programs emphasize the necessity of the inmate taking responsibility for his/her behavior before, during, and after treatment, and inmates play an important role in structuring collective norms and sanctions. TC is a system that validates the humanity of its participants, engages their full resources, and accepts the risk of disorder and confrontations. TC principally targets for change the inmate's sense of self-worth and responsibility. The major vehicle for change is a social environment whose constitutive principle is justice, with corollaries of participation, giving reasons, and personal dignity (Studt, Messinger and Wilson, 1968). While democratic principles underlay the basic philosophy of TC, true prison-based TC programs require highly committed prison staff members and responsive inmates (Toch, 1980). Transition to full membership in the TC requires incremental adjustment to new behavioral modes and participation in a collectivized environment.

Evaluations Of Prison-Based TC

The most recent and state-of-the-art research on prison-based TC was reported in a special issue of the *Prison Journal* (1999, Volumes 3 & 4). Evaluations of prison-based treatment were described in three states (California, Delaware, and Texas) that mounted major treatment initiatives in correctional settings. The three studies all used a common time interval (3 years) for tracking follow-up outcomes, including performance indicators extracted from official criminal justice records in each state. Studies found that graduates of prison TC had lower rates of rearrest, drug relapse, and/or return to custody than comparison samples, especially when prison TC was combined with structured aftercare following release from prison.

In Delaware (Martin et al., 1999), 3-year follow-ups showed that rearrest rates were lowest for those who graduated prison TC and successfully completed an aftercare program (31%). Those who completed TC but no aftercare still did significantly better (45%) than those who dropped out (72%) or those who received no treatment (71%). In California (Wexler et al., 1999), those who successfully completed prison TC plus aftercare showed a rearrest rate of 27% in 3-year follow-up studies, compared to 75% for a no-treatment comparison group. In Texas (Knight, Simpson & Hiller, 1999), those who completed TC plus aftercare had a 3-year rearrest rate of only 25%, compared to 42% of a no-treatment comparison group.

Effectiveness is related to the length of time an individual remains in treatment (Lipton, 1995). Evaluations of New York's Stay'n Out program (Wexler, Falkin, and Lipton, 1990; Wexler, Falkin, Lipton, and Rosenbaum, 1992), Oregon's Cornerstone Program (Field, 1984, 1989, 1992), Delaware's Key-Crest programs (Inciardi, 1995, 1997), California's Amity Prison TC program (Wexler, 1995), the Texas In-Prison TC (Fabelo, 1995; Knight, Simpson, Chatham,

and Camacho, 1997), and the Federal Bureau of Prisons (1998) Triad program illustrate the potential of prison-based therapeutic communities. We briefly summarize these major studies of prison-based TC below, and then identify gaps in our current knowledge to date.

The Amity Prison TC Program.

The Amity Prison TC program is located at the R.J. Donovan facility near San Diego, a medium-security facility housing approximately 4,000 men. Eligible inmates must have a history of drug abuse, demonstrate evidence of institutional participation (or absence of in-prison assaults or weapon possession within the past 5 years and sex-related offenses in prison within the past 10 years), have no history of child molestation or mental illness, and be within 9 to 15 months of release on parole (Office of National Drug Control Policy, 1996). Like many prison-based TC's, the Amity TC was modeled after New York's Stay'n Out Program by Amity, Inc. to fit a correctional setting. Inmates are housed in a 200-man residential unit separate from other inmates, although they eat in a common dining room and participate in activities with other inmates who live in the same yard.

Inmates move through three phases of treatment in the 12-month program. The first phase consists of orientation, diagnosis, and an assimilation process. In the second phase, lasting 5 to 6 months, inmates are expected to take on increased responsibility and involvement in the program. Those who have been in the program longer are expected to share their insights by teaching new members and assisting in the day-to-day operation of the TC. Encounter groups and counseling sessions focus on self-discipline, self-worth, self-awareness, respect for authority, and acceptance of guidance for problem areas. Seminars take on a more intellectual approach. Debate is encouraged as a means of self-expression. During the third phase, community reentry, which lasts 1 to 3 months, inmates strengthen planning and decision-making skills and design their

individual exit plans. A unique program component concerns a core group of residents who are paid prison wages for holding key positions in the TC. These positions are earned by residents who have shown progress in the program and who have won the respect of the community through their hard emotional work. Upon release from prison, program graduates are offered the opportunity to continue in residential TC treatment for up to 1 year in a community facility also operated by Amity.

A study of California's Amity Prison TC was based on an experimental design in which 720 male inmates were randomly assigned to treatment or comparison groups (Wexler, 1995). Information on program retention and recidivism was obtained for four groups: clients who completed the prison TC program, clients who completed the prison TC plus the aftercare program, program dropouts, and a control group. The study sample consisted of felons with extensive criminal histories, and more than 70 percent had committed a violent crime. The average inmate had spent more than half of his adult life in prison, with prison/jail terms averaging 19 years.

After 6 months, half of the TC admissions had completed the program; one-third were still enrolled and in good standing, and the remainder (17%) had been dropped because of serious infractions of prison policy or had left voluntarily. Inmates who went through both the prison TC program and the community-based TC had the lowest reincarceration rate of the 4 groups (Wexler, 1995). Results revealed that inmates who completed both the Prison TC and Aftercare components had a reincarceration rate of 26%, compared to those who graduated the Prison TC program only (43%), program dropouts (50%) and controls (63%). However, the program had a high drop-out rate during its residential phase (23%), and the treatment group evidenced only an

8% lower reincarceration rate compared to control subjects when program failures were included in calculations of recidivism (Austin, 1998).

The Stay'n Out Program

The Stay'n Out Program was established in New York in 1977 (Wexler, Falkin, Lipton, and Rosenbaum, 1992). Treatment was provided by New York Therapeutic Communities, Inc. (staffed by a group of ex-offenders, all recovering addicts), using a modified Phoenix House model. The program was evaluated in a study of 1,626 male and 398 female inmates, beginning in 1984 (Wexler, Falkin, and Lipton, 1990; Wexler, Falkin, Lipton, and Rosenbaum, 1992). Major objectives were to evaluate the effectiveness of prison-based TC treatment and assess the "time-in-program" hypothesis (i.e., length of stay was nine to twelve months rather than three).

Inmates in the Stay'n Out group were compared with two other groups in a non-equivalent control group design: inmates who volunteered for the TC program but who for various administrative reasons never participated (the "no-treatment controls") and inmates similar to those in Stay'n Out but who participated in other types of prison-based drug use treatment programs (counseling and milieu therapy) (Wexler, Falkin, and Lipton, 1990). The samples were comparable except that the male milieu group had a significantly higher mean age and criminal history score and spent more time in prison than the other male groups. The samples of inmates were selected from those released from prison between 1977 and 1984. The follow-up period, which ended in 1986, therefore ranged from 2 years to 9 years, depending on the year of release.

Groups were compared on several recidivism measures: rearrest rates, the mean number of months until arrest, parole success rates, and reincarceration rates. Researchers found that the rearrest rate for the male TC treatment group (27%) was significantly lower than all male

comparison groups, including milieu therapy (35 %), counseling (40%), and the no treatment male group (41%). In addition, there was a strong positive relationship between number of months in the prison TC and success on parole. The male TC treatment group also stayed drug-free and crime-free for significantly longer periods than the comparison groups. Similar arrest results were found among the females, with the TC group having a significantly lower arrest rate than the combined counseling and no-treatment groups. However, the differences between the no-treatment group and the counseling and TC groups were not significant.

The Cornerstone Program

The Cornerstone Program at Oregon State Hospital was a 32-bed TC for correctional inmates that began in 1975 (Field, 1984; 1989; 1992). It was similar to the modified TC concept of Stay'n Out in New York, but had a higher proportion of professional staff and trained correctional officers. In a 3-year follow-up study, Field (1992) tracked about 200 inmates admitted to the program from 1983 to 1985, separating them into four groups: 1) 43 program graduates (PG), 2) 43 nongraduates who completed at least 6 months (NG>6 mo.) of the program, 3) 58 nongraduates who completed 2 to 6 months (NG 2-6 mo.), and 4) 65 nongraduates who left before 60 days (NG 0-2 mo.). In a 3-year follow-up study, program graduates had a significantly lower reincarceration and reconviction rate than all comparison groups. Generally, as the length of time in treatment increased, recidivism rates declined. Three years after release, 37% of program graduates had no rearrests compared to only 21% of Group 2 (NG>6 mo.), 12% of Group 3 (NG 2-6 mo.), and 8% of Group 4 (NG 0-2 mo.). Slightly more than half the program graduates (51%) were not convicted of any crime after three years, compared to only 28 percent of Group 2 (NG>6 mo.), 24% of Group 3 (NG 2-6 mo.), and 11% of Group 4 (NG 0-2 mo.). After three years, 74 percent of the program graduates were not

reincarcerated, compared to only 37% of Group 2 (NG>6 mo.), 33% of Group 3 (NG 2-6 mo.), and 15% of Group 4 (NG 0-2 mo.).

Cornerstone's results have frequently been cited as a demonstration of the success of prison-based TC. However, differences in recidivism rates between comparison groups may be less than 8% when program failures are properly considered (Austin, 1998). Problems with selection bias may also have attenuated treatment impact: program graduates had significantly more severe criminal histories and substance abuse problems than others (Lipton, 1995). Indeed, the use of a post hoc research design based solely on degree of inmate participation in treatment fails to rule out numerous threats to internal validity (see Fletcher and Tims, 1992).

The Texas In-Prison Therapeutic Community (ITC)

In 1991, the Texas legislature and then-Governor Ann Richards began a comprehensive correctional substance abuse treatment initiative. While the initiative faced numerous setbacks and was never fully implemented, it still represents the largest prison-based drug treatment effort attempted in the U.S. to date. State legislation established three criminal justice substance abuse initiatives: 1) a community-based initiative called the Treatment Alternatives to Incarceration Program (TAIP), 2) a Substance Abuse Felony Punishment (SAFP) System for inmates on probation or parole, and 3) an In-Prison Therapeutic Community (ITC) Treatment System. We briefly describe the third type.

The ITC program consisted of 6 to 12 months of intensive chemical dependency treatment. Inmates who completed primary treatment in ITC facilities were expected to re-enter the community through the SAFP system. The ITC system was intended to operate 2,000 treatment beds by the end of 1995. Unfortunately, because of the unprecedented numbers of clients progressing through the system, the effort faced serious implementation problems,

including insufficiently experienced and trained staff, a shortage of quality post-release treatment programs, a very weak selection and diagnostic process, inadequate management of fiscal and accountability requirements, unrealistic expectations for program success, and an unrealistic anticipation of low attrition. The State auditor reported an attrition rate of 58 percent and suggested that correctional officials may have misled the legislature on this point (Lipton, 1995).

A 1-year follow-up study of 1,000 inmates referred to the in-prison treatment units showed that only 7.2 percent of those who completed 3 or more months of treatment had been reincarcerated, in contrast to 18.5 percent of those who had received no treatment, a comparison group of parolees from the general prison population who met all treatment eligibility requirements but did not have enough time left to serve to be able to participate (Fabelo, 1995). Overall, though, experimental cases evidenced only a 5% lower rearrest rate than the comparison group (Austin, 1998).

The flagship ITC program, the 520-bed New Vision Chemical Dependency Treatment Facility operated by Wackenhut (a private contractor), opened in Kyle, Texas in 1992. Initial evaluation research conducted by the Institute of Behavioral Research at Texas Christian University (Knight, Simpson, Chatham, and Camacho, 1997) compared 293 program graduates with a matched sample of 121 TC-eligible parolees. Unfortunately, these TC-eligible parolees had all been rejected from the TC program, because the parole board had judged them either as unlikely to benefit from the program or inappropriate for the program (p. 82). Researchers did not know specific reasons for rejection, but this factor may have introduced substantial selection bias into the research design. Eighty percent of TC admissions graduated, 6% were transferred, and 14% were terminated for noncompliance. Graduates did not differ from dropouts on age, education, marital status, admission offense, or recidivism risk, but graduates overall had a history

of less violence and greater drug use. TC graduates did not differ from the comparison group on race, age, education, marital status, or previous offense, but TC graduates were more likely to be admitted for possessing or selling drugs, and had a higher recidivism risk score.[4]

Six months after leaving prison on parole, ITC graduates were less likely to be rearrested than the comparison group (7 % v. 16 %), based on criminal records checks. Overall, TC graduates evidenced less criminal involvement than the comparison group, based on a composite index of parole officer reports, self-reported arrests, and self-reported illegal activity (41% v. 55%). TC graduates were less likely to report using alcohol (5 % v. 35%), marijuana (2 % v. 8 %), or crack (5 % v. 12 %). Drug testing (hair tests) confirmed that TC graduates were less likely to use cocaine (38% v. 55%), although base rates of relapse obtained by drug testing are obviously much higher than rates obtained by self reports. TC graduates were less likely to be unemployed (12% v. 22%), and more likely to attend Alcoholics Anonymous (AA) (55% v. 31%) and Narcotics Anonymous (NA) (63% v. 31%) than comparison parolees.

The Key-Crest Programs

Recent studies in the Delaware prison system further suggest the efficacy of prison-based TC, especially when combined with a TC-based work release component (Inciardi, 1995; Inciardi, Martin, Butzin, Hooper, and Harrison Inciardi, 1997). The program is built around two TC's: the "Key," a prison-based TC for men, and the "Crest," a residential work release center for both men and women. The program employs a three-stage treatment model. First, the Key, modeled after the Stay'n Out program, is a 12-month residential TC based in the institution. The second stage,

[4] The authors suggest that biases in selection and attrition actually provide a more conservative test of treatment effects, since the experimental group would appear more likely to fail. However, further selection bias is possible due to the comparison group parolees being selected from a pool of rejected TC-eligible inmates.

Crest, is a "transitional TC," designed as a work release program. Inmates approaching their release date are allowed to hold paying jobs in the community while spending their remaining time in a community-based TC. The third stage (aftercare) is for released inmates who have completed the first two stages and are living in the community under parole or other supervision. Aftercare involves participation in an outpatient group and individual counseling, and offers the opportunity to return to the work release TC for refresher sessions.

Evaluation studies contrasted 448 participants classified into four groups: (1) a comparison group of work-release inmates who received HIV prevention education, but neither prison-based nor community-based TC, (2) those who received primary treatment in the Key alone, but no secondary or tertiary treatment, (3) participants in the Crest alone, and (4) participants who received primary treatment in the Key and secondary treatment in the Crest (Key-Crest). A complex research design utilizing a combination of random assignment, purposive selection, and historical comparisons resulted in comparison groups that were somewhat dissimilar (Inciardi et al., 1997:266):

> First, assignment to the COMPARISON or CREST groups was determined by the investigators by random number. Second, the COMPARISON and CREST groups include men and women, whereas the KEY group does not-- until very recently, there was no women's in-prison TC in Delaware. Third, because the determination of group membership was made at the time of the baseline interview, those included in the KEY or KEY-CREST groups were only those still in the KEY program at the time of their release, graduates. The CREST and COMPARISON groups included all those so assigned at the time of their release, regardless of actual attendance. Fourth, the KEY-only group

included those clients who graduate before the CREST program was established. Once the CREST program was established, virtually all KEY graduates were assigned to it. Hence the KEY samples are nonrandom, and the KEY-only group serves as an historical comparison for the KEY-CREST group.

Further, "Many of the so-called no treatment comparison group did get some treatment help" (Inciardi et al., 1997:266). Researchers attempted to statistically control for several extraneous factors including number of days in treatment, time since discharge, and number of times previously incarcerated. Like other evaluations of prison-based TC, the research design remains vulnerable to concerns over selection and attrition biases, as well as treatment migration (Gartin, 1995)[5].

The major outcome variables examined were self-reported arrests and self-reported drug use. Drug testing was used to confirm self reported drug use; unfortunately no criminal records were checked to confirm inmate self-reports of recidivism. Results showed that drug-involved offenders who participated in both the prison TC followed by treatment in the work-release center (i.e., the "Key-Crest" group) had lower rates of drug use (25%) and self-reported rearrest (28%) than drug-involved offenders who participated in shorter treatment programs. At 18 months after release, drug offenders who received 12–15 months of treatment in prison followed by an additional 6 months of drug treatment and job training were more than twice as likely to be drug-free than offenders who received prison-based treatment (Key) alone. Offenders who received both forms of treatment (Key-Crest) were much more likely than offenders who received only

prison-based treatment to be arrest-free (self-reported) 18 months after their release (71 percent compared to 48 percent). Similar to Amity and Stay'n Out, the most consistent pattern of success was found when inmates completed the entire prison TC program and received aftercare in addition to prison treatment.

Triad Study

The Federal Bureau of Prisons (1998) provides drug treatment to all eligible inmates in accordance with requirements of the Violent Crime Control and Law Enforcement Act of 1994. Like TC's, residential drug treatment is generally provided in separate, dedicated units in 42 federal prisons. Not all follow a strict TC (milieu) treatment approach, although treatment strategies are premised on two assumptions typical of TC: the inmate is responsible for his or her behavior, and the inmate can change his/her behavior.

Treatment lasts up to 12 months, although most programs offered 500 hours of treatment over nine months, with a staff-to-inmate ratio of 1:24. Inmates returning to general population go through a transitional program emphasizing group relapse prevention planning and a review of treatment techniques learned during the intensive phase of residential treatment. Typically, inmates enter a residential treatment program 24 to 36 months before release from BOP custody. All inmates who participate in the residential program are required to participate in community transitional services (including contracted group, individual, and/or family counseling) when transferred to a Community Corrections Center. To assess the effects of its programs, the BOP, in

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[5] Treatment migration refers to problems in the delivery of treatment that result in biased comparison groups. Specifically, the wrong treatment is delivered to one or more groups, or different treatment conditions are mixed.

conjunction with the National Institute on Drug Abuse (NIDA), initiated an evaluation project, which has become known as the TRIAD[6] drug treatment evaluation project.

A preliminary six-month follow up study (Federal Bureau of Prisons, 1998) examined drug relapse and rearrest rates for 719 male and 180 female treatment subjects, compared to 805 male and 162 female comparison subjects (inmates who had similar histories of drug abuse and met the criteria for admission to the residential drug treatment programs). Measures of arrest and supervision revocation were based both on criminal records checks and interviews with federal probation officers. Drug use measures were based upon self-report measures as well as urinalysis results.

Researchers sampled treatment subjects from 20 different institutions, including all security levels except maximum security. The residential programs included two components of treatment — an in-prison component and a transitional services component (as part of community placement and supervision). The in-prison treatment programs consisted of two different levels of duration — 9-month programs (500 hours) and 12-month programs (1,000 hours).

Male and female comparison subjects were drawn from more than 40 institutions, some of which had residential drug abuse treatment programs and some of which did not. The comparison subjects consisted of individuals who had histories of previous drug use and, therefore, would have met the criteria for admission to the residential drug treatment programs. While the research design was somewhat vulnerable to problems of selection bias and cross-site variation in treatment implementation (Austin, 1998), Pelissier et al. (2001) more explicitly examined and controlled for selection bias and other extraneous factors in their analyses than any other study of prison-based drug treatment to date.

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[6] TRIAD is the acronym for "Treating Inmates' Addiction to Drugs."

The preliminary study reported that of inmates who completed the residential drug abuse treatment program (DAP), only 3.3% were rearrested in the first six-months after release, compared with 12.1% of the comparison group. Similarly, only 20.5% of the treatment group used drugs during the first six months after release, while 36.7% of subjects in the comparison group did so.

In a 3-year follow-up report (Pelissier et al., 2001), researchers examined the effects of treatment programs on post-release drug use, recidivism, and employment. The sample consisted of inmates who were released to community-based supervision between August 1992 and December 1997 and assessed over a 3-year post-release period. The sample included 2,315 individuals — 1,842 men and 473 women — for whom comprehensive data were available.

Results showed that the approximately 763 male offenders who completed the residential drug abuse treatment program and had been released to the community for up to 3 years were less likely to be rearrested for a new offense, to be rearrested *or* revoked, or to test positive for drug use than was a similar group of untreated. The probability of rearrest or revocation within 3 years after release was 44.3 percent for male treatment completers as compared to 52.5 percent for untreated male subjects. Although the results for women were not statistically significant, the difference between the treated and comparison group suggests that treatment helped to reduce recidivism among women. Among women who completed residential drug abuse treatment, 24.5 percent were arrested for a new offense or had their supervision revoked within 36 months after release compared to 29.7 percent among untreated inmates.

The probability of drug use was 49.9 percent for male treatment completers as compared to a probability of 58.5 percent for untreated subjects. Treated women had a lower probability of

drug use than untreated women (35.0 percent and 42.6 percent, respectively), although the results were not statistically significant.

Women who completed treatment were more likely to be employed full-time during the entire post-release period and had a higher employment rate (that is, the percent of post-release time employed in any capacity) than the comparison group. Women who completed treatment were employed 68.6 percent of the post-release period and untreated women were employed 59.1 percent of the time. Among men, those who completed treatment were employed 70.5 percent of the time and untreated men were employed 68.6 percent of the time.

Gaps in Current Knowledge

Although research on prison-based TC has suggested that the effects of TC are generally positive, especially when coupled with intensive aftercare treatment, studies have been criticized for small sample sizes, failing to adequately control for biased selection and biased attrition, unknown or compromised program implementation, and inadequate attention to interactions between inmate characteristics, treatment process, and treatment outcomes (Austin, 1998; Fletcher & Tims, 1992). Even where the follow-up risk period has been standardized (3 years), different recidivism rates (45 – 79% for TC only; 25 - 31% for TC + Aftercare) using divergent outcome measures (e.g., official arrest records, reincarceration, and self-reports of drug use and offending) have been reported. The potential effects of variations in TC implementation across different sites have rarely been considered.

Many studies have not adequately examined or controlled for possible selection bias in treatment and comparison groups. Self-selection is often the main guide that inmates use to navigate through treatment options, which complicates the clarity of scientific interpretations

(Simpson, Wexler, & Inciardi, 1999). Many factors other than need for treatment (e.g., security concerns, inmate work schedules, mental health or medical problems, minimum length of sentence remaining, inmate refusal to participate, biases in the referral process) may influence program placement decisions in prison (Farabee et al., 1999; Fletcher and Tims, 1992; ONDCP, 1996, 1999; Pearson and Lipton, 1999).

In the Delaware study (Martin et al., 1999), only a partial randomized design was used. Random assignment was used only for one cohort of inmates who were randomly assigned to work release (CREST) or not. No random assignment was used to assign subjects to an experimental treatment (KEY, the TC program) or control group. No pre-service assessment of need for drug treatment guided the creation of comparison groups: "The instruments include much of the Addiction Severity Index (ASI) and NIDA's Risk Behavior Assessment (RBA). It is important to note that these instruments were administered by the researchers after client selection and not as part of the client selection process" (Martin et al., 1999:300). Further, analyses of outcomes (drug relapse, rearrest) relied heavily upon inmate self-reports (Inciardi et al., 1997). Arrestees' self-reports underestimate drug use detected by urinalysis by magnitudes of 40 to 60 percent (Taylor et al., 2001), while problems with self-report measures of criminal behavior are well known (e.g., Cantor and Lynch, 2000; Thornberry and Krohn, 2000).

In the Amity, California prison study (Wexler et al., 1999), researchers used randomization to assign inmates who *volunteered* for treatment to either TC or a wait-listed, "intent-to-treat" comparison group. Volunteers were deemed eligible if they met admission criteria of having a drug problem (no information on the severity of drug problem or the means of assessment was reported), and having at least 9 to 14 months remaining in their sentence prior to parole eligibility. Inmates remained in the TC-eligible pool until they had less than 9 months to

serve, then they were removed from the pool and designated as members of the "no-treatment" control group. In reality, inmates in the "no-treatment" comparison group may have received some unknown mix of drug education, self-help, or outpatient services: "The control group did not receive any formal substance abuse treatment during their prison stay, although limited drug education and 12-step groups were available" (p. 325).

Numerous questions remain about the effectiveness of prison-based substance abuse treatment programs. For example: How is quality of program implementation related to treatment outcomes? Studies of prison-based TC in Texas (Martin, Butzin, and Inciardi, 1995), California (Wexler and Williams, 1986) and Delaware (Inciardi, Martin, Lockwood, Hooper, and Wald, 1992) found numerous implementation problems, including inadequate numbers of trained and experienced counseling staff and lack of standardized screening, assessment, and selection processes (see also Farabee et al., 1999; Linhorst et al., 2001). Variations in TC implementation across different sites may significantly influence treatment outcomes such as recidivism.

Relationships between inmate characteristics, treatment process and outcomes are not yet well understood (Pearson and Lipton, 1999). For example, how are drug and alcohol needs assessments conducted, and how do needs assessments influence treatment process and outcomes? Are inmates with different levels and types of need matched with appropriate treatment (Andrews et al, 1990)? To what degree does appropriate assessment and program placement moderate treatment effects? What kinds of inmates are best suited for TC's?

Finally, what magnitude of treatment effect is to be expected from TC if appropriate extraneous influences are controlled for in analyses (Pearson and Lipton, 1999)? So far, results of prison-based TC have been based upon research conducted mainly in four states (Delaware, Texas, New York, and California), and it is unclear to what extent observed treatment effects

depend upon variations in program implementation, inmate characteristics (e.g., treatment needs assessments, psychological functioning), or research design (e.g., adequacy of matching procedures, and adequacy of controls for extraneous variables that may influence treatment outcomes) (Austin, 1998).

Numerous questions remain about the true impact of prison-based TC, and the potential impacts of unmeasured variations in inmate characteristics, treatment programs, and multiple outcomes. In this study, we examined prison-based TC across multiple sites while including programmatic and contextual variations in analyses of outcome.

III. METHODS

Process Evaluation Design

Process evaluation involves a detailed analysis of the organizational and programmatic processes that are used to provide treatment services (Palmer, 1992; Pawson and Tilley, 1994; Welsh, Jenkins, and Harris, 1996). While outcome evaluation tells one whether or not a given program is achieving results, process evaluation sheds light on *why* a given outcome is being produced. Doing process evaluation prior to outcome evaluation provides researchers with much useful information needed to design a meaningful and valid outcome study. Descriptive research information previously collected through the DOC – Temple research partnership was used to inform the design of the outcome evaluation described below.

Results from a survey of prison-based treatment programs in Pennsylvania (Welsh, 2000a) showed that *Therapeutic Community programs, in contrast to other types of prison-based drug treatment programs, displayed a high degree of program intensity, structure, and consistency.* TC lasted longer (mean = 50 weeks) and provided more total hours of actual treatment

programming per week (mean = 30 hr/wk) than any other program type. TC programs had been in operation an average of nine years (range 8 to 11 years). The average inmate/staff ratio for TC was 1:17. TC Staff were also experienced and well educated: 41% had a Bachelor's Degree in Psychology, Counseling, Social Work, or a related discipline, while 55% had a Master's Degree. TC treatment staff had an average of nine years direct AOD treatment experience, and had been employed an average of 5 years with DOC.

Of the four major types of prison-based drug treatment (Education, Outpatient, TC, and Ancillary), strongest treatment effects were thus expected in TC. It was possible to obtain an acceptable sample size by pooling five therapeutic communities at different institutions, due to their empirically demonstrated consistency across major programmatic dimensions (e.g., treatment duration, intensity, and approach).

Based upon the results of the AOD treatment program survey, Temple researchers created a *Treatment Program Data Base*, which incorporated critical dimensions of service delivery for 119 prison-based AOD programs, including data elements reflecting the intensity and type of treatment services provided by each.

Inmate (TC Participant) Interview Form

We felt it would be worthwhile during our study to complete an additional, small sample of interviews with inmate residents of the five TC programs. A valuable perspective of treatment services provided can often be obtained from the targets of the intervention (Welsh and Harris, 2000). Inmates can provide personal accounts of why they were referred to the program, how they perceived various types of TC groups, classes, and other treatment activities, and what aspects of the program they felt were helpful or not helpful. We used the same interview schedule utilized in our previous process evaluation (Welsh, 2000b); a copy is provided in Appendix 2.

The advantage of this approach is that inmates have detailed, first hand knowledge of the program. The disadvantage is that the information they provide may be limited by subjectivity and their lack of familiarity with interviewers. As a result, responses may be somewhat guarded or biased, depending on their personal experience and personalities. They may wish, for example, to make the program "look good" by exaggerating its positive benefits, or they may wish to make it "look bad" by exaggerating its negative features. Their views provide a supplemental source of information, however, that can be crosschecked against information obtained by other methods (e.g., inspection of program documents, self report inmate surveys, counselor surveys).

At the five institutions, we conducted a total of 53 inmate interviews: 10 at Graterford, 10 at Houtzdale, 10 at Cresson, 11 at Waymart, and 12 at Huntingdon. We also examined program documents (lesson plans, handbooks, policy statements, etc.) for each program to gain further information on program content and structure. All interviews were conducted between July and August of 2000. At each institution, we interviewed at least two inmates from each treatment phase (all TC's were four-phase programs), with a slight emphasis upon inmates entering the latter two phases of their TC programs.

Outcome Evaluation Design

Matched comparison groups made up of TC-eligible inmates participating in less intensive forms of treatment (e.g., short-term drug education and outpatient treatment groups) at the same five institutions were constructed post-hoc based upon known predictors such as drug dependency, need for treatment and criminal history. Process and outcome measures incorporated a range of institutional (e.g., misconducts), intermediate (e.g., attitudinal and behavioral change,

participation in treatment) and post-release measures (e.g., drug relapse, rearrest and reincarceration).

Essential to the task of creating a valid research design is the creation of adequate comparison groups. Formal *classification assessments*[7] and *drug and alcohol assessments*[8] on all inmates were conducted. We examined average scores on the *Pennsylvania Department of Corrections Screening Instrument* (PACSI) and the *TCU Drug Screen*[9] for inmates in each program, and we determined how many inmates fell into low, medium, or high need categories. If TC clients were all "high need" clients, for example, then valid comparison groups would need to consist of high need clients also.

While the advantages of randomized research designs are well known, many programs including state-mandated Alcohol or Other Drug (AOD) programs are obligated by concerns of legality and ethicality to select clients on the basis of their need and suitability for treatment. In such cases, randomization is often not feasible. However, a strong research design is afforded by the opportunity to use ***matched controls*** to form comparison groups (see for example Rossi and Freeman, 1989). Many high need inmates may receive less intensive forms of treatment (e.g.,

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[7] The *Pennsylvania Additive Classification Tool* (PACT) is designed to evaluate the offender's custody and security level requirements based on the nature of current and prior offenses, prior institutional and assaultive behavior, escape history, time to release, and program/work/housing performance, as well as stability factors such as marital status, age, and educational level.

[8] Up until the end of December 2000, DOC used the *Pennsylvania Department of Corrections Screening Instrument* (PACSI) to determine if an inmate had a problem with substance abuse. The instrument assesses previous and current drug use (frequency and type), physical and emotional effects, effects on life circumstances (e.g., relationships, employment, school, family), and previous and current involvement in treatment. The PACSI results in a need for treatment score that ranges from 0 - 10. This screening process was designed to determine who can benefit from treatment and which general category of substance abuse treatment was best suited for each inmate. As of January 1, 2001, DOC began using the TCU Drug Screen (the same instrument used in this study) to screen all inmates for AOD treatment needs (Simpson, 1994; Simpson and Knight, 1998). In fact, the Department's adoption of that instrument was largely in response to recommendations made by Temple researchers as a result of the research partnership between the two agencies (Welsh, 2000a; 2000b).

[9] The TCU Drug Screen has been widely used and validated with inmate populations, and has evidence excellent reliability (Broome, Knight, Joe and Simpson, 1996; Peters et al., 1999). Score values of 3 or greater indicate relatively severe drug-related problems, and correspond approximately to DSM drug dependence diagnosis.

Outpatient, Ancillary Groups or Drug Education only) due to a shortage of intensive treatment slots. Critical to the matching process is the use of matching criteria closely related to the outcome criteria (e.g., recidivism and drug use).

Matching must be sensitive to the three principles of risk, need, and responsivity derived from empirical research. First, effective programs clearly differentiate between low-risk and high-risk clients (Andrews et al., 1990; Bonta, 1996; Gendreau, 1996; Jones, 1996). High-risk cases should receive high levels of intervention and services; low-risk cases should receive minimal intervention. Second, criminogenic ***needs*** are dynamic (i.e., changing) risk factors that are predictive of recidivism (e.g., antisocial cognitions and emotional states, association with antisocial peers, substance abuse, weak self-control and problem solving skills). Programs that effectively target and reduce such individual needs accomplish larger decreases in re-offending. Third, programs that ***appropriately*** target the specific needs and learning styles of their clients are more effective.

One of the drawbacks of matching is that many cases drop out as the number of matching variables increases. It is thus paramount to use a small number of relevant predictors to select candidates for the comparison group. Using ***aggregate matching***, overall distributions in the experimental and control groups are made to correspond on the criterion variables. Although *individual matching* is more precise (i.e., a "partner" for each treated client is selected from the unexposed group of offenders), individual matching is far more expensive, time-consuming, and difficult to execute for a large number of matched variables. Research has consistently indicated the priority of several static predictors: offender age, age at first arrest, number of previous convictions (property, person, or drug offenses), and prior history of drug use (Andrews et al.,

1990; Bonta, 1996; Jones, 1996). These data items were available from Pennsylvania Department of Corrections data systems (see Appendix 1).

In the interests of selecting inmates for the comparison groups to be as similar to inmates in the treatment group (e.g., therapeutic community) as possible, the eligible pool consisted of all those offenders who were eligible for participation in a Therapeutic Community (TC) treatment program. Because a shortage of space precludes intensively treating all those who were assessed with a high need for drug and alcohol treatment, a large pool of eligible offenders who were assigned to less intensive forms of treatment (e.g., outpatient treatment, drug education, or ancillary groups) was accessible. The use of matching criteria and/or statistical controls in data analyses reduced the comparison group to those who most closely resembled the treatment group.

With the assistance of DOC, we previously identified major descriptors of drug and alcohol programming at all DOC institutions, including the number of treatment slots at each institution for inmates assessed with varying levels of need (Welsh, 2000a). Seven institutions carried a full range of drug and alcohol programs including TC: Cresson (Security Level 3, pop. = 1,302), Dallas (Security Level 3, pop. = 1,695), Graterford (Security Level 4, pop. = 3,638), Houtzdale (Security Level = 3, pop. = 1,500), Huntingdon (Security Level 4, pop. = 1,668), Muncy (Female, Security Level 4, pop. = 872), and Waymart (Security Level 2, pop. = 1,218)[10]. Cresson has 52 TC beds; Dallas has 64 TC beds, Graterford has 50 TC beds, Houtzdale has 120 TC beds, Huntingdon has 36 TC beds, Muncy has 50 TC beds, and Waymart has 100 TC beds. Of these six institutions, two differed significantly from the others. The Dallas TC is privately contracted, and treatment content and structure was somewhat different from the DOC-operated programs. Muncy, one of two female institutions in the state, provides highly structured D & A programming, but targets a unique population with unique needs. Finally, research

attention to treatment process, geographical distances between institutions, and the complexity of follow up data collection favored limiting the scope of the current project to five institutions. We thus focused our evaluation efforts on TC programs at Cresson, Graterford, Houtzdale, Huntingdon, and Waymart (see Figure 1).

[10] Institutional security levels range from community (1) to maximum (5) .

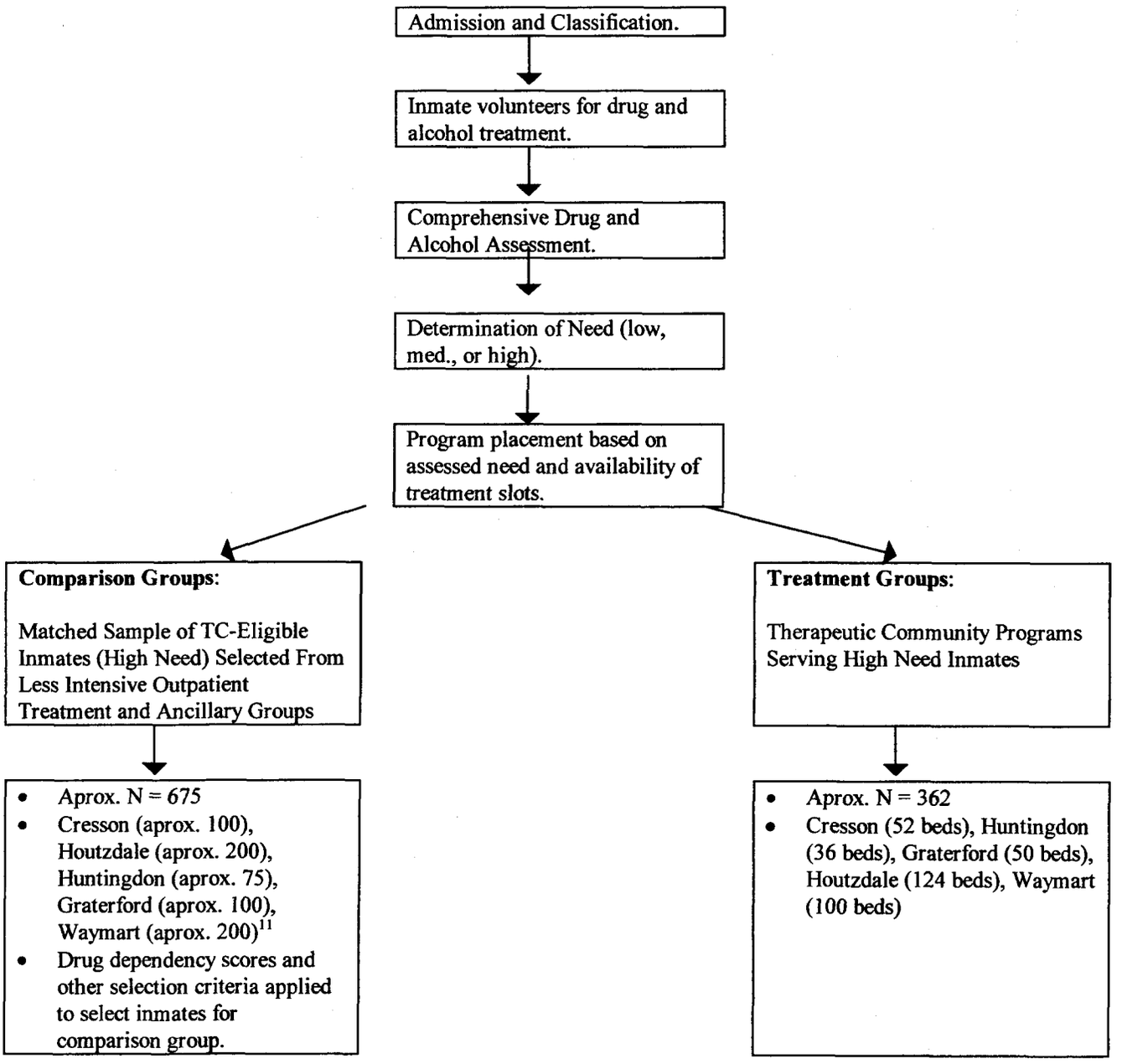

Figure 1. Framework for Research Design.

[11] Oversampling was used to select eligible inmates for comparison groups, so as to offset expected sample attrition due to program non-completion and/or transfer.

Procedures

Inmates were identified and selected for comparison and treatment groups using the criteria described above. Based on current and new admissions to TC, we aimed for a treatment sample of about 362. We included in our treatment sample all current TC residents as of January 1, 2000. We then added new subjects to the study (new admissions after January 1, 2000) as they were admitted to treatment programs. For previously admitted TC residents, we had a limited amount of time to collect institutional and intermediate measures (e.g., responses to and perceptions of treatment, psychosocial and social functioning) before any inmates graduated the program. However, we were still able to collect basic process (e.g., admission and discharge dates, inmate characteristics) and outcome data (reincarceration, rearrest and drug relapse) for this cohort, and thus maximize our sample size.

With a combined TC capacity of 362 and an anticipated attrition rate of about 20%, we expected an initial sample of about 450 TC inmates over the one-year data collection period. We expected a final sample of about 360 inmates to have completed TC treatment prior to their release from prison. Using oversampling to reduce higher anticipated attrition from less intensive Education and Outpatient programs (perhaps as high as 50%), we aimed for an initial comparison sample of about 1,350 inmates, with no less than 675 expected to complete the programs they were assigned to.

All inmates in the treatment and comparison groups had previously undergone ***initial assessment*** via the normal DOC inmate classification system. Inmates in both groups also completed the Pennsylvania Corrections Screening Instrument (PACSI), the TCU Drug Screen,

or both[12]. TC clients were asked to complete additional self-report measures (described below) that tapped psychological constructs and inmate perceptions of the treatment experience, and TC counselors were asked to complete periodic reassessments of each inmate's participation in treatment. The only other difference was that TC clients received much more intensive treatment services, while the comparison groups received much less intensive levels of treatment (which were assessed and factored into analyses as control variables) until their release.

Inmate self reports of treatment process and psychological functioning were gathered within 30 days after admission, again after 6 months, again at the end of 12 months, and again at discharge if the inmate remained in TC longer than 12 months. Counselor ratings of inmate participation in treatment were similarly gathered one month, 6 months, and 12 months following admission to treatment. After release, treatment and comparison groups were tracked over time to monitor rearrest, reincarceration, drug use, and employment.

Data Confidentiality and Human Subjects Protection

Participation in DOC drug treatment programs is voluntary, and inmates grant their written consent to DOC to participate in treatment and in legitimate research examining treatment effects. DOC follows strict guidelines regarding informed consent and confidentiality of data collected from inmates under their authority. Where additional testing of inmates was required for program evaluation purposes, principles of informed consent were closely maintained and adhered to. All research procedures were cleared with the Department of Correction's Research Review

[12] While all inmates entering Pennsylvania state prison prior to January 1, 2001 were supposed to be assessed on the PACSI at the time of their classification, valid scores were missing from the database for a number of inmates. However, all inmates participating in the research study were asked to complete the TCU Drug Screen. Because some inmates had a score on one instrument, some inmates had another, and some inmates had both scores, statistical analyses utilized only standardized z-scores rather than raw scores on these instruments.

Committee, as well as its Office of Chief Counsel. Temple researchers also received approval from their Institutional review Board (IRB). Inmates were informed that their participation in the research was voluntary, and they were asked to sign a Subject Consent Form (see Appendix 3). Researchers retain the responsibility to maintain the security and confidentiality of all information obtained from DOC inmates during all data collection and analyses. At no time was any inmate's identity associated with the reporting of any data collected for research purposes.

Dependent Variables

Measures can be broken down into institutional indicators, intermediate or "proximal" outcomes, and post release indicators (see Table 1). Institutional indicators focus upon program impacts that are internal to the prison environment. For example, the number of misconducts for inmates who participate in a given program can be compared to the number of misconducts committed by inmates who have not participated in specific programs to partially gauge the impact of the program upon inmate adjustment to the prison environment.

Intermediate or "proximal" outcomes refer to reductions in risk and criminogenic needs or values. Measures of treatment process and individual change, implemented in collaboration with DOC treatment staff and members of the Research Partnership Steering Committee, included a combination of client surveys and questionnaires, counselor ratings, and prison records (see below). Factors that may influence drug treatment outcomes include inmate demographics (age, gender, ethnicity); life history (previous drug use, employment, and criminality), psychological status (e.g., depression, anxiety, intelligence), prior drug treatment, current program fit (e.g., fit between treatment services and inmate needs), length of time in treatment, degree of engagement in treatment, and perceptions of the usefulness of treatment (Inciardi et al., 1997).

Post-release indicators focused upon program participant behavior upon release from incarceration. Major post-release indicators examined were drug use and recidivism: whether clients relapsed to drug use or not (including frequency and type of drug use), were rearrested or not, were reincarcerated or not, and amount of time elapsed before rearrest or reincarceration (survival). We were also interested in monitoring participation in employment or employment-related activities (e.g. job training) by the released offender. The Pennsylvania Board of Probation and Parole tracks paroled offenders from the time of their release from prison until their parole period has expired. Rearrest data were accessible through State criminal records, maintained by the Pennsylvania State Police.[13]

[13] The Pennsylvania Commission on Crime and Delinquency (PCCD) provides access to rearrest data and dispositions.

Table 1

Summary of Measures and Sources of Data

Measures	Source Of Data
Inmate Background Factors	
Offenders' employment, family relations, cognitive skills, attitudes toward drug use and criminality, and antisocial values.	• Pennsylvania Additive Classification System (PACT) • Pennsylvania Department of Corrections Screening Instrument (PACSI) • TCU Drug Screen
Demographics (age, ethnicity); life history (previous drug use, employment, and criminality), psychological status (e.g., depression, anxiety, intelligence), prior drug treatment (number and type of admissions).	• Pennsylvania Additive Classification System (PACT) • Pennsylvania Department of Corrections Screening Instrument (PACSI) • TCU Drug Screen
Assessed need for AOD treatment.	• Pennsylvania Department of Corrections Screening Instrument (PACSI) • TCU Drug Screen
Institutional Indicators: Impacts Internal To The Prison Environment	
Misconducts (number and type)	• DOC Misconduct Database
Levels Of Program Participation	• Research and Program Records • TCU Resident Evaluation of Self and Treatment (REST) forms
Drug Abuse Violations in Prison	• DOC Misconduct Database • Random Inmate Selection Process (RISP) for Drug Testing
Intermediate Or "Proximal" Outcomes: Reductions In Risk For Drug Use And Criminal Behavior	
Treatment Process (e.g., length of time in treatment, degree of involvement in treatment)	• Research and Program Records • TCU Counselor Rating of Client (CRC) forms • TCU Resident Evaluation of Self and Treatment (REST) forms
Inmate ratings of treatment program features, participation in therapeutic groups, counselor attitudes and behavior, resident attitudes and behavior, counseling sessions, and motivation for treatment.	• TCU Resident Evaluation of Self and Treatment (REST) forms
Psychosocial Functioning (self-esteem, depression, anxiety, decision-making) and Social Functioning (e.g., hostility, risk-taking, and social conformity).	• TCU Resident Evaluation of Self and Treatment (REST) forms
Post Release Indicators: Inmate Behavior Upon Release From Prison	
Relapse to Drug Use (type of drug, frequency of use)	• PA Board of Probation and Parole (incl. drug tests)
Rearrest or Warrant Issued (number and type of offenses; survival rate)	• PA State Police Records provided by Pennsylvania Commission on Crime and Delinquency (PCCD)
Reincarceration (number and type of offenses; survival rate)	• DOC Inmate Records System
Parole Violation or Revocation	• PA Board of Probation and Parole
Post-Release Employment Status (e.g., full-time, part-time, unemployed and able to work, unemployed and unable to work)	• PA Board of Probation and Parole

Independent Variables

One excellent instrument designed to assess inmate perceptions of the treatment process is the TCU *Resident Evaluation of Self and Treatment* (REST) (Knight et al., 1997; Simpson, 1994). The TCU REST includes inmate ratings of perceptions of drug-related problems and psychological functioning, treatment program features, participation in therapeutic groups, counselor attitudes and behavior, resident attitudes and behavior, and counseling sessions (both group and individual). The TCU ***Psychosocial Functioning*** scales include standardized measures of psychological adjustment (e.g., self-esteem, depression, anxiety, decision-making) and social functioning (e.g. childhood problems, hostility, risk-taking, and social conformity). Items also include measures of the inmate's motivation to seek treatment (e.g., *treatment readiness*), another variable that has been found to influence treatment outcome (Broome, Knight, Knight, Hiller and Simpson, 1997; Czuchry, Dansereau, Sia, and Simpson, 1998). All scales have evidenced good reliability and have been validated upon inmate treatment populations (Simpson and Knight, 1998). We briefly summarize the TCU instruments and subscales here.

TCU Drug Screen

The TCU Drug Screen, created by researchers at Texas Christian University, is a screening tool used to determine the overall level of drug use and dependency of an individual (see Appendix 4). The items in this screening tool represent key clinical and diagnostic criteria for substance dependency as they appear in the DSM and NIMH Diagnostic Interview Schedule. This instrument has shown good validity and reliability in numerous studies of correctional populations (see Broome, Knight, Joe and Simpson, 1996; Shearer and Carter, 1999; Simpson, Knight, and Broome, 1997).

The TCU Drug Screen focuses on daily functioning and the frequency of drug use by inmates prior to incarceration. The instrument includes questions about the use of specific drugs, including the major categories of drugs and alcohol. It asks probing questions concerning problems relating to drug use, including the physical illness that the inmate goes through, psychological issues that the inmate is forced to deal with because of drug use, and the consequences of drug use (e.g., adverse effects on friends, family, and employment).

The inmate's score on the drug screen (0 to 9) helps determine the inmate's level of need for treatment. According to scoring criteria for the TCU Drug Screen, score values of 3 or greater indicate relatively severe drug-related problems, and correspond approximately to DSM drug dependence diagnosis. Once an inmate reaches his home institution, treatment counselors generally complete a more in-depth assessment of treatment needs, including clinical and diagnostic interviews.

The TCU Drug Screen was first created in 1993, growing out of a larger screening instrument called the Brief Background Assessment (BBA). In a study of probationers admitted to the Community Restitution and Treatment Center (CRTC) in Fort Worth, Texas, Broome, Knight, Joe, and Simpson (1996) investigated the degree of agreement between interview-administered and self-administered assessments of the BBA. A high agreement was found between the two distinct administration methods (Simpson et al., 1997).

Peters, Greenbaum, Steinberg, Carter, Ortiz, Fry and Valle (2000) examined the effectiveness of several screening instruments including the TCU Drug Screen and the Addiction Severity Index (ASI) in detecting substance abuse disorders among prisoners. The study included a sample of 400 male inmates admitted to the Holliday Transfer Facility in Florida. This reception facility was designed to provide an initial assessment of inmates during their first 14-60 days in the

state prison system. The test-retest reliability was reported as a Pearson product-moment correlation coefficient, which has a range of –1 to 1. The TCU Drug Screen fared extremely well on this measure, obtaining a test-retest reliability of .95.

Screening instruments were also examined for their utility in identifying alcohol or drug dependence disorders, using the DSM-IV Structured Clinical Interview as a criterion (Peters et al., 2000). The TCU Drug Screen had a high overall accuracy in detecting drug or alcohol dependence (82.1% agreement with the Structured Clinical Interview for DSM-IV). The instrument resulted in relatively few "inappropriate" referrals (the positive predictive value was 83.5%). Sensitivity, which refers to the proportion of dependent participants who were correctly identified by the TCU-DS as dependent, was assessed at 84.9% (Peters et al., 2000). Based on its positive predictive value, sensitivity, and accuracy, the TCU Drug Screen was found to be among the most effective instruments for identifying substance abuse and dependence disorders in an inmate population (Peters et al., 2000).

Resident Evaluation of Self and Treatment (REST)

Researchers at Texas Christian University also created the Resident Evaluation of Self and Treatment (REST) form (Appendix 5). The REST contains a series of questions asking about the inmate's perceptions of his drug-related problems, psychological functioning, and treatment process, including perceptions of program structure, participation in therapeutic groups, counselor attitudes and behavior, and counseling sessions (Knight, Simpson, Chatham and Camacho, 1997:81). The REST allows researchers to pose myriad questions about an inmate's responses to treatment and it allows researchers to observe changes over time (i.e., "dynamic" risk factors).

The REST consists of 111 questions organized into 18 subscales. Item response categories are based on a Likert scale that ranges from 1 ("Strongly Disagree") to 7 ("Strongly Agree"). The first set of REST subscales of interest in this study deal with *psychological functioning*, including measures of self-esteem, depression, anxiety, and self-efficacy.

Research on addiction has indicated that psychopathology frequently coexists with drug abuse (Woody, McLellan, Luborsky, and O'Brien, 1990). Feelings of loneliness, sadness, intense pressure from the outside world, and feelings of inadequacy are among the psychological states linked to drug-abusing individuals. Knight, Holcolm, and Simpson (1994:2) have applied the Health Belief Model (Rosenstock, 1966) to drug treatment, arguing that "an individual's level of psychological and social functioning directly influences the perceived threat of drug abuse and subsequent steps taken to prevent it or treat it." Therefore, an important component of drug treatment is to first assess the inmate's psychosocial functioning and address any needs identified.

Self Esteem. Self-esteem has been positively related to drug treatment outcomes. For example, Berry and Sipps (1991) found that clients with low self-esteem tend to spend less time in drug treatment programs and are less likely to successfully complete treatment. Prior research has shown the self-esteem scale to have high alpha reliability coefficients (see Simpson, 1991; Simpson, Knight, and Ray, 1993).

Depression. The second scale is a measure of *depression*. Untreated depression can have negative effects on treatment. A depressed individual may commit acts that, although risky and disruptive, help pull them out of their depression (Malow, Corrigan, Pena, Calkins, and Bannister, 1992). The depression scale has consistently displayed high alpha coefficient reliabilities (Simpson, 1991, Simpson et al., 1993). Simpson (1991) reported a test-retest reliability coefficient of .86. Evidence of validity of the depression subscale of the REST comes from its

high correlation with the Beck Depression Inventory (Simpson et al., 1992). The Beck Depression Inventory (BDI) is a 21-item self-report instrument designed to determine the relative depression of an individual (Beck and Steer, 1987). Overall, this instrument offers coefficient alphas typically above .80 (Hiller, 1996).

Anxiety. A third scale measures the *anxiety* of the inmate. Malow et al. (1992) found that higher levels of anxiety were significantly related to higher levels of drug use and that higher levels of anxiety contributed to riskier health-related behavior. Prior research has shown acceptable alpha reliability coefficients (see Simpson, 1991; Simpson et al., 1993), and Simpson (1991) found a test-retest reliability of .84 for the anxiety scale using a sample of substance abusers on probation.

Self Efficacy. The *self-efficacy* scale is taken from the Pearlin Mastery Scale (Pearlin and Schooler, 1978). This scale was created in a study looking at the structure of coping mechanisms that people use to cope with various life strains. Using scheduled interviews with approximately 2300 people aged 18-65, Pearlin and Schooler (1978) designed a questionnaire that focused on potential life strains, conflicts, frustrations, and threats, as well as coping responses. Life strains may include issues related to marriage, parenting, financial strain, and occupational stressors. The goal of the researchers was to identify coping resources available to each interviewee, including social resources (interpersonal networks) and psychological resources (personality characteristics such as self-esteem, self-denigration, and mastery). Individuals generally have three types of coping strategies, including responses that change the situation; responses that control the meaning of the experience before the emergence of stress; and responses that function to control stress after its onset (Pearlin and Schooler, 1978).

The second set of subscales included on the REST deal with the *social functioning* of the inmate, including hostility, risk taking, and poor socialization. The need for this subset of scales has been established by previous research (Chien, 1980; Powell and Taylor, 1992; Simpson and Joe, 1993a). According to Knight et al. (1994), the original scale construction relied on the DSM-III classification system.

Hostility. *Hostility* refers to aggression that an inmate feels toward others. Questions ask about urges to fight, getting mad, carrying weapons, and feelings of mistreatment at the hands of others. Chien (1980) found that high levels of hostility are often present in individuals that have a history of drug abuse. The hostility subscale has shown high reliabilities across a number of studies (Knight et al., 1994), with coefficient alphas typically exceeding .75 (Simpson and Joe, 1993a). In a study of probationers, a test-retest reliability of .88 was found (Simpson, 1991).

Risk Taking. A second social functioning scale focuses on the *risk taking* attributes of the inmate. Questions concern the chances the inmate has taken in life, the dangerousness of his actions, and the excitement he perceives from committing certain acts. Studies strongly support the notion that drug and alcohol abusers tend to be great risk takers (Chien, 1980, Murray and Singer, 1988). Risk taking is negatively correlated with self-esteem and social conformity (Simpson and Joe, 1993, Simpson et al. 1992). As with other REST scales, prior research has reported high alpha reliability coefficients (Simpson et al., 1992) and high test-retest reliabilities (Simpson, 1991).

Social Conformity. Questions in this scale pursue the inmate's feelings about honesty, rules and laws, friendships, job longevity, religion, and family importance. Chien (1980) argues that addicts have a deep mistrust of others, and that they tend to approach interpersonal relationships according to what personal rewards they are able to extract from their affiliations.

The social conformity scale has displayed adequate alpha reliability coefficients, typically around .65 or higher (Simpson and Joe, 1993a).

Treatment Readiness. The REST also includes the treatment readiness scale taken from the TCU Treatment Motivation Assessment (Joe, Knezek, Watson, & Simpson, 1991; Simpson and Joe, 1993b). The treatment readiness scale asks questions regarding an inmate's perceptions that treatment could help, or whether treatment would be too demanding for them to complete. Hiller et al. (in press) reported an alpha coefficient of .72 for the treatment readiness scale.

Overall, the motivation of the offender to seek treatment can be a critical factor. Resistance to treatment, and the use of defense mechanisms, provides key obstacles to realizing the full potential of drug treatment (Miller, 1985). Simpson (1997) states that the first stage of treatment readiness involves recognition and acknowledgement by individuals that they are having problems caused by their drug use, particularly in terms of their legal, health, and psychosocial functioning. The second stage of treatment readiness reflects an expressed need for obtaining help, and the third addresses specific commitments to drug treatment services.

External Pressures. External pressures refer to the legal and social pressures felt by the inmate to take part in drug treatment. Items ask about an inmate's perceptions that a recurrence of drug use could cause imprisonment, legal stipulations that might require the inmate to be in treatment, whether urine monitoring forces the individual to get clean or remain in prison for a full prison term, and the desire for early release (i.e., parole). Other pressures to seek, receive or remain in treatment may include pressure from family members or other intimates. This measure is similar to a scale created by Anglin and colleagues (Anglin et al., 1989; Anglin & Hser, 1990; Brecht, Anglin, and Wang, 1993) and later replicated by Hiller et al. (1998).

Therapeutic Engagement. This scale measures the degree to which an inmate is actively involved with and participating in the treatment process. Items assess how an inmate feels and shows concern for others during counseling, ability to confront others in their treatment group about their true feelings, willingness to share feelings, ability to give support and understanding to others, and desire to offer honest feedback to others. The engagement of the individual is recognizable by looking at patient behaviors, including attendance in treatment programs and individual counseling sessions, as well as perceptual measures.

Counselor Rapport. This scale examines the extent to which the inmate feels that counselors support him in the drug treatment program. Items ask about how easy counselors are to talk to, the degree to which counselors respect the inmates, the understanding the counselors have for inmates, and the help offered to the inmates by the counselors.

Counselor Competence. Counselor competence is defined as how qualified or skilled the inmate feels the treatment counselors of the therapeutic community are. Items ask about the level of counselor preparation and organization, how well developed their treatment plans are, the counselor's abilities to teach useful ways to solve problems, and the degree to which inmates feel motivated and encouraged by their counselors.

Program Structure. This scale assesses the degree to which the inmate perceives that TC meetings and activities are well organized, whether the rules are fair and appropriate, whether meetings are productive, and the fairness and appropriateness of work assignments. The goal is to allow the inmate to describe what methods or portions of the program aid in his treatment, and which, if any, portions of the program hinder his progress.

Peer Support. Strong therapeutic relationships, with both peers and counselors, predict lower levels of during-treatment drug use, which in turn lead to longer retention in treatment

(Simpson, 1997). Items assess the extent to which an inmate feels part of a family or community, whether other clients care about the inmate and his problems, and whether other clients are helpful. This variable forms the very cornerstone of the TC philosophy (DeLeon, 2000).

Counselor Rating of Client (CRC)

An additional set of perceptions critical to assessing treatment progress and process is that of the counselors themselves. In addition to running various treatment groups and classes, the counselors on a TC unit are often assigned to work with a certain number of inmates on a one-to-one basis. The expectation is that a close relationship can be formed with the counselor, forming a bond that will help lead to successful recovery.

The CRC instrument (see Appendix 6) asks counselors to rate various client attributes on a set of adjectives (e.g., honest, sincere) using a Likert scale ranging from 1 ("Strongly Disagree") to 7 ("Strongly Agree"). Counselors are also asked to indicate the extent to which counseling activities with each client are focused on specific activities pertinent to recovery, including relapse situations and triggers (Hiller, Knight, Rao, and Simpson, 2000:16).

Hiller, Knight, Rao and Simpson (2000) conducted a factor analysis to determine major themes of the CRC. Through the use of exploratory factor analysis, four clearly identifiable factors had Eigenvalues greater than 1. The first factor was identified as *treatment engagement* (coefficient alpha = .89), composed of eight items describing an inmate's individual involvement in treatment. Counselors strongly agreed to statements such as the inmate "participates in group discussions", pays attention", and "clearly expresses thoughts and feelings" (Hiller et al., 2000:16). The second scale was labeled *rapport with others* (coefficient alpha = .86). This scale was comprised of seven attributes, with counselors strongly agreeing that the inmate is "easy to talk to", "warm and caring", liked by other inmates", and "liked by staff" (Hiller et al., 2000:16).

A third scale dealt with the level of *denial* perceived by the counselor (coefficient alpha = .79). This scale included items dealing with an inmate's unwillingness to believe that he needs help or admit that he has a drug and/or alcohol problem. In particular, counselors strongly agreed with statements that the inmate is "in denial", "unmotivated to recover", and "manipulative" (Hiller et al., 2000:16). Finally, *psychological problems* (coefficient alpha = .71) constituted the last scale, based on the counselor's judgments about an inmate's mental state. Statements that counselors strongly agreed with were those that dealt with the inmate being "hostile or aggressive", "depressed", impulsive", "nervous", "anxious", and "easily distracted" (Hiller et al., 2000:16).

Factor analyses also identified four main content themes addressed by counselors during sessions with their clients, defined by Hiller et al (2000) as *counselor foci*. The first of these scales was *self-confrontation* (coefficient alpha = .87), addressing topics concerning the acceptance of responsibility, inmate reduction of denial, and inmate improvement of objectivity. The second scale was defined as *life skills development* (coefficient alpha = .89), which includes the improvement of communication skills, development of coping mechanisms and strategies to avoid recurrence of drug and/or alcohol use, and the ability to make new friends. *Family* was the third major counseling dimension identified (coefficient alpha = .85), which deals with trust, rapport, the exploration of feelings, specifying short-term goals and objectives, and improving family relations (Hiller et al., 2000:17). A fourth dimension, labeled *financial management*, concentrated on managing finances, job opportunities, occupational issues, and the definition of long-range goals (coefficient alpha = .89).

Sample Characteristics

For each inmate admitted to an AOD treatment program during the study period, we collected the treatment start date, the discharge date, and the treatment outcome. Between January 1 and November 30, 2000, we collected on a monthly basis data on all inmates admitted to or discharged from alcohol or drug treatment programs at each of the five institutions. We continued monthly tracking throughout the study to determine treatment outcomes (e.g., successful v. unsuccessful).

With the aid of standardized forms designed for this project, and regular communication (including on-site visits to each institution), we were able to collect admission and discharge data from each institution consistently on a monthly basis. We continuously inventoried all admission and discharge data for veracity and completeness. For example, we regularly created lists of inmates with missing discharge data. Lists were compiled based upon expected discharge dates, determined from program cycles at each institution. Each institution was asked to look up appropriate discharge dates and/or reason for discharge (e.g., successful v. unsuccessful). We also continuously prepared queries for each institution, where we posed specific questions regarding duplications in admissions and discharges, any unusual data patterns (e.g., discrepancies in reported start or end dates for specific programs), and missing discharge data.

As of November 30, 2000 (the cut-off date for adding new admissions to our sample), we had recorded 4,529 drug treatment *admissions* in our database. Table 2 shows the number of inmates with multiple admissions. Multiple admissions could occur through several mechanisms. For example, one inmate's first admission was into an Education program, his second and third admissions were into different Outpatient programs (a group counseling program, for instance,

and a relapse prevention program). In other cases, an inmate may have multiple admissions because he was unsuccessfully terminated one or more times from the same program and readmitted one or more times.

We were able to account for each treatment outcome separately, and we were able to account for an inmate's total treatment exposure based on the length of time he spent in each program (number of weeks) multiplied by the program's intensity (number of hours per week). The inmate's first admission determines his primary treatment status in this study, that is, his assignment to the treatment (TC) or comparison (Education or Outpatient) group.[14]

Table 2
Admissions to AOD Programs at Five Prisons, Jan. 1 – Nov. 30, 2000

Number of Admissions to AOD Programs	Education	Outpatient	TC	Alumni	Total
First admission	1131	898	742	120	2891
Second admission	322	619	90	42	1073
Third admission	90	261	26	8	385
Fourth admission	37	90	8	0	135
Fifth admission	12	19	3	0	34
Sixth admission	4	7	0	0	11
Total Admissions	**1596**	**1894**	**869**	**170**	**4529**

Because the same inmate may have been admitted into more than one program (e.g., education, outpatient, TC, and alumni) during the study period, the actual number of *inmates* is less than the total number of *admissions*. We break down the sample into the total number of inmates admitted into AOD programs by institution and program type (Table 3). A total of 2,891

[14] If an inmate was admitted to a TC program on a second or subsequent program admission, he was assigned to the TC group. Like other inmates in the sample, these inmates received credit for

inmates participated in AOD programs at the five institutions between January 1 and November 30 of 2000.[15] Of these, 742 (26%) were TC inmates. This subsample constituted the experimental group.[16] Many more inmates entered the less intensive Education (39%) and Outpatient (31%) programs. These inmates formed the total eligible comparison pool (i.e., prior to matching or use of statistical controls).

Table 3
Number of Inmates Participating in AOD Programs at Five Prisons, Jan. 1 - Nov. 30, 2000

	Education	Outpatient	TC	Alumni	Total
Cresson	297	327	77	--	701
Graterford	190	141	120	--	451
Houtzdale	293	308	256	57	914
Huntingdon	293	23	74	42	432
Waymart	58	99	215	21	393
Total Inmates	1131	898	742	120	2891

Note. The "Alumni" category consists of successful TC graduates who have been returned to general population. While not strictly part of our study, we were able to track these inmates on the post-release outcome measures (drug relapse and recidivism).

As noted previously, only a subset of inmates successfully *completed* their AOD programs. The breakdown of program discharges is shown in Table 4. Out of 2,891 inmates examined during the study period (Jan. 1 – Nov. 20, 2000), 2,858 (99%) had completed their

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their prior treatment experience in Education or Outpatient programs (i.e., total treatment exposure).

[15] Included in the total sample (n = 2,891) were all inmates *currently* enrolled in AOD programs as of the study start date of January 1, 2000 (n = 822). A greater portion (n = 2,069) was admitted *on or after* January 1, 2000. Comprehensive data, including inmate self-reports (collected at six-month time intervals) and outcome measures, were thus unavailable for some inmates enrolled but admitted prior to the study start date.

[16] Recall that the Alumni group consisted of inmates that already successfully completed a TC program and returned to general population. In some analyses, therefore, it is possible to add these inmates to the experimental group.

treatment programs as of March 1, 2002. The failure rates for different program types were similar, ranging from 25% (TC) to 30% (Outpatient). [17]

Table 4
Number and Type of Treatment Program Discharges from AOD Programs at Five Prisons

	Education	Outpatient	TC	Alumni	Total
Successful	815 (72%)	448 (52%)	470 (64%)	36 (30%)	1769 (62%)
Unsuccessful	308 (27%)	263 (30%)	185 (25%)	33 (28%)	789 (28%)
Direct Parole	5 (0%)	115 (13%)	72 (10%)	39 (33%)	231 (8%)
Other	3 (0%)	44 (5%)	11 (1%)	11 (9%)	69 (2%)
Total	1131 (100%)	870 100%)	738 (100%)	119 (100%)	2858 (100%)

Note. *"Other"* includes programmatic discharges beyond the control of the inmate, including institutional transfer, writ or court order, medical discharge, etc. "*Direct Parole*" indicates inmates who received parole as the reason for their *treatment program discharge*. In other words, such inmates were paroled *directly* from their treatment program. These figures are unrelated to the number of inmates who may eventually apply for (or receive) parole at a later date following completion of their substance abuse programs.

As expected, the experimental and comparison groups differed considerably on total treatment exposure (Table 5). Treatment exposure was calculated for each inmate in the sample by multiplying the number of weeks he spent in each treatment program by the program's intensity (number of hours of treatment programming per week). TC inmates in general had more than 10 times as much total treatment exposure as inmates in the Education or Outpatient groups, thus providing a strong rationale for the formation of comparison groups. Total treatment exposure can also be entered as a control variable in multivariate analyses, although care needs to be exercised since program type is highly associated with treatment exposure.

[17] As noted earlier, successful and unsuccessful discharges were analyzed separately in outcome analyses in order to help address shortcomings of previous evaluation studies.

Table 5

Treatment Exposure: Total Number of Hours by Program Type

	Education	Outpatient	TC	Alumni	Total
N	1080	826	723	118	2747
Mean	32.0	79.2	836.6	51.1	258.8
Std. Deviation	57.8	138.1	545.7	52.9	452.9
Std. Error	1.8	4.8	20.3	4.9	8.6
95% Confidence Interval for Mean					
Lower Bound	28.6	69.8	796.8	41.4	241.8
Upper Bound	35.5	88.6	876.4	60.7	275.7

The sample can also be described in terms of several important risk factors (e.g., prior and current offense history, assessed level of need for drug treatment, age) and program selection criteria (e.g., time remaining to minimum release date). Table 6 provides descriptive information for inmates in the four program types.

Age at time of admission was calculated by subtracting the inmate's birth date from the date of program admission. DOC supplied time remaining to minimum release date, a primary program selection criterion, as part of monthly data runs on all program admissions. Likewise, DOC, based on the Pennsylvania Sentencing Commission Guidelines, supplied current and prior offense gravity scores. Standardized drug scores, as noted earlier, were calculated based on the inmate's TCU Drug Screen score, if available, or the inmate's PACSI score, if the TCU was not available. Because the TCU is a 0-9 scale, and the PACSI (the former DOC drug screening instrument prior to Jan. 1, 2001) is a 0-10 scale, scores were transformed into standardized z-scores and saved for analyses. Using one-way ANOVA, means were compared for each of the program descriptors shown in Table 6.

Table 6
Sample Characteristics by Program Type

	Education		Outpatient		TC		Alumni		
	Valid N	Mean (s.d.)	Valid N	Mean (s.d.)	Valid N	Mean (s.d.)	Valid N	Mean (s.d.)	
Age at time of admission	1130	34.9 (9.4)	894	35.5 (8.8)	742	35.6 (9.1)	120	36.9 (7.9)	n.s.
Time to minimum (months)	1109	2.5 (107.8)	890	-2.5 (101.0)	739	8.9 (76.8)	118	-5.6 (42.9)	n.s
Current Offense Severity (0-10)	1116	5.1 (3.0)	885	5.1 (2.7)	733	5.5 (2.5)	116	5.4 (3.2)	*
Prior Offense Severity (0-10)	1116	4.6 (3.1)	885	4.8 (2.8)	733	4.8 (2.7)	116	4.2 (3.2)	*
Standardized Drug Score (Z)	909	-.39 (1.0)	670	-.08 (.98)	722	.34 (.88)	78	.36 (.70)	*
TCU Drug Screen Score (0-9)	508	3.5 (2.9)	315	4.2 (2.9)	564	5.6 (2.7)	17	5.8 (2.7)	*
PACSI Drug Score (0-10)	745	6.6 (3.2)	573	7.7 (2.6)	653	8.5 (1.9)	69	8.6 (1.7)	*
Total treatment exposure	1080	32.0 (57.8)	826	79.2 (138.1)	723	836.6 (545.7)	118	51.1 (52.9)	*

* $p < .05$

Inmates in the four program types did not differ significantly in age at the time of program admission, or in the number of months remaining in their minimum sentences at the time of program admission. However, significant variability was observed in time remaining to minimum release date. Many inmates, particularly those in the Outpatient and Alumni groups, were already well past their minimum release date, suggesting that many had already been denied parole at least once.[18]

TC and Alumni inmates were likely to have more serious current offense histories, suggesting that higher risk inmates were targeted for TC placement. However, both TC and Outpatient inmates tended to have more serious prior offense histories. Relatively high prior offense severity scores for Outpatient inmates may partially explain why so many of them have seen their minimum release dates come and go. The Parole Board would certainly consider both prior and current offense histories in considering parole applications.

The four groups also differed significantly on need for treatment, regardless of which of three criteria were examined (TCU Drug Screen score, PACSI score, or standardized Z score on either instrument). In each case, TC and Alumni inmates had slightly higher mean drug scores, suggesting appropriate program placement into TC. However, Table 6 also revealed clearly that most inmates in the sample, even those placed in low-intensity Education and Outpatient programs, met and surpassed the minimum eligibility criteria for TC placement (i.e., a minimum TCU Drug Screen score of 3, or a minimum PACSI score of 5).

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[18] Data inspections conducted by DOC personnel also suggested that some inmates in our sample simply "rolled over" from one sentence to another (e.g., consecutive sentences for different convictions). As a result, they may have been assigned a new inmate number, but their old minimum release date remained attached to their old inmate number in the DOC database. In some cases we were able to make corrections based upon individual database searches.

While appropriate statistical controls and/or matching are required to adjust for these initial selection differences,[19] results shown in Table 6 clearly indicate that the majority of inmates in the sample, regardless of program type, were classified as high-need. We thus have a fortunate situation in terms of research design (i.e., many high-need inmates are present in programs of dramatically different treatment dosages), but an unfortunate one in terms of responsivity (i.e., there are simply not enough TC beds to assign all high-need inmates to high-intensity treatment programs, with the result that many inmates must receive some form of less intensive treatment).

Analytic Approach

Following previous efforts established through this research partnership, two comprehensive databases were assembled: one inmate-specific, the other program-specific (Welsh, 2000a, 2000b). These databases guided post-release inmate tracking and analyses of relationships between treatment process and outcomes. We were thus able to track an inmate before, during, and after treatment, and we were able to factor into our analyses individual inmate characteristics as well as programmatic variations (e.g., treatment intensity and duration) that could influence treatment outcomes. This approach should help advance our ability to separate individual from contextual (programmatic) factors that influence treatment.

Analyses of outcome employed several techniques including multivariate analysis of variance, logistic regression and survival analyses. For example, we examined various within-subject changes over time (e.g., improvement in psychological functioning, changes in inmate participation in treatment), as well as between-subjects factors (e.g., programmatic features) that may influence treatment process and outcomes. Logistic regression was useful for examining

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[19] Criminal history and level of substance abuse problem often drive observed outcomes for this population (Andrews et al., 1990; Bonta, 1996; Farabee et al., 1999; Fletcher and Tims, 1992;

dichotomous outcomes such as reincarceration, rearrest, and drug relapse. Logistic regression also allows the researcher to enter various categorical (e.g., specific treatment program inmate was in) or continuous variables (e.g., level of motivation) into models as covariates.

Finally, survival analysis allows the researcher to examine outcomes such as recidivism in richer detail. Instead of a dichotomous outcome, recidivism is conceptualized as dynamic behavior that occurs along a continuum of time. It requires consideration of how much time has elapsed between release from prison and specific behavioral outcomes such as drug relapse or rearrest for parole violation or a new offense. We are thus concerned not only with examination of inmate and programmatic variables that predict who is left standing at the end of 1-3 years, but variables that influence early v. later relapse over time. This consideration is important in examining outcomes related to drug abuse, since multiple relapses almost inevitably precede any long-term recovery, especially for seriously addicted inmates. Survival analysis and Cox regression techniques allow researchers to add precision to predicting critical outcomes such as drug relapse and recidivism. Cox regression allows for entry as independent variables both categorical and continuous variables, and both individual as well as programmatic variables.

Jones, 1996; ONDCP, 1996, 1999; Pearson and Lipton, 1999).

IV. RESULTS

Process Evaluation Findings

Our sample of TC programs at five different prisons enabled comparisons of implementation differences across sites. Programmatic differences (e.g., duration, intensity, structure) may influence treatment process (e.g., treatment engagement) as well as outcomes (relapse and recidivism).

Sources of data included the following: (1) written program descriptions prepared for each of the five TC programs (see Appendix 7), (2) inmate interviews conducted with 53 TC inmates at the five prisons, (3) results from a previous Survey of Drug and Alcohol Programs (Welsh, 2000a), (4) inmate ratings of treatment process (i.e., several scales from the REST), and (5) program records collected by researchers, including monthly admission and discharge information, program mission statements, inmate handbooks, and operational manuals.

Several major TC program descriptors are summarized in Table 7. First, the five TC units varied in terms of size. Two units had 100 or more beds. Large units make it more difficult to properly implement the TC philosophy, which depends upon positive peer interactions and close staff supervision. At Waymart, the TC is subdivided into two separate units, one upstairs and one downstairs. The two units have separate TC meetings, although they share some of the same treatment groups and the same treatment staff. Houtzdale, on the other hand, has the difficult task of monitoring and supervising complex interactions between 124 inmates who all live on the same unit. The potential for "chaos," as several inmates told us, is high. Morning meetings are held in the cavernous central area of the unit, where hearing (and participation) is difficult. Such factors are discussed in detail elsewhere and will not be repeated here (Welsh, 2000b).

We also observed staffing ratios (inmates per counselor) that ranged from 9:1 to 26:1. Although definitive clinical standards for prison-based TC have not yet emerged, and existing guidelines are voluntary (ONDCP, 1999), experts often recommend a maximum of 15 clients per counselor (DeLeon, 2000).

DOC has largely standardized the content, structure and duration of its AOD treatment programs, and they have done so in large measure directly in response to our previous recommendations (Welsh, 2000a, 2000b; Welsh and Zajac, 2001; Welsh et al., 2001). However, at the time that inmate admission data was collected for our outcome study in 2000, TC programs still evidenced slight variability in terms of duration and intensity. Based upon inspection of program documents, TC schedules, and interviews with the DATS supervisor at each institution, we estimated that 3 TC programs offered approximately 15 hours per week of actual treatment (individual or group counseling, or phase classes run by treatment staff). Two of the TC programs (Huntingdon and Graterford) offered weekly programming of 30 hours or more per week. Only one (Graterford) met the guideline of running 7 days a week (ONDCP, 1999; DeLeon, 2000), although inmates on that unit appeared exhausted at times. One program lasted as little as 36 weeks; another lasted nearly twice as long. While more research into the effects of TC of varying durations and intensity levels is needed (DeLeon, 2000), such differences in treatment exposure may influence observed outcomes. Of course, outcomes also depend on the quality of treatment, not just the quantity (Pearson and Lipton, 1999).

All TC programs offered what they called a "holistic" approach, although one explicitly stated in its mission statement that the 12-step approach was its major framework. According to DOC, the department's overall approach to alcohol or other drug (AOD) programs is informed by a holistic health model that treats substance abuse as a complex problem with physiological,

psychological, emotional, behavioral, spiritual, environmental and sociopolitical dimensions (Pennsylvania Department of Corrections, 2001).

Differences in termination rates were also observed across TC programs. Although the attrition rate overall was about 25%, one program (Waymart) rarely terminated anyone, and another (Graterford) terminated more than two-thirds of its clients. Arguments about program failure rates can go two ways. For example, an intensive supervision probation program that closely monitors clients, enforces the rules vigorously, and demands accountability is likely to have a higher attrition rate (Petersilia and Turner, 1993). Arguably, good programs may have high attrition rates because clients are held accountable. However, another argument could be made that a TC program should attempt to correct the behavior that led to the violation and enlist peer support to encourage the inmate to take responsibility for his/her behavior. Under this premise, programs would rarely bounce out misbehaving inmates, except when a "cardinal rule" (e.g., no physical violence against other TC residents, no sexual relations) has been broken. Data collected through inmate interviews and self-report surveys, however, suggested that a low threshold existed for successfully completing the Waymart program. We did not find evidence for strict rule enforcement or intensive corrective measures as causes for low attrition at Waymart.

Next we observed differences in characteristics of inmates admitted to the five programs (Table 8). Both Houtzdale and Waymart tended to recruit older inmates, who tend to be better behaved and pose lower risks for misbehavior and recidivism. The other units recruited inmates in their early thirties. We found wide variability in time remaining until minimum sentence. The average time remaining at Houtzdale was negative, indicating several possibilities (which are not mutually exclusive). For example, many inmates have already seen their minimum release date come and go, many have already been turned down for parole, many are uninterested in treatment

until they are mandated to go, some minimum release dates in the DOC database are incorrect or outdated (e.g., if an inmate completed one sentence but then began a new one without ever being released), some inmates may have been released on parole and returned for technical violations, without having a new minimum release date set. Our recidivism data suggest the latter explanation. As a result, the minimum release date of record is not necessarily a reliable indicator of TC eligibility, in spite of written policies specifying its use.

We also found significant differences in prior and current offense severity (Table 8). Waymart recruited somewhat lower risk inmates than the other programs.[20] Huntingdon admitted the highest risk inmates. Assessed level of need for treatment was high, regardless of which instrument was examined (PACSI or TCU Drug Screen). TCU Drug Screen results, however, suggested that Huntingdon, Graterford and Cresson recruited the highest need inmates.

We then examined program duration for both graduates and failures (i.e., early terminations). Cresson had the highest mean duration for program graduates at 85.7 weeks. The other institutions were in between (52 – 59 weeks), with the exception of Waymart, which had a mean duration of 42 weeks for successful program graduates. The five TC programs did not differ significantly on program duration for failures, although all five programs took a long time to make a decision about termination. At Cresson, the average amount of time spent in the TC prior to being terminated was 32 weeks.

[20] Waymart is a Level 2 security classification; Cresson and Houtzdale are Level 3 facilities; Graterford and Huntingdon are Level 4 facilities.

Table 7
TC Program Descriptors

	Cresson	Graterford	Houtzdale	Huntingdon	Waymart
Capacity (# of TC beds)	52	50	124	36	100
Number of TC Staff (excluding DATS Supervisor)[a]	2	2	5	4	7
Stated Program Duration (weeks)	56-72	48	48	52	36
Program Intensity (hr/wk)	15	30	15	30	15
Primary Treatment Approach	Holistic[b]	Holistic	Holistic	Holistic	12-step
Termination Rate (# of failures/# of admissions)	32%	71%	20%	22%	5%

[a] Staffing ratios are imprecise due to the fact that TC staff are assigned exclusively to TC in some institutions (Graterford, Cresson, Waymart), while TC staff in others (Huntingdon, Houtzdale) also provide Education and Outpatient programming to the general population.
[b] Includes individual counseling, psychodynamic group therapy, cognitive behavioral therapy, behavior modification, rational emotive therapy, milieu therapy and standard 12-step groups.

Table 8
Inmate Characteristics by TC Program: Oneway ANOVA

	Cresson	Graterford	Houtzdale	Huntingdon	Waymart	F Value
	Mean (s.d.)	Mean (s.d.)	Mean (s.d.)	Mean (s.d.)	Mean (s.d.)	(d.f.)
Age (years)	31.1_{a} (31.1)	31.7_{a} (8.6)	37.4_{b} (9.0)	31.8_{a} (8.2)	38.6_{b} (8.6)	24.74* (4,737)
Time Remaining to Minimum Release Date (months)	13.2_{a} (22.6)	24.1_{a} (119.7)	-1.7_{a} (57.5)	0.39_{a} (54.9)	14.4_{a} (84.2)	2.97* (4,734)
Current Offense Severity (0 – 10)	6.1_{bc} (2.1)	5.3_{ab} (3.2)	5.3_{ab} (2.2)	6.6_{c} (1.9)	5.2_{a} (2.7)	5.94* (4,728)
Prior Offense Severity (0 – 10)	4.7_{b} (2.7)	4.8_{b} (2.9)	5.5_{bc} (2.3)	6.2_{c} (1.8)	3.6_{a} (2.9)	20.82* (4,728)
TCU Drug Screen Score (0 – 9)	6.3_{bc} (2.4)	7.0_{c} (2.3)	5.4_{b} (2.7)	6.7_{c} (2.1)	4.4_{a} (2.8)	18.48* (4,559)
PACSI Screening Score (0 – 10)	8.5 (1.9)	8.4 (2.0)	8.8 (1.8)	8.5 (2.0)	8.2 (1.8)	2.19 (4,648)
Program Duration: Graduates (# wk)	85.7_{a} (18.0)	58.5_{b} (15.5)	55.5_{b} (7.1)	51.9_{b} (6.2)	42.0_{c} (19.3)	81.59* (4,460)
Program Duration: Failures (# wk)	31.8 (24.5)	19.5 (16.1)	22.1 (18.1)	23.4 (17.7)	19.0 (16.6)	22.4 (4,177)

$p < .05$

Means with differing subscripts differ significantly at the .05 level, using Tukey-B post hoc comparison tests.

Interview Summaries

Cresson. The inmates we interviewed indicated that Cresson's TC treatment schedule throughout the day is very full. Inmates are expected to participate in daily rap groups, which are counselor-run groups where the inmates may openly discuss personal issues as well as treatment issues. They also participate in phase classes, groups that deal with specific topics such as stress and anger, cognitive restructuring, rational/irrational thinking, and criminal thinking, and evening NA/AA meetings 2 – 3 times a week. In regards to punishment, inmates receive "block cards" for minor offenses. The 1st block card is considered a warning. If an inmate receives more than one, he meets with the Interpersonal Committee, who may assign extra duties (e.g., cleaning, maintenance) or a seminar (writing an essay and reading it in front of the community). Inmates expressed some problems with security staff. There was a consensus that the C.O.'s on the unit had bad attitudes and were not treatment-oriented. The majority of inmates really liked one of the two main TC counselors, primarily because they felt that he "knows what they are dealing with." They felt that the other TC counselor was straightforward, but a little more "textbook." Inmates perceived a need for more individual counseling and for more counselors in the TC.

Graterford. A TC inmate's day (indeed, evenings and weekends also) at Graterford is quite busy. They are up from 6:30 a.m. till almost 9:00 p.m., with the majority of that time in treatment or treatment-related activities (e.g., "helping measures"). Morning meetings are held at 8:15 a.m. Inmates have treatment groups till 11:00, then lunch, helping measure presentations, count, dinner, one hour of yard time, then evening AA/NA/Alanon meetings. The biggest complaint by inmates was that they needed more free time. They also felt that there should be

more counselors and that the program should be "changed back" to an 18-24 month program[21]. The major distinguishing factor of the Graterford TC program is the extensive use of helping measures. When an inmate gets a haircut (write-up) they must go before a haircut committee (run by 7 inmates), which may give him a helping measure. This helping measure can take many different forms, such as a "think tank" (where the inmate stands and stares at the wall to ponder his transgression), a "blowout" (where inmates who may have a conflict stand in close proximity to each other and express their grievances), an "all-day optional" (where the inmate sits in a hard chair from 8:00 a.m. – 6:00 p.m. and other TC inmates can come in and tell that inmate what they think of him), and a "writer's post" (where they write something on the board ten times). These are only some of the different types of helping measures; many others were described by inmates and by the inmate handbook ("Rules and Tools"). Inmates did not perceive that the helping measures they received were in the least unfair. They felt that these sanctions were exactly what they were intended to be, "helping measures" rather than punishment.

Houtzdale. Houtzdale TC inmates begin their treatment day with the morning meeting and then they have groups up until 3:15 p.m. There are no evening classes. Many of the groups deal with specific issues, such as relapse prevention, anger and stress, cognitive restructuring, addictions education, and criminal thinking. Inmates expressed some concerns about female treatment staff (the majority on this particular unit). For example, several inmates felt that female counselors sometimes wore clothes that were "inappropriate" for that environment. Simply interacting with any female counselor in a prison setting may be an issue for these inmates, however. We witnessed no evidence of inappropriate attire during numerous visits to Houtzdale. Several inmates stated that some feelings about sex and sexuality in treatment groups were

[21] At the time interviews were conducted, DOC was beginning to emphasize a policy that TC

repressed because inmates felt uncomfortable about raising certain issues in the presence of female counselors. Inmates expressed a problem with the C.O.'s on the unit, complaining that they do not treat inmates like people. Inmates felt that C.O.'s should have some AOD training before they are sent to work on the TC. Many inmates expressed negative opinions of the pull-up system. Among their major complaints, they felt that pull-ups should not be anonymous; an inmate should confront another inmate face-to-face rather than simply writing him up and leaving his fate to the pull-up committee. Many felt that some inmates take advantage of the pull-up system for revenge against inmates whom they have had a dispute with. Proper staff supervision of the entire pull-up system is indeed critical, especially for a large TC unit. TC inmates at Houtzdale strongly expressed a need for more frequent individual counseling.

Huntington. A typical day in the TC consists of morning meeting, phase groups, and small groups. Phase groups deal with many topics, such as drug addiction, criminal thinking, and anger and violence. Small groups deal mainly with inmates' personal and therapeutic issues. Inmates are able to express their feelings freely and get feedback from other members of the group. Although several inmates perceived that pull-ups were a good idea in theory, the majority of them felt that pull-ups should not be anonymous. Some inmates, they perceived, may use pull-ups vindictively and they give inmates too much power. Inmates complained that the TC should be moved out of the basement, since there were leaky pipes everywhere.[22] Inmates unanimously expressed positive regard for the treatment program and TC counselors. A strongly supportive treatment environment was the strongest theme that emerged from inmate interviews at Huntingdon.

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should be completed within 12 months.

[22] A well-maintained physical plant may help reinforce the value of treatment and facilitate recovery (ONDCP, 1999).

Waymart. Inmates attend a morning meeting, then have 1 – 2 groups a day depending on what phase they are in. Two nights a week, inmates have evening meetings until 7:00 p.m. According to inmates, treatment groups dealt mainly with "personal issues," although some of the issues they mentioned appeared to address relapse prevention, co-dependency, and interpersonal relationships. The TC counselors were unanimously well liked and well regarded. However, several spoke of little peer support on the unit, and inmates complained that TC residents rarely confronted one another about treatment-related issues. Several complained that treatment activities were infrequent and characterized by a low level of participation. Some inmates (particularly in Phase 3 and 4) complained that they had too little to do. Some inmates stated that they would like more privacy. Since they live in a dormitory-like setting, they have little time to themselves for personal reflection, homework, or reading.

Program Differences: Conclusions

While the five programs consistently implemented the overall TC philosophy and framework, some differences in TC implementation were apparent. Graterford was somewhat more punitive than the other TC programs, as suggested by its higher attrition rate. Huntingdon inmates appeared to be engaged in the treatment and recovery process to a somewhat greater degree than the other programs. Treatment duration at Cresson was longer than in the other TC programs. Waymart TC residents tended to be slightly lower risk, and program intensity was somewhat lower. Houtzdale inmates evidenced the lowest satisfaction overall with the TC. Although several spoke well of their counselors, the general perception was that individual counseling was infrequent, and too many inmates were able to manipulate the treatment

environment (e.g., the pull-up system) toward their own ends. Two TC programs (Cresson and Waymart) did not use pull-ups as part of their system of sanctions and rewards.[23]

Whether inmate and programmatic differences significantly influence treatment outcomes (reincarceration, rearrest and relapse) or not is an important empirical question. Because some significant differences were found across the five TC programs, multivariate analyses of outcome should be sensitive to their potential influence. In multivariate analyses (logistic regression), we entered into equations individual inmate differences such as prior and current offense severity. To examine the potential influence of programmatic differences on outcomes, we entered dummy variables reflecting the influence of each separate TC program. In this way, we could determine the degree to which treatment outcomes were influenced (if at all) by programmatic differences.

Within-Program Changes

When the study began in January 2000, all inmates enrolled in TC, Education, or Outpatient drug treatment programs were approached and asked to participate in the study. Those who agreed to participate signed our Subject Consent Form and completed the TCU Drug Screen. In addition, TC inmates were asked to complete the TCU Resident Evaluation of Self and Treatment (REST) form, and TC counselors were asked to complete the TCU Counselor Rating of Client (CRC) form for each current TC inmate on their caseload. Once initial testing was completed, we approached only new admissions to solicit their participation in the study.

The cut-off date for adding new admissions to the study sample was November 30, 2000. Collection of discharge information for all inmates admitted prior to November 30, retesting of

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[23] Pull-ups are often perceived as an important vehicle for encouraging inmate self-determination and responsibility in a TC program (DeLeon, 2000; ONDCP, 1999).

current TC inmates (REST and CRC forms), and post-release data collection for all inmates proceeded as planned through the end of the study period.

Response rates for TC samples (i.e., completion of Consent, Drug Screen and REST forms) were consistently excellent (548/637 = 86%)[24]. We attribute this high response rate to two major factors. First, TC is an intensive, one-year residential program. Many new TC inmates are highly motivated and interested in recovery when they begin TC, and self-assessment is a critical requirement of their early treatment work. Second, experienced treatment counselors have frequent, daily contact with TC inmates, and counselors tend to form stronger therapeutic relationships (and trust) with TC inmates. Both factors likely enhanced our TC response rates.

Response rates for inmates in the Comparison samples (Subject Consent forms and TCU Drug Screen forms) fluctuated over time, but never equaled those of TC (1030/2029 = 51%). As noted above, inmates participated in non-residential Education and Outpatient programs for much shorter time periods than TC, they tended to have less time remaining in their sentences, and they tended to develop weaker therapeutic relationships (and trust) with their counselors. Indeed, counselors reported a higher degree of suspicion and mistrust among inmates in the Education and Outpatient groups. They also reported that it was more difficult to overcome this suspicion due to their relatively infrequent contact with inmates (1 - 3 hours of group time per week). Because of the lower response rate for the Comparison sample, care was taken in data analyses to examine and control for selection differences potentially related to recidivism (e.g., prior and current offense severity, and assessed need for treatment).

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[24] The number of inmates *approached* (shown here) is less than the number of inmates *admitted* (Table 2). Many inmates *admitted* to D & A programs during the study period were either transferred or unsuccessfully discharged prior to completing their first month of treatment. As such, they would not have been *approached* for participation in the study.

Two other types of measures were collected for TC inmates who agreed to participate in the study: the Resident Evaluation of Self and Treatment (REST) form (completed by inmates), and the Counselor Rating of Client (CRC) form (completed by AOD staff). All inmates who completed the Subject Consent form and Drug Screen (86% of all TC admissions) also completed the initial REST. All TC inmates who initially agreed to participate in the study and still remained in the TC six months later and 12 months later (100%) agreed to be re-tested on the REST. CRC response rates were close to 100% across CRC administrations at 1 month, 6 months, and 12 months (the only exceptions being those inmates who were transferred or paroled before they could be re-assessed).[25]

All subscales of the CRC and REST (see Methods section) utilized seven-point Likert scales. Response categories for each item ranged from 1 (Strongly Disagree) to 7 (Strongly Agree). Using procedures described by Knight et al. (1994) and Simpson (1991), each scale was scored by averaging responses to items and multiplying by 10 (scores therefore ranged from 10 to 70). Following scoring procedures, several negatively worded items were reverse scored prior to calculating scale scores for the REST and CRC.[26] This procedure resulted in a standardized score for each scale, allowing for comparisons across different scales and samples. Each instrument was administered after approximately one month following admission to the TC, 6 months post-admission, and 12 months post-admission.

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[25] We express great gratitude to AOD staff and supervisors for their cooperation and perseverance in the testing process. A study of this magnitude would not have been possible without their assistance. Initially, there were some misunderstandings about the appropriate testing procedures and timing for administering the REST and CRC forms, but discussions with supervisors and staff at each institution and discussions within the larger Steering Committee helped answer questions and alleviate concerns considerably.

[26] Reverse-scored items on the REST included items on the following subscales: Self Esteem (#23, 33, 51, 60), Depression (#28), Self Efficacy (#6, 11, 17, 25, 32), Risk Taking (#31, 48, 57),

However, a number of inmates who were initially tested on the REST and CRC had been admitted prior to January 1, 2000, when the study began, and were thus unavailable for repeated testing six months later (time 2) and twelve months later (time 3) because they had already completed their programs or been terminated. Mean REST and CRC scores for each testing period are presented in Tables 9 and 10. In subsequent statistical analyses, we selected out only those inmates who were admitted after January 1, 2000 to provide a cleaner chronology of repeated measures (i.e., most of these inmates were actually tested close to the proper 1-month, 6-month, and 12-month intervals after their admission to TC). This procedure reduced the potential TC sample from 742 to 395 inmates.[27] While we were able to track recidivism for the entire sample of 742 TC inmates, therefore, only 395 were actually admitted during the study period and subject to repeated administrations of the REST and CRC.

Although the TC attrition rate was only 25% overall, many inmates were paroled or successfully discharged from TC before they could complete all three intended administrations of the REST (i.e., 1-month, 6-month, and 12-months post-admission). Since a maximum of 395 TC inmates admitted after January 1, 2000 were actually subject to repeated REST and CRC testing, this smaller sample was used to examine changes on the REST and CRC subscales over time. Because only a small portion of all TC inmates admitted after January 1, 2000 actually remained in TC programs 12 months later at the third measurement interval (i.e., only 32 inmates for the 3rd REST, and only 43 inmates for the 3rd CRC), we focus instead on the much larger samples available for analyzing differences from time 1 (n = 321 for the 1st REST, n = 320 for the 1st CRC)

Social Conformity (#18, 27), and Treatment Readiness (#7, 19, 34, 44). Reverse-scored items on the CRC included items #6, 7, 8, 9, 11, 22, and 23.

[27] As described in the Methods section, 822 inmates (including 347 in TC) had been admitted prior to January 1, 2000, when the study began, and were thus unavailable for repeated testing on

to time 2 (n = 191 for the 2nd REST, n = 171 for the 2nd CRC). To this end, we used paired-samples t-tests.

Inmate self-reports on REST scales suggested some significant improvements in psychological and social functioning during the first six months of TC treatment, and a significant increase in treatment engagement (see Table 11). For example, inmates reported significant improvement on *self-esteem* and *depression*. No significant changes were observed for self-reported *anxiety* or *hostility* (both of which were already quite low to begin with) or *self-efficacy* (which was already quite high). Inmates did, however, report significant decreases in *risk taking*, perhaps reflecting a heavy emphasis on reducing "criminal thinking" in the first two phases of TC. No significant improvements in *treatment readiness* were reported, although once again inmates already scored quite high on this scale at time 1.

Other REST scales showing significant improvement over time were *therapeutic engagement, personal progress, trust in group, opinion of program staff, counselor rapport,* and *counselor competence*. Together, these changes indicate that inmates felt more engaged and involved in the treatment process over time, dimensions found to be predictive of treatment completion and reduced recidivism (e.g., Broome et al., 1997). Several treatment process scales showed no improvement, however, raising some concerns. For example, there appeared to be little increase in inmate perceptions of peer support over time. Poor peer relationships may mitigate successful implementation of the TC philosophy, and weaken expected treatment outcomes. TC is not structured as a "go-it-alone" program; a high degree of interaction, confrontation and peer support is a critical treatment component.

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the REST or CRC at six-month or 12-month time intervals because they had already completed their programs.

Counselor ratings of client attributes and counseling foci also showed several significant improvements over time, but not across the board (see Table 12). Most importantly, counselors agreed with inmates' perceptions that *treatment engagement* increased over time. One might suggest that treatment engagement is a necessary (but not sufficient) condition for positive treatment outcomes to occur. Unfortunately, counselors also perceived a slight, but significant increase in inmate *psychological problems* over time. It is possible that such problems manifested themselves more frequently or intensely as inmates were exposed to greater group confrontation and pressure over time. Alternatively, it is also possible that the perception of psychological problems by counselors is part and parcel of the treatment process: if an inmate is actively participating in treatment, and is doing so with genuine and sincere intentions, he ought to open up and reveal psychological difficulties over time. However, CRC scores showed no significant decrease in denial and no significant increase in rapport with others. The four counselor foci dealt more with treatment content than process. Issues of self-confrontation, life skills development, family, and financial management received significantly increased attention over time.

Next, we examined changes in inmate ratings on psychosocial and motivational scales from time 1 to time 2 (six months post-admission), broken down by institution (Table 13). Overall, Huntingdon inmates showed the greatest improvement in psychosocial functioning over time, Houtzdale and Waymart inmates showed the least improvement, Graterford and Cresson were in between.

The five TC programs did not differ significantly on changes in *self-esteem* over time, although Houtzdale and Waymart inmates evidenced less improvement than inmates in the other 3 TC programs. Huntingdon inmates showed greater decreases in *depression* than Houtzdale and Waymart inmates; Cresson and Graterford inmates were in between. Similar results were found

for changes in *anxiety* over time, although post hoc comparisons revealed that no two means differed significantly[28]. The same pattern was found for changes in *self-efficacy*-- Huntingdon inmates showed significantly greater improvements than Houtzdale and Waymart inmates; Cresson and Graterford inmates were in between. Huntingdon inmates showed greater reductions in *hostility* over time than all other programs except Cresson. Huntingdon inmates showed greater reductions in *risk taking* over time than all other programs. Graterford inmates showed the greatest increases in *social conformity* over time, while Waymart inmates actually decreased on this measure. While there was generally little change in treatment readiness over time, one program (Cresson) showed a substantial increase, while another (Graterford) showed a substantial decrease. Programs did not differ significantly on changes in external pressures over time.

While we lacked detailed clinical assessment information on individual inmates, these results suggest that inmates at Houtzdale and Waymart may have psychological needs that are not being fully addressed. Huntingdon inmates evidenced the highest levels of improvement in psychosocial functioning from time 1 to time 2, suggesting that the TC at Huntingdon more explicitly addressed individual inmate needs. Our interview data and observations were consistent with this interpretation.

Finally, we examined changes in inmate ratings of treatment process from time 1 to time 2, broken down by institution (Table 14). There were no significant differences across the five programs, although Huntingdon evidenced the greatest improvements in *therapeutic engagement*. Huntingdon, Graterford and Cresson inmates also tended to show greater improvement on *personal progress* over time. While few differences were observed in changes in treatment

[28] Post hoc tests likely failed to detect significant differences because the overall F-test for program differences just barely reached statistical significance (.048), and substantial within-program variation (high standard deviations) weakened tests of significance.

process across the five programs, recall from Table 11 that TC inmates overall showed significant increases in therapeutic engagement, personal progress, trust of group, program staff, counselor rapport, and counselor competence over time. Recall also from Table 9 that mean scores on "*trust group*" were generally low across the five programs at both time 1 and time 2, while inmate ratings of counselor rapport and counselor competence were generally high.

Table 9
Mean REST Scores: Time 1, Time 2, and Time 3

	Time 1 (1 mo.)		Time 2 (6 mo.)		Time 3 (12 mo.)	
	Valid N	Mean (s.d.)	Valid N	Mean (s.d.)	Valid N	Mean (s.d.)
Self Esteem	584	58.6 (7.8)	278	59.7 (7.5)	46	59.7 (6.9)
Depression	579	35.8 (10.3)	275	33.3 (9.4)	46	32.2 (8.8)
Anxiety	579	30.4 (13.0)	277	28.2 (11.9)	46	27.2 (12.4)
Self Efficacy	584	61.9 (5.8)	275	61.8 (5.7)	45	61.1 (5.5)
Hostility	581	30.7 (14.0)	275	29.1 (13.1)	46	29.9 (12.8)
Risk Taking	583	47.9 (9.3)	277	44.5 (8.7)	45	44.1 (8.7)
Social Conformity	577	58.0 (7.3)	274	58.1 (7.0)	46	58.2 (7.0)
Treatment Readiness	574	60.6 (7.9)	273	60.8 (8.0)	45	62.3 (7.0)
External Pressures	581	38.5 (11.4)	277	37.1 (11.0)	46	40.0 (9.5)
Therapeutic Engagement	587	59.1 (10.5)	279	61.2 (8.4)	46	59.8 (12.3)
Personal Progress	586	61.1 (10.0)	278	63.8 (7.6)	46	62.9 (11.3)
Trust Group	584	44.9 (13.6)	277	47.6 (13.2)	46	48.9 (13.4)
Program Staff	585	45.5 (14.2)	279	47.5 (14.2)	45	47.9 (15.5)
Counselor Rapport	583	58.4 (11.7)	277	58.8 (11.7)	46	57.6 (12.9)
Counselor Competence	581	58.5 (11.3)	278	59.9 (11.1)	45	58.9 (12.9)
Program Structure	567	51.8 (11.7)	270	52.6 (11.7)	45	52.1 (12.9)
Program Sessions	583	45.2 (15.1)	275	45.0 (15.6)	45	45.6 (16.4)
Peer Support	582	51.3 (12.3)	278	51.4 (11.9)	44	51.0 (13.7)

Table 10
Mean CRC Scores: Time 1, Time 2, and Time 3

	Time 1 (1 mo.)		Time 2 (6 mo.)		Time 3 (12 mo.)	
	Valid N	Mean (s.d.)	Valid N	Mean (s.d.)	Valid N	Mean (s.d.)
Therapeutic Engagement	535	46.1 (10.2)	238	47.5 (9.7)	60	49.8 (10.3)
Rapport With Others	542	48.6 (9.7)	241	49.4 (9.2)	60	51.8 (8.5)
Denial	535	47.8 (7.2)	239	47.9 (6.9)	60	49.8 (6.4)
Psychological Problems	541	53.1 (6.5)	238	52.8 (5.9)	58	54.2 (6.1)
Self Confrontation	543	50.4 (10.8)	239	51.1 (9.1)	59	53.9 (9.0)
Life Skills Development	544	50.1 (10.3)	237	51.6 (8.6)	60	54.9 (8.3)
Family	547	50.3 (11.7)	240	51.2 (10.9)	59	55.0 (10.7)
Financial Management	547	42.9 (12.9)	241	46.3 (11.6)	60	49.2 (9.3)

Table 11
Mean REST Scores: Paired Sample T-Tests, Time 1 - Time 2

	Valid N	Time 1 Mean (s.d.)	Time 2 Mean (s.d.)	Time 1 – Time 2 Mean (s.d.)	t (2-tailed)
Self Esteem	183	58.3 (8.1)	60.1 (7.4)	-1.74 (8.2)	-2.89*
Depression	177	34.4 (10.0)	32.8 (9.4)	1.66 (9.0)	2.46*
Anxiety	183	29.4 (13.3)	28.2 (12.2)	1.14 (10.8)	1.42
Self Efficacy	181	61.8 (6.0)	61.7 (5.6)	0.13 (6.5)	0.28
Hostility	182	28.5 (13.5)	28.2 (12.7)	0.34 (9.7)	0.47
Risk Taking	180	46.9 (9.0)	43.8 (8.2)	3.14 (7.4)	5.71*
Social Conformity	177	58.2 (7.6)	57.8 (7.0)	0.42 (8.1)	0.69
Treatment Readiness	179	60.1 (7.9)	60.4 (8.0)	-0.24 (7.9)	-0.40
External Pressures	178	37.7 (11.2)	36.8 (10.5)	0.86 (10.2)	1.13
Therapeutic Engagement	186	57.4 (11.1)	60.5 (8.7)	-3.09 (10.5)	-4.02*
Personal Progress	184	59.5 (10.3)	63.5 (7.7)	-4.04 (10.2)	-5.34*
Trust Group	184	44.3 (13.1)	47.7 (13.0)	-3.38 (14.4)	-3.27*
Program Staff	185	45.2 (14.4)	47.6 (14.3)	-2.38 (14.7)	-2.20*
Counselor Rapport	183	56.8 (12.2)	58.8 (11.6)	-2.02 (13.8)	-1.98*
Counselor Competence	183	56.4 (11.5)	59.1 (11.5)	-2.62 (12.9)	-2.76*
Program Structure	171	51.0 (11.1)	52.1 (11.2)	-1.04 (11.6)	-1.17
Program Sessions	182	43.4 (14.2)	43.7 (15.8)	-0.31 (15.8)	-0.26
Peer Support	184	50.5 (11.8)	51.1 (11.2)	-0.60 (13.2)	-0.61

*$p < .05$

Table 12
Mean CRC Scores: Paired Sample T-Tests, Time 1 - Time 2

	Valid N	Time 1 Mean (s.d.)	Time 2 Mean (s.d.)	Time 1 – Time 2 Mean (s.d.)	t (2-tailed)
Therapeutic Engagement	167	45.4 (8.3)	46.8 (9.2)	-1.36 (8.4)	-2.08*
Rapport With Others	170	48.1 (8.6)	49.3 (9.2)	-1.17 (8.4)	-1.82
Denial	166	46.6 (6.4)	47.6 (6.7)	-0.94 (7.0)	-1.72
Psychological Problems	168	51.0 (6.6)	52.5 (6.2)	-1.45 (6.8)	-2.74*
Self Confrontation	170	49.0 (9.8)	50.6 (8.8)	-1.69 (9.7)	-2.27*
Life Skills Development	168	47.9 (10.4)	51.1 (8.7)	-3.16 (9.2)	-4.54*
Family	169	48.4 (11.8)	51.3 (10.6)	-2.91 (11.7)	-3.22*
Financial Management	171	42.0 (13.2)	47.0 (11.4)	-4.95 (12.9)	-5.01*

*$p < .05$

Table 13
Changes in Psychosocial Functioning (Time 2 - Time 1) by TC Program: Oneway ANOVA

REST Subscale (Time 2 – Time 1)	Cresson	Graterford	Houtzdale	Huntingdon	Waymart	F Value
	Mean (s.d.)	Mean (s.d.)	Mean (s.d.)	Mean (s.d.)	Mean (s.d.)	(d.f.)
Self Esteem	3.4 (8.8)	4.6 (6.2)	0.5 (8.6)	2.8 (7.9)	0.4 (7.6)	2.21 (4,263)
Depression	-1.8_{ab} (9.7)	-2.4_{ab} (14.2)	-0.8_{b} (8.5)	-6.7_{a} (8.5)	-1.1_{b} (7.9)	2.86* (4,256)
Anxiety	-3.6_{a} (8.7)	-0.2_{a} (10.8)	-0.2_{a} (10.1)	-6.5_{a} (15.1)	-1.1_{a} (11.4)	2.43* (4,260)
Self Efficacy	0.6_{ab} (5.7)	1.4_{ab} (6.5)	-1.4_{b} (5.9)	2.9_{a} (5.9)	-1.2_{b} (7.0)	3.88* (4,259)
Hostility	0.00_{b} (11.3)	-2.0_{ab} (8.0)	0.4_{b} (9.6)	-5.6_{a} (10.2)	0.9_{b} (8.2)	3.39* (4,259)
Risk Taking	-2.7_{b} (8.2)	-1.8_{b} (9.2)	-1.2_{b} (7.9)	-7.1_{a} (7.0)	-2.7_{b} (7.2)	3.80* (4,259)
Social Conformity	-0.6_{ab} (7.5)	3.7_{a} (8.2)	0.3_{ab} (6.9)	0.8_{ab} (8.6)	-2.3_{b} (7.8)	3.00* (4,256)
Treatment Readiness	3.3_{b} (6.6)	-5.5_{a} (11.6)	-0.6_{b} (7.8)	0.7_{b} (5.1)	-0.2_{b} (8.8)	4.36* (4,255)
External Pressures	-2.7 (10.7)	1.1 (12.9)	-1.1 (11.5)	-2.6 (6.9)	0.3 (9.5)	1.04 (4,257)

* $p < .05$
Means with differing subscripts differ significantly at the .05 level, using Tukey-B post hoc comparison tests.

Table 14
Changes in Ratings of Treatment Process (Time 2 - Time 1) by TC Program: Oneway ANOVA

REST Subscale (Time 2 – Time 1)	Cresson	Graterford	Houtzdale	Huntingdon	Waymart	F Value
	Mean (s.d.)	Mean (s.d.)	Mean (s.d.)	Mean (s.d.)	Mean (s.d.)	(d.f.)
Therapeutic Engagement	3.3 (10.9)	2.1 (11.2)	0.9 (8.9)	4.1 (8.0)	3.0 (10.0)	0.93 (4,266)
Personal Progress	5.2 (9.0)	6.0 (14.1)	1.8 (9.3)	4.6 (10.6)	2.2 (9.1)	1.68 (4,263)
Trust Group	5.6 (16.3)	0.8 (15.7)	2.6 (13.8)	3.8 (11.4)	0.7 (12.6)	0.91 (4,261)
Program Staff	3.2 (15.4)	0.8 (12.4)	2.6 (14.9)	1.2 (15.6)	1.7 (12.9)	0.20 (4,264)
Counselor Rapport	4.4 (9.5)	3.4 (17.2)	-0.6 (12.4)	0.1 (17.4)	2.2 (11.7)	1.40 (4,262)
Counselor Competence	3.5 (9.7)	5.1 (13.2)	0.4 (11.5)	1.6 (13.0)	2.3 (12.3)	0.94 (4,261)
Program Structure	3.3 (10.0)	2.1 (13.1)	0.7 (10.9)	-0.9 (12.7)	1.0 (11.1)	0.76 (4,247)
Program Sessions	-1.3 (15.1)	2.0 (13.7)	1.1 (15.0)	-0.3 (14.9)	1.3 (16.6)	0.30 (4,261)
Peer Support	2.6 (11.9)	0.4 (10.9)	-1.4 (13.2)	-0.1 (11.6)	-0.1 (14.8)	0.68 (4,262)

* $p < .05$

Recidivism Findings

We coded recidivism data for 1,084 total inmates in our sample who were released from DOC custody as of June 21, 2001. Three types of recidivism data were collected: (1) reincarceration data, (2) rearrest data, and (3) parole data. Several critical outcome measures (e.g., reincarcerations) were available through DOC. Others (e.g., rearrests and convictions) were available through the Pennsylvania Commission on Crime and Delinquency (PCCD). Others (e.g., drug testing) were available through the Pennsylvania Board of Probation and Parole. Data sharing agreements and procedures were worked out with each agency.

Reincarceration data were collected by printing out the Department of Corrections "MOVE" screens for each inmate, which contained the inmate's most recent date of release from custody, type of release (e.g., parole v. full sentence served) and any new incarcerations thereafter.

Rearrest data, collected by the Pennsylvania State Police, was available through the Pennsylvania Commission on Crime and Delinquency (PCCD). As with DOC, we submitted a list of all 1,084 inmates released from DOC between January 1, 2000 and June 21, 2001. We received "rap sheets" (printouts) of each ex-offender's criminal history up to the time of the PCCD data run (July 18, 2001). We then coded and entered all data received from PCCD, including date and type of rearrest offense (if any) and disposition.

Parole data provided another important source of post-release data. We met with officials from the Pennsylvania Board of Probation and Parole (PBPP) in November of 2000 to discuss data sharing procedures, and we were granted access to several specific types of data. We wanted to determine whether an inmate successfully completed his term of parole or not, and whether the inmate tested positive for any type of drug use while on parole. If an inmate was resentenced into

DOC custody for a parole violation, we would identify such activity through the DOC "MOVE" system. Examination of parole data, however, allowed us to detect cases where an inmate may or may not have been found guilty of a parole violation, and may or may not have been recommitted to DOC.

PBPP also agreed to provide access to several other measures (e.g., employment, risk scores and level of supervision) that may help interpret findings regarding recidivism. Most importantly, PBPP was able to provide us with drug testing data, giving us a critical measure of drug relapse (number of tests, number of positives, type of drug).

We submitted to PBPP the same list of inmates released between January 1, 2000 and June 21, 2001.[29] On October 19, 2001, we received our first data run from PBPP: 11,247 drug test records (an average of 14 drug tests per inmate over an 18-month time period). On December 1, 2001, we received our second data run from PBPP: 947 parolee records that included level of risk and supervision, employment status, and current parole status.

Inmate Releases From Prison

Only a portion of those inmates who completed their treatment *programs* (see Table 4) had actually been *released from prison* at the time that the most recent recidivism and relapse data were collected for this study (June through December of 2001).[30] As of June 21, 2001, 1,084 inmates in our sample had been released from prison (see Table 15).

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[29] Of 1,084 inmates released, 947 (87%) were under the jurisdiction of state probation or parole.

[30] Although we attempted to chronologically synchronize the preparation of inmate lists and the collection of outcome data from the three cooperating agencies (DOC, PCCD, and Parole) to about the same time, processing times for each agency varied. DOC responded with reincarceration data by the end of June 21, 2000; PCCD responded with rearrest data by July 18; Parole responded with two separate data sets: drug testing data was delivered on October 19, 2001, and employment and supervision data were delivered on December 1, 2001.

Nearly two-thirds of inmates released (65%) were released via parole; this type of release was especially likely for TC inmates (Table 15). An additional one-fifth (21%) of the sample was reparoled (i.e., after serving time for a previous parole violation). Only 12% served their full sentence. A small portion of others (2%) was released via other mechanisms. Four inmates died while in custody. As a result, we were able to obtain 1,071 valid cases (230 + 701 + 133 + 7) for analyses at this time. Of these, 247 inmates (23%) were in the experimental (TC) group, with potentially an additional 28 cases to be added from the Alumni group. The comparison group consisted of 803 inmates from Education (369) and Outpatient (440) groups.

We first present results for reincarceration, then rearrest, and then drug relapse. Sample sizes varied depending upon the number of missing cases in each agency data run, as well as the date of the data run (which influenced the total amount of time that an inmate has been at risk since his release).

Table 15
Number and Type of Releases from Five Prisons by Program Type as of June 21, 2001

Type of Release	Program Type				Total
	Education	Outpatient	*TC*	Alumni	
Reparoled	86 (23%)	120 (27%)	12 (5%)	12 (43%)	230 (21%)
Paroled	216 (59%)	252 (57%)	218 (88%)	15 (54%)	701 (65%)
Maxed Out	57 (15%)	62 (14%)	13 (5%)	1 (4%)	133 (12%)
Deceased	1 (0%)	3 (1%)	0 (0%)	0 (0%)	4 (0%)
Serve Prev. Cty/St/Fed	0 (0%)	1 (0%)	1 (0%)	0 (0%)	2 (0%)
Administrative	4 (1%)	2 (1%)	1 (0%)	0 (0%)	7 (1%)
Court Order	5 (1%)	0 (0%)	2 (1%)	0 (0%)	7 (1%)
Total	369 (100%)	440 100%)	247 (100%)	28 (100%)	1084 (100%)

"Reparoled" = paroled for the second time after serving time for previous parole violation, "Paroled" = inmate applied for and received parole, "Maxed Out" = inmate served full sentence, "Deceased" = inmate died while in prison, "Serve Prev. Cty/St/Fed" = inmate released to custody of other authority, "Administrative" = transfer or change in sentence status without being released from custody, "Court Order" = inmate released by court order.

Reincarceration

A minimum time at risk of six months or greater was used to select cases for reincarceration analyses. Next, we assigned all inmates in TC programs to the experimental group, and all inmates in Education and Outpatient groups to the Comparison group.[31] The third selection criterion was the type of release mechanism (Table 15): we excluded inmates (n = 13) whose "release" was artificial (i.e., inmates who were deceased, now serving a previous sentence, or those simply given an administrative transfer). These selection factors left us with a sample of 149 inmates in the experimental (TC) group, and 497 inmates in the comparison group. Sample characteristics are presented in Table 16.

The TC and Comparison groups did not differ on amount of time at risk since their release from prison (Table 16). As expected, the two groups did differ substantially on the variable most relevant to the formation of comparison groups. The TC group had a mean total treatment exposure nearly 20 times as great as the Comparison group, justifying the use of the response-dosage model as a means of forming valid comparison groups. The two groups differed on a number of other selection criteria, though, indicating the need to use either matching or statistical controls to control for selection bias. For example, the TC group tended to have higher criminal history scores (both prior and current), and a higher assessed need for drug treatment (although the Comparison group clearly evidenced a high need for treatment also, well within in the TC-eligible range).

[31] We did not include Alumni inmates (TC graduates) in the experimental group, since those inmates were no longer in a TC program by the time our study began, and they were distinguished from their colleagues by virtue of the fact that they had not yet been able to secure their release via either parole or sentence expiration.

Because few inmates had been released from prison so far, especially those who completed TC programs, it was preferable to analyze the data using statistical controls rather than matching.[32] *Only multivariate analyses that control for selection differences between the two groups can provide appropriate estimates of program impact.*

Using logistic regression, we examined reincarceration rates, controlling for selection differences between the TC and Comparison groups (Tables 17 and 18). Control variables included prior and current criminal history, time remaining to minimum sentence at the time of program admission, age at the time of program admission, standardized drug score (z-score), and membership in either the TC or Comparison group.[33] Inspections for multicollinearity revealed no difficulties (e.g., no paired correlations exceeded .40).

The first table (Table 17) shows results for all released offenders; the second table (Table 18) restricted the analysis only to inmates who successfully completed their treatment program. The amount of time at risk, as one would expect, was a significant predictor of recidivism in both analyses. The longer inmates were out of prison, the more likely they were to recidivate. When analyses used the full sample (Table 17), the effect of TC on reincarceration was non-significant. When analyses were restricted only to successful program discharges (Table 18), however, TC inmates showed significantly lower rates of recidivism, even after all control variables had entered

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[32] Matching on even a few variables at this time would lead to a precipitous drop in cases, leaving too few cases for valid multivariate analyses. For example, only a handful of cases in the Graterford TC (n = 15) and the Cresson TC (n = 10) had 6 months or more exposure to risk so far. The sample sizes reported here will expand as more of the 2,891 inmates in our sample are actually *released from prison.*

[33] Too few cases were currently available to enter REST and CRC change scores (e.g., inmate psychological characteristics, ratings of treatment process, and ratings of counselors) into the logistic regressions. At the time of this report, few of the inmates who had completed REST and CRC forms for both time 1 and time 2 (n = 186) had been released from prison (n = 66). Of those 66, only three had been reincarcerated.

the equation. It clearly makes a large difference, therefore, whether an inmate *successfully* completes his treatment program or not.

We also examined whether the effects of TC varied by institution, since some differences in TC implementation were observed at the five institutions. We entered a categorical variable that reflected the effect of the institutional setting of each TC program (see Model 2 in Tables 17 and 18). None of these institutional effects were statistically significant, suggesting that the impact of TC on reincarceration was invariant across the five institutions. Finally, we estimated reincarceration rates using predicted probabilities from logistic regression equations (see Figure 2).[34] TC resulted in a significantly reduced probability of reincarceration (19% v. 26%), even when results were adjusted for the effects of control variables (see Table 18, Model 2).

Life tables for survival and risk (hazard) of reincarceration are shown in Table 19. For the comparison group, there was a sizeable drop in cumulative survival from 92% to 76% between six to 9 months following release from prison. Cumulative survival dropped gradually until the 15-month interval, where it declined precipitously from 62% to 25%. This appears to be a particularly high-risk interval, although there are currently too few cases in the longer time intervals to make definitive conclusions about survival at this time. The hazard function shown in Figure 3 reveals the survival advantage enjoyed by TC inmates after 9 months.

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[34] Probabilities of reincarceration for the Comparison and TC groups were estimated using logistic regression equations with all predictor and control variables entered: Prob(event) = $(1/(1 + e^{-Z}))$, where $Z = \Sigma B_k X_{ik}$ (Hanushek and Jackson, 1977; Lichter, 1989, Norusis, 1990). Estimated probabilities show the likelihood of the event (e.g., reincarceration), holding all variables except TC treatment at their means. These probabilities can be interpreted as the average effect of TC v. Comparison group membership on the event if all other variables were the same. The same procedures were used to estimate probabilities of rearrest and drug relapse for the TC and Comparison groups.

Table 16
Reincarceration Sample Characteristics

	Comparison Group		TC Group		
	Valid N	Mean (s.d.)	Valid N	Mean (s.d.)	Sig.
Amount of Time at Risk (months)	497	10.8 (3.08)	149	10.8 (3.0)	ns
Age	495	34.8 (8.4)	149	36.7 (8.5)	*
Time to Minimum (months)	495	-19.9 (34.3)	149	-5.8 (29.5)	*
Current Offense Severity (0 – 10)	495	4.5 (2.6)	149	5.4 (2.2)	*
Prior Offense Severity (0 – 10)	495	4.8 (2.8)	149	5.6 (2.4)	*
Standardized Drug Score	360	-0.2 (1.0)	148	0.4 (0.8)	*
TCU Drug Screen Score (0 – 9)	171	3.9 (3.0)	112	5.8 (2.8)	*
PACSI Screening Instrument (0 – 10)	307	7.6 (2.7)	135	8.6 (1.8)	*
Total Treatment Exposure	480	49.0 (85.6)	148	878.2 (514.0)	*

* $p < .05$ using 2-tailed t-test.

Table 17
Logistic Regression of Reincarceration on Predictor and Control Variables: All Discharges

	Model 1			Model 2		
	b	S.E.	Exp(B)	b	S.E.	Exp(B)
AGE	-.020	.013	.980	-.018	.014	.982
TIME TO MIN	.002	.005	1.002	.003	.005	1.003
OGS-CURRENT	-.002	.049	.998	-.004	.050	.996
OGS-PRIOR	.049	.045	1.050	.051	.046	1.053
DRUG SCORE	.160	.116	1.174	.143	.117	1.153
TIME AT RISK	.116 *	.035	1.123	.116 *	.036	1.123
PROGTYPE(1)	.464	.256	1.591	.373	.271	1.453
PRISON(1)				.451	.441	1.569
PRISON(2)				.163	.499	1.177
PRISON(3)				.257	.401	1.292
PRISON(4)				.299	.478	1.348
Constant	-2.294 *	.705	.101	-2.575 *	.786	.076
Chi-square	20.85 *			22.12 *		
(df)	(7 df)			(11 df)		
-2 Log likelihood	535.28			534.01		
N of cases	505			505		

*p < .05

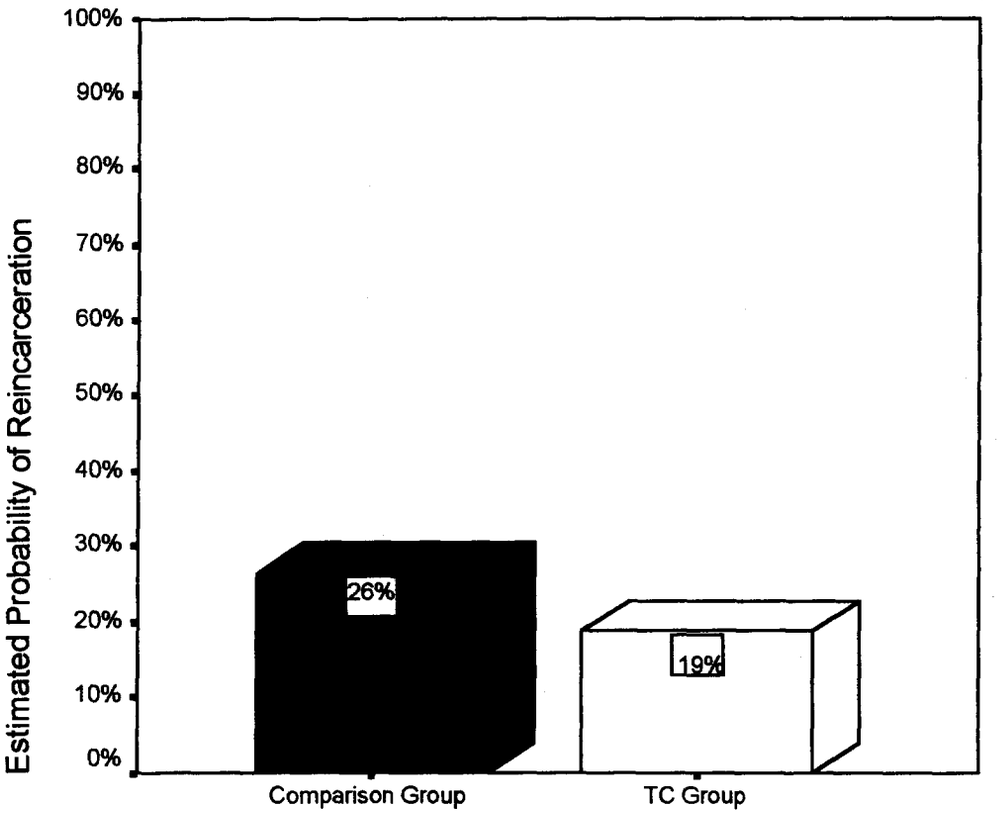
Note. TIME TO MIN = Time remaining to minimum release date at time of program admission; OGS = Offense Gravity Score, Current and Prior (1 - 10); PROGTYPE: 1 = COMPARISON GROUP, 0 = TC. PRISON: 1 = CRESSON, 2 = GRATERFORD, 3 = HOUTZDALE, 4 = HUNTINGDON.

Table 18
Logistic Regression of Reincarceration on Predictor and Control Variables: Successful Discharges Only

	Model 1			Model 2		
	b	S.E.	Exp(B)	b	S.E.	Exp(B)
AGE	-.015	.015	.986	-.012	.016	.988
TIME TO MIN	.001	.005	1.001	.002	.005	1.002
OGS-CURRENT	.024	.055	1.024	.018	.055	1.019
OGS-PRIOR	.042	.048	1.043	.033	.050	1.034
DRUG SCORE	.180	.133	1.197	.177	.136	1.194
TIME AT RISK	.093 *	.039	1.098	.093 *	.040	1.098
PROGTYPE(1)	.604 *	.281	1.829	.583 *	.298	1.792
PRISON(1)				.352	.477	1.422
PRISON(2)				-.114	.571	.892
PRISON(3)				.399	.421	1.490
PRISON(4)				.706	.502	2.026
Constant	-2.421 *	.779	.089	-2.743 *	.869	.064
Chi-square	14.64 *			18.55		
(d.f.)	(7 df)			(11 df)		
-2 Log likelihood	435.78			431.87		
N of cases	409			409		

*$p < .05$

Note. TIME TO MIN = Time remaining to minimum release date at time of program admission; OGS = Offense Gravity Score, Current and Prior (1 - 10); PROGTYPE: 1 = COMPARISON GROUP, 0 = TC. PRISON: 1 = CRESSON, 2 = GRATERFORD, 3 = HOUTZDALE, 4 = HUNTINGDON.



Note. Estimated probabilities are adjusted for all control variables, using logistic regression coefficients reported in Table 18, Model 2.

Figure 2. Estimated Probabilities of Reincarceration for Comparison and TC Groups (Adjusted for Control Variables)

Table 19
Survival Analysis: Life Tables for Reincarceration

Survival Variable: AT_RISK amount of time at risk since release from prison
For: COMP_GRP comparison groups (TC v. Ed. or Outpatient)
= 0 Comparison Group

Intrvl Start Time	Number Entrng this Intrvl	Number Wdrawn During Intrvl	Number Exposd to Risk	Number of Termnl Events	Propn Termi-nating	Propn Sur-viving	Cumul Propn Surv at End	Proba-bility Densty	Hazard Rate
.0	810.0	138.0	741.0	.0	.0000	1.0000	1.0000	.0000	.0000
3.0	672.0	156.0	594.0	11.0	.0185	.9815	.9815	.0062	.0062
6.0	505.0	140.0	435.0	29.0	.0667	.9333	.9160	.0218	.0230
9.0	336.0	117.0	277.5	48.0	.1730	.8270	.7576	.0528	.0631
12.0	171.0	87.0	127.5	24.0	.1882	.8118	.6150	.0475	.0693
15.0	60.0	35.0	42.5	25.0	.5882	.4118	.2532	.1206	.2778

Intrvl Start Time	SE of Cumul Sur-viving	SE of Proba-bility Densty	SE of Hazard Rate
.0	.0000	.0000	.0000
3.0	.0055	.0018	.0019
6.0	.0128	.0039	.0043
9.0	.0233	.0070	.0091
12.0	.0324	.0089	.0141
15.0	.0483	.0167	.0505

Survival Variable: AT_RISK amount of time at risk since release from prison
For: COMP_GRP comparison groups (TC v. Ed. or Outpatient)
= 1 Experimental (TC) Group

Intrvl Start Time	Number Entrng this Intrvl	Number Wdrawn During Intrvl	Number Exposd to Risk	Number of Termnl Events	Propn Termi-nating	Propn Sur-viving	Cumul Propn Surv at End	Proba-bility Densty	Hazard Rate
.0	246.0	51.0	220.5	.0	.0000	1.0000	1.0000	.0000	.0000
3.0	195.0	43.0	173.5	3.0	.0173	.9827	.9827	.0058	.0058
6.0	149.0	44.0	127.0	6.0	.0472	.9528	.9363	.0155	.0161
9.0	99.0	38.0	80.0	11.0	.1375	.8625	.8075	.0429	.0492
12.0	50.0	23.0	38.5	7.0	.1818	.8182	.6607	.0489	.0667
15.0	20.0	13.0	13.5	7.0	.5185	.4815	.3181	.1142	.2333

Intrvl Start Time	SE of Cumul Sur-viving	SE of Proba-bility Densty	SE of Hazard Rate
.0	.0000	.0000	.0000
3.0	.0099	.0033	.0034
6.0	.0208	.0062	.0066
9.0	.0403	.0121	.0148
12.0	.0600	.0169	.0251
15.0	.0944	.0317	.0826

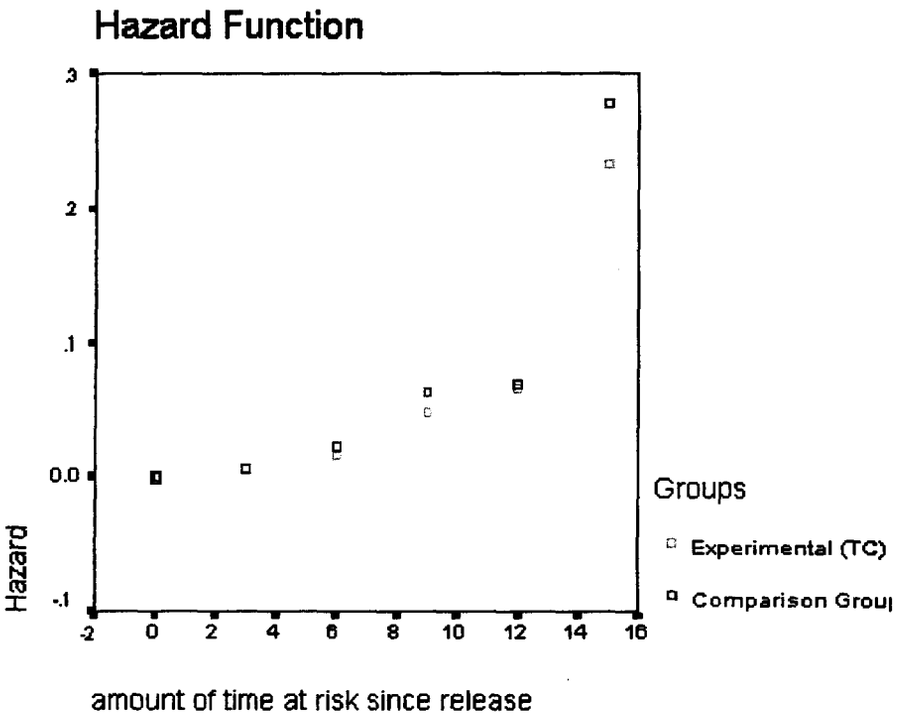


Figure 3. Hazard Function for Reincarceration

Rearrests

Rearrest analyses were based on a sample of 162 inmates in the Experimental (TC) group, and 536 inmates in the Comparison group.[35] Sample characteristics are presented in Table 20. The TC and Comparison groups did not differ on amount of time at risk since their release from prison. As intended, the two groups did differ substantially on the variable most logically relevant to the formation of comparison groups (total treatment exposure). The two groups also differed on a number of other selection criteria, indicating the need to use either matching or statistical controls to control for selection bias. For example, the TC group tended to have higher criminal history scores (both prior and current), and a higher assessed need for drug treatment.

As with the reincarceration analyses, it was preferable to analyze the data using statistical controls rather than matching at this time because only a portion of the sample had been released from prison so far, especially those who completed TC programs. Using logistic regression, we examined the impact of TC on rearrest rates, controlling for selection differences between the TC and Comparison groups. Control variables included prior and current criminal history, time remaining to minimum sentence at the time of program admission, age, standardized drug score, and membership in either the TC or Comparison group. Inspections for multicollinearity among the variables to be entered in the analyses revealed no difficulties. No correlation exceeded .40.

The first table (Table 21) once again shows results for all released offenders; the second table (Table 22) restricted the analysis only to inmates who successfully completed their treatment program. The amount of time at risk, as one would expect, was a significant predictor of recidivism in both analyses. The longer inmates were out of prison, the more likely they were to

[35] As with reincarceration analyses, a minimum time at risk of six months or greater was used to select cases, and we excluded inmates whose "release" was artificial (i.e., inmates who were deceased, now serving a previous sentence, or those simply given an administrative transfer).

get rearrested. Age was also a significant predictor of rearrest, with older inmates showing a lower likelihood of rearrest. In both types of analyses (all discharges v. successful discharges only), the program effect of TC was non-significant.

We also examined whether the effects of TC varied by institution, since some differences in TC implementation were observed at the five institutions. We entered a categorical variable that reflected the effect of the institutional setting (see Model 2 in Tables 21 and 22). None of these institutional effects were statistically significant, suggesting that the impact of TC on rearrest was invariant across the five institutions.

Finally, we estimated rearrest rates using predicted probabilities from logistic regression equations (see Figure 4). TC resulted in a slightly lower probability of rearrest (11% v. 14%), with results adjusted for the effects of control variables. Although the difference between the TC and Comparison groups was not statistically significant, the log-odds ratios reported in Tables 21 and 22 show that Comparison group inmates were 1.3 – 1.4 times as likely as TC inmates to be rearrested when the effects of all other variables were statistically controlled.

Patterns of survival and risk (hazard) for rearrest can be seen in Table 23. For the Comparison group, there was a sizeable drop in cumulative survival from 90% to 81% between six to 9 months following release from prison. Cumulative survival dropped again at the 9-month interval to 62%, and again at the 15-month interval, where it declined precipitously from 62% to 43%. Again, the 15-month interval appears to be a particularly high-risk interval, although the addition of further cases will help clarify survival patterns over time. The hazard function shown in Figure 5 reveals the survival advantage enjoyed by TC inmates after 12 months.

Table 20
Rearrest Sample Characteristics

	Comparison Group		TC Group		
	Valid N	Mean (s.d.)	Valid N	Mean (s.d.)	Sig.
Amount of Time at Risk (months)	536	10.1 (3.05)	162	10.0 (2.9)	ns
Age	534	34.9 (8.4)	162	36.8 (8.7)	*
Time to Minimum (months)	534	-20.1 (35.4)	162	-5.0 (28.7)	*
Current Offense Severity (0 – 10)	534	4.4 (2.7)	162	5.4 (2.2)	*
Prior Offense Severity (0 – 10)	534	4.8 (2.9)	162	5.5 (2.4)	*
Standardized Drug Score	391	-0.1 (1.0)	160	0.4 (0.9)	*
TCU Drug Screen Score (0 – 9)	186	4.0 (2.9)	121	5.7 (2.8)	*
PACSI Screening Instrument (0 – 10)	334	7.6 (2.6)	145	8.6 (1.8)	*
Total Treatment Exposure	519	50.2 (86.4)	160	880.1 (508.0)	*

* $p < .05$ using 2-tailed t-test.

Table 21
Logistic Regression of Rearrest on Predictor and Control Variables: All Discharges

	Model 1			Model 2		
	b	S.E.	Exp(B)	b	S.E.	Exp(B)
AGE	-.049 *	.016	.952	-.042 *	.017	.959
TIME TO MIN	.009	.007	1.009	.010	.007	1.010
OGS-CURRENT	-.088	.056	.916	-.093	.056	.911
OGS-PRIOR	.064	.052	1.066	.061	.054	1.062
DRUG SCORE	.164	.135	1.178	.147	.137	1.158
TIME AT RISK	.091 *	.041	1.095	.100 *	.041	1.105
PROGTYPE(1)	.347	.295	1.415	.243	.312	1.275
PRISON(1)				.449	.502	1.567
PRISON(2)				.652	.544	1.920
PRISON(3)				.098	.468	1.103
PRISON(4)				.332	.542	1.393
Constant	-1.076	.788	.341	-1.566	.893	.209
Chi-square	22.29 *			24.90 *		
(df)	(7 df)			(11 df)		
-2 Log likelihood	444.75			442.14		
N of cases	551			551		

*p < .05

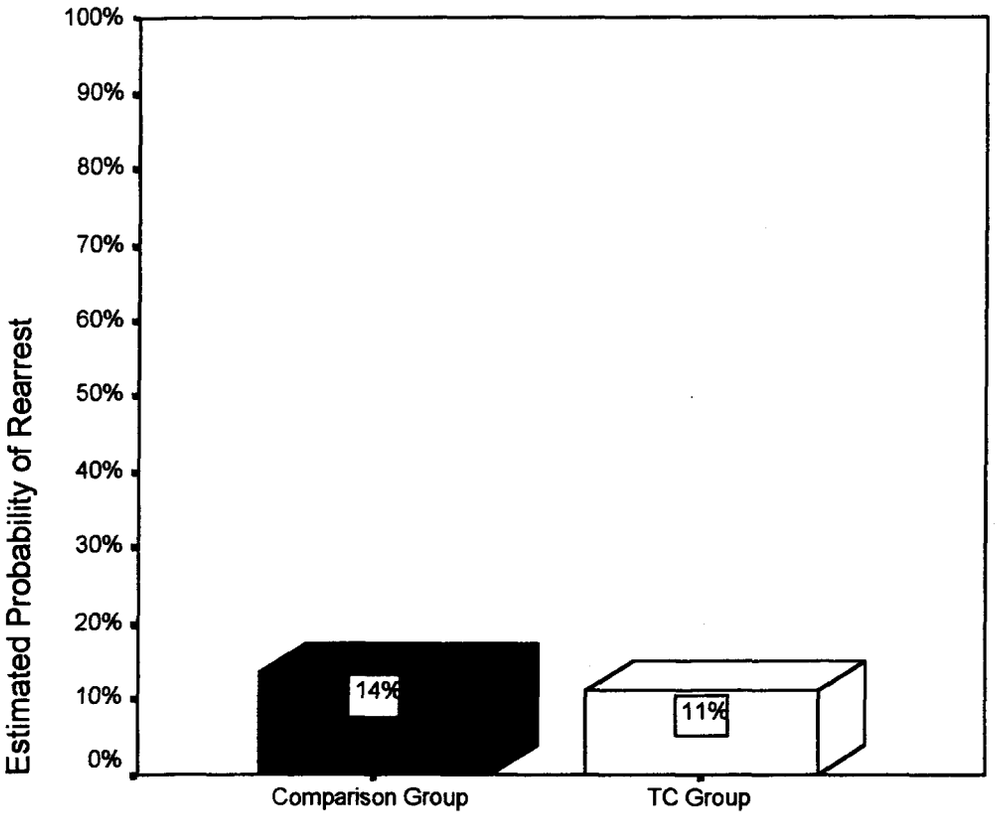
Note. TIME TO MIN = Time remaining to minimum release date at time of program admission; OGS = Offense Gravity Score, Current and Prior (1 - 10); PROGTYPE: 1 = COMPARISON GROUP, 0 = TC. PRISON: 1 = CRESSON, 2 = GRATERFORD, 3 = HOUTZDALE, 4 = HUNTINGDON.

Table 22
Logistic Regression of Rearrest on Predictor and Control Variables: Successful Discharges Only

	Model 1			Model 2		
	b	S.E.	Exp(B)	b	S.E.	Exp(B)
AGE	-.051 *	.019	.950	-.049 *	.020	.952
TIME TO MIN	.007	.008	1.007	.007	.008	1.007
OGS-CURRENT	-.050	.067	.951	-.053	.067	.949
OGS-PRIOR	.086	.063	1.089	.078	.065	1.081
DRUG SCORE	.147	.170	1.159	.154	.174	1.167
TIME AT RISK	.122 *	.049	1.129	.128 *	.051	1.137
PROGTYPE(1)	.296	.341	1.344	.254	.364	1.289
PRISON(1)				-.099	.558	.906
PRISON(2)				.386	.602	1.471
PRISON(3)				-.126	.489	.881
PRISON(4)				.009	.587	1.009
Constant	-1.825	.951	.161	-1.863	1.058	.155
Chi-square	18.28 *			19.52		
(df)	(7 df)			(11 df)		
-2 Log likelihood	323.45			322.21		
N of cases	449			449		

*p < .05

Note. TIME TO MIN = Time remaining to minimum release date at time of program admission; OGS = Offense Gravity Score, Current and Prior (1 - 10); PROGTYPE: 1 = COMPARISON GROUP, 0 = TC. PRISON: 1 = CRESSON, 2 = GRATERFORD, 3 = HOUTZDALE, 4 = HUNTINGDON.



Note. Estimated probabilities are adjusted for all control variables, using logistic regression coefficients reported in Table 22, Model 2.

Figure 4. Estimated Probabilities of Rearrest for Comparison and TC Groups (Adjusted for Control Variables)

Table 23
Survival Analysis: Life Tables for Rearrest

Survival Variable: PCCDRISK time at risk (months) since release
For: COMP_GRP comparison groups (TC v. Ed. or Outpatient)
= 0 Comparison Group

Intrvl Start Time	Number Entrng this Intrvl	Number Wdrawn During Intrvl	Number Exposd to Risk	Number of Termnl Events	Propn Termi-nating	Propn Sur-viving	Cumul Propn Surv at End	Proba-bility Densty	Hazard Rate
.0	810.0	86.0	767.0	3.0	.0039	.9961	.9961	.0013	.0013
3.0	721.0	168.0	637.0	5.0	.0078	.9922	.9883	.0026	.0026
6.0	548.0	218.0	439.0	38.0	.0866	.9134	.9027	.0285	.0302
9.0	292.0	121.0	231.5	23.0	.0994	.9006	.8130	.0299	.0348
12.0	148.0	68.0	114.0	27.0	.2368	.7632	.6205	.0642	.0896
15.0	53.0	42.0	32.0	10.0	.3125	.6875	.4266	.0646	.1235
18.0+	1.0	1.0	.5	.0	.0000	1.0000	.4266	**	**

Intrvl Start Time	SE of Cumul Sur-viving	SE of Proba-bility Densty	SE of Hazard Rate
.0	.0023	.0008	.0008
3.0	.0041	.0012	.0012
6.0	.0138	.0044	.0049
9.0	.0217	.0059	.0073
12.0	.0364	.0109	.0171
15.0	.0567	.0174	.0384
18.0+	.0567	**	**

Survival Variable PCCDRISK time at risk (months) since release
for COMP_GRP comparison groups (TC v. Ed. or Outpatient)
= 1 Experimental (TC)

Intrvl Start Time	Number Entrng this Intrvl	Number Wdrawn During Intrvl	Number Exposd to Risk	Number of Termnl Events	Propn Termi-nating	Propn Sur-viving	Cumul Propn Surv at End	Proba-bility Densty	Hazard Rate
.0	247.0	27.0	233.5	.0	.0000	1.0000	1.0000	.0000	.0000
3.0	220.0	54.0	193.0	3.0	.0155	.9845	.9845	.0052	.0052
6.0	163.0	64.0	131.0	6.0	.0458	.9542	.9394	.0150	.0156
9.0	93.0	43.0	71.5	11.0	.1538	.8462	.7948	.0482	.0556
12.0	39.0	22.0	28.0	3.0	.1071	.8929	.7097	.0284	.0377
15.0	14.0	12.0	8.0	1.0	.1250	.8750	.6210	.0296	.0444
18.0+	1.0	1.0	.5	.0	.0000	1.0000	.6210	**	**

** These calculations for the last interval are meaningless.

Intrvl Start Time	SE of Cumul Sur-viving	SE of Proba-bility Densty	SE of Hazard Rate
.0	.0000	.0000	.0000
3.0	.0089	.0030	.0030
6.0	.0199	.0060	.0064
9.0	.0435	.0134	.0167
12.0	.0605	.0156	.0218
15.0	.0984	.0278	.0443
18.0+	.0984	**	**

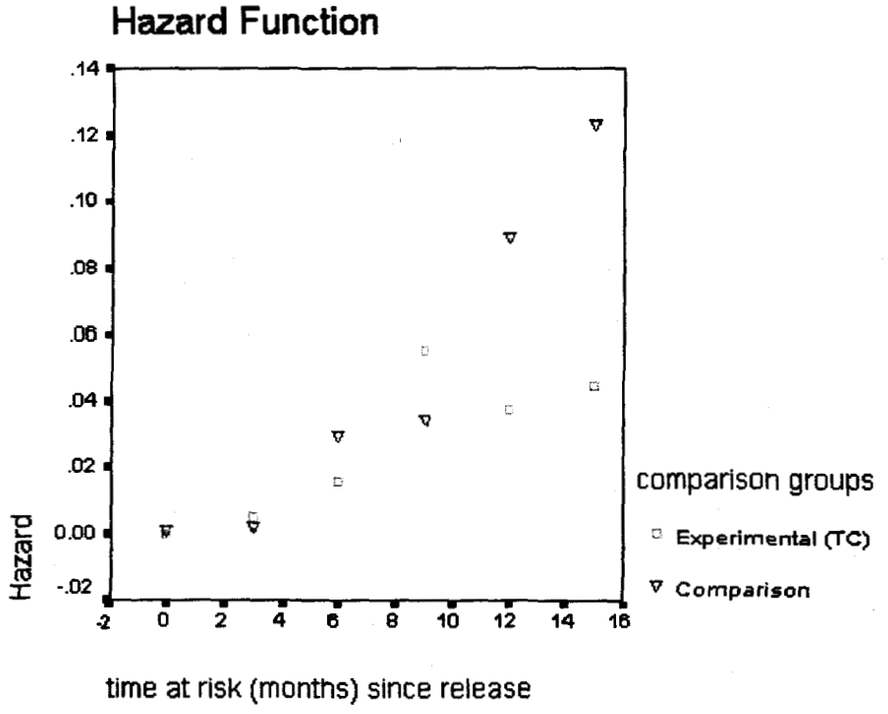


Figure 5. Hazard Function for Rearrest

Drug Relapse and Other Parole Data

We received several types of post-release data from the Pennsylvania Board of Probation and Parole (PBPP), including risk supervision level, current supervision status, drug testing results, and employment status data.[36] Different data types varied in completeness.

Of 894 parolees for whom we received risk level data, 46 (5%) were classified by PBPP as a Minimum risk grade for supervision; 194 (22%) were classified as Medium, 604 (68%) were classified as Maximum, and 51 (6%) were classified as Enhanced.[37] Of the 894 that we received employment data for, 260 (29%) were employed full-time, 34 (4%) were employed part time, 257 (29%) were unemployed but able, and 343 (38%) were unemployed and not able to work.

Of 915 parolees for whom we received current supervision status data, 482 (53%) were reporting regularly, although 74 of the 482 were in Community Correctional Centers, where their freedom and movement were more restricted. Eighteen parolees (2%) were being held on county detainers or in mental institutions. The rest of the sample had already gotten into trouble in various ways. Sixty-one parolees (7%) had simply absconded. No fewer than 124 (14%) were rearrested, and 230 (25%) were revoked for technical violations. The rearrest and reincarceration rates reported earlier, therefore, may be conservative outcome measures by comparison. Many of these wayward parolees may eventually make their way back to state prison, some for a short visit (i.e., technical violators) and others for more extended stays (i.e., new convictions).

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[36] Computerized data on parolee participation in aftercare treatment and more detailed employment measures (e.g., length and type of employment, employee performance) were not available from PBPP at this time. While the quality and intensity of aftercare treatment provided to ex-offenders was unknown, there was no reason to suspect that inmates in the TC v. Comparison group received different levels of aftercare, or that aftercare affected either group differently.

[37] There is little doubt that this was a high-risk sample, as also evidenced by its high assessed need for drug treatment (Table 28).

Drug testing data received for 947 parolees were the most thorough and complete (i.e., fewest missing cases). Relapse analyses examined 189 inmates in the Experimental (TC) group, and 529 inmates in the Comparison group.[38] Sample characteristics are presented in Table 26.

The TC and Comparison groups did not differ on amount of time at risk since their release from prison (Table 24). As expected, the TC group had a mean total treatment exposure nearly 15 times as great as the Comparison group. The two groups differed on a number of other selection criteria, once again indicating the need to use either matching or statistical controls to control for selection bias. Because only a portion of inmates in the sample (especially TC graduates) had been released from prison so far, we preferred the use of statistical controls to matching in order to minimize the loss of cases.

Using logistic regression, we examined the impact of TC on drug relapse rates, controlling for selection differences (Tables 25 and 26). Control variables included prior and current criminal history, time remaining to minimum sentence at the time of program admission, age, standardized drug score, and membership in either the TC or Comparison group. Inspections for multicollinearity among the variables to be entered in the analyses revealed no difficulties. No correlation exceeded .40.

The first table (Table 25) once again shows results for all released offenders; the second table (Table 26) restricted the analyses only to inmates who successfully completed their treatment program. In the first model examined in both tables (i.e., without the effects of institutional setting or employment entered), nothing except the amount of time at risk since release from prison significantly predicted drug relapse. In both analyses (all discharges v.

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[38] As with other outcome analyses, a minimum time at risk of six months or greater since release from prison was used to select cases, and we excluded inmates whose "release" was artificial (i.e.,

successful discharges only), the effect of TC was non-significant, although inmates in the Comparison group were 1.2 times as likely as to relapse as TC graduates.

We again entered a categorical variable that reflected the effect of institutional setting (see Model 2 in both Tables 25 and 26). This time, controlling for other variables such as age, criminal history and level of need for treatment, treatment effects depended on the institutional setting. Inmates at Cresson and Houtzdale had a significantly higher rate of drug relapse than inmates treated at the other three institutions. This effect held constant regardless of whether we examined all releasees or only the subsample that successfully completed their treatment program. Examining the log-odds ratios reported in Tables 25 and 26, we see that Inmates at Cresson and Houtzdale were 2.7 – 2.9 times as likely to relapse as other inmates in the sample.

We then added employment status to logistic regressions, examining all other variables as control variables (e.g., inmate drug scores, criminal history scores, TC v. Comparison group, institutional setting). The results are shown in Model 3 of Tables 25 and 26. Fulltime employment status was strongly related to drug relapse. Those employed full time were only half as likely to relapse as other parolees, regardless of whether we examined all releasees (Table 25) or successful graduates only (Table 26). The effect for "Unemployed but Able" was significant for the sample of all releasees (Table 25), but non-significant for successful treatment graduates only (Table 26).

Finally, using estimated probabilities obtained from the logistic regression analyses, we examined relapse rates for the two groups controlling for all other variables entered into the equation (see Figures 6 through 8).

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inmates who were deceased, now serving a previous sentence, or those simply given an administrative transfer).

First, we examined the drug relapse rates for TC v. Comparison inmates, holding all other variables constant (Figure 6). TC inmates (36%) were slightly less likely than Comparison inmates (39%) to relapse to drug use, but this difference was not statistically significant. Overall, positive drug tests occurred most frequently for cocaine (58% of those testing positive), cannabinoids (25%), opiates (21%), and ethanol (16%).

Next, we examined relapse rates for TC and Comparison groups, broken down by institution (Figure 7). While differences in relapse rates between TC and Comparison groups (0 – 3%) did not reach statistical significance, Figure 7 illustrates the significantly higher rates of relapse (44 – 46%) observed for Cresson and Houtzdale inmates. Significantly lower relapse rates were observed for Waymart (23%), Huntingdon (30 - 31%), and Graterford (32 - 35%).

Finally, we examined relapse rates for each institution, broken down by post-release inmate employment status (Figure 8). In addition to the institutional effect illustrated by Figure 7, Figure 8 shows how full time employment significantly lowers the likelihood of relapse. The lowest rates of relapse were observed for inmates employed full time after completing treatment at Waymart (19%), Huntingdon (25%), and Graterford (27%).

While the effects of employment on reducing drug relapse are impressive, it is impossible to label the observed relationship as direct cause and effect, because those who were gainfully employed may differ in unknown ways (e.g., previous employment history, family support, community ties) from those who were not. More detailed information was not available in parole data, although such information may have influenced the risk supervision grade assigned by PBPP. We entered risk supervision grade into logistic regressions with the other variables, but it failed to reach statistical significance or improve the goodness of fit. Entering numerous combinations of other control variables (e.g., prior and current offense severity, level of need for

treatment, psychological functioning) did nothing to alter or diminish the observed relationship between employment and drug relapse.

Patterns of survival and risk (hazard) for drug relapse are shown in Table 27. For the comparison group, there was a sizeable drop in cumulative survival from 88% to 77% between nine and twelve months following release from prison. Cumulative survival dropped precipitously from 77% to 44% after 15 months. Once again, the 15-month interval appears to be a particularly high-risk interval, although the addition of further cases will help clarify survival patterns over time. The hazard function shown in Figure 9 reveals a tiny survival advantage enjoyed by TC inmates after 12 months.

Table 24
Drug Relapse Sample Characteristics

	Comparison Group		TC Group		
	Valid N	Mean (s.d.)	Valid N	Mean (s.d.)	Sig.
Amount of Time at Risk (months)	529	12.7 (4.1)	189	12.4 (4.3)	ns
Age	529	34.4 (8.6)	189	36.5 (8.5)	*
Time to Minimum (months)	529	-14.6 (32.6)	189	-2.7 (26.9)	*
Current Offense Severity (0 – 10)	528	4.7 (2.6)	189	5.5 (2.1)	*
Prior Offense Severity (0 – 10)	528	4.8 (2.8)	189	5.6 (2.2)	*
Standardized Drug Score	420	-0.2 (1.0)	188	0.4 (0.9)	*
TCU Drug Screen Score (0 – 9)	218	4.0 (3.0)	144	5.7 (2.8)	*
PACSI Screening Instrument (0 – 10)	360	7.5 (2.7)	174	8.7 (1.6)	*
Total Treatment Exposure	514	62.8 (108.4)	186	913.4 (512.8)	*

* $p < .05$ using 2-tailed t-test.

Table 25
Logistic Regression of Drug Relapse on Predictor and Control Variables: All Discharges

	Model 1			Model 2			Model 3		
	b	S.E.	Exp(B)	b	S.E.	Exp(B)	b	S.E.	Exp(B)
AGE	.015	.010	1.015	.017	.011	1.017	.015	.011	1.015
TIME TO MIN	-.002	.003	.998	-.002	.003	.998	-.002	.003	.998
OGS-CURRENT	.028	.039	1.028	.027	.039	1.027	.026	.040	1.027
OGS-PRIOR	-.014	.034	.986	-.021	.036	.979	-.026	.036	.975
DRUG SCORE	.046	.088	1.047	.015	.090	1.015	.002	.092	1.002
TIME AT RISK	.047 *	.021	1.048	.043 *	.021	1.044	.050 *	.022	1.051
PROGTYPE(1)	.192	.193	1.212	.016	.207	1.016	-.085	.212	.918
PRISON(1)				1.075 *	.338	2.931	.946 *	.344	2.574
PRISON(2)				.730	.377	2.076	.597	.383	1.817
PRISON(3)				.978 *	.305	2.659	.830 *	.311	2.293
PRISON(4)				.458	.378	1.581	.338	.384	1.403
EMPST(1)							-.687 *	.218	.503
EMPST(2)							-.272	.423	.762
EMPST(3)							-.283 *	.216	.754
Constant	-1.78 *	.536	.169	-2.425 *	.599		-1.943 *	.621	.143
Chi-square (df)	9.39 (7 df)			25.36 * (11 df)			35.65 * (14 df)		
-2 Log likelihood	800.00			784.03			765.03		
N of cases	608			608			600		

*p < .05

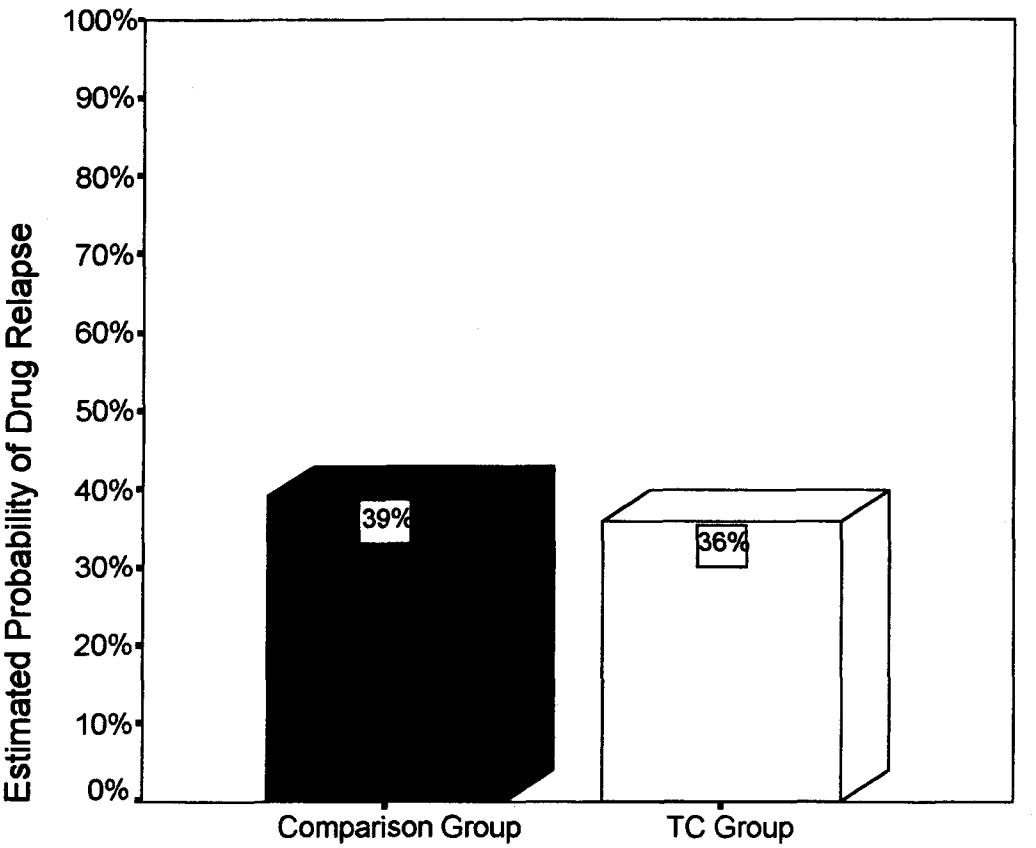
Note. TIME TO MIN = Time remaining to minimum release date at time of program admission; OGS = Offense Gravity Score, Current and Prior (1 - 10); PROGTYPE: 1 = COMPARISON GROUP, 0 = TC. PRISON: 1 = CRESSON, 2 = GRATERFORD, 3 = HOUTZDALE, 4 = HUNTINGDON; EMPST(1) = full time employment, EMPST(2) = part time employment, EMPST(3) = unemployed and able.

Table 26
Logistic Regression of Drug Relapse on Predictor and Control Variables: Successful Discharges Only

	Model 1			Model 2			Model 3		
	b	S.E.	Exp(B)	b	S.E.	Exp(B)	b	S.E.	Exp(B)
AGE	.009	.011	1.009	.010	.012	1.010	.009	.012	1.009
TIME TO MIN	-.002	.003	.998	-.002	.003	.998	-.003	.003	.997
OGS-CURRENT	.017	.041	1.017	.017	.042	1.018	.019	.043	1.019
OGS-PRIOR	-.006	.036	.994	-.015	.038	.985	-.023	.038	.978
DRUG SCORE	.024	.096	1.025	-.004	.099	.996	-.017	.101	.983
TIME AT RISK	.028	.023	1.028	.020	.024	1.020	.027	.024	1.027
PROGTYPE(1)	.174	.208	1.190	.034	.227	1.034	-.066	.233	.937
PRISON(1)				1.058 *	.352	2.879	.937 *	.358	2.551
PRISON(2)				.666	.409	1.947	.555	.415	1.742
PRISON(3)				1.074 *	.316	2.926	.935 *	.322	2.546
PRISON(4)				.455	.390	1.576	.349	.397	1.417
EMPST(1)							-.674 *	.235	.509
EMPST(2)							-.424	.454	.655
EMPST(3)							-.348	.236	.706
Constant	-1.331 *	.583	.264	-1.922 *	.647	1.576	-1.424 *	.675	.241
Chi-square (df)	3.78 (7 df)			20.72 * (11 df)			29.10 * (14 df)		
-2 Log likelihood	684.34			667.40			652.27		
N of cases	518			518			511		

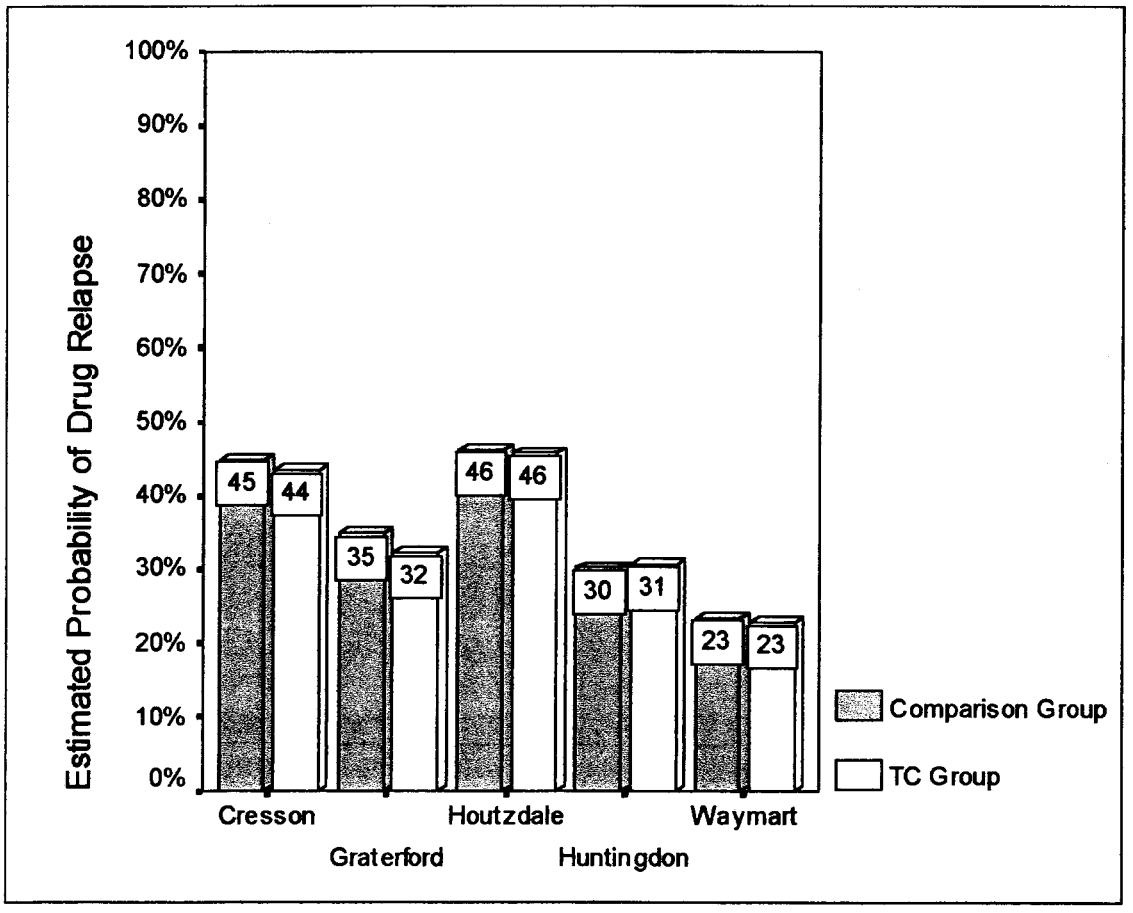
*p < .05

Note. TIME TO MIN = Time remaining to minimum release date at time of program admission; OGS = Offense Gravity Score, Current and Prior (1 - 10); PROGTYPE: 1 = COMPARISON GROUP, 0 = TC. PRISON: 1 = CRESSON, 2 = GRATERFORD, 3 = HOUTZDALE, 4 = HUNTINGDON; EMPST(1) = full time employment, EMPST(2) = part time employment, EMPST(3) = unemployed and able.



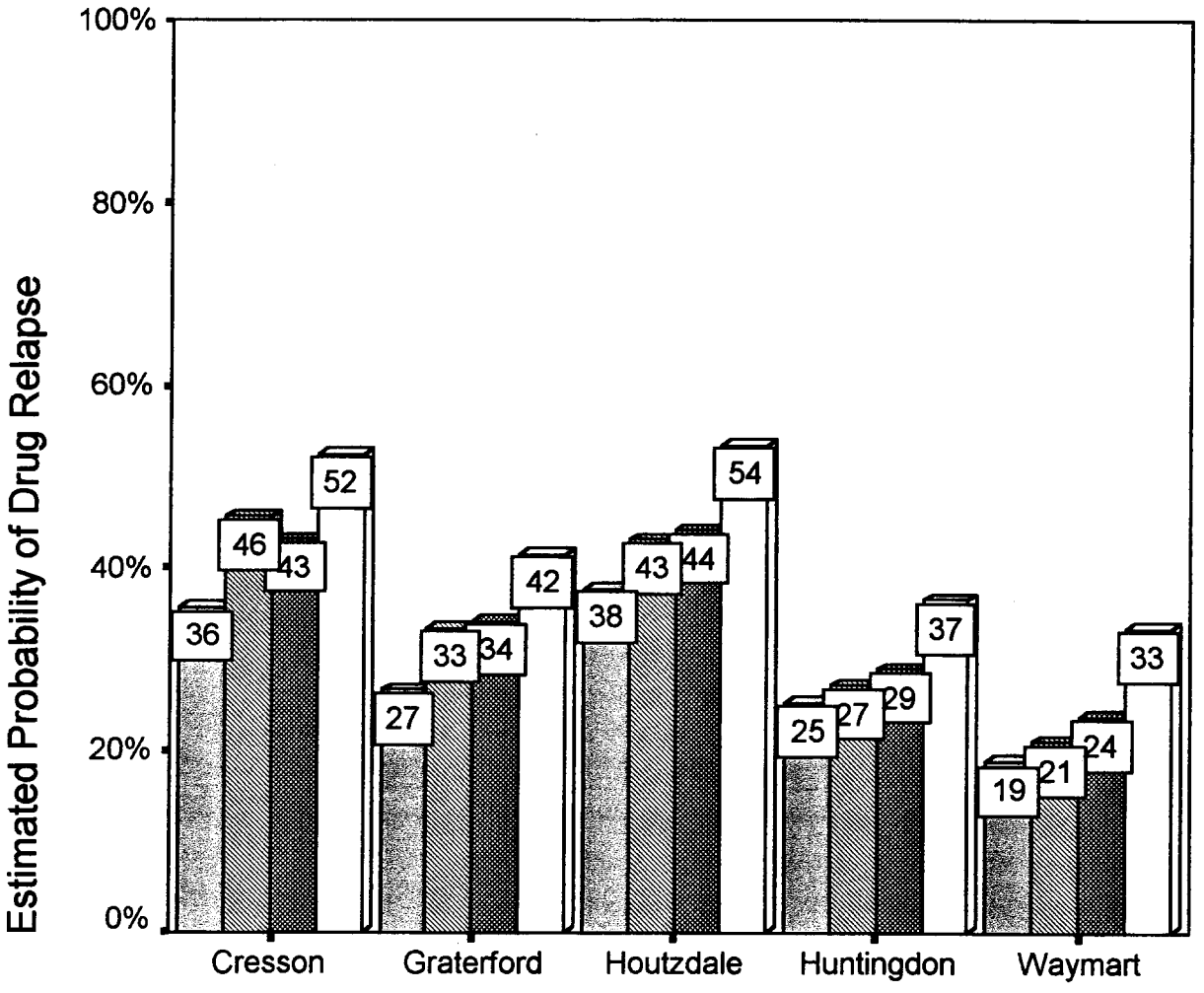
Note. Estimated probabilities are adjusted for all control variables, using logistic regression coefficients reported in Table 26, Model 3. The effect of TC was not significant at the .05 level of statistical significance.

Figure 6. Estimated Probabilities of Drug Relapse by Comparison Group (Adjusted for Control Variables)



Note. Estimated probabilities are adjusted for all control variables, using logistic regression coefficients reported in Table 26, Model 3. The effect of TC was not significant at the .05 level of statistical significance, but the institutional effect was.

Figure 7. Estimated Probabilities of Drug Relapse by Institution and Comparison Group (Adjusted for Control Variables)



Note. Estimated probabilities are adjusted for all control variables, using logistic regression coefficients reported in Table 26, Model 3. Both the effects of employment (full time) and institutional setting were significant at the .05 level of statistical significance. Cresson and Houtzdale had higher relapse rates, on average, than the other three institutions.

Figure 8. Estimated Probabilities of Drug Relapse by Institution and Employment Status (Adjusted for Control Variables)

Table 27
Survival Analysis: Life Tables for Drug Relapse

Survival Variable: DRUGRISK time at risk (MONTHS) between release an
For: COMP_GRP comparison groups (TC v. Ed. or Outpatient)
= 0 Comparison Group

Intrvl Start Time	Number Entrng this Intrvl	Number Wdrawn During Intrvl	Number Exposd to Risk	Number of Termnl Events	Propn Termi-nating	Propn Sur-viving	Cumul Propn Surv at End	Proba-bility Densty	Hazard Rate
.0	579.0	.0	579.0	.0	.0000	1.0000	1.0000	.0000	.0000
3.0	579.0	34.0	562.0	12.0	.0214	.9786	.9786	.0071	.0072
6.0	533.0	80.0	493.0	41.0	.0832	.9168	.8973	.0271	.0289
9.0	412.0	75.0	374.5	46.0	.1228	.8772	.7870	.0367	.0436
12.0	291.0	76.0	253.0	57.0	.2253	.7747	.6097	.0591	.0846
15.0+	158.0	97.0	109.5	61.0	.5571	.4429	.2701	**	**

Intrvl Start Time	SE of Cumul Sur-viving	SE of Proba-bility Densty	SE of Hazard Rate
.0	.0000	.0000	.0000
3.0	.0061	.0020	.0021
6.0	.0134	.0041	.0045
9.0	.0192	.0051	.0064
12.0	.0255	.0070	.0111
15.0+	.0311	**	**

Survival Variable: DRUGRISK time at risk (MONTHS) between release an
For: COMP_GRP comparison groups (TC v. Ed. or Outpatient)
= 1 Experimental (TC)

Intrvl Start Time	Number Entrng this Intrvl	Number Wdrawn During Intrvl	Number Exposd to Risk	Number of Termnl Events	Propn Termi-nating	Propn Sur-viving	Cumul Propn Surv at End	Proba-bility Densty	Hazard Rate
.0	208.0	.0	208.0	.0	.0000	1.0000	1.0000	.0000	.0000
3.0	208.0	16.0	200.0	2.0	.0100	.9900	.9900	.0033	.0034
6.0	190.0	41.0	169.5	14.0	.0826	.9174	.9082	.0273	.0287
9.0	135.0	20.0	125.0	14.0	.1120	.8880	.8065	.0339	.0395
12.0	101.0	28.0	87.0	18.0	.2069	.7931	.6396	.0556	.0769
15.0+	55.0	31.0	39.5	24.0	.6076	.3924	.2510	**	**

** These calculations for the last interval are meaningless.

Intrvl Start Time	SE of Cumul Sur-viving	SE of Proba-bility Densty	SE of Hazard Rate
.0	.0000	.0000	.0000
3.0	.0070	.0023	.0024
6.0	.0219	.0070	.0077
9.0	.0322	.0086	.0106
12.0	.0433	.0119	.0180
15.0+	.0525	**	**

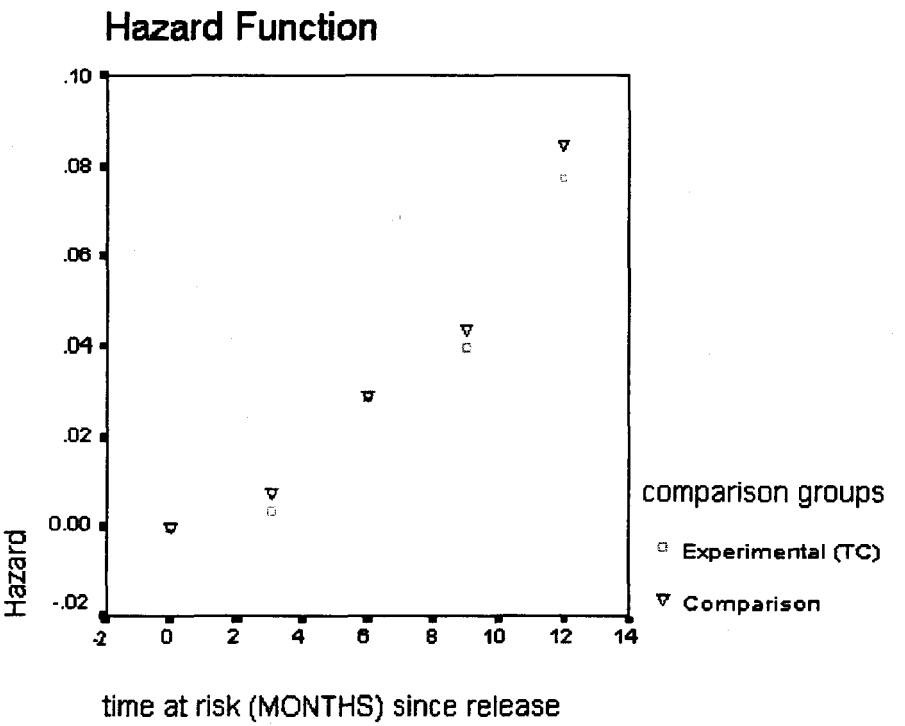


Figure 9. Hazard Function for Drug Relapse

What are the Best Predictors of Effective Treatment Outcomes?

So far, we have presented results for three different outcome variables: reincarceration, rearrest, and drug relapse rates. Using logistic regressions, we entered all relevant predictors into analyses in order to examine the effects of TC while holding other variables (e.g., age, criminal history, level of need for drug treatment, institutional setting) constant. In these previous analyses, we forced the entry of all variables into the regression equations so that the effects of each variable relative to the others could be observed.

In contrast, in this section we examine predictors for each dependent variable using stepwise regression techniques. These techniques enter into regression equations only those variables that exceed a specified probability of statistical significance, and removes variables that fail to reach a specified level of significance. These procedures allow the researcher to estimate models of outcome that reflect only the most robust and significant predictors.[39]

To further explore its robustness as a predictor, we added employment status to the previous logistic regressions for reincarceration and rearrest rates. For each dependent variable, we also included interaction terms for variables found to significantly predict outcomes in previous analyses: institution X employment status, institution X comparison group, and comparison group X employment status.[40]

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[39] Because of the exploratory nature of these analyses, we wanted to maximize the number of cases. To do so, we included all cases where an inmate had been released from prison, regardless of the length of the at-risk period. Recall from previous analyses that we included only inmates who were at risk for periods of six months or more. Because of the additional variables entered here, and the corresponding increase in degrees of freedom, it was more prudent to control for the length of the at-risk period by entering it as a covariate into logistic regression analyses.

[40] Only interaction terms that remained in the final equation (i.e., reached the minimum probability criteria of > .10 for entry and < .20 for removal) are shown in Table 28.

For each of the three dependent variables, employment status significantly predicted treatment outcomes. Full time employment had a robust and significant impact on reducing reincarceration, rearrest, and drug relapse rates.

For rearrest and drug relapse rates, none of the other findings reported previously were substantively altered. Age and length of time at risk since release from prison continued to significantly predict treatment outcomes. As before, institutional effects were observed only for drug relapse, but not for the other two outcome variables.

An interesting finding emerged during analyses of reincarceration, however. The interaction between Comparison group and Employment Status strongly predicted reincarceration, while the main effect of TC v. Comparison group became non-significant. Inmates in the Comparison group who were *not* employed full-time upon release from prison were highly likely to recidivate—9.6 times as likely as other inmates in the sample. The positive effects of in-prison TC treatment, therefore, appear contingent upon favorable post-release conditions such as full time employment.

Table 28

Stepwise Logistic Regression of Outcomes on Predictor and Control Variables

	Reincarceration				Rearrest				Drug Relapse			
	b		S.E.	Exp(B)	b		S.E.	Exp(B)	b		S.E.	Exp(B)
AGE					-.056	*	.017	.945	.019		.010	1.019
TIME TO MIN												
OGS-CURRENT												
OGS-PRIOR												
DRUG SCORE												
TIME AT RISK	.211	*	.027	1.234	.160	*	.035	1.173	.063	*	.020	1.065
PROGTYPE(1)												
PRISON(1)									.874	*	.311	2.396
PRISON(2)									.528		.355	1.696
PRISON(3)									.755	*	.289	2.127
PRISON(4)									.319		.351	1.375
EMPST(1)	-3.776	*	1.014	.023	-2.647	*	.531	.071	-.567	*	.209	.567
EMPST(2)	-1.592		1.148	2.04	-.675		.574	.509	-.211		.417	.810
EMPST(3)	-1.417	*	.520	.242	-1.822	*	.399	.162	-.232		.208	.793
PROGTYPE(1) X EMPST(1)	2.260	*	1.051	9.587								
PROGTYPE(1) X EMPST(2)	.846		1.279	2.330								
PROGTYPE(1) X EMPST(3)	.755		.552	2.127								
Constant	-2.684	*	.291	.068	-.827		.594	.437	-2.282	*	.517	.102
Chi-square (df)	131.83	*			92.39	*			38.81	*		
	(7 df)				(5 df)				(9 df)			
-2 Log likelihood	537.95				376.98				817.43			
N of cases	702				703				649			

*p < .05

Note. Probability required for entry was < .10; probability required for removal was > .20. Coefficients are shown only for variables that remained in the final regression equation. TIME TO MIN = Time remaining to minimum release date at time of program admission; OGS = Offense Gravity Score, Current and Prior (1 - 10); PROGTYPE: 1 = COMPARISON GROUP, 0 = TC. PRISON: 1 = CRESSON, 2 = GRATERFORD, 3 =HOUTZDALE, 4 = HUNTINGDON; EMPST(1) = full time employment, EMPST(2) = part time employment, EMPST(3) = unemployed and able.

V. CONCLUSIONS AND RECOMMENDATIONS

The purpose of this project was to examine multiple post-release outcomes for 2,981 inmates who participated in TC drug treatment programs or comparison groups at five state prisons, and to examine interactions between client selection, program structure, treatment process, responses to treatment and multiple measures of outcome. Matched comparison groups made up of TC-eligible inmates participating in less intensive forms of treatment (e.g., short-term drug education and outpatient treatment groups) at the same five institutions were constructed based upon known predictors such as drug dependency, need for treatment and criminal history. Process and outcome measures incorporated institutional, intermediate (e.g., attitudinal and behavioral change) and post-release measures (e.g., drug relapse, rearrest, reincarceration). Below, we summarize findings and recommendations in five major areas: post-release outcomes, inmate characteristics, treatment process, programmatic variations, and information systems.

Post Release Outcomes

Overall, we found positive effects of TC, especially for successful program graduates (but not failures), and mainly on reincarceration rates (but not rearrest or drug relapse rates). Controlling for selection differences (e.g., criminal history and assessed level of need for drug treatment), reincarceration rates were significantly lower for TC graduates (19%) than Comparison inmates (26%). Interestingly, the positive effects of TC were moderated considerably by post-release employment. With minor exceptions (discussed below), programmatic effects were invariant across the five institutions.

TC significantly lowered the likelihood of reincarceration, although it did so only when successful program graduates were isolated. When program failures were included in analyses, TC

effects became nonsignificant (although still in the right direction). It appears that critics were right: proper diagnosis of treatment effects requires separate consideration of program graduates and failures (Austin, 1998). It is not enough to simply expose an inmate to TC; he/she must successfully complete it to enjoy any significant, lasting advantage. TC graduates who maintained full time employment after release from prison had the lowest reincarceration rates overall. Survival analyses showed visible effects of TC primarily after 12 months, although hazard rates began to rise sharply after 6 – 9 months.

In contrast to findings for reincarceration, TC had no significant effect on rearrests. Arrests, of course, may or may not result in formal charges, convictions, or reincarcerations. Reincarceration may simply be a more reliable indicator of post-release outcome. No significant interactions between TC and other variables (e.g., institutional setting, employment status) were found. However, full-time employment following release from prison once again showed a significant effect in lowering the likelihood of rearrest.

Last, but not least, we examined the effects of TC and other variables on parole outcomes including drug testing. Thirty-six percent of inmates in the TC group and 39% of inmates in the Comparison group had at least one positive drug test during the at-risk period. Although a positive drug test does not necessarily result in a technical parole violation (TPV), a new offense, a new arrest, or a new reincarceration, high relapse rates are certainly of concern. Relapse rates were significantly higher for two of the five institutions examined, the only instance in which we found any significant effect of institutional setting on treatment outcomes. Employment had a strong effect on reducing the likelihood of relapse. Inmates who were employed full-time during the at-risk period were half as likely to test positive for drug use.

Employment may help prevent drug relapse in several ways. First of all, to maintain full-time employment, the ex-offender's daily routine activities must be structured around work to a considerable degree rather than drug use or a criminal lifestyle. Second of all, full-time employment changes the nature and structure of one's peers. One might find positive role models to emulate at work, rather than (or in addition to) some of the negative ones that might be present in his/her neighborhood. Third, full-time employment can be rewarding to an ex-offender, in that it offers highly desired freedom and independence. Finally, full-time employment is heavily emphasized as part of an offender's release plan and recovery from substance abuse. It may be that some ex-offenders see employment as a tool to help them achieve meaningful goals (e.g., food and shelter; the potential for rebuilding meaningful relationships with friends and family). While studies of the reciprocal relationship between employment and incarceration have been inconclusive to date, there is evidence that employment may help an ex-offender to rebuild human and social capital following incarceration, resources that may play a considerable role in reducing the risk of reoffending (Western, Kling and Weiman, 2001).

Toward this end, DOC recently began pilot testing of a new Community Orientation and Reintegration Program (COR) in December of 2001. This program provides structured reentry preparation to inmates through two weeks of prison-based programming immediately prior to release from a state correctional institution, followed by four to six weeks of similar programming in a Community Corrections Facility after release. Programming includes job readiness training and placement, community and family reintegration, and decision-making skills. Beginning in fall of 2002, DOC plans to implement COR on a system wide basis, with a majority of inmates released from DOC being required to participate in the program.

Finding: Of the three major outcomes examined, TC significantly reduced the likelihood of reincarceration alone. Post-release employment was strongly related to a lower likelihood of reincarceration, rearrest, and drug relapse.

Recommendation:

1. Correctional officials, in cooperation with Parole, Probation and privately contracted Community Correctional Facilities (CCF's) should further explore and evaluate strategies to enhance post-release employment prospects.

Inmate Characteristics

Results indicated the necessity for researchers to account for multiple admissions into drug treatment programs. During the study period, 2,891 inmates entered our sample, but they accounted for over 4500 admissions into various programs. Two major consequences follow. First, an inmate's total treatment exposure (duration and intensity) varies depending upon which specific combination of treatments the inmate enters and completes. Time in treatment and treatment exposure are among the most consistent predictors of drug relapse and recidivism (Lipton, 1997). Second, previous TC studies have often not accounted for these multiple program exposures; the perplexing result is that treatment migration seems likely and previously reported findings become questionable.

Treatment migration refers to problems in the delivery of treatment that result in biased comparison groups. The wrong treatment is delivered to one or more groups, or different treatment conditions are mixed. This sort of problem is surprisingly common and frequently unaddressed in evaluation studies, even those that attempt to use random assignment (Gartin, 1995). For example, Inciardi (1997:266) states: "Many of the so-called no treatment comparison

group did get some treatment help" (Inciardi et al., 1997:266). While it is also true in our study that inmates in the comparison group received some treatment, the crucial questions are *what kind* of treatment, and *how much*?

Because we accounted for all admissions and discharges during the study period, we were able to precisely account for total treatment exposure for all inmates in our sample. Previous studies have failed to do so. Although we used a quasi-experimental design, rather than random assignment, we showed that the experimental (TC) and comparison groups differed dramatically on treatment exposure (by a factor of about 20:1), and we were able to examine the effects of treatment exposure as a control variable in our analyses.

Previous studies have often failed to account for program dropouts in analyses, prompting questions about the validity of their findings. As Austin (1998) and others have argued, treatment groups often evidenced only slightly lower reincarceration rates compared to control groups when program failures were included in calculations of recidivism (Austin, 1998). It is instructive to note that randomized designs do not eliminate biased attrition or problems such as treatment migration. Our results clearly indicated that treatment effects were diminished when program failures were taken into account. This does not mean that there was no treatment effect, but rather, that the effect was much smaller than it would be if researchers failed to separate program graduates from program dropouts in analyses of outcome. This finding raises important questions for policy consideration.

While the attrition rates reported in this sample were quite favorable compared to those reported in other drug treatment studies,[41] correctional policy makers must address the question of *why* so many inmates fail to complete TC or other drug treatment programs while in prison,

and further explore means for enhancing the treatment induction and engagement process (e.g., Blankenship, Dansereau and Simpson, 1999; Hiller, Knight and Simpson, 1999). At best, high program attrition rates may indicate a waste of scarce treatment resources. At worst, they spell high rates of recidivism for inmates who fail to become engaged in or complete drug treatment.

While the overall termination rate for TC (25%) was consistent with other studies of prison-based TC (Simpson, 1997; Young, 2002), one program (Waymart) was quite low (5%); another (Graterford) was high (71%). Our data indicated that the Graterford program was fairly intense, and it made extensive use of peer support, confrontation and sanctions (e.g., helping measures). As in most aspects of life, though, neither extreme is ideal. Across TC programs, there appears to be a high level of discretion by treatment staff about appropriate thresholds for success and appropriate grounds for dismissal. Of particular interest was the lengthy period of time inmates spent in TC programs prior to termination (19 – 32 weeks). Clearer guidelines specifying behavioral criteria for treatment success or failure may perhaps be needed, accompanied by strong monitoring of inmate behavior. Good decisions about who is appropriate for TC (or not) could perhaps be made within a shorter time span (DeLeon, 2000; Hiller, Knight and Simpson, 1999, ONDCP, 1999). Further inquiry might examine whether inmates are given adequate opportunity to correct their behavior prior to termination, and whether other procedures might strengthen inmates' therapeutic engagement and retention in the program (Hiller, 2000; ONDCP, 1999).

Finding: We found some inconsistencies in inmate selection and termination procedures across the five institutions. For example, two TC programs tended to recruit older, lower-risk inmates than the other TC programs. Attrition rates varied substantially (5 – 71%) across TC programs.

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[41] A high proportion of inmates entering drug treatment programs fail to complete them; reported dropout rates vary from 30 – 90% (Simpson et al., 1997; Young, 2002).

Recommendations:

2. Correctional administrators, working with researchers, drug treatment specialists, treatment supervisors and program managers, should examine the frequency of different reasons given for program termination at each institution. Officials might examine the manner in which inmates are given opportunities to correct their behavior prior to termination, and whether existing procedures aimed at improving inmates' therapeutic engagement and retention in the program can be strengthened.

3. DOC administrators should work with drug treatment specialists, treatment supervisors and correctional program managers to carefully monitor compliance with recently implemented drug treatment program standards and policies. For example, administrators should ensure that selection criteria for TC and other program types are consistently implemented so that program participants reflect appropriate levels of treatment need. TC drug treatment should be reserved for high-risk, high-need inmates.

Inmates placed into TC programs at the five institutions were definitely high need inmates, as evidenced by their criminal histories and assessed level of need for drug treatment. However, inmates assigned to the Comparison group were almost as high-need. Most inmates in our sample, even those placed in low-intensity Education and Outpatient programs, met and surpassed the minimum eligibility criteria for TC placement (see Table 6). We thus have a gap in treatment responsivity. There are simply not enough TC beds to assign all high-need inmates to high-intensity treatment programs. This is true in general of drug treatment in the correctional system (Welsh and Zajac, 2001).

Finding: Many high-need inmates (e.g., relatively high prior offense severity scores and high need for drug treatment) were assigned to less intensive Outpatient programs rather than TC. These findings suggest that Outpatient programs are being used for many high-need inmates who are unwilling, unsuitable or unable (for other reasons) to participate in more intensive TC programs.

Recommendation:

4. Correctional administrators should carefully monitor the implementation of assessment, screening and program placement procedures specified by treatment policies.[42] Verify that AOD staff at each institution understand and implement these guidelines. Monitor drug treatment program placements at each institution to ensure that high-need inmates are assigned to high-intensity treatment programs. DOC officials should examine variations in the level of need for drug treatment assessed at the Diagnostic and Classification Center (DCC) to determine how many TC beds are needed throughout the state.

An unexpected finding concerned inmate eligibility and selection criteria for AOD programs (see Table 6). Minimum time remaining to release date was stated as a major criterion for admission into all AOD treatment programs including TC (Welsh, 2000a, 2000b). However, there was substantial variation on this criterion. Many inmates (especially those placed in Outpatient programs) were long past their minimum release dates; others still had several years remaining until their minimum release date.

According to DOC policy (Pennsylvania Department of Corrections, 2001), minimum release date is one critical screening criterion for AOD programs, along with an inmate's assessed need for treatment and the availability of different types of treatment slots at each institution. As

[42] While newly developed DOC standards regarding drug treatment content, structure, duration and intensity are generally clear (Pennsylvania Department of Corrections, 2001), standards applicable to Outpatient programming remain less clear than standards governing TC and

an inmate gets closer to his/her minimum release date, he/she should receive a higher priority for AOD placement, especially since completion of AOD treatment can be a major factor influencing parole application decisions. For the five TC programs, minimum time remaining to minimum release date was listed at 15 months for Cresson, 9 months for Waymart, and 6 months for Huntingdon. For Graterford, eligibility criteria required "sufficient time to complete treatment." No written policy statement was found for Houtzdale.

This finding suggests that many inmates in drug treatment programs had already been denied parole at least once. Data inspections suggested that some inmates may have "rolled over" from one sentence to another (e.g., consecutive sentences for different convictions). As a result, they may have been assigned a new inmate number, but their old minimum release date remained attached to their old inmate number in the DOC database. Other inmates may have been released on parole and returned to prison for technical violations, without having a new minimum release date entered. As a result, the minimum release date of record is not necessarily a reliable indicator of TC eligibility, in spite of DOC policies specifying its use. With the assistance of DOC personnel, we were able to make numerous corrections based upon case-by-case searches of the DOC database, but this was an extremely inefficient and time-consuming task.

Thus, a substantial number of inmates in our sample that we expected to be released by the end of June 2001 had in fact not yet been released. DOC drug abuse treatment specialists (DATS) at each institution utilize diverse criteria when making AOD program placement decisions. This does not mean that minimum release dates are not considered, but they receive far less priority (on average) than we had expected based on previous process evaluation research and stated program admission guidelines (Welsh, 2000a; 2000b). Further policy review and/or program

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Education programs. For example, Outpatient standards allow considerable discretion in

monitoring may be helpful to ascertain the degree to which AOD treatment programs follow written DOC policy guidelines (Pennsylvania Department of Corrections, 2001) and/or their own program eligibility criteria (see Appendix 7).

Finding: Considerable variability was observed in time remaining to minimum release date. In contrast to stated policy guidelines, many inmates who were enrolled in drug treatment programs were already well past their minimum release dates.

Recommendation:

5. Correctional administrators should regularly review, update and verify critical data fields entered into automated information systems. Critical data fields include data elements that are used to guide program eligibility, selection and placement decisions. Verify that AOD staff at each institution understand and implement selection guidelines.

Treatment Process

Using various subscales of the REST and CRC, we were able to examine changes in inmate psychological and social characteristics, as well as responses to treatment over time. Significant improvements were observed in inmate psychological and social functioning over the first six months of treatment (e.g., self esteem, depression, risk taking).

Positive responses to treatment were also indicated (e.g., positive increases in perceptions of therapeutic engagement, personal progress, trust in group, program staff, counselor rapport, and counselor competence). Counselor ratings were consistent with inmate ratings in terms of significant improvements in therapeutic engagement, although counselor ratings indicated little change in denial and even an increase in inmate psychological problems.

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treatment program format, intensity and duration.

Findings suggested that certain inmate needs might not be fully addressed by different TC programs. Inmates may need more specialized treatment for psychological problems than what they currently receive. For example, high, untreated anxiety or depression may weaken inmate engagement in treatment and responses to treatment (Chien, 1980; Powell and Taylor, 1992; Simpson and Joe, 1993a). Similarly, many inmates may require much more systematic, intensive induction strategies to help prepare them for the emotional challenges and interpersonal rigors of TC. Induction techniques help inmates identify resources, both internal and external, that can be used to maximize treatment participation and improve treatment outcomes. All TC programs have orientation procedures (Appendix 7), but more intensive strategies such as cognitive enhancement and motivational interviewing should be considered (Blankenship et al., 1999; Farabee, Simpson, Dansereau and Knight, 1995).

Finding: TC inmates may in some cases have psychological needs that are not being fully addressed, as indicated by REST (inmate self-report survey) and CRC (counselor ratings) change scores.

Recommendation:

6. Correctional administrators, working with researchers, drug treatment specialists, treatment supervisors and program managers, should identify clear and consistent standards for assessment of inmate psychological needs at each institution, as well as procedures for ensuring that such needs are adequately addressed during the course of an inmate's treatment.

Programmatic Variations

One rarely finds discussion of programmatic variations or their influence on treatment outcomes in studies evaluating the effects of prison-based TC. This shortcoming, perhaps more than any other, has limited our ability to discern the true impact of TC (Welsh et al., 2000; Welsh and Zajac, 2001). We have attempted to provide some illustrative examples here, although a sample of 5 programs can only go so far. Further research examining larger samples of TC programs, as well as inmates, is needed to properly isolate inmate and programmatic effects.

The strongest area of consistency across the five TC programs was in the high ratings that inmates gave of counselor rapport and counselor competence. Each unit, while consistently implementing the basic TC philosophy, also exhibited some programmatic variations.

Two of the five TC units were quite large (100+ inmates). Large TC units may make it more difficult to foster positive peer interactions (ONDCP, 1999). At Waymart, the TC is subdivided into two separate units. Houtzdale, on the other hand, has 124 inmates who all live on the same unit. Proper supervision and monitoring of inmate behavior on the TC, including inmate committees (e.g., "pull-ups") may become more problematic on large units. Large TC programs, according to voluntary guidelines formulated by Therapeutic Communities of America (ONDCP, 1999), should be subdivided into units no larger than 50-75 (ONDCP, 1999). Staffing levels can also affect treatment process. For example, inmates at two of the TC programs spoke well of their counselors, but complained that there was too little time for individual counseling. All TC programs should aspire to meet guidelines such as CP6 proposed by Therapeutic Communities of America (ONDCP, 1999): "*Participants are accountable to each other and the community on a continuous basis, fostering a strong sense of responsibility for self and others*" (ONDCP, 1999:Appendix B, p. 3).

Finding: TC programs varied little in terms of criteria such as intensity (hours per week) and duration (number of months). However, two of the TC programs did not use pull-ups, and individual counseling was provided inconsistently. Therapeutic engagement and inmate satisfaction, as assessed by inmate interviews, self-report surveys, and counselor ratings, varied somewhat across the five TC programs.

Recommendations:

7. While new DOC drug treatment policies and procedures identify standards for each program type, DOC administrators should carefully monitor (e.g., through inmate self-reports, inmate and counselor interviews, and periodic site visits) the implementation of these standards at different institutions.

8. Correctional administrators, working with drug treatment specialists, treatment supervisors and correctional program managers, should identify strategies for on-site quality control in drug treatment programming. Officials should examine whether current resources devoted to program quality assurance are sufficient (see ONDCP, 1999, DeLeon, 2000). Officials should examine the feasibility of a Statewide Integrated Quality Assurance Model (SIQAM) for prison-based TC programs (Kressel, Zompa and DeLeon, 2002). This model is based upon the TC framework developed by DeLeon (2000) and critical program standards jointly developed by Therapeutic Communities of America (TCA) and the American Correctional Association.

Information Systems

A good information system serves several purposes. First and foremost, a good information system can demonstrate accountability to funding agents (e.g., state legislatures) and other stakeholders. A good information system is also useful for planning: it allows program managers or policy makers to see how well current plans are going, identify problems, and make

adjustments. A useful information system allows for continuous monitoring over time: it is sensitive to both intended and unintended changes in program or policy design. Sad to say, correctional agencies do not always do a stellar job of collecting core data elements.

A recent report by the U.S. Department of Justice (1998) assessed the current status of offender-based information systems in corrections and identified information needs and obstacles. Correctional administrators across the U.S. stated that they often lacked the basic information needed to formulate new policies or to defend existing practices. Researchers highlighted the difficulties of conducting comparative studies in the absence of basic agreement on data concepts and definitions, and diversity in the quality and coverage of data elements in correctional information systems. Such information is indispensable, however, for any correctional agency that wishes to effectively monitor and evaluate its offender programs (U.S. Department of Justice, 1998). Two types of high-priority needs are relevant to the long-term development and success of correctional program evaluation efforts.

Program-Based Databases. Significant variations typically exist in education, outpatient and inpatient drug treatment programs across different sites (Welsh et al., 2000; Welsh and Zajac, 2001). During the first year of the Temple-DOC research partnership (Welsh, 2000a, 2000b), we found that treatment exposure and duration varied, sometimes considerably, for Education and Outpatient programs across different institutions. The Department of Corrections has since adopted numerous of our recommendations for program standardization (Pennsylvania Department of Corrections, 2001). However, programmatic variations in either prison-based or community-based AOD treatment programs, where they exist, need to be assessed and recorded in a program-based database. In this way, any inmate admitted into any program participating in

an evaluation study can be linked with a specific set of program descriptors (e.g., duration, intensity, primary treatment approach, program performance measures, etc.).

Offender-Based Treatment Databases. Prior and current efforts by DOC to establish and develop computerized, *offender-based* treatment databases will strongly facilitate future evaluation efforts. In general, efforts to develop overall information system capacities regarding offender program participation will enhance offender monitoring, treatment integration and communication, and research on the effects of participation in various combinations of prison- and community-based treatment programs.[43]

Finding: At the time of this study, there was a lack of computerized data on several measures (e.g., admissions and discharges from prison-based treatment programs, participation in aftercare treatment) that would facilitate program evaluation.

Recommendations:

9. Correctional, parole and probation officials should ensure that appropriate levels of aftercare treatment are being identified and provided to inmates upon their release from prison. DOC and PBPP administrators should work together to further develop and strengthen automated procedures for tracking inmate post-release behavior and compliance with conditions of supervision.

10. DOC should continue to strongly support the development of offender-based treatment information systems. In response to previous recommendations, DOC recently completed development of a Unit Management System that captures diverse aspects of offender program participation. For example, this database includes an inmate's name and number,

[43] Because aftercare treatment may interact with other variables such as employment to influence recidivism (e.g., Knight, Simpson and Hiller, 1999; Martin, Butzin, Saum and Inciardi, 1999), it would be desirable for correctional and parole agencies to collect and report computerized data on such variables.

date of program admission and discharge, and reason for discharge (successful v. unsuccessful). This database will provide critical information for program monitoring and evaluation. Program admission decisions can be better informed by information about the inmate's previous participation in treatment, as well as the inmate's assessed need for treatment and other program eligibility criteria (e.g., type of offense, minimum release date). The same data are vital for setting up valid comparison groups for outcome evaluation (e.g., matching designs).

Limitations

As noted, the major limitations in the present study were the brevity of the follow-up periods so far and the attendant sample sizes available for multivariate outcome analyses. Inmates were not released from prison as quickly as we had expected based on program eligibility criteria such as minimum release date. As more inmates are released, and as average time at risk increases, we will revisit the analyses and conclusions formulated in this report.

The sample reduction between the first, second and third administrations of the REST and CRC instruments also placed limits on the types of analyses we were able to conduct. Too few of the inmates who completed repeated measures on the REST and CRC instruments had been released from prison at this time, precluding some analyses of interactions between treatment process and outcome. Again, our ability to conduct such analyses will increase as we follow released inmates over greater periods of time.

More research on how prison-based drug treatment interfaces with critical post-release mechanisms such as parolee supervision, employment and aftercare treatment would be valuable. Over the past twenty years, concern about prisoner re-entry has been heightened by the growth in imprisonment rates, the fragmentation of sentencing philosophy, the weakening of parole supervision, and the concentrated return of offenders to disadvantaged communities (Clear, Rose

and Ryder, 2001; Travis and Petersilia, 2001). Prisoners are less prepared for reintegration and less connected to community-based social services such as drug treatment and vocational, family, and health services (Harrison, 2001).

We found a strong, robust effect of full-time employment on all three post-release outcomes examined (reincarceration, rearrest, and drug relapse). However, our ability to examine post-release outcomes was limited by the unavailability of automated data regarding participation in aftercare treatment. Participation in aftercare may interact with employment and other observed predictors to influence outcomes. Future research should examine ways to better integrate prison-based drug treatment with post-release needs and resources.

It was difficult to determine the degree to which full-time employment was a cause or an effect. To do so, we would need more detail on post-release employment (and prior employment history) to examine how non-relapsing parolees might differ from others. For example, it would be useful to obtain more detailed information on parolees' type of post-release employment, employee performance, income, etc. To disentangle potential causes, we would also need to determine how other factors (e.g., personal characteristics, intelligence, cognitive abilities, education, in-prison and pre-prison work history, job training) might influence relationships between employment and drug relapse (as well as reincarceration and rearrest). However, none of the control variables examined in this study (e.g., assessed level of need for drug treatment, prior and current offense severity, age) substantially weakened the observed relationship between employment and reduced recidivism, leaving us with the impression that the effect of post-release employment is quite robust.

Conclusion

The effects of TC were statistically significant and encouraging, although not unqualified. TC significantly lowered the likelihood of reincarceration, although it did so only when successful program graduates were isolated. The effects of TC on rearrest or drug relapse failed to reach statistical significance. Post release employment emerged as the strongest predictor of recidivism.

Results suggest that policies regarding prison-based drug treatment should focus on strengthening and enhancing TC quality and implementation so as to maximize treatment effects. Guidelines formulated by professional associations and informed by both clinical practice and research suggest that the bar could profitably be raised (DeLeon, 2000; Farabee et al., 1999; Kressel, Zompa, and DeLeon, 2002; ONDCP, 1999; Taxman and Bouffard, 2002). Where TC is sufficiently intense but supportive, treatment engagement and completion should be intentionally maximized. The benefits of TC, where they exist, appear to be restricted to those who successfully engage, complete and graduate. Further policy-relevant research should continue to explore and evaluate productive strategies in these directions, while examining more detailed interactions between inmate characteristics, treatment process, and post-release outcomes.

References

Andrews, Donald A. (1995) "Assessing Program Elements for Risk Reduction: The Correctional Program Assessment Inventory (CPAI)." Paper presented at the "Research to Results" conference, sponsored by IARCA, Ottawa, Canada, October 11-14, 1995.

Andrews, Don, Ivan Zinger, Robert D. Hoge, James Bonta, Paul Gendreau, and Francis T. Cullen (1990) "Does Correctional Treatment Work? A Clinically Relevant and Psychologically Informed Meta-Analysis." Criminology 28:369-404.

Argyris, Chris. (1982). Reasoning, Action and Learning. San Francisco: Jossey-Bass.

Austin, James (1998) "The Limits of Prison Drug Treatment." Corrections Management Quarterly 2: 66-74.

Ball, J.C., Shaffer, J.W. and Nurco, D.N. (1983). "Day-to-day criminality of heroin addicts in Baltimore: A study in the continuity of offense rates." Drug and Alcohol Dependence 12: 119-142.

Beck, A.T. and R.A. Steer (1987) Beck Depression Inventory Manual. New York: Harcourt Brace Jovanovich.

Berry, G.W. and Sipps, G.J. (1991). "Interactive effects of counselor-client similarity and client self-esteem on termination type and number of sessions." Journal of Counseling Psychology 38(2): 120-5.

Bonta, James (1996) "Risk-Needs Assessment and Treatment." In Alan T. Harland (ed.), Choosing Correctional Options That Work: Defining the Demand and Evaluating the Supply. Thousand Oaks, CA: Sage.

Broome, K. M., Knight, K., Joe, G. W., & Simpson, D. D. (1996). "Evaluating the drug-abusing probationer: Clinical interview versus self-administered assessment." Criminal Justice and Behavior, 23(4), 593-606.

Broome, K. M., Knight, D. K., Knight, K., Hiller, M. L., & Simpson, D. D. (1997). "Peer, Family, And Motivational Influences On Drug Treatment Process And Recidivism For Probationers." Journal Of Clinical Psychology 53: 387-397.

Cantor, D. and Lynch, J.P. (2000). "Self-report surveys as measures of crime and criminal victimization." In D. Duffee (Ed.), Criminal Justice 2000, Volume 4 (pp. 85-138). Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice (NCJ-182411).

Chaiken, M.R. (1989). In-Prison Programs for Drug-Involved Offenders. Research in Brief. Washington, DC: National Institute of Justice.

Chien, I. (1980). "Psychological, social, and epidemiological factors in juvenile drug use." In D.J. Lettieri, M. Sayers, and H.W. Pearson (Eds.), Theories on drug abuse: Selected contemporary perspectives (NIDA Research Monograph 30, DHHS Publication No. ADM80-967). Washington, DC: U.S. Government Printing Office.

Clear, T.R., Rose, D.R., and Ryder, J.A. (2001). Incarceration and the community: The problem of removing and returning offenders. Crime and Delinquency 47, 335-351.

Czuchry, M. L., Dansereau, D. F., Sia, T. S., and Simpson, D. D. (1998). "Using Peer, Self, And Counselor Ratings To Evaluate Treatment Process." Journal of Psychoactive Drugs 30: 81-87.

DeLeon, G. (2000). The therapeutic community: Theory, model and method. New York: Springer.

Derogatis, L.R., H. Yevzeroff, and B. Wittelsberger (1975) "Social Class, Psychological Disorder, and The Nature of the Psychopathologic Indicator." Journal of Consulting and Clinical Psychology 43:183-191.

Farabee, D., Prendergast, M., Cartier, J., Wexler, H., Knight, K., and Anglin, D. (1999). Barriers to implementing effective correctional drug treatment programs. The Prison Journal 79, 150-162.

Farabee, D., Simpson, D.D., Dansereau, D.F., and Knight, K. (1995). "Cognitive inductions into treatment among drug users on probation." Journal of Drug Issues 25:669-682.

Federal Bureau of Prisons (1998) TRIAD Drug Treatment Evaluation. Six-Month Report: Executive Summary. Washington, DC: U.S. Department of Justice, Federal Bureau of Prisons.

Field, G. (1984). "The cornerstone program: A client outcome study." Federal Probation, 48, 50-55.

Field, G. (1989). "A study of the effects of intensive treatment on reducing the criminal recidivism of addicted offenders." Federal Probation 53(10):51-56.

Field, G. (1992). "Oregon Prison Drug Treatment Programs." In Drug Abuse Treatment in Prisons and Jails, ed. C.G. Leukefeld and F.M. Tims, 246-260. NIDA Monograph No. 118. HHS. Rockville, MD: USGPO.

Fletcher, Bennett W. and Frank M. Tims (1992) Methodological Issues: Drug Abuse Treatment in Prisons and Jails. In C.G. Leukefeld and F.M. Tims (eds.), Drug Abuse Treatment in Prisons and Jails (pp. 246-260). Washington, DC: U.S. GPO.

Gartin, Patrick R. (1995) "Dealing With Design Failures in Randomized Field Experiments: Analytic Issues Regarding the Evaluation of Treatment Effects." Journal of Research in Crime and Delinquency 32: 425-445.

Gendreau, Paul (1996) "The Principles of Effective Intervention With Offenders." In Alan T. Harland (ed.), Choosing correctional options that work: defining the demand and evaluating the supply. Thousand Oaks, CA: Sage.

Gendreau, Paul and Donald A. Andrews (1994) Correctional Program Assessment Inventory (CPAI) Answer Form (4th Edition). Ottawa, Canada: Carleton University.

Gilliard, Darrell K. and Allen J. Beck (1998) Prison and jail inmates at midyear 1997 (NCJ-167247) Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

Gore, Al. (1993). The Gore report on reinventing government. New York: Basic Books.

Gropper, B.A. (1985). Probing the links between drugs and crime. Washington, DC: National Institute of Justice.

Hanushek, Eric A. and Jackson, John (1977). Statistical methods for the social sciences. New York: Academic Press.

Harrison, Lana D. (2001). The revolving prison door for drug-involved offenders: Challenges and opportunities. Crime and Delinquency 47, 462-485.

Hiller, M.L. (1996). Correlates of recidivism and relapse for parolees who received in-prison substance abuse treatment in Texas. Unpublished doctoral dissertation, Texas Christian University, Fort Worth.

Hiller, Matthew L.; Knight, Kevin; Broome, Kirk M.; and Simpson, D. Dwayne (1998). "Legal Pressure and Treatment Retention in a National Sample of Long-Term Residential Programs." Criminal Justice and Behavior, 25(4), 463-481.

Hiller, M.L., Knight, K., Leukefeld, C., and Simpson, D.D. (In press). "Motivation as a predictor of therapeutic engagement in mandated residential substance abuse treatment." Criminal Justice and Behavior 29:56-75.

Hiller, M.L., Knight, K., Rao, S.R., and Simpson, D.D. (2000). Process Assessment of Correctional Treatment (PACT) (Final Report). Fort Worth: Texas Christian University, Institute of Behavioral Research.

Inciardi, J.A. (1979). "Heroin and street crime." Crime and Delinquency. 25:333-346.

Inciardi, J.A. (1995). "The therapeutic community: An effective model for corrections-based drug abuse treatment." In K.C. Haas and G.P. Alpert (eds.), The Dilemmas of Punishment (pp. 406-417). Prospect Heights, IL: Waveland Press.

Inciardi, James A., Steven S. Martin, Clifford A. Butzin, Robert M. Hooper, and Lana D. Harrison (1997) "An Effective Model of Prison-Based Treatment for Drug-Involved Offenders." Journal of Drug Issues 27:261-278.

Inciardi, James A., Steven S. Martin, Dorothy Lockwood, Robert M. Hooper, and Bruce M. Wald (1992) "Obstacles to the Implementation and Evaluation of Drug Treatment Programs in Correctional Settings: Reviewing the Delaware KEY Experience." In C.G. Leukefeld and F.M. Tims (eds.), Drug Abuse Treatment in Prisons and Jails (pp. 176-191). Washington, DC: U.S. GPO.

Joe, G.W., Knezek, L.D., Watson, D.D., & Simpson, D.D. (1991). "Depression and decision-making among intravenous drug users." Psychological Reports 68: 339-47.

Johnson, B.D., Goldstein, P.J., Preble, E., Schmeidler, J., Lipton, D.S., Spunt, B. and Miller,T. (1985). Taking Care of Business: The Economics of Crime by Heroin Abusers. Lexington, MA: Lexington Books.

Jones, Peter R. (1996) "Risk Prediction in Criminal Justice." In Alan T. Harland (ed.), Choosing Correctional Options That Work: Defining the Demand and Evaluating the Supply. Thousand Oaks, CA: Sage.

Knight, K., Holcolm, M., and Simpson, D. D. (1994). TCU psychosocial functioning and motivation scales: Manual on psychometric properties. Fort Worth: Texas Christian University, Institute of Behavioral Research.

Knight, K., Simpson, D.D., Chatham, L.R., and Camacho, L.M. (1977) "An Assessment of Prison-Based Drug Treatment: Texas' In-Prison Therapeutic Community Program." Journal of Offender Rehabilitation 24:75-100.

Knight, K., Simpson, D., & Hiller, M. (1999). Three-year reincarceration outcomes in-prison therapeutic community treatment in Texas. The Prison Journal 79, 321-33.

Kressel, D., Zompa, D., and DeLeon, G. (2002). A statewide integrated quality assurance model for correctional-based therapeutic community programs. Offender Substance Abuse Report 2(4): 49-50,60-64.

Lichter, Daniel T. (1989). Race, employment hardship, and inequality in the American nonmetropolitan South. American Sociological Review 54:436-446.

Linhorst, D.M., Knight, K., Johnston, J.S., and Trickey, M. (2001). Situational influences on the implementation of a prison-based therapeutic community. The Prison Journal 81, 436-453.

Lipton, Douglas S. and Frank S. Pearson (1998) "The Effectiveness of Correctional Treatment Revisited: Preliminary Meta-Analytic Findings from the CDATE Study." Paper presented at

the Physician Leadership on National Drug Policy (PLNDP) meeting, Washington, DC, November 10.

Lipton, Douglas S. (1995) The Effectiveness of Treatment for Drug Abusers Under Criminal Justice Supervision (NCJ 157642). Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice.

Lipton, D.S., Morales Edmundo, and Douglas S. Goldsmith. (1989). Pathways Into Treatment: A Study of the Drug Treatment Entry Process. Final Report of NIDA Project 1 R01 DA-03929-01. NY: Narcotic and Drug Research, Inc.

Lipton, D.S., Falkin, G.P., and Wexler, H.K. (1992). "Correctional drug abuse treatment in the United States: an overview." In Drug Abuse Treatment in Prisons and Jails, ed. C.G. Leukefeld and F.M. Tims, 8-30. NIDA Monograph No. 118. HHS. Rockville, MD: USGPO.

Malow, R.M., Corrigan, S.A., Pena, J.M., Calkins, A.M., and Bannister, T.M. (1992). "Mood and HIV risk behavior among drug-dependent veterans." Psychology of Addictive Behaviors 6(2): 131-4.

Martin, S., Butzin, C., & Inciardi, J. (1995). Assessment of a multi-stage therapeutic community for drug-involved offenders. Journal of Psychoactive Drugs 27, 109-116.

Martin, S., Butzin, C., Saum, C., & Inciardi, J. (1999). Three-year outcomes of therapeutic community treatment for drug-involved offenders in Delaware: From prison to work release to aftercare. The Prison Journal 79, 294-320.

Miller, W.R. (1985). Motivation for treatment: A review with special emphasis on alcoholism. Psychological Bulletin 98(1): 84-107.

Morgan, Gareth (1997) Images of Organization (2nd Edition). Thousand Oaks, CA: Sage.

Mumola, C. J. (1999, January). Substance abuse and treatment, State and Federal prisoners, 1997. Bureau of Justice Statistics Special Report (NCJ-172871). Washington, DC: U.S. Department of Justice, Office of Justice Programs.

Murray, L. and Singer, S.I. (1988). Delinquency, substance abuse, and risk taking in middle-class adolescents [Special issue]. Behavioral Sciences and the Law 6(3): 385-400.

National Center on Addiction and Substance Abuse. (1998). Behind Bars: Substance Abuse and America's Prison Population. New York: Columbia University.

National Institute on Drug Abuse. (1981). Drug Abuse Treatment in Prisons. Treatment Research Report Series. Washington, DC: National Institute on Drug Abuse, U.S. GPO.

National Institute of Justice, (1999, April). 1998 annual report on drug use among adult and juvenile arrestees (NCJ 175657). Washington, DC: U.S. Department of Justice, National Institute of Justice.

Norusis, Maija J. (1990). SPSS advanced statistics user's guide. Chicago: SPSS Inc.

Office of National Drug Control Policy (ONDCP) (1996). Treatment Protocol Effectiveness Study. Washington, DC: Executive Office of the President, Office of National Drug Control Policy.

Office of National Drug Control Policy (ONDCP) (1999). Therapeutic Communities in Correctional Settings: The Prison Based TC Standards Development Project. Final Report of Phase II (NCJ-179365). Washington, DC: Executive Office of the President, Office of National Drug Control Policy.

Osborne, David and Ted Gaebler. (1992). Reinventing Government. New York: Penguin Books.

Palmer, Ted (1992) The Re-Emergence of Correctional Intervention. Newbury Park, CA: Sage.

Palmer, Ted. (1995) "Programmatic and Nonprogrammatic Aspects of Successful Intervention: New Directions for Research." Crime and Delinquency 41:100-131.

Pawson, Ray, and Nick Tilley (1994) "What works in evaluation research?" British Journal of Criminology 34:291-306.

Pearlin, L. and C. Schooler (1978) The structure of coping. Journal of Health and Social Behavior 19:2-21.

Pearson, F. & Lipton, D. (1999). A meta-analytic review of the effectiveness of corrections-based treatments for drug abuse. The Prison Journal 79, 384-410.

Pelissier, B., Rhodes, W., Saylor, W., Gaes, G., Camp, S.D., Vanyur, S.D., and Wallace, S. (2000). TRIAD drug treatment evaluation project final report of three-year outcomes: Part 1. Washington, DC: Federal Bureau of Prisons, Office of Research and Evaluation. Available at http:// www.bop.gov.

Pennsylvania Department of Corrections (2002a, January). Monthly population report as of January 31, 2002.

Pennsylvania Department of Corrections (2002b, January). Monthly institutional profile as of January 31, 2002.

Pennsylvania Department of Corrections (2001, February). Philosophy and framework: Alcohol and other drug treatment. Camp Hill, PA: Pennsylvania Department of Corrections, Bureau of Inmate Services.

Peters, R.H., Greenbaum, P.E., Steinberg, M.L., Carter, C.R., Ortiz, M.M., Fry, B.C., and Valle, S.K. (2000). Effectiveness of screening instruments in detecting substance use disorders among prisoners. Journal of Substance Abuse Treatment. [Vol. XX, 349-358]

Petersilia, J. and Turner, S. (1993). "Intensive probation and parole." In M. Tonry (Ed.), Crime and Justice: A Review of Research, Vol. 17 (pp. 281-335). Chicago: University of Chicago Press.

Peyton, E. A. (1994). A Coordinated Approach to Managing the Drug Involved Offender. The Second Report of the Treatment Access Committee, Delaware Sentencing Accountability Commission, March 11, 1994.

Powell, J.E. and Taylor, D. (1992). Anger, depression, and anxiety following heroin withdrawal. International Journal of Addictions 27(1): 25-35.

Rosenstock, I.M. (1966). Why people use health services. Milbank Memorial Fund Quarterly 44:94-127.

Rossi, Peter H. and Howard E. Freeman (1989) Evaluation: A Systematic Approach. Newbury Park, CA: Sage.

Rossi, Robert J., Kevin J. Gilmartin, and Charles W. Dayton (1982) Agencies Working Together. A Guide to Coordination and Planning. Beverly Hills: Sage.

Rutman, Leonard (1980) Planning Useful Evaluations: Evaluability Assessment. Beverly Hills: Sage.

Shearer, R.A. and Carter, C.R. (1999). Screening and assessing substance-abusing offenders: Quantity and quality. Federal Probation 63(1): 30-4.

Seltzer, M.L. (1971) "The Michigan Alcohol Screening Test: The Quest for a New Diagnostic Instrument." American Journal of Psychiatry 127:89-94.

Simpson, D.D. (1991). Psychosocial measures: Update on TCU/DATAR self-rating scales. Presentation at the Southwest Region NADR Meeting, March 14-15, Dallas TX.

Simpson, D. Dwayne (1994) TCU/PTA Forms Manual: Texas Prison-Based Treatment Assessment (PTA Project). Fort Worth: Texas Christian University, Institute of Behavioral Research.

Simpson, D.D. and Joe, G.W. (1993a). Measurement of social functioning in addicts: Psychometric and validity analyses. Fort Worth: Texas Christian University, Institute of Behavioral Research.

Simpson, D. D. & Joe, G. W. (1993b). Motivation as a predictor of early dropout from drug abuse treatment. Psychotherapy 30: 357-68.

Simpson, D.D., Joe, G.W., Knight, K., Ray, S., and Watson, D.D. (1992). Psychological and cognitive correlates of AIDS-risky behaviors. Community-based AIDS prevention among intravenous drug users and their sexual partners: The many faces of HIV disease (Papers from the Second Annual NADR Meeting, October, 1990). Bethesda, MD: NOVA Research Company.

Simpson, D. Dwayne, Joe, George W., Broome, Kirk M., Hiller, Matthew L., Knight, Kevin and Rowan-Szal, Grace A. (1997). Program diversity and treatment retention rates in the drug abuse treatment study (DATOS). Psychology of Addictive Behaviors, 11, 279-293.

Simpson, D. D. and Knight, K. (1998) TCU Data Collection Forms for Correctional Residential Treatment. Fort Worth: Texas Christian University, Institute of Behavioral Research. [On-line]. Available: www.ibr.tcu.edu.

Simpson, D.D., Knight, K., and Broome, K.M. (1997). TCU/CJ Forms manual: TCU Drug Screen and Initial Assessment. Fort Worth: Texas Christian University, Institute of Behavioral Research.

Simpson, D.D., Knight, K., and Ray, S. (1993). Psychosocial and cognitive correlates of AIDS-risky behaviors. AIDS Education and Prevention 5(2): 121-30.

Simpson, D., Wexler, H., & Inciardi, J. (1999). Introduction. The Prison Journal 79, 291-293.

Smith, Michael F. (1989) Evaluability Assessment: A Practical Approach. Boston: Kluwer Academic.

Studt, E., Messinger, S., and Wilson, T. (1968). C-Unit: The search for community in prison. New York: Russell Sage Foundation.

Substance Abuse and Mental Health Services Administration (SAMHSA) (2000). Substance abuse treatment in adult and juvenile correctional facilities: Findings from the uniform facility data set, 1997 survey of correctional facilities. Available online at http://www.samhsa.gov/OAS/UFDS/CorrectionalFacilities97/ CorrectionalFacilities97.pdf.

Taxman, F. and Bouffard, J.A. (2002). Assessing therapeutic integrity in modified therapeutic communities for drug-involved offenders. The Prison Journal 82: 189-212.

Taylor, B.G., Fitzgerald, N., Hunt, D., Reardon, J.A., and Brownstein, H.H. (2001). ADAM preliminary 2000 findings on drug use and drug markets— adult male arrestees (NCJ 189101). Washington, DC: U.S. Department of Justice, National Institute of Justice.

Thornberry, T.P. and Krohn, M.D. (2000). "The self-report method for measuring delinquency and crime." In D. Duffee (Ed.), Criminal Justice 2000, Volume 4 (pp. 33-84). Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice (NCJ-182411).

Toch, H. (Ed.) (1980). Therapeutic communities in corrections. Westport, CT: Praeger.

Travis, J. and Petersilia, J. (2001). "Reentry reconsidered: A new look at an old question." Crime and Delinquency 47, 291-313.

U.S. Department of Justice (1998) State and Federal Corrections Information Systems: An Inventory of Data Elements and an Assessment of Reporting Capabilities A joint project: Association of State Correctional Administrators; Corrections Program Office, Office of Justice Programs; Bureau of Justice Statistics; and National Institute of Justice (NCJ 171686). Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

Walters, G. (1992). "Drug-seeking behavior: disease or lifestyle." Professional Psychology: Research and Practice 23(2): 139-145.

Welsh, Wayne N. (2000a). Building an effective research collaboration between the Center For Public Policy at Temple University and the Pennsylvania Department Of Corrections. Final report, Volume 1: Development of the research partnership and results from a survey of drug and alcohol programs. Philadelphia, PA: Temple University, Center for Public Policy.

Welsh, Wayne N. (2000b). Building an effective research collaboration between the Center For Public Policy at Temple University and the Pennsylvania Department Of Corrections. Final report, Volume 2: Evaluability Assessment and Process Evaluation of Prison-Based Drug and Alcohol Programs. Philadelphia, PA: Temple University, Center for Public Policy.

Welsh, Wayne N. (1995) Counties in Court: Jail Overcrowding and Court-Ordered Reform. Philadelphia: Temple University Press.

Welsh, W.N. (1993) "Ideologies and Incarceration: Legislator Attitudes Toward Jail Overcrowding." The Prison Journal 73:46-71.

Welsh, Wayne N. and Philip W. Harris (1999). Criminal Justice Planning and Policy Analysis. Cincinnati, OH: Anderson Publishing Co.

Welsh, Wayne N., Philip Harris, and Patricia Jenkins (1996) "Reducing Overrepresentation of Minorities in Juvenile Justice: Development of Community-Based Programs in Pennsylvania." Crime and Delinquency 42 (1):76-98.

Welsh, W.N. and G. Zajac (2001). "Assessing Prison-Based Drug and Alcohol Treatment: Pennsylvania's Ongoing Review Has Improved Programming." Offender Substance Abuse Report 1(6): 83-84,90-93.

Welsh, W.N., G. Zajac, K. Gnall, H. West and D. Close (2001). "Assessing Prison-Based Drug and Alcohol Treatment: A Research Partnership Between the Pennsylvania Department of Corrections and the Center for Public Policy at Temple University." In: The State of Corrections. 2000 Proceedings, American Correctional Association Annual Conferences (pp. 229-245). Lanham, MD: American Correctional Association.

Western, B., Kling, J.R., and Weiman, D.F. (2001). "The labor market consequences of incarceration." Crime and Delinquency 47:410-427.

Wexler, H.K. (1995). Amity/Prison TC: One-Year Outcome Results. Unpublished report to NDRI.

Wexler, H.K. Falkin, G.P., and Lipton, D.S. (1990). "Outcome evaluation of a prison therapeutic community for substance abuse treatment." Criminal Justice and Behavior. 17(1): 71-92.

Wexler, H.K., Lipton, D., Falkin, G.P., and Rosenbaum, A.B. (1992). "Outcome evaluation of a prison therapeutic community for substance abuse treatment." In C.G. Leukefeld and F.M. Tims (eds.), Drug Abuse Treatment in Prisons and Jails (pp. 156-175). Washington, DC: U.S. GPO.

Wexler, H.K., Lipton, D.S. and Johnson, B.D. (1988). A Criminal Justice System Strategy for Treating Cocaine-Heroin Abusing Offenders in Custody. Issues and Practices Paper in

Criminal Justice. U.S. GPO. No. 1988-202-045:8-0082 Washington, DC: National Institute of Justice, March.

Wexler, H., Melnick, G., Lowe, L., & Peters, J. (1999). Three-year reincarceration outcomes for Amity in-prison therapeutic community and aftercare in California. The Prison Journal 79, 321-33.

Wexler, H., and Williams, R. (1986). The Stay'n Out therapeutic community: Prison treatment for substance abusers. Journal of Psychoactive Drugs 18, 221-230.

Wholey, Joseph S. (1979) Evaluation--Promise and Performance. Washington, DC: Urban Institute.

Woody, G.E., McLellan, A.T., Luborsky, L., and O'Brien, C.P. (1990). Psychotherapy and counseling for methadone-maintained opiate addicts: Results of research studies. In L.S. Onken and J.D. Blaine (Eds.), Psychotherapy and counseling in the treatment of drug abuse (Research Monograph No. 104, pp. 9-23, DHHS Publication No. ADM-91-1722). Rockville, MD: National Institute on Drug Abuse.

Young, Douglas (2002). Impacts of perceived legal pressure on retention in drug treatment. Criminal Justice and Behavior 29:27-55.

Appendices

Appendix 1. Overview of DOC Databases and Elements

The following is a summary of key automated databases and elements that are relevant to attempts to evaluate drug treatment programs. This is not necessarily a comprehensive list of all data available to the DOC. For example, there are other databases that keep track of inmate bed assignments and inmate commissary accounts. Also, some databases are currently undergoing refinement or redevelopment. Finally, data may not be complete in all cases.

RISP

RISP refers to the DOC ***random inmate selection process*** for drug testing. The federal government mandated such random testing. The drug testing results database presently contains the following fields.

Inmate number
Race
Custody
Cell block
Date of birth
Effective date (of the sentence)
Minimum sentence date
Job description
Date picked for test
Time of test
No show (inmate did not show up)
Overall summary
Who recorded results (initials)
Retest result
Test type[44]
Name
Counselor (initials)
Population status
Cell number
Date received (in the institution)
Maximum sentence date
Offense
Test person (initials)
Date test is scheduled
Result date of test
No test
Misconduct (given)
Retest date
Comment

MISCONDUCT DATABASE

A *misconduct* is an internal sanction applied to an inmate when that inmate violates an institutional rule of some sort. This may result in *disciplinary custody time* for the inmate, which may involve assignment to a *restricted housing unit* for a specified period of time. DOC is currently working to further develop and refine this database.

Active Sanctions Table

Status
Inmate Control Number
Misconduct Number
Signature Time
Consecutive or Concurrent Sentence
Number of Days
Actual Completion Date
Sanction was amended
Date Served
Sanction Code
Signature Date
User ID
Effective Date
Completion Date (Scheduled)
Sanction Code Description

[44] A field for the test result for each of the following drug types – Alcohol; amphetamines; barb, benzo, phenal, cann, cocaine, opiate, meth, fenta.

Inmate Control Number
Misconduct Number
Reference Code
Signature Time
Counts
Inmate Pleads Guilty
Verdict Guilty
Verdict Dismissed With Prejudice
Verdict Reduced
Flag

Charges Table

Misconduct Date
Category Charge
Signature Date
User ID
Charge Description
Inmate Pleads Not Guilty
Verdict Not Guilty
Verdict Dismissed Without Prejudice
Was Amended

Misconduct Table

Institution
141 Form
Inmate Control Number
Signature Date
User ID
Report Date
Place Code
Misconduct Hour
Others Involved
Category of Charge 2
Category of Charge 4
Confinement
Confinement Hour
Hearings Held
Inmate Version
Recording Staff List (Name)
Reviewing Staff List (Name)
Inmate Notice Date
Inmate Notice Minute
Hearing After Hour
141 Status
802 Reason
Comments

Misconduct Date
Date Follow-up
Misconduct Number
Signature Time
Institution Description
Place of Misconduct
Place Extended
Misconduct Minute
Category of Charge 1
Category of Charge 3
Category of Charge 5
Confinement Date
Confinement Minute
Witnesses
Recording Staff (Number)
Reviewing Staff (Number)
Date Reviewed
Inmate Notice Hour
Hearing After Date
Hearing After Minute
141 Status Description
802 Reason Description

Hearing Table[45]

Inmate Control Number
Misconduct Number
Sequence Number
Signature Time
Hearing Hour
Examiner Number
Inmate Waivers
Witnesses

Continuance Requested
Hearing Date
Signature Date
User ID
Hearing Minute
Examiner Name
Inmate Waivers Description

[45] There are also tables for the PRC review, event scheduling, appeals and history tables for appeal and misconduct charges.

INMATE RECORDS SYSTEM

This database provides a general summary of information about all inmates. It contains the following primary elements.

Inmate ID Number
Photo Number
Parole Number
Indictment Number
FBI Number
Social Security Number
State ID Number
Race
Sex
Date of Birth
Place of Birth
Citizenship
Marital Status
Ethnic Group
Sentencing Judge
Legal Address (at arrest or of family)
Next of Kin
Aliases
Sentence Status
Minimum Sentence/Date
Maximum Sentence/Date
Minimum Offense
Maximum Offense
Parole Status
Parole Violator Data
Detainer Data
Escape Time
Commitment Date
Committing County
Current Location

CLASSIFICATION DATA BASE

This database provides information on the results of the classification process that is applied to all inmates upon reception to the system, and again on a periodic basis while in the system (reclassification). Reclassification may also occur after unusual incidents (e.g. a serious misconduct). The classification database contains the following primary elements.

Classification Date
Reclassify in .....
Severity of Offense
Severity of Criminal History
Escape History
Institutional Adjustment
Number of Prior Commitments
Time to Expected Release
Employed When Committed
Medical Needs
Emotional Needs – How Found
D&A Needs – How Found
D&A Score
Type of Problem
Vocational Needs – How Found
Sexual Problems
Alcohol Problem
Escape Problem
Psychiatric Problem
Drug Problem
Suicide Problem
Assault Problem
Custody Level
Educational Needs – How Found
IQ
Grade Completed
Reading Score
Spelling Score
Arithmetic Score
Institutional Violence
Discipline Report
Work Performance
Housing Performance
Prescriptive Programs

Appendix 2. Inmate Interview Instrument

Inmate (Program Participant) Interview Form: DOC-Temple Research Partnership

Name of Researcher: **Date of Visit:**

Institution:

Name of Program Inmate Participates In:
[Note: This interview is program specific]

Researchers: Thank the inmate for his/her time. The interview should last about half an hour. **Purpose**: Interviews with participants attempt to describe treatment *programming.* The participation of inmates in the research will allow us to accurately **describe** D & A programming from the inmate's point of view and help us determine which types of programs work best for which types of people under which conditions.

---

1. **How long have you been participating** in this program? Are there different "phases"? (If so, **which phase** are you in now?).

2. How did you **first hear about this program**, and what (if anything) did you need to do to **get into** the program (e.g., get a referral? fill out an application? get interviewed by staff or inmates in the program?)

3. How long did you have to **wait** to get into this program?

4. **Why** did you want to participate in this program?

5. Could you describe a **typical day** in this program? For example, what kinds of activities or treatment **methods** are used most often: lecture, video, written assignments, individual counseling, peer-led group discussion, or staff-led group discussion? (**See survey Q#18**).

6. What kinds of **issues (content)** are addressed in this program? (e.g., impacts of drug use, problem solving skills, relapse prevention, etc.). Could you give one or two examples? **(see survey Q#19)**

7. In this program, what has been:
(a) **most helpful** to you?

(b) least helpful to you?

8. What do you think about the **staff** in this program? (e.g., How well do staff **interact** with inmates? Are inmates treated with **respect**? Are the staff **fair** with all inmates?)

9. What kinds of **rewards and punishments** are used in this program? (e.g., are there consequences for good participation? Poor participation?) Please explain.

10. Do the inmates in this program have any **input into program structure or activities**? If "yes," please describe briefly:

11. Have you had any difficulty **accessing** treatment services? If so, please explain.

12. Have you participated in any **other treatment programs** in Pennsylvania state prisons? _____Yes _____No

If yes:
(a) In what ways is your experience in this program **similar?**

(b) In what ways is your experience in this program **different?**

13. Would you **recommend** this program to someone you know? Why or why not?

14. What, if anything, would you **change** about this program?

Appendix 3. Subject Consent Form

TEMPLE UNIVERSITY
A Commonwealth University

Center for Public Policy

Gladfelter Hall, 10th Floor (025-02)
12th St. and Berks Mall
Philadelphia, Pennsylvania 19122
(215) 204-6696
Fax: (215) 204-7779

Subject Consent Form

Participant's Name: _____
(Please Print)

Project Title:

Evaluation of Prison Based Drug Treatment in Pennsylvania: A Research Collaboration Between The Pennsylvania Department of Corrections and the Center for Public Policy At Temple University

Investigators:

Wayne N. Welsh, Ph.D.
Associate Professor, Department of Criminal Justice
5th Floor, Gladfelter Hall (025-02)
Temple University
Philadelphia, PA 19122

Purpose

The purpose of this research study is to evaluate the effectiveness of drug and alcohol education and treatment programs provided by the Pennsylvania Department of Corrections (DOC).

Benefits

I understand that I will be given the opportunity to request a summary of the study results. The information collected from this study will help DOC to assess the effectiveness of its current programs and improve the quality of drug and alcohol programming offered to inmates.

General Research Procedures

By giving my consent to participate, I understand that Temple researchers will have access to my DOC drug and alcohol treatment records and my DOC institutional records. To examine long term outcomes of treatment (e.g., drug relapse or recidivism), researchers will seek access to Department of Probation and Parole records and state criminal records for up to two years following my release from DOC custody. I understand that researchers may ask me to complete a survey and/or interview asking about my experience in this program. I understand that I may refuse to participate in a survey or interview at any time.

CONTINUE TO OTHER SIDE

Confidentiality/Anonymity

I understand that my identity will not be disclosed to anyone at any time for any purpose. I understand that as a participant in this study, all information that I supply will be kept strictly confidential and reviewed only by the investigators and their research assistants.

Disclaimer/Withdrawal

I understand that I am free to decide whether or not to participate in the study described above. I further understand that non-participation in the research or withdrawal from the research will not affect my treatment or any decision regarding my custody in any way. If at any time I should experience any emotional distress as a result of participating in this study, I understand that I should contact my treatment counselor (Drug and Alcohol Treatment Specialist) at once.

Questions

I understand that I am encouraged by the investigator to ask questions at any time, and that my questions will be given prompt and full answers. Questions may be directed to the Investigator at the address listed on the front of this form, or to the Drug and Alcohol Treatment Supervisor who will direct them to the Investigator. If I have any questions about my rights as a research subject, I may contact Ruth S. Smith, Office of the Vice Provost for Research, Institutional Review Board, Temple University, N. Broad St. and Oxford St., Philadelphia, PA, 19122, phone (215) 204-7460.

This study has been explained to me. I have read the consent form, and I agree to participate. A copy of this consent form will be retained in my treatment record.

Participant's Signature	**Date**
Witness' Signature	**Date**
Investigator Signature	**Date**

Appendix 4. TCU Drug Screen

DRUG SCREEN

PLEASE COMPLETE ALL INFORMATION BELOW:

INSTITUTION (CIRCLE ONE):

1 = CRESSON
2 = GRATERFORD
3 = HOUTZDALE
4 = HUNTINGDON
5 = WAYMART

TYPE OF PROGRAM (CIRCLE ONE):

1= EDUCATION
2 = OUTPATIENT TREATMENT
3 = THERAPEUTIC COMMUNITY

LAST NAME: _____ **FIRST NAME:** _____

INMATE #: __ __ __ __ __ __ **TODAY'S DATE:** __ __ __ __ __ __ __ __
MO DAY YEAR

HOW MANY CONSECUTIVE MONTHS HAVE YOU BEEN IN *THIS* PROGRAM? (CIRCLE ONE):

01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25+

During the last 6 months before prison --

	Circle Answer	
1. Did you often use larger amounts of drugs (including alcohol) or use them for a longer time than you had planned or intended?.....	*0=No*	*1=Yes*
2. Did you try to cut down on drugs and were unable to do it?.....	*0=No*	*1=Yes*
3. Did you spend a lot of time getting drugs, using them, or recovering from their use?.....	*0=No*	*1=Yes*
4. Did you often get so high or sick from drugs that it --		
a. kept you from doing work, going to school, or caring for children?.....	*0=No*	*1=Yes*
b. caused an accident or became a danger to you or others?.....	*0=No*	*1=Yes*
5. Did you often spend less time at work, school, or with friends so that you could use drugs?.....	*0=No*	*1=Yes*
6. In the last 6 months before prison, did your drug use often cause --		
a. emotional or psychological problems?.....	*0=No*	*1=Yes*
b. problems with family, friends, work, or police?.....	*0=No*	*1=Yes*
c. physical health or medical problems?.....	*0=No*	*1=Yes*

CONTINUE TO OTHER SIDE

7. Did you increase the amount of a drug you were taking so that you could get the same effects as before?..... *0=No* *1=Yes*

8. Did you ever keep taking a drug to avoid withdrawal or keep from getting sick?..... *0=No* *1=Yes*

9. Did you get sick or have withdrawal when you quit or missed taking a drug?..... *0=No* *1=Yes*

10. Which drugs caused you the MOST serious problems in the last 6 months before prison? [SEE LIST BELOW]

Worst:.....|___|
DRUG #

Next:.....|___|
DRUG #

Next:.....|___|
DRUG #

CHOOSE "DRUG #s" FROM THIS LIST:

0. None	3. Marijuana	6. Tranquilizers or sedatives
1. Alcohol	4. Cocaine or crack	7. Hallucinogens
2. Inhalants	5. Other stimulants	8. Opiates

Appendix 5. TCU Resident Evaluation of Self and Treatment (REST)

EVALUATION OF SELF AND TREATMENT

INSTRUCTIONS:

1. ***Please do not write or mark anything on this questionnaire booklet.*** **Instead, please answer all questions on the red scantron, using a pencil (not a pen). On the left hand side of the red scantron, please provide the following information.**

2. ***LAST NAME, FIRST NAME, AND MIDDLE INITIAL*****: please print in the white squares, then darken in the corresponding circles right underneath.**

3. ***DATE*** **(MONTH, DAY, YEAR): please circle the appropriate month. Then print the day and the year in the white squares, and darken the corresponding circles right underneath.**

4. ***IDENTIFICATION NUMBER*****: please print your *inmate number* in the white squares, then darken in the corresponding circles right underneath.**

5. ***SPECIAL CODE 'J'*****: please enter the assigned number for your institution:**
   1 = CRESSON 2 = GRATERFORD 3 = HOUTZDALE 4 = HUNTINGDON 5 = WAYMART

6. ***SPECIAL CODE 'K'*****: please enter the type of D & A program you are currently in:**
   1= EDUCATION 2 = OUTPATIENT TREATMENT 3 = THERAPEUTIC COMMUNITY

7. Please answer each question by darkening the appropriate circle on the red scantron. Refer to the 7-point scale on your questionnaire booklet (e.g., 1 = "disagree strongly"; 7 = "agree strongly"). Please answer all questions the best you can.

8. Your answers are confidential. When you are done, please insert the red scantron in the envelope provided, seal it, and return it to your counselor. Please hand in the questionnaire booklet separately.

A. RATINGS OF SELF: Circle the answer that shows how much you agree or disagree that each item describes <u>you or the way you have been feeling lately</u>.

	DISAGREE STRONGLY			NOT SURE			AGREE STRONGLY
1. You like to take chances	1	2	3	4	5	6	7
2. You feel people are important to you	1	2	3	4	5	6	7
3. You feel sad or depressed	1	2	3	4	5	6	7
4. You feel honesty is required in every situation	1	2	3	4	5	6	7
5. You have serious drug-related health problems	1	2	3	4	5	6	7
6. You have little control over the things that happen to you	1	2	3	4	5	6	7
7. You have too many outside responsibilities now to be in this treatment program	1	2	3	4	5	6	7
8. You have much to be proud of	1	2	3	4	5	6	7
9. In general, you are satisfied with yourself	1	2	3	4	5	6	7
10. You like the "fast" life	1	2	3	4	5	6	7
11. There is really no way you can solve some of the problems you have	1	2	3	4	5	6	7

Continue to Next Page

EVALUATION OF SELF AND TREATMENT (Continued)

	DISAGREE STRONGLY			NOT SURE			AGREE STRONGLY
12. You could remain in jail or prison for a long time if you are not in treatment	1	2	3	4	5	6	7
13. You feel mistreated by other people	1	2	3	4	5	6	7
14. You have thoughts of committing suicide	1	2	3	4	5	6	7
15. You have trouble sitting still for long	1	2	3	4	5	6	7
16. You like others to feel afraid of you	1	2	3	4	5	6	7
17. There is little you can do to change many of the important things in your life	1	2	3	4	5	6	7
18. You have trouble following rules and laws	1	2	3	4	5	6	7
19. This treatment program seems too demanding for you	1	2	3	4	5	6	7
20. You feel lonely	1	2	3	4	5	6	7
21. You like friends who are wild	1	2	3	4	5	6	7
22. You like to do things that are strange or exciting	1	2	3	4	5	6	7
23. You feel like a failure	1	2	3	4	5	6	7
24. You have trouble sleeping	1	2	3	4	5	6	7
25. You often feel helpless in dealing with the problems of life	1	2	3	4	5	6	7
26. You feel a lot of pressure to be in treatment	1	2	3	4	5	6	7
27. You depend on "things" more than on "people"	1	2	3	4	5	6	7
28. You feel interested in life	1	2	3	4	5	6	7
29. This treatment may be your last chance to solve your drug problems	1	2	3	4	5	6	7

Continue to Next Page

EVALUATION OF SELF AND TREATMENT (Continued)

	DISAGREE STRONGLY			NOT SURE			AGREE STRONGLY
30. You have urges to fight or hurt others	1	2	3	4	5	6	7
31. You avoid anything dangerous	1	2	3	4	5	6	7
32. Sometimes you feel that you are being pushed around in life	1	2	3	4	5	6	7
33. You feel you are basically no good	1	2	3	4	5	6	7
34. This kind of treatment program will not be very helpful to you	1	2	3	4	5	6	7
35. You have a hot temper	1	2	3	4	5	6	7
36. You keep the same friends for a long time	1	2	3	4	5	6	7
37. You have legal problems that require you to be in treatment	1	2	3	4	5	6	7
38. You plan to stay in this treatment program for awhile	1	2	3	4	5	6	7
39. You feel anxious or nervous	1	2	3	4	5	6	7
40. Your temper gets you into fights or other trouble	1	2	3	4	5	6	7
41. You have trouble concentrating or remembering things	1	2	3	4	5	6	7
42. You feel extra tired or run down	1	2	3	4	5	6	7
43. You work hard to keep a job	1	2	3	4	5	6	7
44. You are in this treatment program because someone else made you come	1	2	3	4	5	6	7
45. What happens to you in the future mostly depends on you	1	2	3	4	5	6	7
46. You feel afraid of certain things, like elevators, crowds, or going out alone	1	2	3	4	5	6	7

Continue to Next Page

EVALUATION OF SELF AND TREATMENT (Continued)

	DISAGREE STRONGLY			NOT SURE			AGREE STRONGLY
47. You are concerned about legal problems	1	2	3	4	5	6	7
48. You only do things that feel safe	1	2	3	4	5	6	7
49. You get mad at other people easily	1	2	3	4	5	6	7
50. Your religious beliefs are very important in your life	1	2	3	4	5	6	7
51. You wish you had more respect for yourself	1	2	3	4	5	6	7
52. You worry or brood a lot	1	2	3	4	5	6	7
53. You can do just about anything you really set your mind to do	1	2	3	4	5	6	7
54. This treatment program can really help you	1	2	3	4	5	6	7
55. You have carried weapons, like knives or guns	1	2	3	4	5	6	7
56. You feel tense or keyed-up	1	2	3	4	5	6	7
57. You are very careful and cautious	1	2	3	4	5	6	7
58. You want to be in a drug treatment program	1	2	3	4	5	6	7
59. Taking care of your family is very important	1	2	3	4	5	6	7
60. You feel you are unimportant to others	1	2	3	4	5	6	7
61. You feel a lot of anger inside you	1	2	3	4	5	6	7
62. You feel tightness or tension in your muscles	1	2	3	4	5	6	7
63. You have family members who want you to be in treatment	1	2	3	4	5	6	7

Continue to Next Page

EVALUATION OF SELF AND TREATMENT (Continued)

B. RATINGS OF TREATMENT PROCESS: Circle the answer that shows how much you agree or disagree that each item describes how you feel about your <u>experiences at this treatment program.</u>

	DISAGREE STRONGLY			NOT SURE			AGREE STRONGLY
64. You feel and show concern for others during group counseling	1	2	3	4	5	6	7
65. Your counselors are easy to talk to	1	2	3	4	5	6	7
66. You trust the treatment staff	1	2	3	4	5	6	7
67. Your counselors help you develop confidence in yourself	1	2	3	4	5	6	7
68. You have developed positive trusting friendships while at this program	1	2	3	4	5	6	7
69. Your counselors are well organized and prepared for each counseling session	1	2	3	4	5	6	7
70. The treatment staff cares about you and your problems	1	2	3	4	5	6	7
71. You have made progress with your drug/alcohol problems	1	2	3	4	5	6	7
72. Your counselors develop treatment plans with reasonable objectives for you	1	2	3	4	5	6	7
73. The treatment staff is helpful to you	1	2	3	4	5	6	7
74. You have made progress with your emotional or psychological issues	1	2	3	4	5	6	7
75. Your counselors keep you focused on solving specific problems	1	2	3	4	5	6	7
76. The security staff cares about you and your problems	1	2	3	4	5	6	7
77. You have made progress toward your treatment goals	1	2	3	4	5	6	7
78. Your counselors remember important details from your earlier sessions	1	2	3	4	5	6	7
79. The security staff is helpful to you	1	2	3	4	5	6	7
80. Your counselors help you make changes in your life	1	2	3	4	5	6	7

Continue to Next Page

EVALUATION OF SELF AND TREATMENT (Continued)

	DISAGREE STRONGLY			NOT SURE			AGREE STRONGLY
81. You accept being confronted by others during group counseling	1	2	3	4	5	6	7
82. Your counselors speak in a way that you understand	1	2	3	4	5	6	7
83. You confront others about their real feelings during group counseling	1	2	3	4	5	6	7
84. Your counselors respect you and your opinions	1	2	3	4	5	6	7
85. You are willing to talk about your feelings during group counseling	1	2	3	4	5	6	7
86. Your counselors understand your situation and problems	1	2	3	4	5	6	7
87. You say things to give support and understanding to others during group counseling	1	2	3	4	5	6	7
88. You trust your counselors	1	2	3	4	5	6	7
89. You give honest feedback to others during group counseling	1	2	3	4	5	6	7
90. Your counselors help you view problems/situations realistically	1	2	3	4	5	6	7
91. You have made progress in understanding your feelings and how they can influence behavior	1	2	3	4	5	6	7
92. Your counselors focus your thinking and planning	1	2	3	4	5	6	7
93. You trust other clients in this program	1	2	3	4	5	6	7
94. Your counselors make you feel foolish or ashamed	1	2	3	4	5	6	7
95. Your counselors teach you useful ways to solve your problems	1	2	3	4	5	6	7
96. Your are motivated and encouraged by your counselors	1	2	3	4	5	6	7
97. You trust the security staff	1	2	3	4	5	6	7

Continue to Next Page

EVALUATION OF SELF AND TREATMENT (Continued)

C. RATINGS OF PROGRAM ATTRIBUTES: Circle the answer that shows how much you agree or disagree that each item describes how you feel about the different parts of this program.

	DISAGREE STRONGLY			NOT SURE			AGREE STRONGLY
98. Meetings and activities are well organized	1	2	3	4	5	6	7
99. You need more individual counseling	1	2	3	4	5	6	7
100. The morning meetings are productive and useful	1	2	3	4	5	6	7
101. Other clients at this program care about you and your problems	1	2	3	4	5	6	7
102. House rules and tools are fair and appropriate	1	2	3	4	5	6	7
103. Other clients at this program are helpful to you	1	2	3	4	5	6	7
104. The evening meetings are productive and useful	1	2	3	4	5	6	7
105. You are similar (or like) other clients of this program	1	2	3	4	5	6	7
106. You need more group counseling	1	2	3	4	5	6	7
107. The authority structure among residents is fair and useful	1	2	3	4	5	6	7
108. There is a sense of family (or community) in this program	1	2	3	4	5	6	7
109. Work assignments are fair and useful	1	2	3	4	5	6	7
110. You need more lecture classes	1	2	3	4	5	6	7
111. Privileges are appropriate and given soon after they are earned	1	2	3	4	5	6	7

End of Form

Appendix 6. TCU Counselor Rating of Client (CRC)

COUNSELOR RATING OF CLIENT

PLEASE COMPLETE ALL INFORMATION BELOW:

INSTITUTION (CIRCLE ONE):

1 = CRESSON
2 = GRATERFORD
3 = HOUTZDALE
4 = HUNTINGDON
5 = WAYMART

TYPE OF PROGRAM (CIRCLE ONE):

1= EDUCATION
2 = OUTPATIENT TREATMENT
3 = THERAPEUTIC COMMUNITY

LAST NAME: _____ **FIRST NAME:** _____

INMATE #: __ __ __ __ __ __ **TODAY'S DATE:** __ __ (MO) __ __ (DAY) __ __ __ __ (YEAR)

HOW MANY CONSECUTIVE MONTHS HAVE YOU BEEN IN *THIS* PROGRAM? (CIRCLE ONE):

01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25+

A. CLIENT ATTRIBUTES: Circle the answer that shows how much you agree or disagree with each item based on your interactions with this client.

	DISAGREE STRONGLY			NOT SURE			AGREE STRONGLY
1. Easy to talk to.	1	2	3	4	5	6	7
2. Warm & caring.	1	2	3	4	5	6	7
3. Honest & sincere.	1	2	3	4	5	6	7
4. Cooperative.	1	2	3	4	5	6	7
5. Responsible.	1	2	3	4	5	6	7
6. Hostile or aggressive.	1	2	3	4	5	6	7
7. Depressed.	1	2	3	4	5	6	7
8. Impulsive.	1	2	3	4	5	6	7
9. Nervous or anxious.	1	2	3	4	5	6	7
10. Self-confident.	1	2	3	4	5	6	7
11. Manipulative.	1	2	3	4	5	6	7
12. Freely expresses wishes.	1	2	3	4	5	6	7
13. Motivated to recovery.	1	2	3	4	5	6	7
14. Consistently keeps session appointments	1	2	3	4	5	6	7
15. Is liked by other clients.	1	2	3	4	5	6	7
16. Participates in group discussions.	1	2	3	4	5	6	7
17. Thinks clearly.	1	2	3	4	5	6	7
18. Pays attention.	1	2	3	4	5	6	7
19. Clearly expresses thoughts/feelings.	1	2	3	4	5	6	7
20. Reviews problems logically.	1	2	3	4	5	6	7
21. Has good memory & recall.	1	2	3	4	5	6	7
22. In denial about problems.	1	2	3	4	5	6	7
23. Easily distracted.	1	2	3	4	5	6	7
24. Follows through on commitments.	1	2	3	4	5	6	7
25. Is liked by staff.	1	2	3	4	5	6	7

Continue to Other Side

COUNSELOR RATING OF CLIENT (CONTINUED)

B. COUNSELING FOCUS: Circle the answer that shows how much you agree or disagree with each item as a description of your counseling activities with this client.

	DISAGREE STRONGLY			NOT SURE			AGREE STRONGLY
1. Responding to crises.	1	2	3	4	5	6	7
2. Discussing occupational issues.	1	2	3	4	5	6	7
3. Establishing trust & rapport.	1	2	3	4	5	6	7
4. Discussing family issues.	1	2	3	4	5	6	7
5. Exploring feelings.	1	2	3	4	5	6	7
6. Making new friends.	1	2	3	4	5	6	7
7. Improving communication skills.	1	2	3	4	5	6	7
8. Negotiating & resolving conflicts.	1	2	3	4	5	6	7
9. Improving family relations.	1	2	3	4	5	6	7
10. Reducing denial.	1	2	3	4	5	6	7
11. Confronting.	1	2	3	4	5	6	7
12. Improving objectivity.	1	2	3	4	5	6	7
13. Assuming appropriate responsibility.	1	2	3	4	5	6	7
14. Defining long-range goals.	1	2	3	4	5	6	7
15. Specifying short-term objectives.	1	2	3	4	5	6	7
16. Developing coping plans & strategies.	1	2	3	4	5	6	7
17. Defining personal boundaries.	1	2	3	4	5	6	7
18. Improving self-esteem.	1	2	3	4	5	6	7
19. Building confidence.	1	2	3	4	5	6	7
20. Praising and encouraging.	1	2	3	4	5	6	7
21. Developing problem-solving skills.	1	2	3	4	5	6	7
22. Managing finances.	1	2	3	4	5	6	7
23. Discussing relapse situations and "triggers."	1	2	3	4	5	6	7

End of Form

Appendix 7. Descriptions of TC Programs

INDIVIDUAL PROGRAM REPORTS: DOC-TEMPLE RESEARCH PARTNERSHIP

Institution: Cresson
AOD Program: Chance to Change Therapeutic Community

General Program Goals and Intervention Philosophy

1. What are the **general goals** or **mission** of this program? What does it try to do? Length: 2-3 paragraphs. **[Source: program documents, DATS Supervisor/Mgr.].**

The Chance to Change handbook states that their general goals and mission are: 1.) To establish an environment in which the inmate can develop the concepts and living skills required for controlling drug and alcohol addiction/abuse; 2.) To assist the inmate in understanding and being able to explain factors contributing to his substance abuse prior to re-entry to the community; 3.) To provide opportunities for the inmate to develop educationally, vocationally, and emotionally through participation in individualized program objectives; 4.) To assist the inmate in establishing standards of conduct for living and to establish a release plan to enhance his using the standards in the community; and 5.) To enable staff and community members to work together in assisting the individual member to accomplish his objectives by providing an atmosphere of honesty, sincerity, responsibility, non-hostile feedback, and emotional support through a combination of staff professional services and community member self-help programs.

2. What is the main **treatment approach** or **philosophy** used in this program? (e.g., see survey Q#12). Could you give one or two examples of *how* this approach is used? **[Source: program documents, DATS Supervisor/Mgr.].**

According to the *Operating Manual* for the Chance to Change Program, the TC brings a holistic approach that addresses the whole person, not just their different diseases or problems; it addresses that person in a micro-community that operates in a unified way. The community of the TC itself is the primary teacher. Staff and inmates serve as guides, teachers, and role models in the recovery process. The inmates spend all their time monitoring, assessing, and giving feedback on each other's social behaviors, attitudes, values, and feelings. Staff and inmates, under the rules and structure of the TC, reinforce behaviors that are prosocial, positive, and socially acceptable. Inmates considered to be asocial or antisocial are dealt with through a variety of sanctions, techniques, and activities, generally called "therapeutic tools". Also, the TC is systematic in its approach. The driving force behind TC's efforts is a profound perspective on chemical abuse-related disorders, the individual, and focus on recovery. Specific treatment models used in the TC are eclectic, including behavior modification, confrontation, and cognitive behavioral therapy.

Target Population and Target Selection

3. For this program, describe inmate **recruiting, outreach, or referral procedures** (e.g., How do inmates hear about this program? Who makes referrals? What are the reasons for referral)? **[Source: program documents, inmate interviews, DATS Supervisor/Mgr.].**

According to the *Operating Manual* for the CTCP, individuals can be referred to the program at the time of their initial drug and alcohol assessment interview or during subsequent interviews.

4. What are the specific **eligibility** requirements for this program (e.g., type and seriousness of D & A problem, time remaining in sentence)? Are exceptions made? **[Source: program documents, DATS Supervisor/Mgr.].**

The *Operating Manual* for the CTCP also states the criteria for eligibility for the CTCP. These requirements are that it must be no less than 15 months until the inmate's release date; the inmate must be assessed as dependent on a chemical substance per criteria of the DSM-IV; the inmate must have successfully completed Sex Offender programming if his offense is sexual in nature; the inmate must have no more than 3 Class II misconducts or one Class I misconduct during the last 12 months; BETA IQ scores greater than 70 are preferred, however, if assessed by the psychological or education department as literate sub-70 scores will be assessed; the inmate can not be on psychotropic medication(s); SCI-Cresson referrals are required to have honor status or be able to achieve it within 60 days of entry into the program; referral from other institutions will be processed without honor status if they meet the other criteria for admittance; and exceptions to these criteria may be granted by administrative staff as needed.

5. **Decision to admit (or not):** Who makes the decision? What are the most important criteria? About what percentage of referrals are rejected? **[Source: program documents, DATS Supervisor/Mgr.].**

According to the *Operating Manual* for the CTCP, the Program Director will maintain a chronological file of those recommended for consideration for CTCP placement. As inmates are needed to maintain the capacity of the unit, the Program Director will interview candidates to ascertain that they meet the requirements listed above. During this interview, the Program Director will review the case file and obtain the inmate's version of his past usage patterns and document significant drug and/or alcohol problems and a willingness by the inmate to make significant lifestyle changes. If a substance dependency exists, the non-clinical criteria are met, and there is an expressed receptiveness to CTCP placement, the inmate will be scheduled to see the Intake/Orientation Committee of the CTCP. Upon receiving a recommendation from this committee, the Program Director will prepare a vote sheet for entry into the CTCP. Paper staffing will follow with votes recorded from the work boss, housing officer, and present counselor. Based on all information received, the Program Director will make the final decision as to the appropriateness of the inmate for entry into the CTCP.

Intake, Exit, and Follow-up Procedures

6. Describe the **intake/admission process** (e.g., What happens to an inmate when they first attend this program? Is there an orientation, intake interview, etc.?) **[Source: program documents, DATS Supervisor/Mgr.].**

During the admission process, the primary DATS shall complete the psychosocial history and psychosocial evaluation form with the new inmate. This history form is used to gather information on the inmate with respect to previous treatment programming, severity of drug pattern, drug use

pattern, chemical abuse and health history, his perception on his chemical abuse problems, and family history regarding chemical abuse. The evaluation form is an assessment of this information. It is used to formulate the initial treatment plan for the inmate. The individual treatment plan should be completed after the inmate has been in the program for 6 weeks. It should be developed by using the evaluation, inmate's responses to questions, staff comments, and community member's comments.

7. What is the normal **program enrollment**? (i.e., at one specific time) **[Source: program documents].**

The Chance to Change Program holds a maximum of 52 inmates at one time.

8. What is the normal **length of stay** for an inmate in this program? **[Source: program documents].**

According to the DATS Supervisor, the normal length of stay is 56 - 72 weeks.

9. What are the **criteria for successful program completion**? **For an unsuccessful discharge**? **[Source: program documents, DATS Supervisor/Mgr.].**

Completion of all phase requirements is required for successful program completion.

Specific Program Content and Structure

10. Attach a copy of the weekly program schedule. **List and briefly describe**: (a) the different **program activities** (see survey Q# 19 for examples of specific activities), and (b) the **intended result or objective** of each activity **[Source: inmate interviews, observations, program documents]**. Include the following:

- Provide a **title and brief description** of the activity.
- How many **hours** weekly do inmates participate in each activity? How often do they meet?
- Describe a few **examples of program content** from lesson plans, printed program descriptions, observations or interviews (i.e., what do they do and how do they do it?)
- For each **activity or group**, what is the **intended result or objective?** (i.e., what change in inmate attitudes or behaviors is expected)?

According to the *Chance to Change Inmate Handbook*, the TC is composed of four Phases that each last 12 weeks.

While in **Phase I,** an inmate will participate in the following components: Rational Behavior Training (1 hour a week for 12 weeks), Goal Planning And Time Management (.5 hours a week for 12 weeks), Introduction To Group Process (1 hour a week for 12 weeks), establishment of the initial treatment plan with a signed treatment agreement, completion of assigned self-report measurements, including a daily journal, individual counseling sessions with a Drug and Alcohol Treatment Specialist (DATS), participation in other areas as established in the prescriptive

program plan, and participation in maintenance and sanitation concerns of the Modular Therapeutic Community.

In **Phase II**, each inmate will participate in the following components: Responsible Self-Assertiveness Training (1.5 hours a week for 12 weeks), Cognitive Restructuring group (1.5 hours a week that is ongoing), Family Issues (1.5 hours a week for 12 weeks), Step Study (1.5 hours a week for 12 weeks), continuation of utilization of daily journal, individual counseling sessions with a Drug and Alcohol Treatment Specialist, participation in other areas established in the prescriptive program plan, active volunteering for Activities Committee, Education/Library Committee, Laundry/Maintenance Committee, and participation in maintenance and sanitation concerns of the modular Therapeutic Community.

In **Phase III**, each inmate will participate in the following components: Stress Management and Relaxation Skills (1 hour a week for 12 weeks), Re-entry to Community/Life Skills (1 hour a week for 12 weeks), AIDS Education and Sexually Transmitted Diseases (2 hours a week for 4 weeks), Continuation of Cognitive restructuring (1.5 hours a week), continuation of a daily journal, individual counseling sessions with a Drug and Alcohol Treatment Specialist, participation in other areas as established in the prescriptive program plan, active volunteering for activities committee, education/library committee, laundry/maintenance committee, orientation/intake committee and interpersonal committee, and participation in maintenance and sanitation concerns of the modular Therapeutic Community.

Finally, in **Phase IV**, each inmate will participate in the following components: Interpersonal Skills Training (1 hour a week for 12 weeks), Relapse Prevention training (1 hour a week for 12 weeks), continuation of Cognitive Restructuring (1.5 hours a week), continuation of a daily journal, individual counseling sessions with a Drug and Alcohol Treatment Specialist, participation in other areas as established in the prescriptive program plan, active volunteering for activities committee, education/library committee, laundry/maintenance committee, orientation/intake committee and interpersonal committee, and participation in maintenance and sanitation concerns of the modular Therapeutic Community.

Daily Activities. According to the TC program schedule and inmate interviews, each morning the inmate participates in a morning meeting from 8am to 9am. Once completed, the inmates have Cognitive Restructuring groups, which are also referred as their rap groups. In these groups, inmates pretty much identify the issues that will be discussed. Topics are dealt with on a more personal level than other groups. After this group, they have lunch and then the rest of their afternoon is spent doing a variety of groups, such as Rational Behavior, AIDS/STD's, Relapse Prevention, Education, Stress and Anger Management, Release Planning, Family Issues, and Step groups which are all more counselor-run groups compared to the rap groups. Groups end around 4:30 p.m. each day.

11. How is treatment structured to address **individual inmate needs** (e.g., individual counseling)? **[Source: inmate interviews, program documents, DATS Supervisor/Mgr.]**.

During the admission process, the primary DATS shall complete the psychosocial history and psychosocial evaluation form with the new inmate. This history form is used to gather information

on the inmate with respect to previous treatment programming, severity of drug pattern, drug use pattern, chemical abuse and health history, his perception on his chemical abuse problems, and family history regarding chemical abuse. The evaluation form is an assessment of this information. It is used to formulate the initial treatment plan for the inmate. The individual treatment plan should be completed after the inmate has been in the program for 6 weeks. It should be developed by using the evaluation, inmate's responses to questions, staff comments, and community member's comments.

Program Staff

12. Provide a brief description of the full time AOD staff. **[Source: DATS Supervisor/ Mgr.]**. Indicate which staff work regularly on the TC.

Name of Staff Member:	**Job Title:**	**Highest Degree Awarded:**	**Academic Discipline or Major:**	**Specialized Certification, if any:**	**Length Of Employment With DOC:**	**Number Of Years Experience Providing Direct D/A Treatment To Clients:**
1.Mauree McGrough	DATS II	M.ED.	Counselor Ed./ Addictions Counseling	CISM	3 ½ yrs.	9 yrs.
2. Tim Smith	DATS Supervisor	BS	Psychology		14 ½ yrs.	8 yrs.
3. Shelly Helsel	DATS II	M.ED.	CN. ED Chemical Dependency	Certifications: HIV/AIDS Counselor; Impact of Crime Class Facilitator; Victim Advocate;	10 yrs.	Approx. 20 yrs.
4. Gary A. Griep	DATS II	M. Div.	Pastoral Counseling	Clinical Pastoral Education	12 yrs.	14 yrs.
5. Mark Harshberger	DATS II	MSW	Social Work	LSW	6 ½ yrs.	9 ½ yrs.
6. Keith Davis	DATS II	BA	Clinical Sociology	CAC II	8 yrs.	10 yrs.

Staff Demographics (full time AOD staff only):

Number of male staff ___4__
Number of females ___2__

Number of Caucasian staff ___6__
Number of African American staff _____
Number of Native American staff _____
Number of Hispanic staff _____
Number of Asian staff _____
Number of Other staff _____

INDIVIDUAL PROGRAM REPORTS: DOC-TEMPLE RESEARCH PARTNERSHIP

Institution: Graterford
TC Program: Jericho

General Program Goals and Intervention Philosophy

1. What are the **general goals** or **mission** of this program? What does it try to do? Length: 2-3 paragraphs. **[Source: program documents, DATS Supervisor/Mgr.].**

According to staff at SCI-Graterford the mission statement is as follows: To have each man gain a sense of self and the desire to become the best individual he can be in order to contribute positively to the greater whole (society) and self (family) such that anti-social thinking and behavior as well as drug/alcohol abuse becomes a thing of the past.

In addition there are two general goals that the program strives to achieve for each inmate. The first goal is to parallel daily life experiences that each man will have as a productive member of society such experiences include, a commitment to something other then self (program jobs) and handling responsibility. The second goal is to provide adequate education in order for each man to earn his GED if necessary.

2. What is the main **treatment approach** or **philosophy** used in this program? (e.g., see survey Q#12). Could you give one or two examples of *how* this approach is used? **[Source: program documents, DATS Supervisor/Mgr.].**

Use of TC Model provides general parallel for society in that the TC has established rules for living, responsibilities of committees and work (self-sufficient) and the provision of consequences when these commitments and responsibilities are not met. An example of this approach is behavior modification with cognitive intervention at the group and individual level via provision of primary therapeutic groups and individual sessions with primary caregiver.

Target Population and Target Selection

3. **For this program**, describe inmate **recruiting, outreach, or referral procedures** (e.g., How do inmates hear about this program? Who makes referrals? What are the reasons for referral)? **[Source: program documents, inmate interviews, DATS Supervisor/Mgr.].**

According to inmate interviews, the majority of inmates were informed about the program through other inmates or friends. In addition, counselors referred the inmates to the program.

4. What are the specific **eligibility** requirements for this program (e.g., type and seriousness of D & A problem, time remaining in sentence)? Are exceptions made? **[Source: program documents, DATS Supervisor/Mgr.].**

There are three specific eligibility requirements for admission in Jericho:

1. Presence of AOD problem that has caused long-term life consequences.
2. Willingness to attend in order to address these issues at any cost.
3. Time to complete (exceptions are made in cases where the client may max out prior to completion of course treatment or he is a possible violator who will be transferred back to another jail in the mid treatment process).

5. **Decision to admit (or not):** Who makes the decision? What are the most important criteria? About what percentage of referrals are rejected? **[Source: program documents, DATS Supervisor/Mgr.].**

The most important criteria when making an admission decision are the inmates' score on the screening and assessment tool, along with his expressed desire and presence of need. Severe mental health issues may preclude admission.

Intake, Exit, and Follow-up Procedures

6. Describe the **intake/admission process** (e.g., What happens to an inmate when they first attend this program? Is there an orientation, intake interview, etc.?) **[Source: program documents, DATS Supervisor/Mgr.].**

The intake process consists of the following: a face to face interview with the primary caregiver, signing consent forms and program description, and initial treatment plan is proposed, the client is assigned a Big Brother and put into the Orientation Phase for five weeks, committee and job responsibilities begin immediately.

7. What is the normal **program enrollment**? (i.e., at one specific time) **[Source: program documents].**

Jericho has a maximum capacity of fifty inmates.

8. What is the normal **length of stay** for an inmate in this program? **[Source: program documents].**

The normal length of stay in Jericho is 48 weeks.

9. What are the **criteria for successful program completion**? **For an unsuccessful discharge**? **[Source: program documents, DATS Supervisor/Mgr.].**

According to Rick Voytko, DATS Supervisor, the criteria for successful program completion consist of an inmate working through each phase and the classes that are proscribed for each phase. Essentially, successful completion means that an inmate has completed al of the work and has attained a certificate. In most instances, this completion takes one year, but this is not a mandatory time frame. Inmates have been able to complete the treatment program in 10-11 months, depending on the setbacks they might encounter during the program (i.e., reprimand, failure to successfully grasp concepts in a timely manner).

The criteria for an unsuccessful discharge is: an inmate not complying with the rules, not complying with treatment requests, refusing treatment, or breaking one of the 6 Cardinal rules of the TC. Furthermore, an inmate may choose to voluntarily leave the treatment program at any time. When this happens, the counselors will sit down with the inmate to convince him to remain in the treatment program. If the inmate is still determined to leave, often the counselor will require the inmate to write a paragraph, explaining why he wants to leave. The thought is that this type of exercise will allow the inmate to see that treatment is his best option and will choose to stay on the unit.

Specific Program Content and Structure

10. Attach a copy of the weekly program schedule. **List and briefly describe**: (a) the different **program activities** (see survey Q# 19 for examples of specific activities), and (b) the **intended result or objective** of each activity **[Source: inmate interviews, observations, program documents]**. Include the following:

- Provide a **title and brief description** of the activity.
- How many **hours** weekly do inmates participate in each activity? How often do they meet?
- Describe a few **examples of program content** from lesson plans, printed program descriptions, observations or interviews (i.e., what do they do and how do they do it?)
    - For each **activity or group,** what is the **intended result or objective?** (i.e., what change in inmate attitudes or behaviors is expected)?

Jericho Therapeutic Community is structured in a family role-playing setting. Every inmate upon entering the program is assigned family members. These family members, Big Brothers, Uncles etc., encourage the inmates to assist each other in their recovery.

According to the Jericho inmate handbook, Rules and Tools, the program consists of an orientation level in addition to four distinct treatment phases. As the inmates work through each level of the program there are several committees of which they become a part. Through these committees, in addition to several therapeutic tools, educate the inmates in basic communication skills, compromising, and other life skills necessary for their recovery. There are ten different Jericho Committees.

Committees

The *Rotating Committee* is responsible for rotating and processing family members through different committees. They also assign chairpersons for each committee as necessary from Phase II and III inmates. The members of this committee must work together to maintain record keeping of all inmate movement through different committees, chairperson and observer positions. It is the responsibility of this committee to test all observers and chairpersons.

The *Haircut Committee* addresses negative and positive attitudes and behaviors. Haircuts can occur in several different settings. One type of Haircut is when two chairs are sat facing each other, a family member is in each chair, and one is allowed to address the other on any negative behavior that they may have been demonstrating. A Helping Measure is the result of a Haircut,

and consists of suggestions on how to correct a negative behavior or attitude. The members of this committee construct Helping Measures and review them with staff.

The *Orientation Committee* is responsible for sending out applications and interviewing those who wish to join Jericho. This committee establishes the family by assigning Big Brothers and Uncles. They hold training for Uncles and run Big Brothers and Little Brothers Rules and Tools classes. They give the Orientation test and approve of the phase change to Phase I. In addition the members of this committee approve titles of Pop-Sheets. A Pop-Sheet is constructed when an inmate communicates with fifteen or more family members gaining insight and feedback on a recovery topic. The inmate is then required to write down this information in his own words and communicate it to the family. The orientation committee is also responsible for assembling the intake folders.

The *Recreation Committee* is responsible for all maintenance and organization of entertainment activities including: weights, games, television, and athletic equipment. This committee is also responsible for the Milestone Board and Reality Board. The Milestone Board contains postings of any new family circles and announcements of clean time. The Reality Board posts the date and weather, also the thought for the day. The recreation committee meets on Sundays to assign responsibilities.

The *Ways and Means Committee* maintains telephone and visitor add on sheets for family members. Necessities such as clothing, haircuts, commissary and outside purchases for family members are all handled by this committee. The members of this committee run the Confront and Challenge meetings.

The *Image Committee* assists family members in gaining a positive self-image. The give out image exercises to correct negative images, conduct mock job interviews and select an MVP and Runner-up each week. They conduct image patrols and hand out positive citations, when an individual receives a positive citation they are acknowledged at the morning meeting with a positive pull-up. After an individual accumulates five positive citations, they receive a positive Haircut. This committee is also responsible for organizing the acknowledgement of an individual's birthday, as long as that person is comfortable with it.

The *Re-Entry Committee* is responsible for assisting those who are reaching the end of their stay in Jericho. There is a partnership with the image committee in working with those who are going to be graduating to assist them in feeling comfortable and confident with their recovery. This committee maintains follow-ups of previous family members through questionnaires. They keep up dates of admissions and discharges.

The *Crisis Prevention Committee* assists family members cope with times of difficulty. They hold concerns meetings; share their own experiences, strengths and hopes as a way of guiding the family member toward a positive attitude. Members of this committee are on the job 24 hours a day. They must log all crisis interventions and immediately report any issues concerning suicide.

The *Education Department* is responsible for all paperwork concerning the educational needs/wants of all family members. This committee orders all supplies, and writes all letters of

proposals and/or requests from family members. Members of this committee consist of a principle and teachers. There are specified duties for each position laid out in Jericho's inmate handbook, Rules and Tools.

The *Spiritual Committee* attempts to reach out to family members and get them in touch with a higher power. They post the days and times for all religious services, and hand out passes to family members who wish to attend. The members are also responsible for the maintenance of the Spiritual library. Spiritual services offered at Jericho include a variety of religious sectors including: Jehovah Witness, Hispanic, Jumah, Catholic, Protestant, Jewish and Native American.

Treatment Phases

The orientation phase has a length of six weeks to two months. Responsibilities during the orientation phase include: accepting guidance from the assigned Big Brother, identifying educational needs, and understanding and applying the Jericho Rules and Tools, consistently.

Also during the orientation phase the family member must demonstrate the ability to write Haircuts. Haircuts as described in the Rules and Tools Handbook as is a verbal elaboration given to a family member on a negative or positive attitude behavior. This activity allows the inmates to show concern for one another.

In order to advance from the orientation phase to **Phase I,** the inmate must complete several tasks including pass a Rules and Tools examination to ensure that they are aware of their responsibilities in the program. The new family member must demonstrate knowledge of and apply the therapeutic tools used in the program, and choose one to give a seminar on.

To initiate the treatment process, the new family member must identify personal shortcomings that led to their drug abuse/crime. After identifying them, the member must then describe how those shortcomings have affected their past; how they affect the present, and how they have the ability affect the future. In addition to the described tasks, the family member must receive 100% approval from the family in order to advance to Phase I. Phase I is three months long. The family member has the following responsibilities:

- They must join a committee
- Develop a treatment plan with their counselor
- Develop an academic goal, and identify how to obtain that goal
- If selected, they must be an Uncle to an Orientation Phase Member
- Work the first 3 steps of the 12 Step Program, read the AA Big Book, and NA Text (in reference to the first 3 steps).

In order to advance from Phase I to Phase II, the inmate must complete a 60-day term on a committee. They must be able to demonstrate that they have made progress towards their education goal set in Phase I. After evaluating their treatment plan goals, additional goals must be developed and recorded. By explaining how the first 3 steps of the 12 Step Program impact their life, the inmate must demonstrate knowledge of each step. Upon completion of all the required

tasks, the inmate must receive a favorable vote from Phase III and IV members in order to advance to the next level.

Phase II is approximately three and a half months long. Responsibilities include:

- Accept the responsibilities of a Big Brother, if selected
- Work and advance in all identified educational goals
- Focus on shortcomings identified in Phase I, begin a journal and share with family members. While sharing with family members, the family member must discuss how they are working on turning those shortcomings into positive qualities
- Required to chair 3 committees for at least 20 day terms.

In order to advance from Phase II to **Phase III**, the inmate will demonstrate progress in reaching educational goals. The inmate must study toward getting their GED. If they have already received their GED, they must develop goals towards higher education or vocational/technical training program. The inmate must also be active in the Spiritual program, while working on Step 4 and 5. They must share Step 5 with a family member who has successfully completed the step. They also must have satisfactorily completed terms on 3 committees. In addition the inmate must receive a favorable vote family members in Phase III and IV, and their counselor. Phase III is approximately three and a half months long. Phase 3 includes the following responsibilities:

- Serving as a peer counselor to the Orientation group as needed
- Responsible to serve on either the Haircut or Orientation Committee
- Continue to explore options of higher/technical/vocational education
- Must design a departure or Exit plan and present it to staff for approval
- Work on steps 6 and 7 of the 12 Step Program
- Provide guidance to others on Jericho Rules and Tools
- Possibly develop new tools with staff approval
- Continue work on steps 1,2,and 3 of the 12 step program, develop relationships and support from NA/AA attendees and Jericho alumni
- The inmate will put themselves in a Confront and Challenge Meeting
- The inmate will participate in a Hold Back Group.

In order to advance from Phase III to **Phase IV** an inmate must have a staff approved Department or Exit Plan, this plan has to be signed by a staff member. Each inmate applying for Phase advancement is required to have documentation of specific changes made in outside relationships with family or significant others, their purpose in life, and their stand on life, in addition to where they are in recovery. They must document one experience in teaching the proper use of Jericho tools. And once again receive a favorable vote by Phase III, Phase IV and group members. Phase IV Responsibilities include:

- Deliver a full seminar including a bibliography
- Review Haircuts and assist in designating Helping Measures for the identified Haircuts
- Using packet entitled "Gentle Path through the 12 Steps," work Steps 8 and 9

- Document and have available AA/NA meeting locations, identification of a sponsor and Home Group (if available).

Phase four is the final phase of the program. It lasts approximately two weeks; during this time the inmate must make aftercare preparations.

11. How is treatment structured to address **individual inmate needs** (e.g., individual counseling)? **[Source: inmate interviews, program documents, DATS Supervisor/Mgr.]**.

Each inmate, upon entry into the TC treatment program, is given an individual treatment plan, which lays out what the inmate is to accomplish while in treatment. This plan explains the problems to be worked out and the type of groups the inmate must take part in before successful completion. As far as individual treatment is concerned, each inmate is assigned to a counselor at the entrance into the treatment unit. Conversely, every counselor has a caseload of inmates that he/she is required to meet with approximately once a month. This meeting allows the inmate and counselor to review the treatment plan, making sure that the inmate is following a successful path to completion. In any case where an inmate feels there is a crisis, he can meet with his counselor to discuss the relevant problems and issues.

When asked about the possibility of an inmate that has a special problem or need that is not currently addressed by the present treatment groups, Rick explained that groups can be created for individual needs. As an example, inmates with a gambling problem may get together for Gambler's Anonymous, a group not normally offered to the population of TC inmates. However, it was seen to be a problem among a small group of inmates, and the staff created a group to deal with this issue. Though possible, it is rare that a group needs to be created to deal with special needs of the inmates. The program is thorough, touching upon the majority of problems dealt with by drug-addicted criminals.

Program Staff

12. Provide a brief description of the full time AOD staff. **[Source: DATS Supervisor/ Mgr.]**. Indicate which staff work regularly on the TC.

Name of Staff Member:	**Job Title:**	**Highest Degree Awarded:**	**Academic Discipline or Major:**	**Specialized Certification, if any:**	**Length Of Employment With DOC:**	**Number Of Years Experience Providing Direct D/A Treatment To Clients:**
1.Rick Voytko	DATSIII	M.Ed.	Counseling	Rehabilitation	6 years	10 years
2. Audrey Brickly	DATS II	M.S.	Human Svcs	D&A Counseling	2 years	13 years
3. Suzanne Karpinski	DATSS II	B.A.	Addiction Sc.	CAC	6.5 years	13 years

Staff Demographics (full time AOD staff only):

Number of male staff	1	Number of Caucasian staff	2
Number of females	2	Number of African American staff	1
		Number of Native American staff	0
		Number of Hispanic staff	0
		Number of Asian staff	0
		Number of Other staff	0

INDIVIDUAL PROGRAM REPORTS: DOC-TEMPLE RESEARCH PARTNERSHIP

Institution: Houtzdale
AOD Program: Courage to Change Therapeutic Community

1. What are the **general goals** or **mission** of this program? What does it try to do? Length: 2-3 paragraphs. **[Source: program documents, staff interviews].**

The Drug and Alcohol Department *Procedures Manual* describes the CCTC as follows: The CCTC addresses the physical, mental spiritual, emotional and social problems associated with drug and alcohol abuse. If you decide to enroll in the CCTC, you will be entering an atmosphere that fosters motivation, self-help and learning. The CCTC is not just a housing area, but also a community that strives to help each other and provide constructive feedback.

It further states that the goal of SCI – Houtzdale's Drug and Alcohol Treatment Department is to provide quality drug and alcohol treatment and education to inmates whose lives have been affected by chemical substance abuse.

2. What is the main **treatment approach** or **philosophy** used in this program? (e.g., see survey Q#12). Could you give one or two examples of *how* this approach is used? **[Source: staff interviews, program documents].**

The Drug and Alcohol Department Procedures Manual states that a multimodal approach to treatment is used at SCI – Houtzdale. The CCTC is a treatment intensity level III program whose specific treatment approach is non-hospital, residential treatment – total immersion. A variety of levels of treatment and therapeutic approaches are used.

According to *Policy Statement 7.4.1HOU2* "General Description of Institutional Drug and Alcohol Treatment Package," the TC program adheres to the Bio-Psychosocial model of addiction, and utilizes a total immersion treatment approach.

The specific treatment approach is non-hospital, residential treatment in which the cognitive, spiritual, social, physical and emotional aspects of the person will be addressed. The Survey of Prison Based Drug and Alcohol Treatment Programs indicated that other treatment approaches used by the CCTC include cognitive therapy, behavior modification, psychotherapy, RET, and reality therapy.

Target Population and Target Selection

3. **For this program**, describe inmate **recruiting, outreach, or referral procedures** (e.g., How do inmates hear about this program? Who makes referrals? What are the reasons for referral)? **[Source: program documents].**

Both the *Drug and Alcohol Department Procedures Manual* and *Policy Statement 7.4.1* HOU8 "Weekly General Population Inmate Drug and Alcohol Orientation" indicate that new arrivals to SCI – Houtzdale will attend an orientation in which verbal and written information is

provided describing drug and alcohol programming. Inmates or DOC staff can generate referrals. Each referral is tracked according to an automated system that lists inmates according to their minimum and referral dates. According to the *Inmate Handbook*, referrals from DOC staff could include the Corrections Counselor, Unit Manager, or DATS. A vote sheet system is then initiated with the Deputy Superintendent having the final decision. As per Policy Statement 7.4.1 HOU4, inmates self-referring should complete form DC-135A, and staff-generated referrals should use a DC-134 form.

4. What are the specific **eligibility** requirements for this program (e.g., type and seriousness of D & A problem, time remaining in sentence)? Are exceptions made? **[Source: program documents].**

The *Procedures Manual for the Drug and Alcohol Department* articulates the eligibility for the CCTC. Inmates must be six months misconduct free; must voluntarily enter the program; and must have one or more of the following: a Psychoactive Dependence Scale Score reflecting a need for intensive treatment, a documented drug and alcohol history, drug and alcohol related charges, drug and alcohol related misconducts, admits to a drug and alcohol problem, previous drug and alcohol placements, admit to being under the influence at the time of the offense, or commission of a crime for monetary support for his addiction. Each of these criteria are also listed in *Policy Statement 7.4.1 HOU6 "Referral Process for CCTC."*

The Inmate Handbook outlines some additional entrance criteria. One criteria is that there be no psychosis or intellectual functioning that precludes comprehension of objectives or participation in activities. Another is that he may not be using illicit drugs, which will be assessed through urinalysis. Also, a "Z" code, according to page 4 of the Inmate Handbook may preclude consideration of a candidate.

5. **Decision to admit (or not):** Who makes the decision? What are the most important criteria? About what percentage of referrals are rejected? **[Source: program documents].**

According to *Policy Statement 7.4.1 HOU6, "Referral Process for CCTC,"* the Corrections Counselor circulates a vote sheet (form DC-46) to the Unit Manager, DATS Supervisor, Inmate Program Manager, and the Deputy of Centralized Services, who makes the final decision.

In response to question #27 of the *Survey of Prison-Based Drug and Alcohol Treatment Programs*, the most important screening criteria of all those listed previously are level of drug involvement, and institutional record of drug use and misconducts.

In addition to all of the eligibility requirements outlined above, the *Drug and Alcohol Department Procedures Manual* states that other important individual qualities include genuine heart, courage, and determination.

Intake, Exit, and Follow-up Procedures

6. Describe the **intake/admission process** (e.g., What happens to an inmate when they first attend this program? Is there an orientation, intake interview, etc.?) **[Source: program documents].**

Procedure X in the *Drug and Alcohol Department Procedures Manual* addresses the needs of newly arriving CCTC members. The screening process includes an interview with DATS staff, where rules and expectations are discussed. If the inmate is deemed appropriate for treatment, they will be added to the TC as space becomes available. Once approved and during their orientation, the DATS gives the inmates their Community Resident Handbook, behavior objectives, treatment records packet, and his AA/NA books. The inmate also signs the disclosure, inmate rights, and consent to treatment forms.

In addition, the Inmate Handbook states that each new resident will meet with the Intake Committee the day he arrives on the TC, and will be assigned a big brother to assist him with his transition to the unit. Each new inmate is granted a two-week orientation period in which they become familiar with the schedules and routines. They each complete a "pop sheet" to help them become familiar with their small group members. They must also sign a six-month celling agreement.

7. What is the normal **program enrollment**? (i.e., at one specific time) **[Source: program documents].**

The normal program enrollment in the CCTC is 124 inmates, according to the *Drug and Alcohol Department Procedures Manual.*

8. What is the normal **length of stay** for an inmate in this program? **[Source: program documents].**

According to the Drug and Alcohol Department Procedures Manual and the DATS Supervisor, the length of stay for the inmates in the CCTC is 12 months. However, the Inmate Handbook also indicates that the actual time in the program may be more or less than this because time frames are based on individual considerations.

9. What are the **criteria for successful program completion? For an unsuccessful discharge**? **[Source: program documents].**

The Inmate Handbook outlines discharge procedures and definitions. A successful discharge occurs when a TC member has completed all the requirements of the three phases of the CCTC. A neutral discharge is granted when a TC member prematurely leaves the program prior to completion due to circumstances beyond his control (parole, pre-release, medical reasons, limited mental capacities). An unsuccessful discharge occurs when a TC member with the ability to complete the program prematurely leaves due to termination or voluntary withdrawal.

The Inmate Handbook also lists reasons for termination, including misconducts, violation of rules, non-adherence to treatment plan, several medical or emotional problems, sentence status change or failure to adjust.

According to the response to question #13 of the *Survey of Prison-Based Drug and Alcohol Treatment Programs*, the two most important criteria to determine successful completion are Measures of Attitudinal or Behavioral Change, and Case Progress Review by Treatment Staff.

Specific Program Content and Structure

10. Attach a copy of the weekly program schedule. **List and briefly describe**: (a) the different **program activities** (see survey Q# 19 for examples of specific activities), and (b) the **intended result or objective** of each activity **[Source: inmate interviews, observations, program documents]**. Include the following:

- Provide a **title and brief description** of the activity.
- How many **hours** weekly do inmates participate in each activity? How often do they meet?
- Describe a few **examples of program content** from lesson plans, printed program descriptions, observations or interviews (i.e., what do they do and how do they do it?)
  - For each **activity or group**, what is the **intended result or objective?** (i.e., what change in inmate attitudes or behaviors is expected)?

According to the *Proposal for the TC* dated 1996, there are four goals of the TC. These include: to increase knowledge and dispel myths by education of chemical dependency; to improve knowledge and practice cognitive and behavioral coping strategies to use throughout recovery and to improve and practice interpersonal skills and the group process; to develop intrapersonal skills and to become aware of social and re-entry issues; and to develop refusal skills and an awareness of relapse warning signs and symptoms necessary to facilitate long-term recovery. Page 19 of the Proposal states that weekly activities designated to achieve these goals include morning meeting; seminars; pull up hearings; Phase I, II, and III classes; small groups; AA/NA meetings; and the confrontation support group.

According to the *Drug and Alcohol Department Procedures Manual*, both individual and group therapy are provided to inmates in the CCTC. In addition, numerous classes are offered in a wide range of topics, such as basic concepts, cognitive restructuring, and communication. The TC Proposal also identifies classes in sexuality, inter/intra personal skills, and confrontation support.

According to the *Course Outline for the Basic Concepts of Recovery* Phase I Class, the sections include: What is AA/NA, Spirituality vs. Religion, The Disease Concept, the Process of Recovery, and Sponsorship. A final exam completes the section.

As per the lesson plans for the Phase II Communications course, topics such as Speaking in Code, Cycles of Communication, Active Listening, and Blocks to Effective Listening are included in this section.

The Phase III Cognitive Restructuring Course involves eight sessions of one hour each, such as Emotions as Problems, Thinking and Emotions, Irrational Beliefs, and Rational Emotive Homework.

The *Inmate Handbook* and the *TC Proposal* also list and describe each of the committees inmates are required to attend or be assigned to. These included committees for Activities, Education, Intake, Interaction, Maintenance, Programs, and Public Relations.

The Inmate Handbook states that TC members are compensated for a 30-hour workweek, and are expected to complete committee assignments and attend groups, meetings, and classes. Inmates with a fifth grade reading level or less will be required to attend school on a half-day basis (in lieu of work assignment, where applicable).

Policy Statement 7.4.1 HOU17 "CCTC Amended Pay Schedule," reflects the following levels of compensation: Phase I inmates receive .18/hr., Phase II .19/hr., Phase III .23/hr., and Phase IV (chairman and secretary positions) receive .24/hr.

According to the Unit Schedule, each day (excluding weekends) includes one hour each of a Phase Class, Small Group, and AA/NA meeting. Each week, Pull-up Hearings and Seminars are held, and each month, Counselor Hours are available to TC inmates.

According to the inmate interviews, all inmates must report to their morning meeting at 8:15 am, which lasts till 9am. Morning meeting is immediately followed by Phase class, in which inmates discuss such issues as self-esteem, behavior modification, family, drug addiction, relapse prevention, anger management, responsibility, criminality, and cognitive restructuring. After phase class, the inmates have their lunch, then attend their small groups, which are when the inmates get to deal with more personal issues and are able to give feedback to one another. After small group is count, then they go to either pull-up hearings or seminars, depending on the day.

Pull-ups are helping measures in which inmates write up other inmates for wrongdoings and then hearings are held to decide if the write-ups were justifiable and to hand out an assignment for the inmate to do as a punishment or helping measure. At 2:15 pm, when this is over, inmates attend AA/NA meetings and then their treatment programs are completed for the day.

11. How is treatment structured to address **individual inmate needs** (e.g., individual counseling)? **[Source: inmate interviews, program documents, DATS Supervisor/Mgr.]**.

The inmates are given a treatment plan with specific goals that may include group exercises, written assignments, and oral presentations, according to the Drug and Alcohol Department Procedures Manual. Treatment plans are categorized according to Phase I, II, and III, with action steps, including goals and objectives, specified for each problem areas. DATS staff can add individual action steps for each inmate, if desired.

Examples of Phase I problem areas are lack of investment in TC, lack of knowledge and practice of communication skills, lack of knowledge of the dynamics of addiction, and need to sustain recovery and abstinence.

Examples of Phase II problem areas are limited ability to practice cognitive and behavioral coping strategies, denial, lack of knowledge and practice of the12 steps of recovery, and need to sustain recovery and abstinence.

Examples of Phase III problem areas are lack of knowledge of inter- and intrapersonal skills, lack of knowledge of relapse, and lack of experience in effective and consistent application of recovery tools. For each problem area and for every phase, generalized action steps are suggested, and often include developing a seminar, attending classes, discussing an issue, completing a plan or reading, etc. Additional problem areas and action steps may be added to each treatment plan as needed.

Program Staff

12. Provide a brief description of the full time AOD staff. **[Source: DATS Supervisor/ Mgr.]**. Indicate which staff work regularly on the TC.

Name of Staff Member:	**Job Title:**	**Highest Degree Awarded:**	**Academic Discipline or Major:**	**Specialized Certification, if any:**	**Length Of Employment With DOC:**	**Number Of Years Experience Providing Direct D/A Treatment To Clients:**
1. Frank Hartnett	DATS Supervisor	MS in Counseling & a MA in Management	Counseling and Management	CAC	7 months @ Houtzdale	
2. Jennifer Rossman	DATS II	BA	Administration of Justice		2 years, 10 months	6 years, 8 months
3. Heather Yasolsky	DATS II	MA	Counseling/w Specialization in Substance Abuse	CAC	3 years, 6 months	6 years, 6 months
4. Rachelle Thompson	DATS II	BA	Criminology		2 years	Over 5 years
5. Marilee Close	DATS II	M. Ed.	Education specializing in Psychiatric Rehabilitation	CRC – Certified Rehabilitation Counselor	2 years, 4 months	6 years, 4 months
6. Cherie Williams	DATS II	MA	Counseling Services		3 ½ years	4 years

Staff Demographics (full time AOD staff only):

Number of male staff __1__
Number of females __5__

Number of Caucasian staff ___5__
Number of African American staff ___1__
Number of Native American staff _____
Number of Hispanic staff _____
Number of Asian staff _____
Number of Other staff _____

INDIVIDUAL PROGRAM REPORTS: DOC-TEMPLE RESEARCH PARTNERSHIP

Institution: Huntington
AOD Program: Living Sober Therapeutic Community

General Program Goals and Intervention Philosophy

1. What are the **general goals** or **mission** of this program? What does it try to do? Length: 2-3 paragraphs. **[Source: program documents, DATS Supervisor/Mgr.].**

According to the LSTC Community Inmate Handbook, a Therapeutic Community is a group of individuals living together and helping each other in a constructive way within a closed environment through social learning. All staff and residents are part of the Treatment Community. All inmates of the LSTC are required to use the various areas of treatment, the proper use of the therapeutic tools and procedures of the activities that they are obliged to participate in during their stay in the program. This knowledge should help the inmates come to the understanding of the objectives and goals of any treatment they may receive, on how to utilize the tools, and how to gain the most benefits from each function within the program. This is a behavior driven program that is seen as both a treatment program as well as an up-close examination of inmate behaviors in a community setting. Daily interaction with other inmates, DATS Staff and Corrections Officers provide a rich source of information that can be used by the DOC for making decisions about the inmate's potential for rehabilitation, recidivism, and behaviors not readily observed in a standard housing unit with cells.

2. What is the main **treatment approach** or **philosophy** used in this program? (e.g., see survey Q#12). Could you give one or two examples of *how* this approach is used? **[Source: program documents, DATS Supervisor/Mgr.].**

The LSTC Community Inmate Handbook says that their main treatment approach is to combine drug/alcohol treatment (group and individual) with education in a therapeutic atmosphere, which helps the inmate to focus on his addiction, behavior, attitudes, and criminality. The last phase of this program involves goal planning and a structured reintegration into the community. All inmates of the LSTC are required to use the various areas of treatment, the proper use of the therapeutic tools and procedures of the activities that they are obliged to participate in during their stay in the program. This knowledge should help the inmates come to the understanding of the objectives and goals of any treatment they may receive, on how to utilize the tools, and how to gain the most benefits from each function within the program.

Target Population and Target Selection

3. **For this program**, describe inmate **recruiting, outreach, or referral procedures** (e.g., How do inmates hear about this program? Who makes referrals? What are the reasons for referral)? **[Source: program documents, inmate interviews, DATS Supervisor/Mgr.].**

According to Policy 7.4.1 – HUN 1 and the SCI-Huntingdon Addiction Counseling Overview, inmates are informed about the LSTC at an orientation through their assigned correctional

counselor and through institutional TV and routine interviews via a call list. Referrals can be made by their correctional counselor, who is asked to provide the group leader or Drug and Alcohol Supervisor with the inmate's name, number, and housing and work assignment on a standard "memorandum report form". The correctional counselor is also to identify the target date on this memo, which could be the minimum release date or other important date (such as pre-release staffing date, etc.). This allows enough preparation time for proper programming efforts. Referrals can also result from inmate interviews. Referrals can be made by counselors or by the inmates themselves. Admission to the LSTC can be initiated by the established institution staffing procedure, by using the DC-46 Vote Sheet, which includes a space for the DATS Supervisor as a voting member.

From the inmate interviews, we found that inmates heard about the TC program in a number of ways. Several heard about it during their initial interview when they arrived at Huntington. Several had counselors suggest it to them because they knew they had addiction problems. One inmate saw a friend of his go into TC and come out a changed person in all his aspects of life, not just with addiction, so he wanted to change also.

4. What are the specific **eligibility** requirements for this program (e.g., type and seriousness of D & A problem, time remaining in sentence)? Are exceptions made? **[Source: program documents, DATS Supervisor/Mgr.].**

A Condensed Summary of the LSTC says that the DAT Supervisor makes the decision about the inmate's needs and appropriateness for TC treatment based on a drug & alcohol interview and an assessment conducted by DATS Supervisor. For a specific inmate whose case file we examined, his eligibility was determined by looking at the Pennsylvania Substance Abuse Screening Instrument (on which he scored a 9), the Housing Performance report (which is completed by the C/O's, like a vote sheet), and the Work Supervisor Evaluation form.

5. **Decision to admit (or not):** Who makes the decision? What are the most important criteria? About what percentage of referrals are rejected? **[Source: program documents, DATS Supervisor/Mgr.].**

Policy 7.4.1-HUN 1 illustrates ten specific criteria that are considered when an inmate is referred to the LSTC:

- It cannot be less than 6 months to their minimum parole date.
- The inmate must have documented drug and/or alcohol dependency.
- The inmate cannot display any psychosis or intellectual functioning that precludes comprehension of objectives and participation in program activities.
- There must be voluntary commitment to complete the program.
- They must have medical clearance. Inmates that are referred cannot be undergoing other forms of treatment that will interfere with their ability to participate in the program.
- The inmate must be literate or at least have the capacity to become so. A major portion of the program involves reading and maintaining a written journal. Education is also a major component.
- Must be double cell status.

- The inmate cannot have any misconduct related to escape, assaultive behavior, and over-all problematic institutional adjustment. These actions may preclude consideration.
- The inmate may have to undergo a current psychological evaluation that may have significant impact on final approval and should be available. The Living Sober Therapeutic Community staff will determine the need for this evaluation during their preview of the case.
- The referral must secure approval of the Major of the Guard and the Inmate Program Manager via the DC-46 Vote Sheet.

Intake, Exit, and Follow-up Procedures

6. Describe the **intake/admission process** (e.g., What happens to an inmate when they first attend this program? Is there an orientation, intake interview, etc.?) **[Source: program documents, DATS Supervisor/Mgr.].**

The LSTC *Outline of the Four Phases* states that participants in the LSTC, while in Phase I, will to read, understand, and sign a consent to treatment form which clearly outlines participants' and the department's expectations within the therapeutic community. The inmate will participate with his individual counselor on the development of a comprehensive therapeutic treatment plan. This plan will include the specific goals of the Therapeutic Community and also address the individual needs of the participant. The inmate will have to participate in an Introduction to Group Process, which is a lecture on skills that are needed to be able to participate in a group properly. The purpose of this group is to assist the participant in understanding how to be a productive and contributive group member. They will also have to participate in an Introduction to Communication Dynamics lecture that will teach the verbal and non-verbal skills needed to effectively communicate and listen to other group members. According to one inmate's case file, forms that the inmates need to fill out for admission and orientation are: Various written consent forms, inmate rights and client rights forms, DATS Department Disclosure of Admission/Discharge and Consent to Treatment criteria, Psychosocial History, Psychoactive Substance Abuse/Dependency Scale, Multimodal Life History Questionnaire, Medical History, Classification Summary, and Intake Orientation sheet.

7. What is the normal **program enrollment**? (i.e., at one specific time) **[Source: program documents].**

Normal program enrollment is 36 inmates; that is the maximum amount of beds in the TC.

8. What is the normal **length of stay** for an inmate in this program? **[Source: program documents].**

According to the LSTC Community Inmate Handbook, the program will usually take 8 to 13 months to complete, based on the completion of various behavioral objectives. According to the DATS Supervisor, the normal length of stay is around 52 weeks. Actual time in the program may be more or less than this "ideal" time frame depending upon individual progress.

9. What are the **criteria for successful program completion**? **For an unsuccessful discharge**? **[Source: program documents, DATS Supervisor/Mgr.].**

The LSTC Community Inmate Handbook says that successful program completion occurs upon an inmate's satisfactory fulfillment of behavioral objectives as designated in the inmate's Individual Treatment Plan.

Neutral discharge from the program occurs when inmates are unable to complete the program through no fault of their own (e.g., medical problems, emotional problems, sentence status change, etc.). "Neutral discharge" means that no negative consequences or implications will occur as a result of leaving the program.

Unsuccessful discharge or program failure may result based upon unsatisfactory performance or the award of a Class I or Class II misconduct (i.e. violation of the Inmate Handbook's rules and regulations); decision of staff via vote sheet based on non-fulfillment of treatment plan; or commission of a felony or misdemeanor or failure to adhere to the individual treatment plan or to program guidelines.

Specific Program Content and Structure

10. Attach a copy of the weekly program schedule. **List and briefly describe**: (a) the different **program activities** (see survey Q# 19 for examples of specific activities), and (b) the **intended result or objective** of each activity **[Source: inmate interviews, observations, program documents]**. Include the following:

- Provide a **title and brief description** of the activity.
- How many **hours** weekly do inmates participate in each activity? How often do they meet?
- Describe a few **examples of program content** from lesson plans, printed program descriptions, observations or interviews (i.e., what do they do and how do they do it?)
- For each **activity or group**, what is the **intended result or objective?** (i.e., what change in inmate attitudes or behaviors is expected)?

The LSTC Summary describes the program components as broken down into four Phases.

Inmates in **Phase I** focus on an orientation and probation period in which the inmate and staff have time to determine if the TC is effective for the individual and how well he affects other members of the TC. This phase has several main objectives, according to the *Phase I Treatment Plan.* The first objective is to define treatment issues by having the inmate sign a consent form, complete a life history questionnaire, complete a chemical history questionnaire, complete a global treatment sheet, and to meet with a counselor to discuss Phase I's Units A, B, C, & D.

The second Phase 1 objective is to initiate a Phase I treatment plan by meeting with a counselor, agreeing to and signing a Phase I treatment plan, being assigned to a committee, and o go to each member and have them initial a sign up form.

The third Phase 1 objective is to obtain a passing score on the Design for Living Tests by attending sessions A, B, & C of the Design for Living program. These sessions explore the nature of drugs and drug use, additional risks associated with chemical use and to introduce the relationship between criminal thinking and chemical use, and to understand and change awareness.

The fourth Phase 1 objective is to obtain a better understanding/awareness of self by attending five therapeutic journaling classes in which the inmate is expected to maintain a daily written journal and review in individual sessions. They are also expected to participate in individual counseling once a month and identify and review issues discussed during small group participation.

The fifth objective is to obtain knowledge of interpersonal skills and group processes by attending 14 sessions of interpersonal skills classes, completing all homework assignments satisfactorily, and attending all small group therapy sessions 2 times per week.

The sixth objective is to obtain knowledge of the basic concepts of recovery by attending 8 sessions of the Basic Concepts of Recovery Class and obtaining a passing score on the test. The Basic Concepts class introduces basic vocabulary and concepts of addiction, treatment, recovery, and self-help programs, provides a foundation of key recovery and treatment concepts that will help participation into other therapeutic activities, develops an understanding of the depth of problems experienced by an individual who is a chemically dependent offender, confronts the complexity and depth of the recovery process so that they can understand a need for a full-time, long-term commitment to addiction treatment, aftercare, and recovery, and introduces and explains basic principles of the 12 Step Programs, self-help and the role of spirituality in the treatment/recovery processes.

The seventh objective is to sustain recovery utilizing 12 Step Support System by attending AA/NA support group and completing requirements of a treatment plan supplement.

The eighth objective is to utilize a Helping Measure System by initiating at least one encounter or one pull-up while in Phase I.

The final objective is to advance to Phase II by having been successfully staffed, having received peer recommendation by means of a pop sheet, having maintained at least an average score on the Program Participation Index, having had functioned as a member of 2 different committee's, having initiated a Phase II Treatment Plan, having obtained approval for Phase II ITP from small groups and having each member give feedback for advancement to the next phase, having demonstrated understanding/use of recovery tools and giving a seminar on "What tools I learned in Phase I."

In **Phase II,** the inmate enters into more focused psycho-educational programming, including interpersonal communication, criminal thinking, cognitive restructuring, and the relapse prevention. The inmate is also required to participate on 2 committees, be more actively involved in group therapy and the pull-up system. This phase involves several specific objectives according to the Phase II Treatment Plan.

The first Phase II objective is for the inmate to obtain knowledge and begin to understand realistic self-examination/intrapersonal skills. This objective is reached by attending the Intrapersonal Skills Training Class and by completing all the homework assignments to the satisfaction of the instructor. The inmate is expected to verbalize in small group therapy sessions what they were thinking at the time they committed their offense and to listen as others share what their thoughts were during their own experiences. The inmate is to identify at least 3 examples of behaviors, emotions, and thoughts which could trigger relapse, discuss these triggers with others in at least 9 small group sessions, and then review with their counselor in an individual session. To accomplish this objective, the inmate is expected to demonstrate mastery of assertiveness skills. They are to demonstrate this by listing 10 examples of aggressive behavior

and then listing an alternative assertive behavior for each, show assertiveness instead of passive or aggressive behaviors in at least 3 small groups, and discuss assertiveness during individual counseling sessions. The inmate is also expected to begin the process of cognitive restructuring by attending 8 sessions of Cognitive Restructuring Group. This group's objective is to for the inmate to learn to employ rational emotive techniques in everyday life. This objective is reached by having participants understand how cognitive restructuring (changing beliefs) can change the course of one's future and prevent taking paths of self-defeating and socially damaging behaviors. They are to develop and understand the nature and importance of emotions and look at Albert Ellis's 11 irrational ideas and how to challenge them. The inmates are also expected to complete 10 satisfactory homework assignments that address addiction, criminal behavior, authority figures, underachievement, and family/relationships, and complete an essay on "What I learned and what helped me most from the Cognitive Restructuring Classes."

The second objective is to obtain an understanding of the Twelve Steps and receive a passing score on the tests. Participants are to accomplish this by attending and participating in 14 Twelve-Step Study Classes.

The third objective is to attend 19 sessions of Spirituality, Sexuality, and AIDS Education and obtain a passing score on the test. Participants must also write an essay and discuss "What I learned and benefited from in Spirituality, Sexuality, and AIDS Classes."

The fourth objective of Phase II is for the inmate to obtain practical knowledge of Steps 1 through 3 by attending sessions D through H of the Design for Living Program and write an essay on what they learned from that program.

The fifth objective is for the inmate to sustain recovery by attending an AA/NA support group 3 times a week, submit 6 AA/NA Attendance/Log/Reaction Sheets, maintain a journal that they review with a counselor monthly, tell their own story in one AA or NA meeting, complete the requirements of the treatment plan supplement, complete an educational activity, an exercise program, and they are also expected to begin to address spiritual issues during counseling sessions.

The sixth objective of Phase II is for the inmate to advance to Phase III. They are advanced to Phase III after they have been successfully staffed, received peer recommendations by pop sheets, maintained an average score on the Program Participation Index, obtained small group approval for Phase III ITP, and have demonstrated that Phase II treatment goals have been completed and learned/retained.

The last objective is for the inmate to utilize the Helping Measure System by initiating at least 1 encounter or 1 Pull-up per month during Phase II.

In **Phase III**, the inmate focuses more on intrapersonal/intrapsychic issues dealing with anger management, individualized inventorying of criminal history, thinking and behavior. This phase focuses specifically on the inmate dealing with and understanding denial; demonstrating a mastery of cognitive behavioral techniques by successfully modifying his moods in a stable and socially

appropriate manner; and continuing to develop group process skills. This Phase has several key goals according to the Phase III Treatment Plan.

The first goal is for the participant to understand and deal with the issue of denial. This goal is accomplished by having the inmate identify and confront their own denial, point out denial symptoms in 3 different members of their group, identify examples of people or things who strengthen that denial, and complete cognitive restructuring exercises.

The second goal of this phase is to have the participants obtain practical knowledge of Steps 4 - 9 by attending sessions I - N of the Design for Living program and writing an essay on what they learned.

The third goal is for the inmate to sustain recovery by attending AA/NA support groups 3 times a week, maintain a journal, meet individually with a counselor, and tell their life story in a combined AA/NA meeting. They are also expected to continue to attend spiritual recovery, participate in an educational activity and an exercise program, and discuss examples of addiction.

The fourth goal is for the inmate to gain insight into criminal thinking. They are to acquire this insight by attending 5 Criminal Thinking classes and discussing why they themselves are criminals and their own criminal thinking. They are also given a relapse warning sign list for criminal behavior that will help them understand how they may return to criminal behavior, even though they don't want too.

The fifth goal of this phase is for the participant to utilize the helping measure system by initiating 9 Pull-ups per month.

For the sixth goal, they are expected to demonstrate understanding/use of recovery tools in Phase III, by giving a seminar on 5 tools they have learned and used, discussing what they have learned in Phase III and receive feedback on issues that still need to be addressed, and discussing their own strengths and weaknesses with their individual counselor.

The seventh goal of this phase is the advancement to Phase IV. They are advanced to Phase IV after they have been successfully staffed, received peer recommendations by pop sheets, maintained an average score on the Program Participation Index, obtained small group approval for Phase IV ITP, and completed requirements of the treatment plan supplement. The treatment plan for this phase requires that the inmate think about future plans, such as their general goals, their personal goals for their home life, employment, education, and their own personal improvement.

The final goal of this phase is for the inmate to learn productive strategies for expressing and coping with anger. They are expected to attend 13 sessions of Basic Anger Management. In these sessions they are to identify what anger is and learn constructive anger management techniques. Inmates also receive Cage Your Rage: An Inmate's Guide to Anger Control, a book by Murray Cullen that will help them understand their anger and how to control it.

Finally, in Phase IV the inmate is given the chance to integrate his knowledge and experiences and plan for reentry into general population and/or progressive moves to a lower custody level housing unit and/or a CCC. Part of aftercare planning includes a periodic staff follow-up questionnaire or interview. This phase focuses specifically on the inmate demonstrating and presenting a written plan to utilize the support services within the community to which he will be discharged; writing an extensive and personalized individual essay regarding his own recovery and future recovering, which will be reviewed by staff and group members and will be used as a therapeutic tool to assess the individual's readiness for treatment termination and discharge; engaging in group termination and group closure exercises; counseling geared towards the continuity of addictions treatment within the specific community to which referral was made following discharge from the SCI; demonstrating effective utilization of 3 relaxation techniques; being involved in the Activities Department's Life Skills/Leisure Activities Program, being involved in a standardized parent education training program(PET); and continuing to impress his assertiveness skills with specific progress towards relapse prevention. Inmates must show knowledge of stress management techniques, life skills and leisure activities, relapse prevention, assertiveness skills, community support services, show recovery tools that they use, and demonstrate positive leadership skills.

When all that is completed, inmates will be successfully discharged after they have been successfully staffed, received peer recommendations via pop sheet, maintained an average PPI score weekly, conducted a final farewell speech to members of the LSTC, and completed and reviewed an Aftercare Plan.

Daily Activities

According to inmate interviews, each inmate must report to the morning meeting every day, which begins at 8:15 am and lasts until 8:45 am. After that time, each inmate participates throughout the day in phase groups, AA/NA groups, and small groups. Inmates described Phase groups as a school-like atmosphere. Inmates listen to a lecture and are expected to hand in homework assignments and take tests. Topics in phase groups include criminal thinking, cognitive restructuring, anger management, and drug addiction. Small groups were described as smaller, more personable groups, in which the inmates can discuss any problem they may be dealing with and are able to acquire feedback from other inmates. In these groups, inmates are able to learn from each other and help each other with their problems, whether it concerns drug addiction or something else they may be going through at that moment. AA/NA groups are the basic 12-step groups and they mainly meet in the afternoon or evening hours.

For each activity and group, the intended objective is for inmates to learn how their addiction and other issues led to their incarceration, and what they can do to change their previous behavior. It is also hoped that by receiving an adequate education on these topics and from listening to other's situations, inmates will gain the knowledge and tools to help them from relapsing and recidivating once they are on the outside.

12. How is treatment structured to address **individual inmate needs** (e.g., individual counseling)? **[Source: inmate interviews, program documents, DATS Supervisor/Mgr.]**.

According to documents describing Phase I of the LSTC, an individual treatment plan, constructed by the inmate and his individual counselor, is devised when the inmate first enters the program. The primary function of the treatment plan is to give the individual insight into past behavior, values, goals, and how these traits have helped or hindered him in living within the expectations of society. The treatment plan is an introduction, as well as a chronology of what he believes to be significant events in his life. This plan may also be used in various other ways, such as requesting for a modification of sentence, requesting for employment, and introducing the individual to an aftercare agency.

Program Staff

11. Provide a brief description of the full time AOD staff. **[Source: DATS Supervisor/ Mgr.]**. Indicate which staff work regularly on the TC.

Name of Staff Member:	**Job Title:**	**Highest Degree Awarded:**	**Academic Discipline or Major:**	**Specialized Certification, if any:**	**Length Of Employment With DOC:**	**Number Of Years Experience Providing Direct D/A Treatment To Clients:**
1. Mike Ciaverella	DATS Supervisor	B.A.	Sociology	CAC	10 years	10 years
2. Will Matthews	DATS II	M.A.		N/A	5 years	6 years
3. Joel Ritchie	DATS II	B.A.		N/A	2 years	12 years
4. Christina Smith	DATS II	B.A.		N/A	1.5 years	2.5 years
5. Renee McMurray	DATS II	B.A.		N/A	6 months	2-3 years

Staff Demographics (full time AOD staff only):

Number of male staff __3__
Number of females __2__

Number of Caucasian staff ___5__
Number of African American staff _____
Number of Native American staff _____
Number of Hispanic staff _____
Number of Asian staff _____
Number of Other staff _____

INDIVIDUAL PROGRAM REPORTS: DOC-TEMPLE RESEARCH PARTNERSHIP

Institution: Waymart
AOD Program: "Family Rap" Therapeutic Community

General Program Goals and Intervention Philosophy

1. What are the **general goals** or **mission** of this program? What does it try to do? Length: 2-3 paragraphs. **[Source: program documents, DATS Supervisor/Mgr.].**

Waymart's Therapeutic Community was established to meet the treatment needs of inmates who are seeking recovery from drug and alcohol addiction. Staff believe that through treatment and abstinence, the recovering addict can lead a productive, responsible and satisfying life. The purpose of the TC is to redirect the addict away from a self-destructive lifestyle and towards a better life, beginning with abstinence from all mood altering chemicals. They believe that addiction is the inmate's primary problem and demands his highest priority. And addict must first deal with his/her addiction in order to attempt to cope with their other problems.

2. What is the main **treatment approach** or **philosophy** used in this program? (e.g., see survey Q#12). Could you give one or two examples of *how* this approach is used? **[Source: program documents, DATS Supervisor/Mgr.].**

According to the DATS Manager, the main treatment approach used at Waymart is the 12 Step for Recovery approach that is used in Alcoholics Anonymous.

Target Population and Target Selection

3. **For this program**, describe inmate **recruiting, outreach, or referral procedures** (e.g., How do inmates hear about this program? Who makes referrals? What are the reasons for referral)? **[Source: program documents, inmate interviews, DATS Supervisor/Mgr.].**

According to the inmate interviews, inmates stated that they were referred or heard about the TC by staff, through their initial interview, other inmates, or their evaluation at Camp Hill recommended it.

4. What are the specific **eligibility** requirements for this program (e.g., type and seriousness of D & A problem, time remaining in sentence)? Are exceptions made? **[Source: program documents, DATS Supervisor/Mgr.].**

According to the Inmate Handbook, the admission criteria for the TC are as follows: 1.) Admission is open to any male inmate currently incarcerated in the PA DOC; 2.) The inmate, through a DATS, Correctional Counselor, or State Correctional Institution, may apply for entrance into Waymart's TC; 3.) Anyone applying for admittance should have at least 9 months to their minimum expiration date; 4.) No transfers will be accepted if they are or have been in the RHU-DC Status within the last 30 days and candidate must not have a Class I or more than one Class II misconduct within the last 9 months; 5.) All pending candidates will be processed and

interviewed prior to admission; 6.) Admissions are available to anyone without regard to race, age, national origin, religious affiliation, or other characteristics; 7.) All admissions must be ambulatory; 8.) If an inmates mental status is questionable, a referral to the Mental Health Coordinator will be initiated; 9.) Being able to read, write, and communicate in English at the sixth grade level, or above, is preferable.

5. **Decision to admit (or not):** Who makes the decision? What are the most important criteria? About what percentage of referrals are rejected? **[Source: program documents, DATS Supervisor/Mgr.].**

According to the DATS Manager, almost every inmate that applies for the TC program gets admitted. The only reason that they would not admit someone is for physical or mental health problems.

Intake, Exit, and Follow-up Procedures

6. Describe the **intake/admission process** (e.g., What happens to an inmate when they first attend this program? Is there an orientation, intake interview, etc.?) **[Source: program documents, DATS Supervisor/Mgr.].**

According to the Inmate Handbook, each inmate must complete an intake application and other consent forms with their assigned DATS. They must also complete a psychosocial assessment with their DATS.

7. What is the normal **program enrollment**? (i.e., at one specific time) **[Source: program documents].**

According to the Evaluation Procedures, normal program enrollment is 100 beds, although the DATS Manager stated that the number would be going up to 110 shortly.

8. What is the normal **length of stay** for an inmate in this program? **[Source: program documents].**

According to the DATS Supervisor, the normal length of stay is 36 weeks.

9. What are the criteria for successful program completion? For an unsuccessful discharge? [Source: program documents, DATS Supervisor/Mgr.].

The DATS Manager stated that the criteria for a successful completion are that each inmate must meet all treatment plan goals and have no misconducts. For an unsuccessful discharge to take place an inmate would have to have broken rules, have misconducts, or have broken confidentiality.

Specific Program Content and Structure

10. Attach a copy of the weekly program schedule. **List and briefly describe**: (a) the different **program activities** (see survey Q# 19 for examples of specific activities), and (b) the **intended result or objective** of each activity **[Source: inmate interviews, observations, program documents]**. Include the following:

- Provide a **title and brief description** of the activity.
- How many **hours** weekly do inmates participate in each activity? How often do they meet?
- Describe a few **examples of program content** from lesson plans, printed program descriptions, observations or interviews (i.e., what do they do and how do they do it?)
- For each **activity or group**, what is the **intended result or objective?** (i.e., what change in inmate attitudes or behaviors is expected)?

According to the Inmate Handbook, while in **Phase I,** each inmate is required to: 1.) Not work off the block until given permission by his primary DATS and is in Phase III; 2.) Complete an intake application and all consent forms with their assigned DATS; 3.) complete a psychosocial assessment with their DATS; 4.) Complete a Step 1 Prep and Step 2 prep with assistance form his "Big Buddy" and reviews it with their assigned DATS, then it will be shared with peers; 5.) Maintain a positive attitude and behavior, specifically towards recovery, no tardiness or absenteeism from groups or specialty groups, and performs block duties regularly; 6.) No major misconducts while in Phase I; 7.) Positive housing and work reports, 8.) Be familiar with the TC philosophy and rules when asked by any staff member, 9.) Read the TC Handbook; 10.) Attend weekly drug and alcohol education groups and home/therapy groups as well as other scheduled groups; 11.) Be in Phase I for a minimum of 30 days, and only one 15 day extension may be granted, extending this phase a maximum of 45 days; 12.) Pursue educational goals while on the TC, but must postpone vocational training until permitted to return by his primary DATS; 13.) May participate in religious services as long as he also participates in all required groups; and 14.) He may participate in organized sports as provided by the Activities Department with the approval of his primary DATS.

While in **Phase II,** each inmate is required to: 1.) Prepare, write, and present a DATS approved seminar to his home group; 2.) Write his life story, have it reviewed by DATS, present it to his home group and receive feedback from them, and then DATS will review the peer feedback with the inmate and begin to help the inmate develop appropriate change objectives; 3.) Share appropriately in therapeutic groups, chair the morning meeting, and attend all evening 12-step meetings; 4.) Complete at least 2 of the following specialized groups: Anger/Stress Management, Codependency, and Relapse Prevention; 5.) Maintain a positive attitude and behavior specifically towards recovery, no tardiness, no absenteeism from groups or specialty groups, etc.; 6.) Maintain good housing and work reports; 7.) Be available for expeditor/ramrod positions; 8.) Help others through self disclosure and confronting inappropriate behavior and attitudes; 9.) Be in Phase II for a minimum of 4 months and a maximum of 8 months; 10.) Continue to attend drug and alcohol education, home groups, and all other scheduled activities; 11.) After completing Phase II requirements 1-3, he will be eligible to enroll in vocational training or college courses

upon consultation with DATS; and 12.) The inmate may be considered for staffing by the primary DATS after consultation with the DATS Supervisor.

While in **Phase III,** each inmate is required to: 1.) Write and share with his home group a paper on "Why I Want to Stop Using Chemicals"; 2.) Begin working on Steps 3 and 4; 3.) Maintain positive housing and work reports; 4.) Continue in appropriate vocational training and continue in appropriate educational programming; 5.) Must be in Phase III for a minimum of 30 days; 6.) Complete a TC Aftercare Plan; 6.) Completion of this phase allows the inmate to move to a Community Corrections Center (CCC), go out on parole, or be moved to another block in Waymart, and if he stays in the institution he will be allowed to participate in TC Aftercare; 8.) Inmates who complete Phase III may also be eligible to move into Phase IV.

Finally, to enter **Phase IV**, each inmate must be approved by vote of the Unit Team, which is the DATS Manager, DATS Supervisor, DATS who work on his block, and security officers. Phase IV inmates may return to the TC if there is space available, if not, he will return to the TC to work as a "teacher's aide" between 0815 and 1600 daily, Monday through Friday. The Phase IV inmate's responsibilities will include facilitating groups in the presence of his primary DATS, assist other inmates with written assignments as requested by primary DATS, and he may also be asked to be the group clerk, assisting primary DATS in filing handouts or in pulling handouts from nonconfidential files before group. A misconduct for a Phase IV inmate means immediate loss of job.

Treatment Activities

According to the Inmate Interviews, Inmate Handbook, and the TC Group Schedule, a meeting is held every morning to review the overall progress, interaction and participation of family members from the previous day. This also provides an opportunity to stimulate and motivate everyone to correct and improve unacceptable behavior and to continue appropriate behavior and attitudes. After morning meeting, the day is spent participating in other groups such as Drug/Alcohol Therapy Group, Anger and Stress Management, Relapse Prevention Group, Education Group, Sex Offender therapy, Recovery, Relationships, and 12 traditions, Co-Dependency group, Dual Diagnosis Group, AA/NA, and small groups, which are the smaller more personal groups in which inmates can discuss issues and gain feedback from their peers.

11. How is treatment structured to address **individual inmate needs** (e.g., individual counseling)? **[Source: inmate interviews, program documents, DATS Supervisor/Mgr.]**.

According to the DATS Manager, treatment is structured through individual treatment plans that get updated every 60 days to tailor their individual needs.

Program Staff

12. Provide a brief description of the full time AOD staff. **[Source: DATS Supervisor/ Mgr.]**. Indicate which staff work regularly on the TC.

Name of Staff Member:	Job Title:	Highest Degree Awarded:	Academic Discipline or Major:	Specialized Certification, if any:	Length Of Employment With DOC:	Number Of Years Experience Providing Direct D/A Treatment To Clients:
1. John R. Gelatt	DATS Manager	MA	Human Services	N/A	11 ¾ yrs.	25+ yrs.
2. Frederick J. Arnold	DATS Supervisor	MS	School Counseling	N/A	10 ½ yrs.	15 yrs.
3. Kathryn A. Manley	DATS Supervisor	MA	Counseling Psychology	N/A	10 ½ yrs.	13 ½ yrs.
4. Michael Lukasevic	DATS 2	BSSW	Social Work	CAC	11 ¼ yrs.	11 ¼ yrs.
5. Ronald F. Mussari	DATS 2	MA	Counseling Psychology	N/A	10 ½ yrs.	10 ½ yrs.
6. Francis M. Breuninger	DATS 2	Associates Degree	Human Services	N/A	10 yrs.	15 yrs.
7. Lora M. Zalepa	DATS 2	BA	Psychology	N/A	3 yrs.	5 ½ yrs.
8. Laurie Hess	DATS 2	BSW	Social Work	N/A	1 ½ yrs.	4 ½ yrs.
9. Judith Vescovi	DATS 2	BS	Clinical Psychology	N/A	1 ¼ yrs.	4 ¼ yrs.
10. Cynthia Mathews	DATS 1	MS	Public & Community Health Education	N/A	1 ½ yrs.	2 ½ yrs.

Staff Demographics (full time AOD staff only):

Number of male staff __5__
Number of females __5__

Number of Caucasian staff __10__
Number of African American staff __0__
Number of Native American staff __0__
Number of Hispanic staff __0__
Number of Asian staff __0__
Number of Other staff __0__