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Evaluation of the Florida Department of Corrections Residential Substance Abuse Treatment (RSAT) for State Prisoners Program

Final Technical Report

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Executive Summary: Evaluation of the Florida Department of Corrections Residential Substance Abuse Treatment (RSAT) for State Prisoners Program

The U.S. Department of Justice (USDJ), recognizing that many correctional inmates need treatment for both mental illness and substance abuse or dependence, established a program to expand the availability of services to dually diagnosed inmates and to promote the development of integrated approaches to treating members of this group. Under this program, the USDJ granted funds to the Florida Department of Corrections (DOC) in 1997 to establish within correctional facilities a largely self-contained program of integrated mental health and substance abuse treatment for inmates who manifest both types of disorder.

In 1997, the National Institute of Justice also granted funds to the Institute for Health and Human Services Research (IHHSR) at Florida State University to evaluate the implementation of the FDOC Dual Diagnosis Treatment Program (DDTP) and its short-term impact on participating inmates. Although departures by FDOC from the original implementation schedule and from plans to use standardized psychometric instruments to assess inmates limited the possibility of evaluating the DDTPs' impact on inmates, these departures did not disrupt the primary research agenda–that of evaluating DDTP implementation.

As a single case study, the FDOC implementation process illustrates the many inter-related concerns which attend the establishment of this type of program. Beyond this, the case offers those who seek to implement similar programs insights which may help them to avoid, or at least reduce, some of the difficulties FDOC encountered.

Methodology

A combination of research methods was used to evaluate the implementation of the FDOC dual diagnosis treatment program. The two principal methods were face-to-face interviews with individuals in key positions and observation of planning, training and treatment activities. Between mid-1997 and early 1999, two to four interviews were conducted with a number of key personnel at FDOC headquarters, regional offices and correctional facilities. The interviews were conducted at intervals in order to obtain respondents' views at several stages of program implementation, and to relate expectations and concerns expressed at early stages to conditions, concerns and activities at later stages.

IHHSR researchers observed all DDTP staff training sessions, most planning sessions involving FDOC personnel and expert consultants, most tele-conferences between FDOC headquarters, regional and facility staff concerning DDTP implementation and, over a period of days, most of the range of activity on the DDTP units. Each setting afforded some opportunity to talk with participants and to have questions answered, so that additional insights could be gained.

The methods described above were supplemented with a review of FDOC documents and correspondence regarding the DDTP to identify concerns which arose and the extent to which formal lines of communication were used during implementation. In combination, the two principal methods and the review of documents provided a basis for judging both the extent to which DDTP implementation progressed according to plan and the adequacy of responses undertaken when the process did not unfold as intended.

Program Description

The FDOC had planned to establish programs at two sites for females and one for males, but, by Spring 1997, had scaled back this plan. As implemented, the DDTP took the form of two residential therapeutic communities: an 80-bed program at Zephyrhills Correctional Institute (CI) for males, consisting of a 40-bed primary treatment phase and a 40-bed relapse prevention phase; and a 40-bed program for females at Jefferson CI, with 20 beds for each phase. Inmates were to spend four months in each institutional phase before moving to Phase III, a four-month period of community-based treatment which, for some, would include residence in an FDOC halfway house.

The original DDTP plan emphasized treatment in a therapeutic community segregated from the general prison population. Inmates were to move from phase to phase as members of identifiable treatment cohorts. FDOC administrators were optimistic that inappropriately admitted inmates in any cohort could be efficiently replaced from an estimated pool of over 2000 diagnostically appropriate others. Inmates' move from Phase II to Phase III was to be planned and supervised jointly by FDOC case managers and forensic service coordinators employed by the Florida Department of Children and Family Services (FDCF) to assure continuity of treatment and access to necessary services during Phase III.

The reality of setting up the new treatment units and the systems of inmate screening and referral was more complex than the FDOC plan. Implementation fell behind the schedule originally projected. Screening and referral procedures, program staffing, the treatment curriculum and the disposition of inmates upon completion of Phase II all departed from the original plan. To date, far fewer inmates than expected have graduated from the program. Various factors, ranging from an initial delay in the receipt of DDTP funding to the division of

authority within FDOC, influenced the departures from plan. Despite the difficulties encountered and, in some sense, because of them, the experience of the FDOC in implementing the Dual Diagnosis Treatment Program (DDTP) should be instructive to others seeking to establish similar programs.

The FDOC case demonstrates the interdependence of many facets of the implementation process. Throughout, decisions regarding most aspects of the new program influenced, and even constrained, decisions about other aspects. This principle, which is demonstrated in every program start-up, is especially salient in the present case, in which the needs of both the segregated treatment program and its correctional environment had somehow to be met.

Each major program process–from recruiting inmates to assuring their movement from phase to phase–represents a host of specific responsibilities, and implies the need for preparation of staff and facilities for new patterns of coordinated activity. But the framework of existing relationships and priorities within FDOC constrained both what could be done and the procedures available for getting things done. Many examples of these constraints occurred as FDOC planned and established the DDTP units: in order to save on travel costs, some categories of staff were excluded from the program's main training event; this contributed to later difficulties in inmate recruitment to the DDTP and in the development of working relationships between DDTP treatment staff and security staff. A desirable adjustment in the treatment program could not be made within the fixed schedule of institutional security routines. Concern at headquarters about the political consequences of operating a residential unit below capacity led to a decision to increase the capacity of the DDTP unit, thereby straining the ability of treatment staff to conduct

both group and individual counseling. Each of these occurrences demonstrated the inter-dependence of nearly every aspect of planning, implementation and operation of the new DDTP.

Principal Findings and Implications

Taken together, the findings of this study and the recommendations of FDOC staff and administrators have implications for several aspects of program design and implementation. The implications are presented here in terms of the relevant aspect of program design or implementation. In addressing each focus, the implications follow a brief summary of the findings upon which they are based.

The Organizational Context:

Several organizational factors contributed to difficulties in DDTP implementation. Lines of authority became unclear when lead responsibility for implementing the DDTP was assigned to the Bureau of Substance Abuse Program Services (BSAT) a unit within the Division of Education and Job Training, entirely separate from the Mental Health Program Office (MHP) in the Division of Health Services. The ambiguity was intensified by the fact that, as Senior Psychologists, the DDTP unit directors were under the direct authority of the Institutional Medical Directors at their respective facilities, who were answerable to Regional Medical Directors, although neither of the latter were responsible for substance abuse services. From the beginning, the two DDTP units were deeply embedded in a multi-level bureaucracy in which they were subject to demands and constraints from each level.

Assigning lead responsibility to BSAT effectively maximized the organizational distance between the responsible unit at headquarters and the DDTP units within the prisons. Decisions

concerning the units had to be negotiated across multiple, semi-autonomous organizational levels. The notable effects of deliberating many details in this way included delays in implementation and uncertainty among DDTP treatment staff and unit directors that FDOC headquarters was fully committed to establishing the program as it had been planned.

Program Staffing:

Providing both group and individual services within a therapeutic community makes greater demands on staff than do most treatment arrangements. Programs which approximate the therapeutic community model require higher staffing ratios than do most others. Neither of the DDTP units in FDOC was ever fully staffed according to the original plan. Because staff activities are the basis of "program operation," the lack of staff invariably affected program performance.

Strong consensus existed with regard to the preferred background of treatment staff who work in the program. Virtually all respondents agreed that the combination of training in mental health services and some experience in substance abuse services provided better preparation than training only in substance abuse and some mental health service experience. Staff for the DDTP were recruited from the ranks of direct-service mental health staff within FDOC.

During DDTP planning, the possibility of including security staff on DDTP treatment teams was actively considered. Once DDTP operation began, however, this possibility tended to be discounted. Although some security officers expressed interest in a more active role in the program, their regular rotation to different units within the prisons effectively precluded any from becoming regular participants in the therapeutic community. Also, a consensus existed among

DDTP treatment staff and administrators that security staff would need to be trained carefully for any treatment-related role.

Screening and Referral Procedures:

Both the DDTP eligibility criteria and referral procedures were revised several times during the first fifteen months of program operation, and may undergo further change. At the end of that period, reception centers either did not routinely diagnose substance abuse or did not convey this information to the DDTP units to assist their assessment of inmates. This suggests the difficulty of establishing standardized admission criteria to accommodate a great many combinations of psychiatric disorder and chemical dependency. The persistent problems in screening and referral also stem from the failure within FDOC to "get everyone on board" by taking timely steps to inform all affected units about the new DDTP and the procedures to be used to identify appropriate candidates.

The difficulties in establishing uniform screening and referral procedures also reflect organizational impediments confronted by the BSAT in seeking to change screening procedures at FDOC reception centers and other residential facilities. The request to change the procedures had to be reviewed and approved at the level of assistant secretaries, and then conveyed through FDOC regional offices to the reception centers. This suggests that, in implementing a program of this type within an agency the size of the FDOC, it is advisable to assign someone above the level of Bureau Chief to oversee the development and implementation of specific program components. In the absence of sufficient organizational authority to assure a uniform approach to screening and referral, even the clearest eligibility criteria would not have assured the admission of appropriate inmates to the DDTP.

DDTP Inmate Characteristics:

With minor exceptions, inmates in the DDTP are demographically similar to those in the general FDOC inmate population. The average age of DDTP inmates is only slightly higher than that of all FDOC inmates. The racial proportions among female DDTP inmates are nearly identical to those in the general population; however, the proportions of black (44%) and white (56%) male DDTP inmates are the reverse of those in the general population, where whites constitute only 43 percent and Blacks, 55 percent. The proportion of DDTP inmates who have had prior prison sentences (43%) differs little from that in the general prison population (46%). The proportion of DDTP inmates sentenced for drug crimes (14%) slightly exceeds that in the general population (10%). In sum, inmates in the DDTP do not appear to differ significantly from the general inmate population, in terms of demographic and background characteristics.

In most regards, the distribution of psychiatric diagnoses differs only slightly between male and female DDTP inmates. A slightly larger proportion of females (42%) than males (36%) in the DDTP were given Axis I diagnoses of mood disorder. The proportion of females diagnosed with an Axis II anxiety disorder (38%) exceeded the proportion among males (27%) by a slightly higher margin. Just over half (55% $\pm$ 1%) of DDTP client in each gender group were diagnosed as schizophrenic. The most striking difference by gender among DDTP inmates was that while over 90 percent of females were identified as opiate abusers, only 22 percent of males were so diagnosed. This difference strongly implies the need to tailor the emphases in drug counseling in the respective single-gender units.

Provision of Treatment:

Appropriately, the treatment curricula for the respective DDTP units differ in some specifics related to differences in the distribution of diagnoses, substance use patterns and life concerns of males and females. Most differences reflect the divergence of treatment orientations and primary treatment models used at the respective facilities. Both curricula, however, have undergone repeated revision since the program began. Most changes have occurred in the effort to arrive at workable, effective approaches to treating the diverse DDTP population. But some curriculum changes, such as discontinuing a medication group at one unit in favor of individual medication counseling, appear to have been based on concerns other than inmates' treatment needs, and were made against the objections of DDTP treatment staff.

During the early stages of planning for the DDTP, those responsible for developing the program foresaw inmates entering and passing through each four-month phase as members of distinct cohorts. The near impossibility of achieving the necessary coordination of inmate movement became increasingly apparent, however, once inmates began to be recruited to the program. It is probable that, even if screening and referral become far more efficient and waiting lists are developed from which to select cohort members, the low rate of program completion and the diversity of inmates' conditions and treatment needs are likely to continue to preclude the development of a fully cohort-based pattern of movement through the DDTP. The persistent ambiguity of respective membership in Phase I and Phase II suggests this as well.

Aftercare:

In the original design, Phase III of the DDTP was to begin at the time of an inmate's release from prison. Based upon an individualized plan and preparations made by a transition

officer or case manager in the DDTP unit, each inmate was to be linked with the community-based services necessary to sustain appropriate psycho-social functioning and resistance to relapse in drug use. Given the diversity of inmates' diagnoses and circumstances, the process would seem to require active working relationships between DDTP staff and a range of service providers in numerous communities. During DDTP planning, FDOC administrators identified district forensic service coordinators in the Florida Department of Children and Family Services (FDCF) as the key source of potential help in linking inmates with services outside FDOC institutions. But little effort was apparently made to establish working relationships with FDCF forensic service coordinators, even though the DDTP units lacked the staff necessary to identify and establish direct links with community-based agencies. Under-staffing and staff turnover on the DDTP units made it unlikely that a staff member who was otherwise responsible for treatment activities on the unit could adequately conduct case management and planning for Phase III. Finally, the separation of responsibility for DDTP implementation from the authority necessary to negotiate with another state agency for assistance with aftercare links may have contributed to the difficulty the DDTP units have encountered in attempting to establish those links.

External factors posed additional impediments to the implementation of Phase III. FDCF forensic service coordinators, in response to priorities set by their employer, tend not to regard newly discharged FDOC inmates as their responsibility. Few community-based service agencies place high priority on enrolling discharged inmates. The net result of these conditions was that Phase III of the DDTP did not receive the attention given to Phases I and II, and was only minimally established when this study was completed. The FDOC sought to avoid the worst consequence of this condition–discharges without service referrals–by seeking permission from

DCA–the state agency that manages the RSAT grant to FDOC–to return inmates who have completed Phase II to the general institutional population. The fact that DCA consented is indicative of the limited progress made in establishing the links and agreements necessary to a viable, community-based final phase of treatment.

In view of the faint interest among FDCF and community-based agencies in serving "ex-convicts," the question remains as to how the DDTP units will establish effective links with community-based agencies that can respond to the special needs of newly discharged dually diagnosed inmates. Clearly, if Phase III is to function as intended, the units need reliable working agreements with community-based agencies, whether directly or through an intermediary agency such as the FDCF. In some states, correctional systems have budgeted funds with which to contract with community-based providers to assure discharged inmates timely access to essential services. In the most ideal circumstances, those providers conduct in-reach to inmates and work with institutional treatment staff to develop individual aftercare plans.

Conclusions and Recommendations

Most of the delays and departures from initial plan as the DDTP was implemented appear to have resulted from inadequate planning and preparation for the new program. For example, although the reluctance of inmates to volunteer for the program did not originate with the actions of FDOC employees, improved planning and a more realistic implementation schedule may have helped to minimize the delays in recruitment that arose from inmates' being unaware of the new program. Similarly, the low rate of referral to the DDTP has been largely the result of the failure to include those who would screen and refer inmates in planning and training sessions. In short, a

more comprehensive implementation plan and more effective communication with affected units and employees at each stage of implementation would have helped to assure the external links necessary to the voluntary treatment program. This general conclusion, however, supports several specific recommendations regarding the conduct of program implementation.

Recommendations

1) Early in implementation, assign responsibility for active oversight at a sufficiently high level in the department to assure timely and appropriate actions by each division and staff category for which the new program will result in new or additional responsibilities.

2) As early as is practical, identify lines of authority over specific aspects of program implementation and subsequent operation.

3) Identify all staff categories for which the new program will result in new responsibilities; conduct appropriate training and instructions for each.

4) Provide follow-up in-service training to DDTP treatment staff, as well as to other staff who participate in screening or referring inmates to the DDTP. Allocate time at training events to enable participants to discuss their experience with the program and to identify and address their concerns about the DDTP and its interactions with other FDOC entities.

5) Give adequate attention, at sufficiently high departmental levels, to establishing the external links necessary to assure the effective movement of inmates from the institutional phases of the DDTP to the community-based final phase.

Introduction

The U.S. Department of Justice (USDJ), recognizing that many correctional inmates need treatment for both mental illness and substance abuse or dependence, established a program to expand the availability of services to dually-diagnosed inmates and to promote the development of integrated approaches to treating members of this group. Under this program, the USDJ granted funds to the Florida Department of Corrections (FDOC) in 1997 to establish a largely self-contained program of integrated mental health and substance abuse treatment within correctional facilities for inmates who manifest both types of disorders.

In 1997, the National Institute of Justice (NIJ) also granted funds to the Institute for Health and Human Services Research (IHHSR) at Florida State University to evaluate the implementation of the FDOC Dual Diagnosis Treatment Program (DDTP) and its short-term impact on participating inmates. Although departures by FDOC from the initial implementation schedule and from plans to use standardized psychometric instruments to assess inmates limited the possibility of evaluating the DDTPs' impact on inmates, these departures did not disrupt the primary research agenda–that of evaluating DDTP implementation.

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Summary of Research on Dual Diagnosis

Among professionals working in the corrections, mental health, and substance abuse treatment fields, the possibility of integrated approaches to treating comorbid mental illness and substance abuse or dependency has drawn increasing attention (Bachrack, 1983; Brown, Ridgely, Pepper, Levine, and Ryglewicz, 1989). Nearly a decade ago, Minkoff and Drake (1991) observed that "although there has been fairly extensive research describing and documenting the clinical characteristics of the dual diagnosis population, little controlled research is available so far to guide clinical treatment or program development" (p. 1). These authors highlighted two issues that persist at this convergence of mental health and substance abuse treatment. One is the uncertainty about how these two types of treatment should be joined. The other is the uncertain relationship between treatment and outcome. More recently, Peters and Hills (1996) have reported advances in both the integration of treatment for the dually diagnosed and the growing recognition of their extraordinary need for aftercare planning and coordination.

It is widely accepted that people with mental disorders are at greater risk of developing substance abuse disorders than those without mental disorders (Mueser, Bennett, and Kushner, 1995). In addition, the problems in social functioning experienced by individuals with mental and substance abuse disorders may exacerbate difficulties in diagnosis and treatment (Cuffel, 1996). These problems pose a special challenge for treating the dually diagnosed in correctional settings. As state prison populations have increased in recent years, correctional institutions have received a growing number of offenders with comorbid mental and substance abuse disorders. This increase has generated concern about how to treat dually-diagnosed inmates in correctional settings.

The Dual Diagnosis Label

The defining characteristic of the dually-diagnosed is the combination of a chronically severe mental disorder and a history of abuse of alcohol or other drugs (Drake, McLaughlin, and Minkoff, 1996). According to Sheehan (1993) "dual diagnosis or comorbidity is said to exist when a patient is suffering with more than one disease. Psychiatry and the addictive medicines refer to the co-existence of a psychoactive chemical use disorder with another major psychiatric disorder" (p. 108). This broad descriptive category, however, encompasses many specific combinations of DSM-IV diagnoses of mental disorders and chemical dependence or abuse. The question of which combinations are treatable underlies a number of practical issues of program design, from screening and recruitment to aftercare planning.

The U.S. Prison Population

The U.S. prison population grew approximately 134% between 1980 and 1995 (National Council on Crime and Delinquency, 1995). At the end of 1996, more than 1.7 million adults were behind bars (National Center on Addiction and Substance Abuse [NCASA], 1997). The rate of increase in the female prison population has exceeded the male rate by 90% in the past fifteen years (Sheridan, 1996). Women represent 130,430 (7.7%) of the 1.7 million current inmates (NCASA, 1997).

The NCASA (1997) found that 81% of state prison inmates share one or more of the following characteristics: they committed offenses such as selling drugs or driving while intoxicated; were under the influence of drugs or alcohol when they perpetrated crimes; committed a crime to get money to buy drugs; or had histories of regular illegal drug use, alcohol

abuse, or alcoholism. These characteristics suggest a rise in the number of drug offenders in prisons. In fact, some experts view the combination of a rise in drug use and the advent of determinate and mandatory sentencing in drug cases as a major factor in increasing the number of drug users in prison (Wexler, Blackmore, and Lipton, 1991).

A recent three-year analysis of substance abuse in American prisons revealed that 1.4 million (82%) of the 1.7 million adults in prison were seriously involved in the use of drugs and alcohol (NCASA, 1997). This estimate is supported by the 1997 Survey of Inmates in State and Federal Correctional Facilities, which reported that 33% of State prisoners and 22% of Federal prisoners were under the influence of an illegal drug at the time of their offense (Bureau of Justice Statistics, 1999b). But drug users are not a homogenous group. Some use drugs occasionally; some are compulsive users. Studies indicate that criminal behavior increases with heavy drug-use, but infrequent users may also comprise a considerable percentage of arrestees testing positive for drugs (Bureau of Justice Statistics, 1999a).

Many prison inmates have psychiatric disorders. Approximately 283,800 offenders defined as mentally ill were incarcerated in the nation's prisons and jails as of mid-1998. A recent survey by the Bureau of Justice Statistics found 16% of State prison inmates, 7% of federal inmates, and 16% of those in jails reported having a mental condition or staying overnight in a mental facility (Ditton, 1999). Previous research on the prevalence of severe mental illness in prison or jail shows similarly that the mentally ill comprise from 8% to 16% of the incarcerated population (Guy, Platt, Zwerling, and Bullock, 1985; Steadman, Fabisiak, Dvoskin, and Holohean, 1989; Teplin, 1990).

The Link Between Drug Abuse and Mental Disorders

Two comprehensive studies have analyzed the prevalence of dual diagnoses: the Epidemiologic Catchment Area (ECA) study which began in 1978 and the National Comorbidity Survey (NCS), which was conducted between 1990 and 1992. According to the ECA study, a mental disorder more than doubles a person's chances of having an alcohol diagnosis, and it increases the chances of a drug abuse diagnosis by more than four times. The NCS revealed rates of substance abuse and dependence exceeding 50% among those with both affective and anxiety disorders (Regier et al., 1990).

Although both studies found dual disorders to be prevalent, the ECA study focused primarily on institutional populations in mental hospitals, prisons, and nursing homes. Among these, mental hospitals had the highest lifetime rate of mentally disordered substance abusers (82.2%), followed by prisons (82.0%), and nursing homes (65.5%) (Regier et al., 1990). As used here, "lifetime rate" represents the percentage of clients who, at some point during their lives, meet the diagnostic criteria for a mentally disordered substance abuser. McNeece and DiNitto (1998) found that 20% to 50% of all psychiatric patients also have substance abuse problems.

The high rate of mental disorders among prisoners is primarily attributable to a remarkably high lifetime prevalence of substance abuse (72%), in which 56.2% have abused alcohol and 53.7% evidence some other type of drug disorder (Regier et al., 1990). Researchers have estimated that up to 26% of correctional inmates experience both alcohol or drug abuse and a mental disorder (Cote and Hogins, 1990). ECA researchers also found that in prisons, mental disorders co-occurred with addictive disorders in 90% of the cases (Regier et al., 1990). Peters and Hills (1993) estimate more conservatively that from 3% to 11% of prison inmates meet dual

diagnostic criteria. The proportion of dually-diagnosed individuals in prison populations is roughly four times that of the general population (NCASA, 1997). Many offenders with dual diagnoses have done poorly in addiction treatment programs because their psychiatric symptoms have been undetected. Some sign themselves out of treatment against advice or are discharged because of treatment resistance. Dually-diagnosed individuals rarely receive simultaneous treatment for both problems, as is required for successful treatment (Weiss, Najavits, and Mirin, 1997).

The high prevalence of substance abuse among prisoners diagnosed with mental disorders increases the importance of understanding how these conditions are related. Researchers have investigated the etiological link between these disorders. Mueser et al. (1995), offered a typology of four relationships between substance abuse and mental disorders: 1) the secondary substance abuse disorder, 2) the secondary mental disorder, 3) the common factor, and 4) the bi-directional models. The secondary substance abuse disorder model emphasizes how mental disorders increase clients' vulnerability to substance abuse and how the symptoms of mental disorders may mimic those of alcohol and drug use. The secondary mental disorder model suggests that substance abuse precipitates an emerging mental disorder (Weiss, Najavitz, and Mirin, 1997).

The common factor explanation asserts that dual disorders may be linked to some common third variable. This model, for example, relates genetic factors to comorbid mental and substance abuse disorders. Finally, the bi-directional explanation suggests that pre-existing mental disorders can be worsened by substance abuse.

Research on Treatment Programs in Prisons

In recent years, correctional systems have undergone an ideological shift away from punishment toward rehabilitation (Wexler, 1995). Preceding this shift, research on corrections populations during the 1970s and 80s provided considerable evidence that prison-based treatment reduced drug use and recidivism. The Drug Abuse Reporting Program (DARP) and the Treatment Outcome Prospective Study (TOPS) were national studies on the effectiveness of substance abuse treatment. The DARP study was a 12-year follow-up of a national sample. The TOPS research sample consisted of 10,000 persons admitted to 41 drug treatment programs in 10 cities (Gerstein and Harwood, 1990).

These studies emphasized the link between prison-based and community-based treatment, reduced recidivism, and cost savings. Both found that increased time in treatment was associated with better treatment outcomes. Specifically, DARP revealed that clients who stayed in treatment more than 90 days experienced less recidivism. Similarly, TOPS research discovered that clients in treatment for a year or more were less involved in drug use than clients who dropped out of treatment (Gerstein and Harwood, 1990).

Along with the ideological shift in corrections in recent years, prison systems have increasingly adopted approaches to drug treatment developed in non-institutional settings. The therapeutic community model has become prominent in this trend as a treatment approach that can be imported into correctional settings without undermining discipline and security (Wexler and Williams, 1986).

Research on the effectiveness of therapeutic community treatment for criminal justice clients has lagged behind the implementation of prison Therapeutic community models. The two

most famous studies, the Stay'n Out and the Cornerstone programs, followed offenders released from a prison-based treatment program. Outcome data from the first three years of the program showed steady improvements in post-release performance as the time in the program increased from nine to twelve months. Similar findings were reported from the Cornerstone Study. This study showed that 29% of program graduates were reincarcerated within three years after release, compared to 74% of the treatment dropouts. More recently, a therapeutic community at Donovan prison in California released findings indicating that 34% of program graduates were reincarcerated within a three-year follow-up period, compared to 53% of program dropouts (Winett, Mullen, Lowe, and Missakian, 1992).

Historically, mental health and substance abuse treatment systems have operated independently. Treatment in these two systems has been either sequential or parallel. A sequential approach treats one disorder before treating the other; parallel treatment consists of the simultaneous treatment in two different settings (Weiss, Najavitz, and Mirin, 1997). The essential feature of integrated treatment is that both illnesses are treated concurrently by the same staff in a single setting (Wexler, 1995). Integrated treatment does not consist simply of combined treatment, but the integration of treatment approaches. The literature identifies psycho-educational, pharmacological, cognitive-behavioral, and 12-step approaches to treating this population (Peters and Hills, 1996; Weiss and Najavits, 1997). Pharmacological treatment of substance abusers has been controversial in combination with 12-step approaches because the latter approach has historically regarded abstinence from drugs as a fundamental requirement. Cognitive-behavioral techniques provide a basis for relapse-prevention training. A twelve-step

program is a self-help program that allows offenders to process issues of abstinence simultaneously with issues related to their mental disorders.

Although integrated treatment has been undertaken for a number of years, the research supporting this form of treatment is limited and has shown mixed results. Drake, McHugo, and Noorsdy (1993) reported positive long-term results from an integrated approach. They reported that 60% of clients with chronic mental disorders achieved stable abstinence during a four-year follow-up. On the other hand, Lehman, Herron, Schwartz, and Myers (1993) found no reduction in substance abuse among dually-diagnosed clients who were treated for one year in an integrated program. Both studies examined integrated treatment systems. Studies on integrated systems have focused on treatment from either a mental health perspective or a substance abuse perspective, but not both. Also, research has yet to be conducted on certain combinations of treatment such as pharmacologic and psycho-education approaches (Weiss, Najavitz, and Mirin, 1997).

At the time the initial planning for the dual diagnosis program in Florida Department of Corrections began, three states (Alabama, Delaware, Wisconsin) reported specialized program services for dually-diagnosed prison inmates. Three states (Illinois, Maryland, Oklahoma) indicated that plans were under way to develop a dual diagnosis program. Another (Wisconsin) has formally established a goal of developing services for this population (Edens, Peters, and Hills, 1997).

Challenges Confronting Research on Treatment Programs in Prisons

Despite the evidence cited earlier, many prison-based studies of the dually diagnosed have been methodologically weak (Wexler, 1994). The absence of control groups and random assignment to treatment conditions has precluded assessment of the direct effects of treatment programs (Catalano, Hawkins, Wells, Miller, and Brewer, 1991). Another research practice, pooling clients from many different programs, as was done in the Stay'n Out study, obscures program processes which affect outcomes. Generally, statistical controls are not applied to account for pre-existing group differences (Rouse, 1991). High attrition rates, which are characteristic of many prison drug treatment programs, often lead to findings based on shrinking samples (Platt, Perry, and Metzger, 1980). Finally, it is difficult to determine if success of treatment is due to the program itself or to high levels of motivation (Rouse, 1991). Motivation for treatment by prisoners is confounded when participation in treatment occurs for reasons unrelated to the disorder being treated. In this regard, inmates' motivation for treatment may involve relief from undesirable work assignments or access to better living accommodations.

In summary, few studies have been conducted on the effectiveness of mental health or substance abuse programs for dually-diagnosed inmates (Peters and Hills, 1993). Formative research conducted on programs being developed for the dually-diagnosed can provide a basis both for improvements in implementation processes and refinements in program design.

Background

The earliest planning for the FDOC dual diagnosis project began in approximately 1991 with assistance from the Florida Mental Health Institute (FMHI) at the University of South

Florida. The relationship between FMHI and FDOC has spanned approximately 11 years and has involved a number of projects related to substance abuse treatment. One project consisted of the preliminary planning for the dual diagnosis treatment at FDOC.

During the early 1990s, FMHI was responsible for organizing and coordinating a group of consultants to assist FDOC in investigating the need for a dual diagnosis treatment program. The consultant organizations included the GAINS Center, Operation Par, and the Center for Substance Abuse Treatment. During 1995, FDOC determined that funding was available for such a program. In January 1996, FMHI developed a program manual for FDOC which was to serve as a blueprint for a future dual diagnosis program, and a contract was awarded to FDOC in June 1996. After receiving funding approximately one year later, active preparation for the project began.

Evaluation Design and Research Methods

The "ground-up" implementation of the DDTP by FDOC provided an opportunity to examine the difficult process of establishing new, specialized treatment units and the functional links they require with other units. At the same time, the prison setting contributed to the inability to conduct controlled experimental tests of alternative forms of staff training and inmate treatment. In effect, the implementation of the new program represented a one-case, one-trial phenomenon. Given this, researchers sought to gather sufficiently detailed information to support conclusions about specific aspects of the process and its results and, simultaneously, to maintain a focus broad enough to enable general judgements about how the process itself was undertaken and carried out.

Despite what the director of the FDOC Substance Abuse Program described as "several years of preliminary planning," the implementation of the DDTP required lengthy deliberation regarding many aspects of the program, including the roles of, and coordination between, each of the major functional divisions of the Department. The manner in which FDOC conducted the program implementation process, its responses to unanticipated difficulties, and the program's operational status as of June 1998 (when field research was completed), offers lessons that may assist other agencies in implementing similar programs. The basic focus of this research was program implementation.

A conventional sociological conception of organizational structure and process underlies this assessment of program implementation. Within this conceptual framework, both individuals and larger organizational entities are viewed in terms of their roles and relationships. The attainment of organizational objectives is considered to require interaction among these entities. Organizational performance is assessed from this perspective in terms of two aspects of activity: one is the timely attainment of organizational goals and objectives; the other is the conduct of activities undertaken in pursuit of goals and objectives. This distinction between process and outcome is particularly important in assessing program implementation. It is important that processes be considered both separately and in relation to the outcomes they yield.

The concepts of communication, coordination, and authority, as commonly understood, are used to describe relationships between and among organizational entities. Further, because goal attainment and other outcomes are substantially determined by goal-related activity, these concepts provide a basis for relating implementation outcomes to the activity and interaction of entities within FDOC. In general, more complete communication and coordination and more

clearly defined authority are associated with more effective and efficient goal attainment. At the same time, the conceptual scheme employed here enables recognition of other factors that influence the conduct and outcomes of program implementation. These factors range from pre-existing organizational conditions to the variety of operational issues that arise and are somehow resolved during implementation.

Individual interviews for this study were conducted with members of FDOC management, treatment, and correctional staff who were willing to participate. A very small number refused to be interviewed. Some who were interviewed in the first round refused to participate in the second round. Field work to assess program implementation was begun in April 1997 and completed in July 1998. This 15-month period enabled researchers to begin examining the implementation process approximately five months before the first inmate entered the DDTP and to continue until after inmates who entered the DDTP in November 1997 had completed the first two prison-based phases of the three-phase program.

The qualitative and quantitative data used in the study were obtained by several methods. These included participant observation at management team meetings and teleconferences; telephone and face-to-face interviews with program administrators, staff, and other key position holders; observation of monthly meetings with program directors, the grant coordinator, and the contract manager; and automated data from the Offender Base Information System (OBIS) at FDOC. A deliberate effort was made to examine DDTP implementation from the perspectives of all FDOC units for which the new program implied new responsibilities and patterns of interaction.

Assessment of DDTP Implementation

The Pre-implementation Phase:

During the first stage of field research, evaluators attended management team meetings in which FDOC Substance Abuse and Mental Health administrators, regional administrators, reception center staff, dual diagnosis treatment teams, and consultants met to resolve the multitude of practical issues raised by the proposed new program. More specifically, those who met deliberated on the criteria and logistics of inmate screening and referral, issues of treatment design and curriculum, and the establishment of aftercare arrangements. Transcripts of these meetings served as one basis for developing questions for later interviews.

Screening and Referral:

Staff from four facilities were screened and interviewed. Initially, they were asked about their role in the referral process, the clarity of referral criteria or decision rules, and the adequacy of instruction received concerning the process. Later, telephone interviews with these and other FDOC staff were used to determine the extent to which the screening and referral processes functioned as planned. In early interviews, these staff were asked specifically about the adequacy of instructions they received and their overall understanding of the referral process, including the paperwork and other communications associated with it. In addition, treatment staff were asked about their expectations and concerns regarding the screening and referral process. At later stages, staff in both categories were asked, on the basis of their experience, about the utility and effectiveness of the screening criteria and the effects of any changes to the referral criteria or other aspects of the process.

Treatment Implementation:

Data for this component were collected at regular intervals through interviews with central office, regional, institutional, and treatment staff and through a review of documents and program records. Interviews with staff were conducted throughout the implementation period to obtain their perceptions of the program's functioning. Individuals in a number of staff and administrative positions were interviewed on two or more occasions in order to obtain their expectations regarding implementation and, subsequently, their impressions on the way in which implementation had actually progressed.

The use of repeated interviews helped to assure that respondents' perceptions, expectations, and concerns regarding program functioning were obtained at several distinct stages of program development. Issues identified in the first round of interviews provided a basis for some of the questions used in later rounds. The first set of interviews focused on respondents' perceptions and concerns about the implementation process. As the program evaluation progressed, the interview focus was broadened to include departures from planned procedures, arrangements, conditions, or factors which respondents believed significantly facilitated or impeded the implementation process, as well as their assessments of the adequacy of responses to difficulties encountered.

The second round of interviews also addressed respondents' perceptions of strengths and weaknesses of the program. These interviews helped to confirm and clarify initial interview findings. Although the interviews followed a generally structured format, some questions were modified according to the position of the interviewee and his/her role in the implementation process. This approach allowed interviewees some freedom to define issues themselves, thereby

helping to assure that unanticipated or emergent concerns associated with program implementation were identified.

Observation of treatment groups and other activities on the DDTP units complemented other sources of information on the extent to which the program was implemented as planned and operated as expected. It is important to note, however, that the observations were not made by clinicians nor for the purpose of judging the clinical performance of staff. Rather, observation on the DDTP units added substance and reality to descriptions obtained in interviews or documents and provided a basis for further inquiry into several specific concerns, including the preparation of program space, the adequacy of schedules and curricula, and the nature of interaction between DDTP units and other entities within and outside the prisons where they are located. In short, observations of treatment contributed to a more complete account of program implementation, but they were not intended to yield clinically-based judgements about the performance of treatment staff.

Aftercare:

Another focus of the research on implementation was the development of aftercare referral links and procedures intended in the initial program design to assure inmates' safe, effective movement into a community-based service system. In addition to addressing this topic in interviews within FDOC, researchers interviewed Department of Children and Family District Forensic Coordinators, the FDCA staff, FMHI staff, and treatment staff responsible at each DDTP unit for coordinating inmates' release to the community. These interviews were conducted early in the implementation process and at least once after the program had become operational. The purpose of these interviews was to ascertain what specific arrangements FDOC had

established to assure that inmates were connected with community-based treatment and family networks.

The implementation of Phase III of the program was the focus of semi-structured interviews with FDOC transition officers whose role was to assist inmates in preparing to move to Phase III. These topics and the availability of appropriate treatment and support services were also addressed in interviews with representatives of community-based service providers.

Assessment of DDTP Treatment Impact

Several circumstances combined to preclude clear conclusions about the treatment needs of dually-diagnosed inmates. The newness of the treatment program was one general factor which confounded the possibility of analysis of these relationships. During the early months of DDTP operation, the size and composition of the treatment group changed; the program schedule and curriculum were being revised, and the procedures to be followed in response to psychiatric or behavioral incidents were still evolving. Each of these factors may have influenced responses to treatment in unanticipated ways. The absence of repeated standardized assessments and lack of data on inmates' manifest responses to treatment, including their level of participation and compliance, essentially eliminated the possibility of analyzing the links between psychiatric diagnosis and the short-term impact of treatment in the DDTP.

Inmate Data:

IHHSR staff used information from the FDOC Offender Base Information System, a computerized system of records on all offenders placed in FDOC custody, to describe the demographic, criminal justice, and diagnostic characteristics of inmates. Data from the OBIS

were provided to the researchers by FDOC in November 1998, approximately four months after the field research was completed.

For purposes of analysis, each inmate was placed into one of three mutually exclusive categories. The first consisted of inmates who were referred to the program and entered both phases of treatment. The second consisted of inmates who entered but did not complete the first phase of treatment. The third consisted of inmates who were screened for, but did not enter, treatment and who did not meet program eligibility criteria according to FDOC. Comparisons were made between inmates who remained in treatment and inmates who dropped out of treatment. However, in order to assess inmates' institutional adjustment, those who were screened but not referred for treatment were compared to those who entered treatment, regardless of whether they dropped out.

IHHSR staff requested information necessary to describe the sample of inmates screened for the program. Data obtained from FDOC's computerized information system included inmates' age, race, sentencing counties, FDOC psychological classification, referring institution, sentence length, time served, offense, prior sentences, diagnoses, and treatment information. The data also included information on inmates' drug use history, institutional transfers, custody classification, disciplinary reports, internal movements, test scores, program participation, mental health status, and medical procedures. The files contained information on 257 inmates, and 214 inmates were screened for the program. These inmates included:

$n_1 =$ 75 who were screened but not referred
$n_2 =$ 72 who entered Phase I and dropped out
$n_3 =$ 67 who entered both phases of treatment

Program Impact:

The OBIS data was descriptive and exploratory. The descriptive analysis focused on demographic, criminal justice, and diagnostic information for inmates in the DDTP. The analysis delineates factors that account for an inmate continuing in treatment versus dropping out. The clients in the treatment program were compared with inmates in the general prison population.

The program proposal submitted by FDOC to the U.S. Department of Justice (USDJ) indicated that several standardized psychometric and diagnostic instruments were to be administered to DDTP participants on a periodic basis. In planning sessions held by FDOC with expert consultants, time was devoted to the selection of specific instruments to be used to assess program participants' psychological status and social functioning. The evaluation of treatment effects was expected to be facilitated by use of several standardized instruments to assess inmates either at reception centers or in the treatment programs or both. The instruments were expected to provide baseline and subsequent periodic measures of social and psychological functioning. However, no diagnostic instruments were employed by FMHI in the assessment of inmates for this study. Although the diagnostic instruments were identified, they were not put into use. Treatment staff were unwilling for several reasons to administer the instruments proposed by FMHI. In group meetings with IHHSR research staff, treatment staff assigned to the DDTP indicated that other demands of the program schedule left insufficient time for them to conduct multiple standardized assessments. Beyond this, treatment staff members expressed uncertainty regarding the usefulness of the assessment results as a guide to treatment and felt that the instruments tended to serve the research interests of the FMHI consultants, who had advocated for their use, more than the needs of treatment staff or inmates.

Data Limitations:

A major concern surrounding research in criminal justice is the quality of data. There were a number of problems with the data obtained from the FDOC. First, FDOC did not present the data in a single flat file. Instead the data were provided in 14 separate files, each arranged and designed differently. The files appeared in two formats: a single record-per-case format and a multiple record-per-case format. Often, however, individual records were duplicated. In short, the files provided to researchers by FDOC were not ready for analysis when they were received in December 1998. Although the program admission cut-off date specified by IHHSR for inmates to be included in the data was June 30, 1998, the files provided by FDOC contained inmates who were admitted into the program well after that date. In fact, the files contained inmates admitted to the program up to the time IHHSR staff received the data. In addition, inmate identification numbers were inconsistent from file to file. Finally, there were a number of discrepancies related to inmates' program participation. One was that some inmates appeared to enter and exit the dual diagnosis program multiple times; a few inmates appeared to enter the program as many as five times. Another discrepancy was that inmates appeared to participate in other correctional programs while they were in dual diagnosis treatment, including programs that were not offered at the facilities where the DDTPs were housed.

Program Implementation

Coordination and Collaboration

The Mental Health Program (MHP) and the Bureau of Substance Abuse Treatment (BSAT) hoped to set up a well-coordinated program with minimum conflict and waste; however,

there appeared to be very few linkages established between the BSAT and regional offices. According to a BSAT staff member, a well-coordinated program was difficult to achieve:

> In November when we went down to the opening, I asked the Regional Mental Health Consultant if he would please photocopy me or [send] any memo or instructions that he gave to the program directors [if he] was going to give them instructions regarding something in the DDTP. The Regional Mental Health Consultant's response back to me was basically if he thought it affected me he would photocopy me, but it was a regional issue. Then he says [there was] no reason for me to be photocopied.

Although FDOC developed a plan for implementing the DDTP with the help of consultants at FMHI, they failed to follow through with the plans and to establish written agreements between entities involved in the implementation process. Due to the failure by BSAT to develop an implementation schedule and objectives and to establish written agreements, there was little useful collaboration and coordination during the implementation process.

Site Selection and Preparation

The initial FDOC plan described the development of three institutional residential dual diagnosis treatment programs at Dade Correctional Institution (CI) in Miami, Broward CI in Fort Lauderdale, and Florida CI in Lowell. All three sites were subsequently rejected, however, because no one could accommodate the physical space needs of the programs. The next sites considered for the program were Charlotte CI and Jefferson CI. Charlotte CI, in Ft. Myers, would accommodate an 80-bed male dual diagnosis program; Jefferson CI (JCI), near Monticello, is a privately operated facility and one of only three female FDOC institutions that would house a 40-bed female program.

FDOC's initial proposal to the National Institute of Justice targeted March 1, 1997 as the program start date. However, due to the inability of FDOC officials to acquire a location for the male program, the program start date was changed a second time. Charlotte CI not only lacked adequate physical space to accommodate the program, but they also had recently experienced problems with defective cell locks. The locks could not be replaced before the projected program start-up date. Consequently, the male program was moved to Zephyrhills CI near Tampa where the first inmates entered the program on November 1, 1997.

Only after treatment began was physical space at each of the two sites modified to accommodate the programs. According to the initial plan, inmates were to receive treatment in areas separate from the general population. However, physical modification of treatment areas at both sites was difficult to achieve. At Zephyrhills CI, the FDOC Bureau of Substance Abuse Treatment requested modifications to an open dormitory to allow treatment in a self-contained environment. The alternative was for inmates to leave the dormitory for some treatment groups, but this threatened the integrity of the therapeutic community model that was being implemented. In effect, treatment could be contaminated by DDTP inmates' contact with inmates in the general population. Regardless, the modifications were not approved by upper management.

The results of the request to modify the dormitory at Zephyrhills suggests a lack of coordination between upper management and program administrators. There was no clear line of authority for decisions or a single locus of responsibility for program oversight. In response to the BSAT request to modify the dormitory, regional office staff, the Assistant Secretary of Education and Job Training, and the Chief of Health Services in the Division of Health Services (DHS) visited the DDTP unit. Although the Assistant Secretary of Administration generated a

memorandum for renovations to take place, the Chief of Health Services, who had the final word on the renovations, denied the request because of a lack of funding to cover the costs.

Jefferson CI experienced similar difficulties with physical space. When the program opened, there was no treatment space. Corrections officials debated whether to provide treatment in the dormitory, the institution's chapel, or to share space with existing mental health or substance abuse programs. The dormitory where program participants were housed was not available for treatment. For unspecified reasons, the chapel was unavailable as well. Thus, the dual diagnosis patients shared treatment accommodations in a building that was designated for traditional substance abuse treatment. The treatment space for the DDTP at Jefferson CI consisted of two group rooms, one of which was shared with the traditional substance abuse treatment program, and three offices for the seven staff members.

During the Spring of 1998, FDOC decided to move the DDTP at Jefferson CI to Broward CI. The decision was based on the inability of the DDTP to reach full capacity at Jefferson CI. FDOC officials believed that inmates with family members in South Florida were unwilling to transfer to Jefferson CI for the DDTP. The program relocation was scheduled to occur in February 1999.

Staff Recruitment

Staff recruitment for the program should have been centered on whether mental health substance abuse professionals were qualified to provide treatment to dually-diagnosed inmates.

The staff needed to be able to draw on their knowledge of dealing with both mental health and substance abuse issues. However, DDTP staff recruitment was based more on which professions had the legal authority to make clinical decisions concerning inmate care.

Although the DDTP originated with the BSAT, legal authority for inmate care resided with the MHP. Mental health professionals in supervisory positions were required to be licensed based on the necessity that they diagnose inmates according to DSM-IV categories. In contrast, substance abuse treatment staff are not required to be licensed or to diagnose inmates. Mental health professionals at FDOC exercised greater legal authority than substance abuse professionals in rendering inmate care. An FDOC official said:

> A mental health background is perfect for this population. The typical substance abuse program has fairly low-paid people with little clinical training. That arrangement generally works fairly well for a pure substance abuse program. However, when you add the fact that someone is also diagnosed under the DSM-IV-R as mentally disoriented, and a substance abuser, you've got to have the skills and flexibility to train people to deal with that.

There were significant differences between the staffing pattern described in the initial DDTP plans and the staff actually recruited. The initial plan indicated that a wide range of professional staff was required to deliver services to inmates at each treatment site. Staff identified in the initial plan included a psychiatrist, senior psychologist, psychological specialist, clinical social workers, registered nurses, and human service specialists and counselors.

Staffing Patterns by Profession

DDTP Site	ZCI (80-beds)		JCI (60-beds)	
Staff Category	Initial Plan	Actual Staff	Initial Plan	Actual Staff
Psychiatrist	1.5	0	1.0	0
Sr. Psychologist	2.0	1.0	1.5	1
Psych. Sp.	5.0	5.0	3.0	4
Social Workers	4.0	0	2.5	0
Reg. Nurse	6.0	0	2.0	0
Human Ser. Sp.	2.0	0	1.5	0
Human Ser. Cou	2.0	0	1.5	0
Secretary Sp.	2.5	1.5	1.5	.5
Total	25.0	7.5	14.5	4.5

According to the initial plans, psychiatrists in the DDTP were responsible for supervising registered nurses and coordinating other medical and pharmacological services. Senior psychologists' duties consisted of supervising psychological specialists, developing clinical policies and procedures, coordinating programs, and personnel management. The psychological specialist and clinical social workers led mental health/dual diagnosis groups, provided individual counseling, oriented clients, and participated in team meetings. Also, the psychological specialist and clinical social workers served as cases managers and liaisons with community treatment agencies in order to coordinate inmates' re-entry into the community. The registered nurse specialist coordinated inmate medication management, as directed by the psychiatrist, and managed inmates' other health needs.

The initial plan required that human service professionals be Certified Addictions Professionals (CAP). The human services program directors were to be responsible for coordinating program activities, psycho-educational groups, and community meetings. Human services counselors supervised inmates' recreation and leisure activities and led psycho-

educational groups. The secretary specialist provided clerical support to clinical staff, including typing, filing, and management of records.

Initially, staffing plans at Zephyrhills CI called for 25 staff members, or approximately one staff member per three inmates. At Jefferson CI, the plans called for 14.5 staff members, representing approximately one staff member per four inmates. Each DDTP unit developed a program manual. However, the descriptions of staff roles and functions in the manuals did not correspond to the job descriptions articulated in the initial plans.

Staff recruited for the program from Zephyrhills CI were drawn primarily from the outpatient mental health program there. Only two positions were filled from outside the mental health program. One position was filled by a transfer from another institution, where the staff member worked in a Tier V Substance Abuse Therapeutic Community. The other was filled when the only substance abuse staff member at Zephyrhills was transferred to the program to coordinate evening substance abuse treatment and to provide aftercare planning.

During the assessment period, IHHSR staff requested a memorandum from BSAT in order to confirm the number of staff members working at both treatment sites by profession. The memorandum indicated that, in contrast to the initial plans, fewer staff members were working at each treatment site. At Zephyrhills CI, staff working in the program represented only 18% of the staff initially requested for the program. At Jefferson CI, the staff working in the program represented 31% of the staff initially requested for the program. According to the women's DDTP program director, more staff was required to run the programs effectively:

> I would have six or seven staff. One would do victims of abuse groups. Another would do HIV groups. I would have another one doing parenting skills. The other one would do an intro to mental illness class. Plus one doing aftercare planning.

Additionally, they might run one specialty group a week.

Both the lack of staff and the rate of staff turnover were concerns throughout implementation. The programs were never fully staffed with medical personnel. Although the BSAT indicated that both sites had psychiatric staff and were negotiating nursing time, IHHSR staff observed no medical staff working in either program unit during the week-long site visits. According to the program director at Zephyrhills CI, psychiatric staff was available on a consultative or emergency basis. In addition, he indicated that nursing staff from the outpatient mental health program had expressed interest and willingness to treat DDTP inmates. However, their supervisors did not assign them on a part-time basis to the program. The program director attributed the unwillingness of outpatient supervisors to assign nurses to the program as a form of resentment. He said, "There are definitely problems and resentments within outpatient mental health regarding acquiring nursing staff for the program."

When asked about their role in the program, psychiatric staff reported little contact. One psychiatrist at Zephyrhills stated:

> We do not have much interaction with the program. The dual diagnosis program people more or less have stayed to themselves. We do not get a lot of information about what is going on in the program. One of the areas where there has been staff turnover has been the frequent changing of psychiatrists at Zephyrhills CI and also the mental health nursing staff, so it disrupts the continuity here. The recommendation is to find a way to hire more psychiatric staff.

At Jefferson CI, different staff concerns arose. There was greater staff instability at Jefferson CI than at Zephyrhills CI. First, the program was never fully staffed. The staff at Jefferson was recruited from outpatient mental health programs. The staff was not selected by the DDTP Unit Director. Some of the staff transferred to the DDTP were problem employees. One

was dismissed after staff in both the dual diagnosis program and traditional substance abuse program, as well as inmates, experienced difficulties with the staff member. Another difficult staff member who had been transferred to the program was transferred back and forth between the DDTP and mental health outpatient programs multiple times before being dismissed.

According to treatment staff, the transfer of problem employees to the DDTP had a disruptive effect on treatment. DDTP staff described the transfers as institutional management decisions and explained that institutional management did not distinguish between staff for the dual diagnosis program and staff for the outpatient mental health program and, instead, regarded them as interchangeable. The following positions were vacated:

1. November 1997- Psychiatrist at Jefferson CI
2. December 1997- Psychological Specialist at Jefferson CI
3. January 1998- Psychiatrist at Jefferson CI
4. March 1998- Psychological Specialist at Jefferson CI
5. March 1998- Psychological Specialist at Zephyrhills CI
6. April 1998- Psychological Specialist at Jefferson CI
7. May 1998- Senior Psychologist (Director of DDTP) at Jefferson CI

Inmate Screening and Referral

Those in charge of DDTP implementation expressed the expectation that once the new program was established and operating, new candidates would be identified quickly enough to maintain an appropriate number of program participants. Their initial optimism rested in part on an estimate that two thousand current inmates were diagnostically appropriate for the program. This view was reflected in the MH director's statement to a planning group that, "The program will operate as a cohort. Slots will be quickly refilled if new referrals are inappropriate." In reality, recruiting inmates to the DDTP was more difficult than expected.

The question of for whom treatment is appropriate is basic in planning a new treatment program. The answer is typically couched in terms of eligibility criteria based on diagnosis and other variables. Ideally, the criteria would unambiguous, and the information needed to determine whether they are met would be available for each potential candidate for treatment. Neither condition was fully realized at FDOC.

One significant impediment to identifying candidates for the new program was the absence of substance-abuse diagnoses in the assessment results conveyed to residential institutions from FDOC Reception Centers, where new inmates enter the department. The absence of procedure for diagnosing substance dependence and abuse as inmates enter FDOC may reflect the absence of any legal requirement that substance abuse services be provided to FDOC inmates. Classification staff at the reception centers, following departmental policy, typically do not assign substance abuse diagnoses.

According to one FDOC regional mental health consultant, if reception center staff would record an Axis I diagnosis of "substance abuse in remission in the controlled environment" in appropriate cases, then staff at residential institutions would receive the information needed to identify potential candidates for the DDTP. But reception center staff usually note only "a suspected substance abuse problem," an indication which does not constitute a diagnosis and serves only to prompt referrals to conventional substance abuse services. In short, information on inmates' substance-abuse histories that is typically captured in FDOC records has been insufficient to identify appropriate DDTP candidates, thereby contributing to the difficulty of recruiting inmates to the program.

Another source of uncertainty for those responsible to screen and/or refer inmates was the range of eligible psychiatric diagnoses. Here, as with chemical dependence, seemingly clear intentions were difficult to translate into specific procedures for selectively recruiting inmates who needed integrated treatment. The director of mental health services described the intended DDTP participants to members of a September 1997 planning group as "a select sub-population of treatment failures and dropouts (who) will be clinically different from inmates who go into traditional treatment," and explained that, "if inmates are adjusted well enough to take part in traditional programs, they aren't candidates for this program."

Admissions criteria presented a special problem for this program. During the management team meetings, the MHP director expressed concern about eliminating certain types of diagnoses from the program:

> If somebody has what was considered a primary Axis II diagnosis of borderline, they're excluded from this program. You would be amazed at how many people will then be excluded. I think we are at risk programmatically if we do that.

The issue of establishing a clearly defined set of criteria for inmates admitted to the program was never fully resolved. Consequently, the diagnostic criteria for admissions have functioned more as guidelines than as categorical requirements.

Eligibility Criteria

The initial DDTP plan contained two sets of eligibility criteria for admissions to the program. One set required an Axis I mood disorder and an Axis I substance abuse disorder. Another set required either an Axis I or Axis II mental disorder, and an Axis I substance abuse disorder. According to the original plan, to be eligible for the program an inmate should have an

Axis I schizophrenia disorder, mood disorder, or anxiety disorder, as well as Axis II disorder of schizotypal personality disorder or borderline personality. However, the eligibility criteria presented a special problem for this program. During the management team meetings, an FMHI consultant expressed concern about the eligibility criteria:

> I am just a little confused here because, going back a couple of years ago, we talked about focusing on the affective disorders, and I think the point that you made at that point was we really need to focus on the more severe disorders. I am hearing you coming back away from that now, saying, 'Well, we are not really focusing on the major affective or psychotic spectrum anymore.'

According to the initial plan, inmates identified as dually-diagnosed were to receive two diagnoses: one for a mental disorder and another for a substance abuse disorder. Throughout the implementation process, it was difficult to determine when inmates screened for the program received either diagnosis. Mental health staff provided diagnoses for mental disorders. According to FDOC rules and regulations, they had the legal and clinical authority to do so. FDOC rules also require that mental health treatment staff be supervised by clinically licensed professionals. In contrast, substance abuse personnel did not have the authority to diagnose inmates' substance abuse disorders. According to the BSAT, they provided only clinical impressions of substance abuse. Given this, the use of diagnostic requirements as admissions guidelines was inappropriate, considering the difficulties in diagnosis and the complexity of causation associated with comorbid mental illness and substance abuse.

Inmate Characteristics:

According to FDOC officials, the program began accepting inmates on November 1, 1997, when ten males and eight females were admitted at Zephyrhills CI and Jefferson CI,

respectively. The demographic and criminal justice characteristics of the DDTP inmates are described below.

The 214 inmates screened for the program prior to June 30, 1998 included 149 (70%) males and 65 (30%) females. One hundred and thirty-nine (65%) of those screened, including 94 (68%) males and 45 (32%) females, were referred and admitted. The racial distribution of inmates at the two treatment sites differed slightly. The majority of the 54 inmates at Zephyrhills CI were white (54%), and the remainder were categorized as black (46%). At Jefferson CI, 13 of the 25 female inmates were black (52%), 11 were white (44%), and one was Hispanic (4%). The racial distribution of inmates in the Jefferson CI Program was more consistent with that of all inmates in the prison population. Most of the inmates in the general prison population are black (55%), white inmates comprise a smaller proportion (43%), and Hispanics a very small proportion (2%) (Florida Department of Corrections, 1997-97).

The average age of inmates in the DDTP on June 30, 1998 differed only slightly from that of inmates in the general prison population. The average age of males admitted to the DDTP was 35 years, slightly older than the 33-year average of all male inmates. The average age of admitted females was 33 years, slightly younger than the 34-year average of all female inmates.

Criminal Justice Characteristics:

The criminal justice characteristics of inmates in the DDTP differed considerably from those of inmates in the general prison population (See Appendix A). The average sentence length for inmates in the DDTP is approximately three years, compared to an average of 17 years in the general population. Over half of the DDTP inmates (63%) have sentence lengths of three years or less. Only two inmates in the DDTP were serving a life sentence. Three DDTP inmates (2%)

were serving sentences for murder or manslaughter, compared to 14.8% of inmates in the general population (Florida Department of Corrections, 1997-97). The percentage of inmates in the DDTPs currently sentenced on drug charges (17%) slightly exceeded that in the general prison population (15%). The distribution of offenses associated with current convictions was similar at each treatment site. Also, DDTP inmates were more likely to have prior sentences, 57% versus 46%. Among the sixty-five inmates referred to the program for whom a custody classification was reported, 40 (62%) were classified as medium custody and 25 (38%) as minimum custody.

Diagnostic Characteristics:

The distribution of diagnostic categories in the DDTP reflect a high prevalence of mood disorders among female inmates (See Appendix B). Eighty-eight women with Axis II disorders (63%) were admitted to the program versus 48 (35%) with Axis I disorders, and there were 3 (2%) with no diagnosis. Most inmates in the DDTP had used several substances including alcohol. Sixty-five (46%) were classified as poly-substance abusers; 44 (32%) were classified as opiate users, with 15 (11%) reporting alcohol use, and 15 (11%) had no substance abuse diagnosis.

The Screening Process:

The programs had not reached full capacity by the end of the field research period (June 30, 1998). This situation is largely due to the failure of FDOC to successfully operationalize an effective screening process. The original plan indicated that a two-phase screening process would precede treatment. Classification and mental health staff at FDOC reception centers conducted the first phase of screening. The plan called for preliminary screening of inmates for the DDTP to take place at FDOC reception centers and institutions. Reception centers receive new inmates

and process and route them to appropriate facilities. Inmates at reception centers received a preliminary screening for the DDTP to determine their readiness for treatment. Mental health personnel at institutions throughout the state conducted preliminary screening on inmates already in the system. The initial DDTP plan described cohort treatment; it consisted of each facility filling all their beds before treatment in Phase I began. That would be 40 inmates for Zephyrhills CI and 30 inmates for Jefferson CI. FDOC planned to admit 10 inmates per week until they reached their capacity. After inmates were transferred to the DDTP unit either from reception centers or other institutions, more detailed assessments were conducted on their readiness and motivation for treatment as a basis for individual treatment planning.

Throughout the implementation process, FDOC officials were concerned about the low number of referrals to the DDTPs. As a response to the concerns of upper management, the BSAT initiated a state-wide teleconference on March 20, 1998 to inform FDOC mental health personnel about the importance of using the Drug Simple Screening Instrument (DSSI) to screen inmates for the program. BSAT asked staff at reception centers and referring institutions to use the DSSI. According to BSAT personnel, the bureau had not "sold" the program to the field and had not waged a campaign to convince institutions throughout the department of the importance of the program. The March teleconference presented information on the two-phase screening process. The teleconference originated from the Region V offices. The DDTP coordinator, the program director at Zephyrhills CI, the Region V mental health consultant, and Bob Neri, an unspecified consultant, participated in the presentation.

The teleconference served two purposes. The first was to begin to inform personnel outside of BSAT about the existence of the DDTP. The second purpose was to standardize one

aspect of the DDTP screening process by establishing the use of the Drug Simple Screening Instrument (DSSI) at reception centers. The DSSI is a fourteen-item instrument to assess a person's readiness for substance abuse treatment. The abbreviated version of the DSSI consists of four questions. The plan was for reception staff to administer the brief DSSI to identify inmates with substance abuse problems. If an inmate responded "Yes" to one of the initial four questions, then the additional ten questions were administered.

A telephone survey of reception centers in June 1998 indicated that only one reception center out of four was then using the DSSI as a screening instrument for inmates in the DDTP. According to OBIS, of the 214 inmates screened for the program, only four percent received the DSSI at a reception center or other institution. Nine of these inmates were screened before the teleconference and one inmate was screened after the conference. This suggests that the teleconference had little effect on the screening process.

BSAT personnel in later interviews indicated that, in spite of efforts to formalize the screening process at the March 20, 1998 teleconference, a different screening process had emerged. During an April 9, 1998 monitoring meeting with BSAT personnel, that process was described in terms of the following steps:

1. The program directors received a referral package from an institution.
2. The program directors contacted the program coordinator at BSAT with the inmate's name, place of referral, and referral status.
3. The program coordinator at the BSAT had a staff assistant check the OBIS to determine the following:

a. The extent to which the 85% rule[1] applied to an inmate's earliest release date.

b. How much gain time is applied to the inmate's release date.

4. If an inmate's release date was within twelve months, then the inmate would be admitted into the program.
5. If the inmate's release date was beyond twelve months, then the inmate would go on a waiting list for the program.

Two months later during a June 1, 1998 monthly monitoring meeting, BSAT personnel described a more elaborate screening process:

1. The program directors received a referral package from an institution.
2. The program directors reviewed the referral package from a clinical perspective and determined whether inmates were appropriate for admissions.
3. Inmates determined to be inappropriate for admissions were not admitted.
4. If inmates were appropriate for admissions, then the program directors called the program coordinator, where a referral acceptance review form was completed.
5. An office assistant checked the extent to which the 85% rule applied to an inmate's earliest release date.
6. The staff assistant completed a referral acceptance form.
7. The form is then given to the program coordinator.
8. The program coordinator evaluates the release date and determines if the inmate will be released in twelve months or less.
9. The program coordinator sends an e-mail message to the Division of Health Services at FDOC directing them to move the inmate to the institution where the DDTP is located.

If the program coordinator determined that the inmate cannot be released in twelve months, the following additional screening and referral actions were prescribed:

1. A staff assistant reviewed the FDOC screens to determine if the inmate is a sex offender or an escape risk.
2. If the inmate was not a sex offender or an escape risk, then the grant coordinator or the staff assistant notes on the referral and acceptance form that the inmate is eligible for work release.

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[1] According to state statute, certain inmates must serve at least 85% of their sentence.

3. If the inmate had not committed a sex offense or an escape attempt and has a release date within 36 months, then the grant coordinator e-mails the community corrections staff in the classification department to review the chart in-depth for work-release eligibility.
4. The inmate is then placed on the waiting list.
5. A note is made on the waiting list form that the inmate is a potential DDTP client.
6. The program coordinator's staff assistant checks and updates the list every two weeks.

Difficulty arose in the screening process with regard to several eligibility criteria, including whether inmates were free of disciplinary infractions or confinement within twelve months of release and were at least a psychological grade II. During a telephone conference on November 11, 1999, one DDTP director characterized one referring institution's reaction to the screening and eligibility criteria:

> We had a conference call from two psychologists at Washington CI. They indicated that the issue of confinement was kind of confusing. So I told them to interview the inmate when he gets out of confinement. If the time and dates are OK, I'll take them into the program. I think people are hesitant to complete the screening if someone has been in confinement.

The de facto advisory character of the screening process is evidenced by the number of inmates admitted to the DDTP with disciplinary infractions or confinement, more than a year remaining in prison, and a psychological grade less than II. Fifty-one percent of the inmates in the program had a disciplinary infraction, with 38% receiving disciplinary confinement. Inmates admitted to the program average 15.3 months of incarceration before release. Sixty percent of the inmates in the program had more than a year to serve on their sentence when admitted to the program. According to BSAT personnel, these admissions were inconsistent with the screening criteria. However, the most prominent indication that few eligibility criteria were adhered to by

the DDTP was the number of psychological grade I inmates who had no mental disorder and were admitted to the program (Table 1).

DDTP Inmates by Psychological Grades[2]

Grade	Frequency	Percent
Psych I	67	48.2
Psych II	52	37.4
Psych III	19	13.6
Psych IV	1	0.8
Total	139	100

Diagnostic Tests:

In both their initial DDTP proposal and subsequently at DDTP planning meetings, FDOC staff and FMHI consultants identified several specific psychometric instruments for use both in screening inmates for admission to the DDTP and in conducting more refined inmate assessments at the DDTP units. Each DDTP unit director selected diagnostic instruments to administer to DDTP inmates. According to the program director at Zephyrhills CI during a monthly monitoring meeting on May 18, 1998, FMHI administered the Beck Depression Inventory (BDI), the Substance Abuse Subtle Screening Inventory (SASSI), and the Revised Symptom Checklist (SCL-90-R) to male DDTP inmates. However, the tests did not provide information to staff concerning the diagnostic or behavioral status of inmates in the program. After the diagnostic measures were in place, BSAT personnel expressed concern about the purpose of the diagnostic measures. According to a BSAT employee:

[2] Tables derived from OBIS records supplied by FDOC.

> If I knew that these tests were going to give me something tangible to help me with treatment that I could not get from any other resources, then I might say this is worth the time invested. But some of the tests that we did not agree to are being recommended for research purposes.

In addition, the program director at Jefferson CI commented during a monthly monitoring meeting on June 26, 1998:

> I am implementing the diagnostic test myself and I am sending the results to central office. From there I do not know what happens to them. I am implementing the SCL-90-R, the BDI, the SASSI, and the University of Rhode Island Change Assessment.

Program Criteria:

The Department of Community Affairs, the state agency that administered the federal grant to FDOC, required that inmates be admitted to the program on a voluntary basis, that they be within a year of release at the time of admissions, and that they be treated in a contained environment. According to FDOC officials, these requirements were the primary reasons the programs did not reach capacity. Many FDOC officials questioned whether any prison-based program can be voluntary in the same manner as community-based programs.

In addition, it was generally acknowledged among FDOC administrators and staff concerned with the DDTP implementation that inmates were not inclined to participate in a program that segregated them from the general inmate population and precluded their participation in other educational or treatment programs outside the DDTP. However, data obtained from OBIS indicated that some inmates did participate in other educational and treatment programs while in the DDTP. Thirty-three percent of the inmates who entered the DDTP participated in an additional FDOC-sponsored educational or treatment program while they were in treatment at the DDTP.

FDOC officials convinced DCA that relaxing the program criteria would encourage more inmates to participate in the DDTP. DCA relaxed the program criteria, which allowed inmates to go back to the general population after treatment. DCA allowed inmates with release dates beyond twelve months to enter the program, provided inmates were eligible for work release. The criteria were relaxed on the condition that institutions where inmates are housed after treatment provide supplemental treatment. But relaxing the program criteria did not enhance the programs' ability to attract more inmates; the programs did not reach capacity by the end of the assessment period. FDOC officials' response to the inability of Jefferson CI to meet its capacity was to move the female DDTP to Broward CI in FDOC's Region IV. According to BSAT staff, no new referrals were sent to Jefferson CI after June 30,1998.

Treatment Implementation

Tobin, Elliot, and Anderson-Ray (1986) identify four characteristics of organizations which affect treatment integration and program implementation. The characteristics are cooperation, communication, collaboration, and coordination. Each characteristic stresses the importance of service linking during an implementation process. Cooperation and communication are essential for program implementation and for integrating treatment systems and approaches.

Cooperation:

Through cooperation two or more separate organizational entities plan and implement a program by working toward similar goals (Petersilia, 1990). The initial DDTP plan called for multiple leadership. Although both the MHP and BSAT assumed some responsibility for implementing the DDTP, the two organizational entities defined their roles differently. The

director of BSAT described her role as a change agent. While the BSAT director was willing to take all the credit for the implementation for the program, the director of MHP saw his role as less involved with the implementation process. The BSAT director stated:

> I had the key role in the development, implementation, and planning. There was no other staff involved with me during that process. I made all of the initial collaborative contacts inside and outside the department. I had the initial role, the leadership role. Internally and externally, I developed the job descriptions for the positions connected with the program at the central office and at the treatment institutions.

The MHP director described his role as primarily that of a consultant. He acknowledged that substance abuse administrators and staff had some expertise in both substance abuse and mental health and that the BSAT, as the source of the grant application, had formal lead responsibility in implementing the new program.

Despite this, the director of MHP was a key participant in management team meetings and teleconferences, which served as planning sessions for the implementation. He announced his disengagement from the implementation process on October 2, 1997, when he facilitated a section of the teleconference concerning physical modifications to the treatment sites.

A lack of cooperation between MHP and BSAT was particularly evident when identifying lines of authority for program staff. Treatment staff expressed concern about hierarchy and supervisory authority. There was a great deal of confusion among treatment staff concerning which treatment system had clinical authority over patient care for inmates in the DDTP.

Communication:

Formal Communication. Communication during the implementation process moved through both formal and informal channels. IHHSR staff requested that all written communication be shared to provide documentation on program activities. Written

communications during the period between February 28, 1997 and October 14, 1998 concerning the DDTP were provided to IHHSR staff. There were 199 documented communications during the 20 months of documented correspondence. Two-thirds (68%) of the written communication was internal, and 30% was to external organizations, including 2% to hired consultants. The bulk of the written communication to external organizations was to DCA regarding one or more of the eventual seven contract amendments to the initial proposal.

Informal Communication. A great deal of communication concerning the program's implementation occurred informally. Decisions based on informal communications addressed such issues as physical modifications to Zephyrhills CI and obtaining equipment at Jefferson CI. Although there were written communications concerning the need to make modifications at Zephyrhills CI, the final decision regarding modification occurred through informal lines of communication.

BSAT requested physical modifications to an open dormitory at Zephyrhills CI, as required by the United States Department of Justice grant, rather than house DDTP inmates with the general population. A number of FDOC officials responded to the request. First, the dormitory was visited by the Assistant Secretary of Education and Job Training who gave tacit approval of the renovations. The Assistant Secretary of Administration then wrote a memorandum on October 20, 1999 approving the renovations. Finally, the Chief of Health Services was asked by the Deputy Secretary of Corrections during a Missions and Habitability Committee meeting to visit the facility. The Mission and Habitability Committee's responsibility is to ensure that all institutions are in compliance with their mission. As a result, this committee

had final approval over the DDTP's implementation, including the request for renovations at Zephyrhills CI. The BSAT request for renovations was denied.

It was difficult to determine how or why the decision was later made to renovate the treatment site at Zephyrhills CI. The Deputy Secretary refused to be interviewed concerning the implementation of the DDTP. However, the Chief of Health Services partly explained his role in the decision by saying, "The program is housed in a health services building. I work directly for the Assistant Secretary of Health Services. I have the authority and responsibility for all health services facilities."

Similar difficulties in decision processes were evident in the allocation of equipment to DDTP staff at Jefferson CI. When inmates began entering the program, the program director there did not have a telephone. Both management at Jefferson CI and the BSAT refused to cover the purchase of a telephone for the program director. Institutional management did not regard the expense as a part of their operating cost at Jefferson CI. According to the BSAT, the grant did not allow for such expenses. There were no written communications between the BSAT and Jefferson CI management concerning the telephone. However, once the Region I Medical Director and the Chief of Health Services learned of the situation, the program director was provided a telephone in a matter of days, as the apparent result of communications through informal channels.

Treatment Integration:

During program implementation, treatment integration was addressed through the merging of the traditional mental health and substance abuse treatment systems at FDOC. Integration of treatment systems was predicated on the degree of coordination between the two entities. FDOC

failed to successfully integrate treatment because they failed to establish an interdependent relationship between the affected units of bureaucracy.

Institutional management exercised a great deal of control over the DDTP. This contributed to the program being implemented differently at the respective sites. At Zephyrhills CI, the therapeutic community was interrupted by inmates from another dormitory because the locks at that dorm were defective. After weeks of having inmates from the general population reside in the DDTP dormitory and treatment area, staff were able to convince institutional management that the inmates were disrupting the therapeutic community.

At Jefferson CI, DDTP inmates were housed with inmates who received traditional substance abuse treatment. DCA discovered this and informed FDOC that this violated the intent of the program. As a result, inmates in the traditional substance abuse program were moved to another dormitory and the capacity for the DDTP was increased from 40 to 60 beds.

The initial plan was to combine psycho-educational, cognitive-behavioral and pharmacologic treatment. At Zephyrhills CI, treatment adopted from Alcoholics Anonymous (AA) was to be conducted during evening support groups. However, most staff in the program were not willing to work evening hours. Psychological specialists were unwilling to change their work schedules to provide evening support groups. Ultimately, one staff member was assigned this responsibility. Community volunteers available to run AA groups were inconsistent. Some inmates did not attend groups because they were voluntary, and there was no one to enforce their attendance.

At Jefferson CI, the DDTP program was modeled after AA and other 12-step recovery programs. Every group opened and closed with the AA serenity prayer. Client treatment issues

were addressed during individual counseling sessions. Phase I of treatment at Jefferson CI focused on teaching inmates about co-occurring disorders. Time was allowed for self-examination in a supportive peer environment. The second phase centered on developing societal transition and relapse prevention skills. The average time in treatment in Phase I was 2.5 months for males and 5.9 months for females. The average time in treatment for males in phase II was 4.5 months, and the average time for females in phase II was 4.1 months.

Initially, the program was scheduled to be administered to successive cohorts in four-month phases. However, due to the slow referral to the program and inability of programs to maintain inmates once they arrived, the plan changed. Under the revised approach, inmates participated in the same groups, but they moved into the next phase on an individual basis. The program director at Zephyrhills CI indicated that standardized criteria were used for determining when inmates moved from Phase I to Phase II. These were that the inmate complete all written assignments and treatment plan objectives satisfactorily and pass a written comprehensive examination on topics covered in the Phase I curriculum. Both criteria called appropriately on the collective judgement of the treatment staff to determine who was ready to move to the next phase.

Although the program directors could not readily identify the number of inmates who moved from Phase I to Phase II, six inmates at Zephyrhills CI and five from Jefferson CI were reported to have graduated from the program. However, according to OBIS, 11 males (23%) completed treatment, 8 (17%) were enrolled on June 30, 1998, and 28 (60%) were removed for other reasons. One female inmate at Jefferson CI was reassigned to another treatment program, three (15%) were enrolled on June 30, 1998, and 27 (80%) were removed for other reasons.

The treatment curriculums utilized at the two DDTP sites differed from one another. In November 1997, when inmates began entering the DDTP units, neither program had a curriculum for Phase I. The treatment directors developed their own curriculums. Within a few months a draft of the treatment curriculum for Phase I was provided to staff by the consultant at FMHI.

Inconsistencies in how the curriculum was implemented at each program continued throughout the implementation process. At Zephyrhills CI the curriculum was reviewed in March 1998 by FMHI consultants during their only visit to the program prior to June 30, 1998. The consultants felt that too few dual diagnosis groups were being conducted at Zephyrhills CI, and they recommended that dual diagnosis groups be increased to 30 hours per week. The dual diagnosis groups at Zephyrhills were increased to eight hours.

FMHI offered similar reviews and recommendations to Jefferson CI. They informed staff that more dual diagnosis groups should be conducted. However, the staff at Jefferson CI did not adopt the recommendation. During the interviews, DDTP staff expressed the view that the curriculum favored by the FMHI consultants was too cognitive-behaviorally based for inmates who had severe learning deficits. Staff also felt the curriculum did not provide any time for psycho-education treatment. Jefferson CI never fully implemented FMHI's recommendations.

Security Staff:

During planning meetings which occurred before the DDTP units opened, consideration was given to the possibility that security staff could assume an active role in the therapeutic community model to be employed on the units. In actual practice, this possibility was precluded by the rotation of security staff from unit to unit. By limiting the amount of time any individual security staff member was on the dual diagnosis unit, the rotation made it impossible to assign

security staff to a role in the therapeutic community and restricted the opportunities available to security staff to learn about the program and to assume informal treatment-related roles.

On the other hand, we cannot tell what may have resulted if security staff were not rotated. The DDTP unit director at Jefferson CI offered the opinion that most security staff lack sufficient interest in treatment to seek increased involvement in the process. He reports having inquired about the possibility of orienting security staff at Jefferson CI to the DDTP unit as part of their required ongoing education, but he received no support. His stated impression was that administrators at the institution had not been adequately prepared for the "installation" of the new program and knew too little about it to respond to his request. This impression was reinforced by his indication that psychological specialists at Jefferson CI had been recruited as what they were told would be "liaisons" to the DDTP, and they did not learn until they were in training at FMHI that they were, in fact, to be re-assigned to the new unit.

Many security staff from Zephyrhills CI attended the training which was approximately 40 miles from the training site. None from Jefferson CI attended. The Security of FDOC identified geography as the primary reason security staff from Jefferson CI did not travel 250 miles to attend. Although a number of security staff from Zephyrhills CI attended the training seminar, only one of them worked with DDTP inmates, and he was moved within several months to another dormitory in the prison. The officer who replaced him had not attended the cross-training or subsequent training. Officers who worked in the DDTP declined to be interviewed during the second round of interviews. DDTP staff at Zephyrhills CI attempted to include security staff input in program decisions, particularly decisions relating to inmate discipline. However, with the arrival of untrained security staff, the continuity of security staff input was disrupted.

At Jefferson CI, security staff had little contact with DDTP inmates. The only contact occurred when inmates were in the dormitory. In addition, there was a great deal of turnover in correctional staff at Jefferson CI. Many correctional officers regarded the DDTP inmates as more disruptive than inmates in the general population. Further, they reported that DDTP inmates were particularly disruptive during weekends when staff were not around.

Treatment Schedule:

The lack of treatment curricula was one factor that contributed to treatment being implemented differently at each site. At Zephyrhills CI, cognitive-behavioral and psycho-educational treatment were emphasized. The bulk of the treatment consisted of dual diagnosis and process groups. Phase I and II inmates participated in the same groups.

Treatment staff indicated that working simultaneously with inmates in different phases of treatment did not present a problem. In fact, they felt that having inmates in different treatment phases in the same group was helpful to inmates in Phase I treatment because they were better able to learn from inmates in Phase II. According to the initial plan, orientation consisted of a two-week physical, diagnostic, and psychological assessment. However, the resident handbook at Zephyrhills CI described the phase as a three-week overview of the program. Orientation groups were led by treatment staff. Staff reviewed the resident handbook and selected topics for discussion. The day IHHSR staff sat in, the discussion centered on the program's treatment phases. In addition, staff described to inmates how they may move from one phase of treatment to the next.

A staff member led the motivational enhancement group through a didactic process of identifying the advantages and disadvantages of maintaining sobriety. For example, inmates

identified being able to think clearly as an advantage to maintaining sobriety and loss of friends as a disadvantage. The dual diagnosis group reviewed destructive behaviors associated with narcotic use. Inmates identified destructive feelings of grandiosity and invincibility as associated with illicit drug use. The group had two exercises, one conducted in small groups and another which consisted of role play designed to reinforce positive coping skills. The staff member leading the group played a spouse or significant other during the role play.

Group activities appeared to be well received by inmates. The inmates were enthusiastic about participating in treatment, and the treatment staff were prepared for group activities and were energetic in their presentations. It appeared, however, that the treatment schedule was difficult to maintain. The schedule created by the treatment staff at Zephyrhills CI in January 9, 1998 reveals a full list of activities for inmates. Staff were allotted four hours per week for process groups. Dual diagnosis groups, defined as didactic and practice groups that addressed mental health and substance abuse issues, were allotted six hours per week. The schedule indicated that staff was providing individual counseling five hours per week. Individual counseling consisted of staff developing a treatment plan, evaluating the inmate's progress through treatment, and providing one-on-one counseling. Recreational activities, step groups, and medication groups were dispersed throughout the remainder of the schedule.

There number of activities scheduled often prevented some of them from taking place. Activities were canceled when staff were absent or inmates were not willing to participate. Many activities were scheduled at the same time. Although the schedule indicated that individual therapy was a part of treatment activity, the program director expressed concern about the inability of staff to conduct individual counseling, given the level of group activity:

> Well, I think the major difference in this program in comparison to other programs is there is no flexibility at times. The problem is trying to fit all these activities and that causes problems. It causes organizational problems at times because we have to figure out when we are going to do what. We have got sometimes six dual diagnosis groups running at a time with six different counselors. So that structurally does not work well. The people that designed the groups, I do not think they realized what we were thinking about here. They limited the participants to ten. They said that they wanted it done that way because they felt it would run better.

Both programs were urged by FMHI to alter their treatment schedule to accommodate more groups. FMHI recommended that dual diagnosis groups be increased from approximately 20 to 30 hours per week. The consultant's insistence on increasing dual diagnosis hours for patients in the program was confusing to treatment staff. Although treatment staff at Zephyrhills CI acknowledged that modifications were made to increase the hours for dual diagnosis groups, there was no formal curriculum presented during the assessment period that showed an increase in these groups.

At Jefferson CI, the treatment curriculum was based on the AA model, emphasizing individual therapy and dual diagnosis groups. A draft of an inmate guidebook for treatment at Jefferson CI identified the core treatment components as individual therapy, psychotropic medication and management, morning meetings, symptom management groups, a double trouble program, changing criminal thinking patterns, dual diagnosis education and processing, thinking through trouble, cognitive groups, life after prison (adjustment issues), medication education, communication skills training, and AA and Narcotics Anonymous (NA) 12-Step Programs.

Each morning, inmates in the DDTP at Jefferson CI began with a motivational enhancement group at the dorm that consisted of each inmate stating her goal for the day. Before

each inmate stated her goal, she identified herself as a substance abuser. The peer-led group opened and closed with the AA serenity prayer.

Similar to Zephyrhills CI, it was difficult to determine which inmates were in Phase I and which were in Phase II at Jefferson CI. The treatment staff at Zephyrhills CI presented treatment schedules for inmates in Phase I and in Phase II. IHHSR staff observed dual diagnosis, dual disorders anonymous, process, and criminal thinking groups. The dual diagnosis group was led by a charismatic staff member who appeared to inspire participation. The inmates enthusiastically participated in a series of didactic activities to illustrate the effects of illicit drugs on mental illness. The information was presented from the content of a curriculum manual to which the staff member referred while directing the group.

The program director led a group called "Dual Disorders Anonymous." The group was run according to an AA format in which every inmate who got up to speak introduced herself as being in recovery. Each inmate participated in a process of self-disclosure that described something new they had learned about their dual disorder. The group opened and closed with the AA serenity prayer.

Criminal thinking groups at Jefferson CI were similar to those at Zephyrhills CI. The groups were led by staff who used a didactic approach to help inmates identify thinking processes that lead to criminal activity. Inmates were less enthusiastic about this group. The lack of enthusiasm during the group may have been due to inmates' dislike for the staff leading the group or concerns about community filtering into the group.

There were conflicts between inmates on the unit that appeared to surface during process group activities. The process groups appeared to lack structure. Inmates seemed to go over the

same material at each group. The group dealt with false beliefs associated with drinking. As a result of the redundancy, inmates appeared lethargic during the group activity.

The schedule of activities presented to IHHSR staff indicated that there were two treatment programs going on at once at Jefferson CI. One was for inmates in Phase I; the other was for inmates in Phase II. Four hours of activities in the dual diagnosis groups were scheduled for inmates in Phase I, and eight hours were scheduled for inmates in Phase II. This curriculum made no distinction between process and dual diagnosis groups; they were the same. Inmates in each phase participated in the same amount of group activity. The double trouble group met for two hours a week, and the criminal thinking group met for one hour a week. Other activities scheduled included relaxation skills, medication education, self enrichment, and smoking cessation groups.

After a couple of days of observing treatment, the treatment schedule appeared to falter. While some inmates were participating in groups, others were wandering around the halls of the DDTP. Inmates indicated that they were receiving mixed messages from staff about where they should be and what they should be doing. They claimed not to know whether they should be in treatment, in the dormitory, or involved in work duties. Frequently, group activity was canceled.

Treatment Phases:

The treatment schedule at Zephyrhills CI was divided into two phases. In the first, all inmates participated in all group activities, including dual diagnosis groups. Activities for Phase I consisted of group therapy, dual diagnosis group, AA/NA participation, recreational therapy, individual counseling, board meeting activities, and therapeutic community activities. The therapy

groups addressed such issues as co-occurring disorders, drug using behaviors, violence, substance abuse, and criminal thinking.

Phase II activities focused on relapse prevention treatment and employed a cognitive-behavioral approach. Also, inmates participated in aftercare planning that included seeking community-based AA/NA sponsorship. Finally, according to the resident handbook, residents were to obtain educational and vocational skills training.

Once a week, phase-up boards were held where a panel composed of inmates and staff decided whether other inmates were ready to move from Phase I to Phase II of the DDTP. Criteria for inmates moving from orientation to phase I consisted of completing all homework assignments satisfactorily, attending all required treatment activities, and passing an oral examination. Criteria for inmates moving from Phase I to Phase II consisted of participating in all treatment activities, completing homework assignments, and a recommendation from the inmate's caseload group and counselor to attend the phase-up board. The same general criteria were the basis for an inmate's movement from Phase II to Phase III.

According to the inmate guidebook at Jefferson CI, Phase I of treatment was the primary prevention phase. Inmates attended an orientation program and were evaluated and assessed in order to develop individual treatment plans. There was no description of Phase II treatment in the inmate guidebook.

Each program indicated a different length of treatment phases. At Zephyrhills CI, the program was described in the resident handbook as including an Orientation Phase, Phase I, Phase II, and Phase III. The Orientation Phase was described as being three weeks long, and the others were described as each being four months long. At Jefferson CI, no distinction was made

between the Orientation Phase and the other Phases of Treatment. In addition, there was no mention of a Phase III curriculum.

Inmate Movement:

As of June 30, 1998, roughly half (52%) of the 79 active inmates who entered Phase I treatment had not entered Phase II treatment. At Zephyrhills CI, 46% of the 54 active male inmates entered only the first Phase of treatment. Jefferson CI reported 64% of the 25 active female inmates entered only Phase I treatment. The average time in Phase I treatment for male inmates was 4.0 months and 6.2 months for female inmates. The table below provides a breakdown of inmates who left Phase I by gender.

Phase I DDTP Inmates by Gender

Type	All		Men		Women	
Exit	Freq	%	Freq	%	Freq	%
Completed	41	51.9	33	61.1	8	32.0
Enrolled	5	6.3	1	1.9	4	16.0
No Long Hsed	5	6.3	2	3.7	3	12.0
Removed	11	13.9	11	20.4	0	.0
Reassigned	12	15.3	2	3.7	10	40.0
Vol Withdrawn	5	9.7	5	9.2	0	.0
Total	79	100.0	54	100.0	25	100.0

Thirty-eight percent (38%) of the 79 inmates in the program entered phase II. Twenty-nine (54%) of the 54 male inmates at Zephyrhills CI entered Phase II, and nine (36%) of the female inmates at Jefferson CI entered Phase II. The average time in Phase II treatment was 7.5 months for males and 4.8 months for females. The table below provides a distribution of inmates by gender who left Phase II.

Phase II DDTP Inmates by Gender

Type	All		Men		Women	
Exit	Freq	%	Freq	%	Freq	%
Completed	8	21.1	8	27.6	0	.0
Enrolled	10	26.3	7	24.1	3	33.0
No Long Hsed	8	21.1	7	24.1	1	11.1
Removed	7	18.4	6	20.8	1	11.1
Reassigned	4	10.5	0	.0	4	44.5
Vol Withdrawn	1	2.6	1	3.4	0	.0
Total	38	100.0	29	100.0	9	100.0

Disciplinary Infractions:

Each DDTP unit employed a modified therapeutic community approach to treatment. Each had to interrupt treatment during the site visits to address disciplinary issues. At Zephyrhills, the disciplinary concern involved a peer facilitator who used pull-ups[3] to obtain favors from inmates in the DDTP. At Jefferson CI, the observed disciplinary procedures centered on rule violations by inmates during the weekends while staff were away. Both DDTPs used community meetings to address the disciplinary infractions. Although each program had rules for inmates that applied throughout the treatment process, punishment varied according to the nature of the infraction.

The program at Zephyrhills CI had four sets of rules: cardinal, program, house, and group rules. The cardinal rules included remaining drug-free, and avoiding inappropriate physical touching, the use of weapons, breeches of confidentiality, verbal threats, physical confrontations, and refusal to submit to urinalysis. Cardinal rule violations resulted in immediate suspension from the program. Program rules encompassed the rules of the institution as well as the DDTP unit

[3] Pull-ups occur when one inmate reports another inmate for an infraction.

rules regarding attendance and participation in treatment, racial or ethnic slurs, gambling, criminal activity, intimidation, and profanity. Program rule violations resulted in inmates being referred for review and assigned a learning experience to promote personal growth and behavioral change. House rules focused on interaction between inmates and addressed tobacco use, dorm rules, grooming, group confidentiality, and bunk compliance. In addition, house rules required compliance with recreational activities, time-out, use of bathrooms and television, and games in the day room. Group rules focused on each person sharing personal experiences; they also addressed compliance with program rules, speaking in turn, use of formal English, confidentiality, listening, honesty, and group behavior. The range of punishment for rule violations included verbal warnings, pull-ups, a learning experience, suspension, and discharge.

Jefferson CI listed only cardinal rules for inmates in the program. These rules regarded remaining drug and alcohol free, avoiding violence, threats of violence, gangs, weapons, theft, vandalism, and sexual activity, adherence to confidentiality guidelines, and urinalysis. Violation of any cardinal rule resulted in expulsion from the program.

Each DDTP described a different method for processing rule infractions. At Zephyrhills CI, the program director described how the DDTP stopped discharging inmates for rule infractions and began suspending inmates. Although he felt that inmates should have multiple chances to complete treatment, he said, "If an inmate was suspended for an infraction, returned, and committed the infraction again, they would be discharged from the program." He indicated that while inmates are suspended, they are required to complete disciplinary exercises such as writing an essay and apologizing to residents. Also, he indicated that security staff had been slow

to move suspended inmates out of the unit and that some inmates had stayed around for days before being transferred to another dormitory.

Although there were no written procedures that described how to handle disciplinary infractions, staff members at Jefferson CI described a number of ways in which these infractions were addressed. They could provide a consultation to inmates that could result in a loss of gain time and they could work with security staff in administering a disciplinary report. The leaders of the therapeutic community also met to discuss disciplinary action for inappropriate behavior.

It was difficult for IHHSR staff to determine the dropout rate for the DDTPs. The program director at Zephyrhills CI indicated that the treatment staff's response to disciplinary issues changed during the implementation process. Initially, inmates who committed disciplinary infractions were expelled or discharged from the program. Later, staff began to suspend inmates from the program for disciplinary infractions with the stipulation of reentry once program related assignments were completed. Unfortunately, the codes used in the FDOC data system to represent inmates' departures from the DDTP units make no distinction between voluntary withdrawal, expulsion, and suspension. Consequently, specific counts by category could not be derived from the data.

Therapeutic Community

The therapeutic communities provided a structured environment for treating inmates–one that reinforced the discipline of the prison environment. The DDTP modified therapeutic community was modeled after FDOC's residential substance abuse treatment program, called Tier V, and was modeled after community-based therapeutic community programs. The modified

therapeutic community of the DDTP retained the essential elements of the curriculum and structure of the Tier V substance abuse program. These elements included a planned duration of treatment, staff as role models, peer facilitators, sanctioning process, community meetings, and therapeutic and educational groups. Staff members and peers facilitated the development and growth of clients in the modified therapeutic community. Twelve-step groups and dual diagnosis groups were elements of the modified therapeutic community not found in the Tier V program.

IHHSR staff observed treatment at each program site for one full week.[4] Both DDTP units employ modified therapeutic community models. During the site visits, the treatment schedule in both programs was interrupted by the need to address disciplinary issues in the therapeutic community. At Zephyrhills CI, disciplinary infractions were handled by a tribunal consisting of one staff member and three inmates. At Jefferson CI, staff used individual counseling sessions and town meetings to address problems that arose.

In addition, there was not a system in place to integrate therapeutic community discipline with institutional discipline. Although Zephyrhills CI obtained input from security staff, there was no systematic basis for deciding how and when the larger institution would become involved in response to disciplinary infractions in the DDTP unit. Staff there recommended the following arrangement:

- Disciplinary infractions should be included in the structure of sanctions at the therapeutic community.
- Staff should handle disciplinary infractions and administer sanctions.
- Peer facilitators should serve as roles models.

[4] The DDTP unit director at Zephyrhills asserted that the presence of research staff in any "process group" might violate inmate rights. He defined approximately half of all treatment groups as "process groups." Consequently, during the week-long site visit there, researchers were able to observe only about one half of group activity which occurred.

- Security staff should participate in any review of rule violations in the therapeutic community.

Issues related to the disruptive nature of the therapeutic community may be related to the high number of inmates admitted with Axis II DSM-IV diagnoses. Forty-eight (35%) of the inmates had an Axis I diagnosis and 88 (63%) had an Axis II diagnosis.

Aftercare

As described in the DDTP plan, Phase III programs, which were to be contracted with community treatment providers, would last four months and bring the total time in treatment to twelve months. Program staff were intended to develop comprehensive individual treatment plans for inmates entering the program, and to meet routinely with correctional mental health staff at several points in the treatment process to conduct multi-disciplinary case reviews. Other substance abuse, educational, and vocational staff at the institution were to be invited to participate when needed. Following inmate screening and referral into the program, reviews were to consist of initial, midpoint, and discharge case staffing. At each review, inmate progress was to be evaluated and treatment goals updated.

Development of comprehensive aftercare plans and community care linkages were to begin when inmates entered Phase II. Inmate treatment information was to be shared among substance abuse, mental health, and contracted treatment staff. Information on educational, vocational, and other skills and services was also to be shared and used in aftercare planning. FDOC was to have provided halfway house treatment beds and funding for mental health overlay services for two non-secure probation/parole residential substance abuse treatment units, one for

each gender. The halfway house and treatment units were to be used as Phase III "step-down" placements in the community while inmates completed their year of treatment. Inmates were to be supervised by FDOC parole and probation staff during this program phase.

The linkage to community treatment services is critical to the DDTP because it helps assure inmates' continuous involvement in services. FDOC, however, made no formal effort to establish linkages with community service organizations. Neither did they provide continuing treatment nor develop a network of community services to treat offenders following completion of the DDTP. During the site visit, treatment staff at Zephyrhills CI conducted pre-release treatment planning for inmates. However, the planning did not identify a full array of post-release services or determine their suitability for dually disordered inmates.

One staff member was assigned to coordinate aftercare treatment plans. That staff member contacted the Florida Department of Children and Families forensic coordinator in the same district as Zephyrhills CI, who was familiar with the staff member and had logged in inmates on her patient log. However, the forensic coordinator indicated that the responsibility for linking and referring inmates to community-based care was not hers, but resided with the host agency, FDOC. In an interview, the forensic coordinator in FDCF District V, which encompasses Zephyrhills CI, indicated that the DDTP there had not contacted her. The absence of this link limited the ability of DDTP staff at Zephyrhills CI to select community-based post-release services to assure inmates' access to services, or even to examine the range of services available to offenders. Also, FDOC staff did not develop a community resource directory.

There was no attempt at Jefferson CI to conduct pre-release planning or to locate

post-release services. Interviews with forensic coordinators in the surrounding area indicated that most had poor relationships with FDOC in coordinating aftercare services for inmates. One forensic coordinator indicated that she had never heard of the DDTP. In addition, she wondered if the local judges were aware of the program, and she indicated that if they were, they might refer offenders.

Conclusions and Recommendations

The FDOC case demonstrates that, just as the appropriate operation of each DDTP unit depends upon many other units within FDOC, so successful implementation of such a program depends upon the cooperative efforts of staff in many parts of an agency the size of FDOC. The difficulties which FDOC encountered in implementing the new program illustrate the consequences of failing to address adequately the operational interdependence between the DDTP and other departmental entities. Throughout the planning and implementation processes, decisions regarding most aspects of the new DDTP influenced, and even constrained, decisions about other aspects of the program. This principle, which is demonstrated in every program start-up, is especially salient in the present case, in which the needs of both the segregated treatment program and numerous other entities within FDOC had somehow to be met. Each major program process represents a host of specific responsibilities and implies the need to prepare staff and facilities for new patterns of coordinated activity.

As commonly occurs when a new program is implemented within a large service bureaucracy, the framework of existing relationships and priorities within FDOC constrained both what could be done and the procedures available for getting things done. Many examples

occurred as FDOC planned and established the DDTP units. For example, because of the distance to the training site, administrators and security staff from Jefferson CI and classification staff from more distant institutions did not attend the program's main training event; this contributed to later difficulties in inmate recruitment to the DDTP and in the development of working relationships between DDTP treatment staff and security staff. In another instance, a desirable adjustment in the treatment schedule was precluded by the fixed schedule of institutional security routines. Each of these occurrences demonstrated the interdependence of nearly every aspect of planning, implementation and operation of the new DDTP.

Site Selection

FDOC administrators selected and subsequently rejected in turn each of two facilities as sites for the men's DDTP unit. The same occurred in locating the women's unit. Beyond reference to faulty locks, the issue of security, and the adequacy of treatment space, however, little was disclosed to researchers concerning the site selection process[5]. Despite this, several lessons can be drawn from this case.

The location of a facility in relation to others in a state system and to population centers from which significant proportions of all inmates come should be a fundamental consideration in selecting a facility at which to establish a treatment unit. Program location influences inmate and

[5] The apparent reluctance of some FDOC administrators to openly discuss concerns with IHHSR research staff is well illustrated by an occurrence in April 1997, when the DDTP was still at the planning stage. The BSAT bureau chief invited one IHHSR researcher to attend a meeting at Charlotte CI (one of the initially selected DDTP sites, but which had experienced recent problems with cell locks). The purpose of the meeting was to discuss alternative DDTP sites; the researcher accepted immediately. Within two hours, however, the BSAT chief telephoned again to explain that, because the MHP director objected to the presence of any non-FDOC personnel at the meeting, the researcher could come, but would have to wait outside.

staff recruitment, the logistics and cost of inmate transfers, the possibility of in-reach services by external providers, and the proximity and availability of agencies that may serve inmates during both the final, community-based phase of treatment and thereafter.

At a more microscopic level, site selection should consider the security levels of prospective facilities, the adequacy of space for treatment–including appropriate space for individual counseling–and other staff and administrative functions, and the availability of psychiatric crisis services. The presence of other related programs and staff may represent additional considerations, depending upon the anticipated approach to treatment and staffing in the new program unit.

Screening and Referral

As a departmental undertaking, this FDOC program illustrates the difficulties that are likely to arise if those staff responsible for assessing and referring inmates have received little or no training specifically for these tasks, and/or when the referral process is begun before referral criteria are clarified for those who will use them. It is generally appropriate to revise eligibility or referral criteria as program experience dictates. On the other hand, as demonstrated in this program, the appropriateness of a set of criteria cannot be effectively appraised if they and the specialized treatment program for which they were established are poorly understood by those responsible for applying the criteria.

In all likelihood, some consensus on the interpretation and relative weight of criteria will eventually be reached, either through the efforts of staff such as the FDOC Regional Substance Abuse Consultants and DDTP unit directors, or through the trial-and-error process of attempting

to use the criteria. But if broad participation in both developing and disseminating referral criteria can be assured, then it is more likely that the criteria will be understood and applied uniformly, and that they will be adequately tested in practice before being discarded or revised.

Staff Training

The desirability of more comprehensive training, in terms of both content and the types of staff who are trained, is suggested by the difficulties the new DDTP units encountered in interactions with units at other FDOC facilities to identify and recruit appropriate inmates to the program. The successful conduct of these interactions could not be assured by brief training focused on the characteristics, needs and treatment of the dually diagnosed. Ideally, the training would have included specific instruction regarding the procedures to be used to identify and refer inmates to the DDTP. Unfortunately, owing to a severely compressed implementation schedule, neither the screening and referral procedures, nor the criteria for DDTP admission had been clearly defined by the time the training occurred. As a result, most trainees expressed concern that the training had not included instruction in the activities they must carry out to assure that the DDTP and its working relationships with other departmental entities would function as intended.

Aftercare

The inadequate development of links with agencies and service providers outside FDOC appears, like other difficulties, to have resulted from reliance on an overly general plan, and the related failure to address the many detailed concerns and arrangements necessary to assure inmates' effective transition to community-based service systems. The limited participation of

entities at higher administrative levels within FDOC in efforts to establish these links suggests that lack of oversight and managerial involvement in the implementation resulted in administrators at lower departmental levels having to establish these interagency links without much support or assistance from management.

Conclusion

Perhaps the most basic lesson to be drawn from the implementation of the DDTP by the FDOC is that planning is paramount. Although the department had developed a general implementation plan, it became apparent as the process moved forward that the plan did not reflect the complexity of the process. Also, by concentrating the focus of planning and implementation activity on the establishment of the DDTP units themselves, those who directed the process gave insufficient attention to assuring that other FDOC units with which the DDTP units would routinely interact were prepared. Problems which originated from the lack of detailed planning were exacerbated by a delay in the start of implementation activity.

Recommendations

The FDOC implementation of the DDTP offers a number of insights into difficulties that may arise if the plan for implementing this type of program is not sufficiently detailed, and if broad responsibility for implementation is delegated to lower organizational levels. The DDTP case provides a basis for several recommendations for improving the likelihood of avoiding such difficulties.

1) Early in implementation, assign responsibility for active oversight at a sufficiently high level in the department to assure timely and appropriate actions by each division and staff category for which the new program will result in new or additional responsibilities.

2) As early as possible, identify lines of authority over specific aspects of program implementation and subsequent operation.

3) Identify all staff categories for which the new program will result in new responsibilities; conduct appropriate training and instructions for each.

4) Provide follow-up in-service training to DDTP treatment staff, as well as to other staff who participate in screening or referring inmates to the DDTP. Allocate time at training events to enable participants to discuss their experience with the program and to identify and address their concerns about the DDTP and its interactions with other FDOC entities.

5) Give adequate attention, at sufficiently high departmental levels, to establishing the external links necessary to assure the effective movement of inmates from the institutional phases of the DDTP to the community-based final phase.

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Appendix A

Acronym List

AA	Alcoholics Anonymous
BDI	Beck Depression Inventory
BSAT	Bureau of Substance Abuse Treatment
CI	Correctional Institute
DCA	Department of Community Affairs
DEJT	Division of Education and Job Training
DHS	Division of Health Services
DARP	Drug Abuse Reporting Program
DDTP	Dual Diagnosis Treatment Program
DSM-IV	Diagnostic and Statistical Manual, Fourth Edition
DSSI	Drug Simple Screening Instrument
ECA	Epidemiologic Catchment Area
FDCA	Florida Department of Community Affairs
FDCF	Florida Department of Children and Families
FDOC	Florida Department of Corrections
FMHI	Florida Mental Health Institute
IHHSR	Institute for Health and Human Services Research
JCI	Jefferson Correctional Institute
MHP	Mental Health Program
NA	Narcotics Anonymous
NCASA	National Center on Addiction and Substance Abuses
NCS	National Comorbidity Survey
NIJ	National Institute of Justice
OBIS	Offender Base Information System
SAA	State Administrative Agency
SASSI	Substance Abuse Subtle Screening Inventory
SCL-90-R	Symptom Checklist - Revised
TOPS	Treatment Outcome Prospective Survey
USDJ	United States Department of Justice
ZCI	Zephyrhills Correctional Institute

Appendix B

DDTP Inmate by Offense Category and Program

Guidelines	Total		Zephyrhills CI		Jefferson CI	
Offense Category	Freq	%	Freq	%	Freq	%
Murder/Manslaughter	3	2.2	1	1.1	2	4.4
Sex	9	6.5	7	7.4	2	4.4
Robbery	16	11.5	11	11.7	5	11.1
Violent Personal	23	16.5	17	18.1	6	13.3
Burglary	37	26.6	26	27.7	11	24.4
Theft-Forgery-Fraud	18	12.9	14	14.9	4	8.9
Drugs	24	17.3	13	13.8	11	24.4
Weapons	1	.7	0	.0	1	2.2
Other	8	5.8	5	5.3	3	6.7
Total	139	100.0	94	100.0	45	100.0

Appendix C

DDTP Inmate by Diagnostic Category and Program

Diagnostic	Total		Zephyrhills CI		Jefferson CI	
Category	Freq	%	Freq	%	Freq	%
Anxiety	61	43.9	46	50.0	15	34.1
Mood Disorder	46	33.8	27	29.3	19	43.2
Organic Disorder	15	11.0	11	8.7	7	15.9
Schizophrenic Disorder	14	10.3	17	12.0	3	6.8
Total	136	100.0	92	100.0	44	100.0

Appendix D

Interview List

Central Office

01/20/98	Assistant Secretary of Security & Informational Management
02/03/98	Bureau Chief of Substance Abuse Program Services
02/03/98	Deputy Assistant Secretary of Education & Job Training
02/05/98	Assistant Secretary of Education & Job Training
02/06/98	Correctional Program Administrator of Substance Abuse Program Services
02/06/98	Operations & Management Consultant II (Fiscal) of Substance Abuse Program Services
02/06/98	Operations & Management Consultant II of Substance Abuse Program Services
02/23/98	Senior Human Services Program Specialist
02/25/98	Assistant Secretary of Health Services
03/02/98	Director of Mental Health Services
03/12/98	Deputy Assistant Secretary of Security Informational Management
03/20/98	Bureau Chief of Inmate Classification & Management
03/23/98	Correctional Classification Program Administrator
03/24/98	Assistant Secretary of Security & Institutional Management
03/31/98	Secretary
04/02/98	Correctional Classification Services Administrator
04/02/98	Correctional Classification Services Assistant Administrator
04/05/98	Chief of Health Services
04/06/98	Bureau Chief of Health Services
10/12/98	Bureau Chief of Inmate Classification & Management
10/12/98	Correctional Classification Services Administrator
10/12/98	Assistant Secretary of Security & Informational Management
10/12/98	Correctional Program Administrator of Substance Abuse Program Services
10/12/98	Director of Mental Health Services
10/13/98	Bureau Chief of Security & Institutional Management
10/13/98	Operations & Management Consultant II (Fiscal) of Substance Abuse Program Services
10/14/98	Operations & Management Consultant II of Substance Abuse Program Services
10/21/98	Secretary
10/22/98	Deputy Assistant Secretary of Education & Job Training

Regional

12/09/97	Region I Director
12/16/97	Region I Director of Health Care
12/16/97	Region I Mental Health Consultant
12/16/97	Region I Substance Abuse Consultant
01/22/98	Region V Administrator
01/22/98	Region V Director
01/22/98	Region V Director of Education & Job Training
01/22/98	Region V Director of Health Care
01/22/98	Region V Mental Health Consultant
01/22/98	Region V Substance Abuse Consultant
09/09/98	Region I Director of Education & Job Training
09/09/98	Region I Director of Health Care
09/09/98	Region I Mental Health Consultant
09/09/98	Region I Substance Abuse Consultant
09/10/98	Region V Director
09/10/98	Region V Director of Education & Job Training
09/10/98	Region V Director of Health Care
09/10/98	Region V Mental Health Consultant
09/10/98	Region V Substance Abuse Consultant

Jefferson Correctional Institution

11/10/97	Senior Psychologist of Dual Diagnosis Program
11/10/97	Dual Diagnosis Program Treatment Staff
12/03/97	Business Manager
12/03/97	Superintendent
12/03/97	Corrections Staff
01/06/98	Senior Psychologist of Mental Health Program
01/06/98	Assistant Superintendent
01/06/98	Senior Staff of Substance Abuse Program
01/06/98	Substance Abuse Treatment Staff
01/06/98	Mental Health Treatment Staff
05/14/98	Substance Abuse Treatment Staff
06/24/98	Substance Abuse Treatment Staff
09/10/98	Senior Psychologist of Dual Diagnosis Program
09/10/98	Dual Diagnosis Program Treatment Staff
09/10/98	Corrections Staff

09/15/98 Senior Staff Substance Abuse Program

Zephyrhills Correctional Institution

11/18/97 Superintendent
11/18/97 Senior Psychologist of Dual Diagnosis Program
11/18/97 Senior Psychologist of Mental Health Program
11/18/97 Senior Staff of Substance Abuse Program
11/18/97 Substance Abuse Treatment Staff
11/18/97 Dual Diagnosis Program Treatment Staff
11/18/97 Mental Health Treatment Staff
11/18/97 Corrections Staff
01/21/98 Business Manager
02/12/98 Assistant Superintendent
09/17/98 Assistant Superintendent
09/17/98 Business Manager
09/17/98 Superintendent
09/29/98 Senior Psychologist of Dual Diagnosis Program
09/29/98 Senior Psychologist of Mental Health Program
09/29/98 Dual Diagnosis Program Treatment Staff

Ancillary

02/16/98 Florida Mental Health Institute Consultant, University of South Florida
04/30/98 Florida Department of Community Affairs
09/28/98 Forensic Staff, District II
09/30/98 Florida Mental Health Institute Consultant, University of South Florida
10/01/98 Forensic Staff, District VI
10/08/98 Forensic Staff, District V
11/09/98 Florida Department of Community Affairs

Appendix E

Interview Questionnaires for the Florida Department of Corrections Dual Diagnosis Program

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A. Central Office Interviews

B. Regional Office Interviews

C. Jefferson Correctional Institution Interviews

D. Zephyrhills Correctional Institution Interviews

E. Ancillary Interviews

First Round Interview Questions

Central Office Interviews:

Bureau Chief of Substance Abuse Program Services (02/03/98)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your work experience since being here?

2. What is your educational background?

3. Describe your work experience in substance abuse treatment?

4. Describe your work experience in mental health treatment?

5. What was your role in the decision to seek federal funding for the Dual Diagnosis Program in the Department?

6. What was your role in the implementation of the Dual Diagnosis Program in the Department?

7. What role did you play in recruiting staff for the Dual Diagnosis Program?

8. What were the most important factors in selecting or recruiting staff for the Dual Diagnosis Program?

9. Were you looking for specific types of prior experiences, a willingness to work with the dually-diagnosed, particular educational background, or was there nothing in particular that had been identified as more less desirable in the choice of staff?

10. Did you find that some applicants lost interest in the job once they learned more about the proposed Dual Diagnosis Program?

11. What proportion of staff lost interest in the job once they learned more about the proposed Dual Diagnosis Program?

12. When did you begin to recruit program staff for the Dual Diagnosis Program?

13. During the implementation of the Dual Diagnosis Program at FDOC, what personnel problems and difficulties have you experienced?

14. During the implementation of the Dual Diagnosis Program at FDOC, what kind of direction and input have you provided to the Regional Office?

15. What were the main aspects of the implementation process that the bureau of substance abuse services depended upon the Regional Offices to handle?

16. During the implementation of the Dual Diagnosis Program at FDOC, what kind of direction and input have you provided to Jefferson and Zephyrhills Correctional Institutions?

17. Who is your supervisor? What kind of direction and input have you received from your supervisor and upper management in implementing the Dual Diagnosis Program?

18. What is the Mission and Habitability Committee?

19. What role has the Mission and Habitability Committee played in the implementation of the Dual Diagnosis Program?

20. What is the Executive Leadership Committee?

21. In general, what role has the Executive Leadership Committee played in the implementation of the Dual Diagnosis Program?

22. How different is the Dual Diagnosis Program from other substance abuse and mental health programs provided at FDOC?

23. In general, what is the difference between inmates on the Dual Diagnosis Unit and inmates in traditional mental health and substance abuse treatment programs at FDOC?

24. During the management team meeting on the Dual Diagnosis Program, staff indicated that there was a need to modify physical space and allocate additional resources at Jefferson C.I. and Zephyrhills C..I. to treat dually-diagnosed inmates. What role did your office play in resolving the problem of insufficient space, furniture, and equipment for the Dual Diagnosis Program Unit?

25. During the management team meetings and teleconferences you have initiated at least three separate plans to modify treatment space at Zephyrhills C.I., could you describe those plans and explain what happened to them?

26. Although the Dual Diagnosis Program has been described as a substance abuse program, there is no substance abuse treatment staff working in the programs. Why is there no substance abuse treatment staff assigned to the Dual Diagnosis Program?

27. The staff in the Dual Diagnosis Program appears to have more work experience in mental health than substance abuse treatment, how did this occur?

28. Given the lack of substance abuse treatment staff in the Dual Diagnosis Program, how do you know that integrated treatment is taking place?

29. What is the most important way the cross-training has helped the implementation of the Dual Diagnosis Program?

30. Why do you think training was sufficient?

31. Describe the manner in which you go about monitoring the implementation of the Dual Diagnosis Program?

32. During the cross training security staff was invited to participate in the Dual Diagnosis Program. Why has there been little involvement of security staff in the Dual Diagnosis Program at each facility?

33. What elements of the Dual Diagnosis Program have you implemented thus far?

34. How did the Division of Health Services come to play a role in the implementation of the Dual Diagnosis Program?

35. Why isn't nursing staff assigned to the Dual Diagnosis Program?

36. Why isn't psychiatric staff assigned to the Dual Diagnosis Program?

37. Why was a grant coordinator hired for the Dual Diagnosis Program?

38. Recently, you decided to increase the number of patients at Jefferson C.I. from 40 to 60. Why did you decide to increase the number of patients participating in the Dual Diagnosis Program at Jefferson C. I.?

39. During the management team meetings and teleconferences there was discussion about providing dual diagnosis treatment during evening hours. Why isn't treatment being provided during the evening hours?

40. During the first two months of the program Bob Trifiletti, the Dual Diagnosis Program Supervisor, has been without a telephone. Why was Bob Trifiletti without a telephone for so long?

41. Throughout the implementation of this program, there has been concern about the low number of inmates participating in treatment at each Dual Diagnosis Programs. What do you think accounts for the low number of inmates being referred to the Dual Diagnosis Program thus far?

42. How is the problem of a low census in the programs being addressed by your office?

43. During our management team meeting, discussion occurred concerning the use of peer facilitators. What progress have you made thus far in recruiting and using peer facilitators?

44. Who makes referrals to the Dual Diagnosis Program?

45. How are referrals to the Dual Diagnosis Program Processed?

46. How are dually-diagnosed inmates screened and identified?

47. What are the diagnostic criteria necessary for an inmate to enter the Dual Diagnosis Program?

Deputy Assistant Secretary of Education & Job Training (02/03/98)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your work experience since being at FDOC?

2. What kind of work experience do you have in substance abuse treatment?

3. What was your role in implementing the Dual Diagnosis Program in the Department?

4. What was your role in the implementation of the Dual Diagnosis Program in the Department?

5. What role did you play in recruiting program staff for the Dual Diagnosis Program?

6. While implementing the Dual Diagnosis Program at FDOC, what personnel problems and difficulties have you experienced?

7. While implementing the Dual Diagnosis Program at FDOC, what kind of direction and input have you provided to the Regional Offices?

8. While implementing the Dual Diagnosis Program at FDOC, what kind of direction and input have you provided to Jefferson and Zephyrhills Correctional Institutions?

9. Who is your supervisor? What kind of direction and input have you received from upper management in implementing the Dual Diagnosis Program?

10. What role does the Mission and Habitability Committee play in the implementation of the Dual Diagnosis Program?

11. What role does the Executive Leadership Committee play in the implementation of the Dual Diagnosis Program?

12. How is the Dual Diagnosis Program different from other substance abuse and mental health programs provided at the Department of Corrections?

13. During management team meetings, the Dual Diagnosis Program staff indicated a lack of physical space and resources at Jefferson to treat the dually-diagnosed inmates. What role did your office play in resolving the problem of insufficient space, furniture, and equipment for the Dual Diagnosis Program Unit?

14. During one of the teleconferences held at FDOC's central office, you felt relatively assured renovations to the dormitory that house the Dual Diagnosis Program at Zephyrhills C. I. would take place? Whatever happened to your recommended renovations at Zephyrhills C. I.? (October 14 or 28, 1997 teleconference).

15. How has the Dual Diagnosis Program affected the activity and responsibility of the Division of Education and Job Training?

16. The responsibility of the Division of Education and Job Training seems to be unrelated to substance abuse issues. How is substance abuse treatment related to educational or vocational training?

17. Throughout the implementation of the Dual Diagnosis Program there has been some confusion over whether the Mental Health Program Office or the Bureau of Substance Abuse Treatment has authority over the Dual Diagnosis Program? Explain who has authority over the Dual Diagnosis Program and the basis of your explanation

18. How have the cross-training helped in implementing the Dual Diagnosis Program?

19. Throughout the implementation of these programs, there has been concern over the low number of inmates participating in treatment at each Dual Diagnosis Site. What do you think accounts for the small number of inmates being referred to the Dual Diagnosis Programs?

Assistant Secretary of Education & Job Training (02/05/98)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your work experience since being at FDOC?

2. Describe your work experience in substance abuse treatment?

3. What was your role in the decision to implement the Dual Diagnosis Program in the Department?

4. What was your role in the implementation of the Dual Diagnosis Program in the Department?

5. What role did you play in recruiting program staff for the Dual Diagnosis Program?

6. While implementing the Dual Diagnosis Program at FDOC, what personnel problems and difficulties have you experienced?

7. While implementing the Dual Diagnosis Program at FDOC, what kind of direction and input have you provided to the Regional Offices?

8. While implementing the Dual Diagnosis Program at FDOC, what kind of direction and input have you provided to Jefferson and Zephyrhills Correctional Institutions?

9. Who is your supervisor? What kind of direction and input have you received from upper management in implementing the Dual Diagnosis Program?

10. What role does the Missions and Habitability Committee have in the implementation of the Dual Diagnosis Program?

11. What role does the Executive Leadership Committee play in the implementation of the Dual Diagnosis Program?

12. How is the Dual Diagnosis Program different from other substance abuse and mental health programs provided at FDOC?

13. During management team meetings, the Dual Diagnosis Program staff indicated a lack of physical space and resources at Jefferson to treat the dually-diagnosed inmates. What role did your office play in resolving the problem of insufficient space, furniture, and equipment for the Dual Diagnosis Program Unit?

14. It appears that you were actively involved in initiating renovations to the dormitory that houses the Dual Diagnosis Program at Zephyrhills C. I. What happened to your recommendations to renovate the dormitory at Zephyrhills C.I.? (Memorandums to Nancy Wittenberg dated September 8, 1997, entitled renovations at Zephyrhills C. I. , Visit to Zephyrhills C. I.).

15. How has the Dual Diagnosis Program affected the activity and responsibility of the Division of Education and Job Training?

16. The overall responsibility of the Division of Education and Job Training seems to be unrelated to substance abuse issues. How is substance abuse treatment related to educational and vocational training?

17. Who is ultimately responsible for implementing of the Dual Diagnosis Program?

18. How have the cross-training assisted in implementing the Dual Diagnosis Program?

19. Throughout the implementation of these programs, there has been concern over the low number of inmates participating in treatment at each Dual Diagnosis Site. What do you think accounts for the small number of inmates being referred to the Dual Diagnosis Programs? .

Correctional Program Administrator of Substance Abuse Program Services (02/06/98)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your work experience here?

2. Describe your work experience in substance abuse treatment?

3. What has been your role in the implementation of the Dual Diagnosis Programs?

4. What role did you play in recruiting staff for the Dual Diagnosis Program?

5. During the implementing of the Dual Diagnosis Program at FDOC, what personnel problems and difficulties have you experienced?

6. During the implementing of the Dual Diagnosis Program at FDOC, what kind of direction and input have you provided to the Regional Office?

7. During the implementing of the Dual Diagnosis Program at FDOC, what kind of direction and input have you provided to Jefferson and Zephyrhills Correctional Institutions?

8. Who is your supervisor? What kind of direction and input have you received from your supervisor and upper management in implementing the Dual Diagnosis Program?

9. What role has the Mission and Habitability Committee played in the implementation of the Dual Diagnosis Program?

10. What role has the Executive Leadership Committee played in the implementation of the Dual Diagnosis Program?

11. How is the Dual Diagnosis Program different from other substance abuse and mental health programs provided at the Department of Corrections?

12. During the cross training security staff was invited to participate in the Dual Diagnosis Program. Why has there been little involvement of security staff in the Dual Diagnosis Program at each facility?

13. Do you foresee any expansion of the treatment role of security staff on the Dual Diagnosis Units?

14. What role does the Division of Health Services play in the implementation of the Dual Diagnosis Program?

15. How do you monitor the implementation of the Dual Diagnosis Program?

16. How have you communicated with treatment staff on the Dual Diagnosis Unit?

17. What are the differences between inmates on the Dual Diagnosis Unit and inmates in traditional mental health and substance abuse treatment programs at FDOC?

18. The staff in the Dual Diagnosis Program appears to have more work experience in mental health than substance abuse treatment. How are you assured that integrated treatment is taking place in the programs?

19. Why isn't nursing staff assigned to the Dual Diagnosis Program?

20. Why isn't psychiatric staff assigned to the Dual Diagnosis Program?

21. Recently, you decided to increase the number of patients at the Jefferson program from 40 to 60. Why did you decide to increase the number of patients participating in the Dual Diagnosis Program at Jefferson C. I.?

22. During the management team meeting there was discussion about providing Dual Diagnosis Program treatment during evening hours. Why isn't the program providing treatment during the evening hours?

23. During the first two months of the program Bob Trifiletti, the Dual Diagnosis Program Supervisor, was without a telephone. Why was Bob without a telephone for so long?

24. Throughout the few months of this program, there has been concern about the low number of inmates participating in treatment at each Dual Diagnosis Site. What do you think accounts for the small number of referrals and low number of inmates participating in the Dual Diagnosis Program thus far?

25. How is the problem of low census being addressed by your office?

26. Recently, your office made an amendment to the Dual Diagnosis Grant. Why was the grant amendment made?

Operations & Management Consultant II (Fiscal) of Substance Abuse Program Services (2/6/98)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your work experience since being at FDOC?

2. Describe your work experience in substance abuse treatment?

3. What has been your role in the implementation of the Dual Diagnosis Programs?

4. What role did you play in recruiting staff for the Dual Diagnosis Program?

5. During the implementing of the Dual Diagnosis Program at FDOC, what kind of direction and input have you provided to the Regional Office?

6. During the implementing of the Dual Diagnosis Program at FDOC, what kind of direction and input have you provided to Jefferson and Zephyrhills Correctional Institutions?

7. Who is your supervisor? What kind of direction and input have you received from your supervisor and upper management in implementing the Dual Diagnosis Program?

8. As fiscal manager for this office, what contact if any do, you have with the Dual Diagnosis Program?

9. What is your role in this contact?

10. How do you communicate with treatment staff on the Dual Diagnosis Unit?

11. Since the start of the Dual Diagnosis Program implementation, what has been the most unexpected issues and problems you have encountered?

12. Since the implementation of the Dual Diagnosis Program, what issues have been the most difficult to resolve?

13. During the management team meetings on the dual Diagnosis Program, staff indicated that there was a lack of physical resources at Jefferson to treat the dually-diagnosed inmates. How has your office assisted in resolving the problem of not having enough resources to treat the dually-diagnosed inmates?

14. Describe how fiscal allocations are made to the Dual Diagnosis Program.
15. Recently your office submitted a formal amendment to The Department of Community Affairs in relations to the Dual Diagnosis Program Grant? Why was an amendment to the grant application submitted?

Operations & Management Consultant II of Substance Abuse Program Services (02/06/98)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your work experience since being at FDOC?

2. Describe your work experience in substance abuse treatment?

3. What was your role in the implementation of the Dual Diagnosis Programs in the Department?

4. What role did you play in recruiting staff for the Dual Diagnosis Program?

5. In recruiting staff for the Dual Diagnosis Units, what were the most important factors in selecting individuals?

6. Were you looking for specific types of prior experiences, a willingness to work with the dually-diagnosed, particular educational background, or was there nothing in particular that had been identified as more less desirable in the choice of staff?

7. Did you find that some applicants lost interest in the job once they learned more about the proposed Dual Diagnosis Program?

8. If yes, about what proportion of staff lost interest in the job once they learned more about the proposed Dual Diagnosis Program?

9. During the implementing of the Dual Diagnosis Program at FDOC, what personnel problems and difficulties have you experienced?

10. During the implementing of the Dual Diagnosis Program at FDOC, what kind of direction and input have you provided to the Regional Staff?

11. During the implementing of the Dual Diagnosis Program at FDOC, what kind of direction and input have you provided to Jefferson and Zephyrhills C. I.?

12. Who is your supervisor? What kind of direction and input have you received from your supervisor and upper management while implementing the Dual Diagnosis Program?

13. What has been the role of the Mission and Habitability Committee in the implementation of the Dual Diagnosis Program?

14. What has been the role of the Executive Leadership Committee in the implementation of the Dual Diagnosis Program?

15. How different is the Dual Diagnosis Program from other substance abuse and mental health programs provided at the Department of Corrections?

16. How has the cross-training helped in implementing of the Dual Diagnosis Program?

17. During the cross training security staff was invited to participate. Why has there been little involvement of security staff in the Dual Diagnosis Program at each facility?

18. How has the Security Staff assisted the Dual Diagnosis Program in providing treatment to dually-diagnosed inmates?

19. How do you monitor the implementation of the Dual Diagnosis Program?

20. How do you communicate with treatment staff on the Dual Diagnosis Unit?

21. What are the differences between inmates on the Dual Diagnosis Unit and inmates in traditional mental health and substance abuse treatment programs at FDOC?

22. During the management team meeting on the Dual Diagnosis Program, staff indicated that there was a need to modify physical space and allocate additional resources at Jefferson C. I. and Zephyrhills C. I. to treat dually-diagnosed inmates. What role did your office play in resolving the problem of insufficient spaced, furniture, and equipment for the Dual Diagnosis Program Unit?

23. What role has the Division of Health Services played in the implementation of the Dual Diagnosis Program?

24. The staff in the Dual Diagnosis Program appear to have more experience in mental health treatment than substance abuse treatment. How are you assured that integrated treatment is taking place in the programs?

25. Although the Dual Diagnosis Program has been described as a substance abuse program, there are no substance abuse treatment staff working in the programs. Why are there no substance abuse treatment staff assigned to the Dual Diagnosis Program?

26. Why aren't nursing staff assigned to the Dual Diagnosis Program?

27. Why aren't psychiatric staff assigned to the Dual Diagnosis Program?

28. Recently, you decided to increase the number of patients at Jefferson C. I. from 40 to 60. Why did you decide to increase the number of inmates participating in the Dual Diagnosis Program at Jefferson C. I.?

29. Was the decision to increase the number of inmates participating in the Dual Diagnosis Program at Jefferson C. I. based on program design considerations or non-program factors (e.g. bed or space utilization)

30. During the management team meeting there was discussion about providing treatment during evening hours. What happen to the idea of the Dual Diagnosis Program providing treatment during the evening hours?

31. During the first two months of the program Bob Trifiletti, the Dual Diagnosis Program Supervisor, was without a telephone. Why was Bob without a telephone for so long?

32. Throughout the few months of this program, there has been concern about the low number of inmates participating in treatment at each site. What do you think accounts for the small number of referrals and low number of inmates participating in the Dual Diagnosis Program thus far?

33. How has your office been directly involved in any efforts to increase the census or to encourage more referrals?

34. By whom and how are referrals made to the Dual Diagnosis Program?

35. How are dually-diagnosed inmates screened and identified?

36. Recently your office began training staff on a new drug screening instrument, why was there a need to implement such an instrument?

37. What are the necessary diagnostic criteria for an inmate to enter the Dual Diagnosis Program?

38. Recently, your office made a formal amendment to the Dual Diagnosis Grant. Why was the grant amendment made?

39. During the management team meetings and teleconferences you have initiated at least three separate plans to modify treatment space at Zephyrhills C.I., could you describe those plans and explain what happened to them?

40. What elements of the Dual Diagnosis Program do you regard as fully implemented?

41. During our management team meeting, discussion occurred concerning the use of peer facilitators. What progress have you made thus far in recruiting and using peer facilitators?

42. During the week of December 1, 1997, John Burke recommended that no physical modifications be made to the treatment site at Zephyrhills C.I., describe how you have participated in that process.

43. What is the current status of the diagnostic testing for the Dual Diagnosis Program?

Senior Human Services Program Specialist (02/23/98)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your work experience here?

2. Describe your work experience in substance abuse treatment?

3. Describe your work experience in mental health treatment?

4. What has been your main role in the implementation of the Dual Diagnosis Programs?

5. While implementing the Dual Diagnosis Program at FDOC, what problems and difficulties have you experienced as it relates to inmate movement?

6. While implementing the Dual Diagnosis Program at FDOC, what kind of direction and input have you provided to the Regional Offices?

7. While implementing the Dual Diagnosis Program at FDOC, what kind of direction and input have you provided to Jefferson and Zephyrhills Correctional Institutions?

8. Who is your supervisor? What kind of direction and input have you received from upper management in implementing the Dual Diagnosis Program?

9. What role does the Mission and Habitability Committee play in the implementation of the Dual Diagnosis Program?

10. What role does the Executive Leadership Committee play in the implementation of the Dual Diagnosis Program?

11. How is the Dual Diagnosis Program different from other substance abuse and mental health programs provided at the Department of Corrections?

12. What role does the Division of Health Services play in the implementation of the Dual Diagnosis Program?

13. How do you monitor inmate movement as it relates to the implementation of the Dual Diagnosis Program?

14. How have you communicated with treatment staff on the Dual Diagnosis Unit?

15. What are the differences between inmates on the Dual Diagnosis Unit and inmates in traditional mental health and substance abuse treatment programs at FDOC?

16. Recently, the department decided to increase the number of patients at the Jefferson program from 40 to 60. What are the main reasons for the expansion?

17. Throughout the few months of this program, there has been concern about the low number of inmates participating in treatment at each Dual Diagnosis Site. What do you think accounts for the small number of referrals and low number of inmates participating in the Dual Diagnosis Program thus far?

18. How is the problem of low census being addressed by your office?

Assistant Secretary of Health Services (02/25/98)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your work experience since being at FDOC?

2. What has been your experience with Substance Abuse Treatment Program Services?

3. What has been your experience with Mental Health Services?

4. What was your role in the decision to implement the Dual Diagnosis Program in the Department?

5. What was your role in the implementation of the Dual Diagnosis Program in the Department?

6. What role did you play in recruiting program staff for the Dual Diagnosis Program?

7. In recruiting staff for the Dual Diagnosis Units, what was the most important factor in selecting individuals?

8. Were you looking for specific types of prior experiences, attitudes or educational, or was there nothing in particular that had been identified as more less desirable in the choice of staff?

9. What proportion of staff lost interest in the job once they learned more about the proposed Dual Diagnosis Program?

10. During the implementing of the Dual Diagnosis Program at FDOC, what personnel problems and difficulties arose?

11. During the implementing of the Dual Diagnosis Program at FDOC, what kind of direction and input have you provided to the Regional Offices?

12. During the implementing of the Dual Diagnosis Program at FDOC, what kind of direction and input have you provided directly to Jefferson and Zephyrhills Correctional Institutions?

13. Who is your supervisor? What kind of direction and input have you received from upper management in implementing the Dual Diagnosis Program?

14. What is the role does the Missions and Habitability Committee in implementing the Dual Diagnosis Program?

15. What is the role does the Executive Leadership Committee in implementing the Dual Diagnosis Program?

16. How is the Dual Diagnosis Program different than other substance abuse and mental health programs provided at FDOC?

17. How has the Dual Diagnosis Program affected the activities and responsibilities of the Division of Heath Services?

18. The Bureau of Substance Abuse Program Services is currently in the Division of Education and Job Training. Why do you think Substance Abuse Program Services is in the Division of Education and Job Training as opposed to the Division of Health Services.

19. Throughout the implementation of the Dual Diagnosis Program there seems to have been some confusion over whether the Mental Health Program Office or the Bureau of Substance Abuse Treatment has authority over the Dual Diagnosis Program? Explain who has ultimate authority and responsibility for providing treatment to dually-diagnosed inmates, and give the basis for your explanation.

20. Throughout the implementation of these programs, there has been concern over the low number of inmates participating in treatment at each Dual Diagnosis Site. What do you think accounts for the small number of inmates being referred to the Dual Diagnosis Programs?

Director of Mental Health Services (03/02/98)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your work experience since being at FDOC?

2. Describe your work experience in substance abuse treatment?

3. Describe your work experience in mental health treatment?

4. What was your role in the implementation of the Dual Diagnosis Programs in the Department?

5. What role did you play in recruiting staff for the Dual Diagnosis Program?

6. In recruiting staff for the Dual Diagnosis Units, what was the most important factor in selecting individuals?

7. Were you looking for specific types of prior experiences, attitudes or educational, or was there nothing in particular that had been identified as more less desirable in the choice of staff?

8. Did you find that some applicants lost interest in the job once they learned more about the proposed Dual Diagnosis Program?

9. What proportion of staff lost interest in the job once they learned more about the proposed Dual Diagnosis Program?

10. What personnel problems and difficulties have you experienced so far?

11. During the implementing of the Dual Diagnosis Program at FDOC, what kind of direction and input have you provided to the Regional Staff?

12. During the implementing of the Dual Diagnosis Program at FDOC, what kind of direction and input have you provided directly to Jefferson and Zephyrhills C. I.?

13. Who is your supervisor? What kind of direction and input have you received from your supervisor and upper management while implementing the Dual Diagnosis Program?

14. What has been the role of the Mission and Habitability Committee in the implementation of the Dual Diagnosis Program?

15. What has been the role of the Executive Leadership Committee in the implementation of the Dual Diagnosis Program?

16. How different is the Dual Diagnosis Program from other substance abuse and mental health programs provided at the FDOC?

17. What do you think is the biggest difference between the Dual Diagnosis Program and traditional mental health and substance abuse programs provided at the FDOC?

18. How have the cross-training helped in implementing the Dual Diagnosis Program?

19. How has the Security Staff assisted the Dual Diagnosis Program in providing treatment to dually-diagnosed inmates?

20. How do you monitor the implementation of the Dual Diagnosis Program?

21. How do you communicate with treatment staff on the Dual Diagnosis Unit?

22. What are the differences between inmates on the Dual Diagnosis Unit and inmates in traditional mental health and substance abuse treatment programs at FDOC?

23. During the management team meeting on the Dual Diagnosis Program, staff indicated that there was a need to modify physical space and allocate additional resources at Jefferson C. I. and Zephyrhills C. I. to treat dually-diagnosed inmates. What role did your office play in resolving the problem of insufficient space, furniture, and equipment for the Dual Diagnosis Program Unit?

24. What role has the Division of Health Services played in the implementation of the Dual Diagnosis Program?

25. The staff in the Dual Diagnosis Program appears to have more experience in mental health treatment than substance abuse treatment. How are you assured that integrated treatment is taking place in the programs?

26. Although the Dual Diagnosis Program has been described as a substance abuse program, there is no substance abuse treatment staff working in the programs. Why is there no substance abuse treatment staff assigned to the Dual Diagnosis Program?

27. Why isn't nursing staff assigned to the Dual Diagnosis Program?

28. Why isn't psychiatric staff assigned to the Dual Diagnosis Program?

29. Recently, the department decided to increase the number of patients at the Jefferson program from 40 to 60. Can you tell me why the expansion was made?

30. Was the decision to increase the number of inmates participating in the Dual Diagnosis Program at Jefferson C. I. based on program design considerations or non program factors (e.g. bed or space utilization).

31. During the management team meeting there was discussion about providing treatment during evening hours. What happened to the idea of providing treatment during evening hours?

32. During the first two months of the program Bob Trifiletti, the Dual Diagnosis Program Supervisor, was without a telephone. Why was Bob without a telephone for so long?

33. Throughout the few months of this program, there has been concern about the low number of inmates participating in treatment at each Site. What do you think accounts for the small number of referrals and low number of inmates participating in the Dual Diagnosis Program thus far?

34. How has your office been directly involved in any efforts to increase the Dual Diagnosis Program census or to encourage more referrals?

35. By whom and how are referrals made to the Dual Diagnosis Program?

36. How are inmates with dual disorders screened and identified?

37. Recently your office began training staff on a new drug screening instrument, why was there a need to implement such an instrument?

38. What are the necessary diagnostic criteria for an inmate to enter the Dual Diagnosis Program?

39. What elements of the Dual Diagnosis Program do you regard as fully implemented?

40. During the week of December 1, 1997, John Burke recommended that no physical modifications be made to the treatment site at Zephyrhills C.I., describe how you participated in that process.

41. Where is the use of standardized instruments to assess inmates' symptoms or progress in treatment?

Deputy Assistant Secretary of Security & Informational Management (03/12/98)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your work experience since being at FDOC?

2. What was your role in implementing the Dual Diagnosis Program in the Department?

3. What was your role in the implementation of the Dual Diagnosis Program in the Department?

4. What role did you play in recruiting program staff for the Dual Diagnosis Program?

5. In recruiting staff for the Dual Diagnosis Units, what was the most important factor in selecting individuals?

6. Were you looking for specific types of prior experiences, a willingness to work with the dually-diagnosed, particular educational background, or was there nothing in particular that had been identified as more or less desirable in the choice of staff?

7. Did you find that some applicants became disinterested in the job once they had learned more about the proposed Dual Diagnosis Program?

8. What proportion of applicants lost interest in the job once they had learned more about the proposed Dual Diagnosis Program?

9. While implementing the Dual Diagnosis Program at FDOC, what personnel problems and difficulties have you experienced?

10. While implementing the Dual Diagnosis Program at FDOC, what kind of direction and input have you provided to the Regional Offices?

11. While implementing the Dual Diagnosis Program at FDOC, what kind of direction and input have you provided to Jefferson and Zephyrhills Correctional Institutions?

12. Who is your supervisor? What kind of direction and input have you received from upper management in implementing the Dual Diagnosis Program?

13. What role does the Mission and Habitability Committee play in the implementation of the Dual Diagnosis Program?

14. What role does the Executive Leadership Committee play in the implementation of the Dual Diagnosis Program?

15. How is the Dual Diagnosis Program different from other substance abuse and mental health programs provided at the Department of Corrections?

16. During management team meetings, the Dual Diagnosis Program staff indicated a lack of physical space and resources at Jefferson to treat the dually-diagnosed inmates. What role did your office play in resolving the problem of insufficient space, furniture, and equipment for the Dual Diagnosis Program Unit?

17. During one of the teleconferences held at FDOC's central office, you felt relatively assured renovations to the dormitory that house the Dual Diagnosis Program at Zephyrhills C. I. would take place? Whatever happened to your recommended renovations at Zephyrhills C. I.? (October 14 or 28, 1997 teleconference).

18. How has the Dual Diagnosis Program affected the activity and responsibility of the Division of Security & Institutional Management?

19. Throughout the implementation of the Dual Diagnosis Program there has been some confusion over whether the Mental Health Program Office or the Bureau of Substance Abuse Treatment has authority over the Dual Diagnosis Program? Explain who has authority over the Dual Diagnosis Program and the basis of your explanation.

20. During the cross training security staff members were invited to participate in the Dual Diagnosis Program. Why has there been little involvement of security staff in the Dual Diagnosis Program at each facility?

21. How have the cross-training helped in implementing the Dual Diagnosis Program?

22. Do you foresee any expansion of the treatment role of security staff on the Dual Diagnosis Units?

23. What role does the Division of Health Services play in the implementation of the Dual Diagnosis Program?

24. Does your office have responsibility to monitor the implementation of the Dual Diagnosis Program?

25. What methods are you using to monitor implementation?

26. How have you communicated with treatment staff on the Dual Diagnosis Unit

27. The staff in the Dual Diagnosis Program appears to have more work experience in mental health than substance abuse treatment. How are you assured that integrated treatment is taking place in the programs?

28. Although the Dual Diagnosis Program has been described as a substance abuse program, there is no substance abuse treatment staff working in the programs. Why is there no substance abuse treatment staff assigned to the Dual Diagnosis Program?

29. Recently, the department decided to increase the number of patients at the Jefferson program from 40 to 60. What was the main reason for that decision?

30. Throughout the implementation of these programs, there has been concern over the low number of inmates participating in treatment at each Dual Diagnosis Site. What do you think accounts for the small number of inmates being referred to the Dual Diagnosis Programs?

Bureau Chief of Inmate Classification & Management (03/20/98)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your work experience here?

2. Describe your work experience in mental health treatment?

3. Describe your work experience in substance abuse treatment?

4. What has been your role in the implementation of the Dual Diagnosis Programs?

5. What role did you play in recruiting staff for the Dual Diagnosis Program?

6. During the implementing of the Dual Diagnosis Program at FDOC, from an institutional management perspective what personnel problems and difficulties have you experienced?

7. During the implementing of the Dual Diagnosis Program at FDOC, from an institutional management perspective what kind of direction and input have you provided to the Regional Office?

8. During the implementing of the Dual Diagnosis Program at FDOC, from an institutional management perspective what kind of direction and input have you provided to Jefferson and Zephyrhills Correctional Institutions?

9. Who is your supervisor? What kind of direction and input have you received from your supervisor and upper management in implementing the Dual Diagnosis Program?

10. What role has the Mission and Habitability Committee played in the implementation of the Dual Diagnosis Program?

11. What role does institutional management play on that committee?

12. What role has the Executive Leadership Committee played in the implementation of the Dual Diagnosis Program?

13. What role does institutional management play on that committee?

14. How is the Dual Diagnosis Program different from other substance abuse and mental health programs provided at the Department of Corrections?

15. During the cross training institutional management staff was invited to participate in the Dual Diagnosis Program. Why has there been little involvement of institutional management staff in the Dual Diagnosis Program at each facility?

16. Do you foresee any expansion of the treatment role of institutional management staff on the Dual Diagnosis Units?

17. What role does the Division of Health Services play in the implementation of the Dual Diagnosis Program?

18. How do you monitor the implementation of the Dual Diagnosis Program?

19. How have you communicated with treatment staff on the Dual Diagnosis Unit?

20. What are the differences between inmates on the Dual Diagnosis Unit and inmates in traditional mental health and substance abuse treatment programs at FDOC?

21. Recently, you decided to increase the number of patients at the Jefferson program from 40 to 60. Why did the department decide to increase the number of patients participating in the Dual Diagnosis Program at Jefferson C. I.?

22. What effect did the decision to increase the number of patients at the Jefferson program have on your office's involvement with the Dual Diagnosis Program?

23. During the management team meetings, there was discussion about providing Dual Diagnosis Program treatment during evening hours. What sort effect does such a decision have on institutional management staff.

24. Throughout the few months of this program, there has been concern about the low number of inmates participating in treatment at each Dual Diagnosis Site. What do you think accounts for the small number of referrals and low number of inmates participating in the Dual Diagnosis Program thus far?

25. How is the problem of low census being addressed by your office?

Correctional Classification Program Administrator (03/23/98)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your work experience here?

2. Describe your work experience in mental health treatment?

3. Describe your work experience in substance abuse treatment?

4. What has been your role in the implementation of the Dual Diagnosis Programs?

5. What role did you play in recruiting staff for the Dual Diagnosis Program?

6. During the implementing of the Dual Diagnosis Program at FDOC, from a transitional program perspective what personnel problems and difficulties have you experienced?

7. During the implementing of the Dual Diagnosis Program at FDOC, from a transitional program perspective what kind of direction and input have you provided to the Regional Office?

8. During the implementing of the Dual Diagnosis Program at FDOC, from a transitional program perspective what kind of direction and input have you provided to Jefferson and Zephyrhills Correctional Institutions?

9. Who is your supervisor? What kind of direction and input have you received from your supervisor and upper management in implementing the Dual Diagnosis Program?

10. What role has the Mission and Habitability Committee played in the implementation of the Dual Diagnosis Program?

11. What role do transitional programs play on that committee?

12. What role has the Executive Leadership Committee played in the implementation of the Dual Diagnosis Program?

13. What role do transitional programs play on that committee?

14. How is the Dual Diagnosis Program different from other substance abuse and mental health programs provided at the Department of Corrections?

15. During the cross training transitional program staff was invited to participate in the Dual Diagnosis Program. Why has there been little involvement of transitional program staff in the Dual Diagnosis Program at each facility?

16. Do you foresee any expansion in the role of transitional program staff in the implementation of the Dual Diagnosis Programs?

17. What are the differences between inmates on the Dual Diagnosis Unit and inmates in traditional mental health and substance abuse treatment programs at FDOC?

18. During the management team meetings, there was discussion about providing Dual Diagnosis Program treatment during evening hours. What effect does such a decision have on institutional management staff?

19. Throughout the first few months of this program, there has been concern about the low number of inmates participating in treatment at each Dual Diagnosis Site. What do you think accounts for the small number of referrals and low number of inmates participating in the Dual Diagnosis Program thus far?

20. How is the problem of low census being addressed by your office?

Assistant Secretary of Security & Institutional Management (03/24/98)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your work experience since being at FDOC?

2. Describe your work experience in mental health treatment?

3. Describe your work experience in substance abuse treatment?

4. What was your role in the decision to implement the Dual Diagnosis Program in the Department?

5. What was your role in the implementation of the Dual Diagnosis Program in the Department?

6. What role did you play in recruiting program staff for the Dual Diagnosis Program?

7. During the implementation of the Dual Diagnosis Program at FDOC, what personnel problems and difficulties arose?

8. During the implementation of the Dual Diagnosis Program at FDOC, what kind of direction and input have you provided to the Regional Offices?

9. During the implementation of the Dual Diagnosis Program at FDOC, what kind of direction and input have you provided directly to Jefferson and Zephyrhills Correctional Institutions?

10. Who is your supervisor? What kind of direction and input have you received from upper management in implementing the Dual Diagnosis Program?

11. What role does the Missions and Habitability Committee have in the implementation of the Dual Diagnosis Program?

12. What role does the Executive Leadership Committee play in the implementation of the Dual Diagnosis Program?

13. How is the Dual Diagnosis Program different from other substance abuse and mental health programs provided at FDOC?

14. During management team meetings, the Dual Diagnosis Program staff indicated a lack of physical space and resources at Jefferson to treat the dually-diagnosed inmates. What role did your office play in resolving the problem of insufficient space, furniture, and equipment for the Dual Diagnosis Program Unit?

15. It appears that you were actively involved in initiating renovations to the dormitory that houses the Dual Diagnosis Program at Zephyrhills C. I. What happened to your recommendations to renovate the dormitory at Zephyrhills C.I. (Memorandum to Nancy Wittenburg dated September 8, 1997 entitled renovations at Zephyrhills C. I., Visit to Zephyrhills C. I.).

16. How has the Dual Diagnosis Program affected the activity and responsibility of the Division of Security and Institutional Management?

17. Who is ultimately responsible for implementing of the Dual Diagnosis Program?

18. How have the cross-training assisted in implementing the Dual Diagnosis Program?

19. Throughout the implementation of these programs, there has been concern over the low number of inmates participating in treatment at each Dual Diagnosis Site. What do you think accounts for the small number of inmates being referred to the Dual Diagnosis Programs?

Secretary (03/31/98)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your experience since being at FDOC?

2. When did you learn that the Dual Diagnosis Program would be implemented at FDOC?

3. What role have you played in the implementation of the Dual Diagnosis Program?

4. What role has your immediate or office staff played in the implementation of the Dual Diagnosis Program?

5. During the implementation of the Dual Diagnosis Program at FDOC, what personnel problems and difficulties have you experienced?

6. During the implementation of the Dual Diagnosis Program at FDOC, what kind of direction and input have you provided to your subordinates in central office?

7. During the implementation of the Dual Diagnosis Program at FDOC, what kind of direction and input have you provided to the Regional Offices?

8. During the implementation of the Dual Diagnosis Program at FDOC, what kind of direction and input have you provided to Jefferson and/or Zephyrhills Correctional Institutions

9. What role has the Executive Leadership Committee played in the implementation of the Dual Diagnosis Program?

10. What role has the Mission and Habitability Committee played in the implementation of the Dual Diagnosis Program?

11. During our management team meetings on the Dual Diagnosis Program, staff indicated that there was a need to modify physical space and allocate additional resources at Jefferson C.I. and Zephyrhills C.I. to treat dually-diagnosed inmates. What role did your staff play in resolving the problem of insufficient space, furniture, and equipment for the Dual Diagnosis Program Units?

12. What effect has the Dual Diagnosis Program had on the duties and responsibilities of central office staff?

13. What effect has the Dual Diagnosis Program had on the overall organization?
14. Why has more staff from Region V staff participated in cross-training than staff from Region I?

15. Why has there been more staff participation in central office teleconferences by Region V than Region I?

16. Throughout the implementation of the Dual Diagnosis Program, there has been concern about the low number of inmates participating in treatment at each Dual Diagnosis Site. What do you think accounts for the low number of inmates being referred to the Dual Diagnosis Program thus far?

17. How has the problem of a low census in the program been addressed by your office?

18. As the Dual Diagnosis Program moves into the second phase of treatment, it appears that the program at Zephyrhills C.I. is moving a lot slower than the program at Jefferson C.I. What do you think accounts for the slow progress of the program at Jefferson?

19. How has the slow progress at Jefferson C.I. been addressed at your office?

Correctional Classification Services Administrator (04/02/98)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your work experience here?

2. Describe your work experience in mental health treatment?

3. Describe your work experience in substance abuse treatment?

4. What has been your role in the implementation of the Dual Diagnosis Programs?

5. What role did you play in recruiting staff for the Dual Diagnosis Program?

6. During the implementing of the Dual Diagnosis Program at FDOC, from a release management perspective what personnel problems and difficulties have you experienced?

7. During the implementing of the Dual Diagnosis Program at FDOC, from a release management perspective what kind of direction and input have you provided to the Regional Office?

8. During the implementing of the Dual Diagnosis Program at FDOC, from a release management perspective what kind of direction and input have you provided to Jefferson and Zephyrhills Correctional Institutions?

9. Who is your supervisor? What kind of direction and input have you received from your supervisor and upper management in implementing the Dual Diagnosis Program?

10. What role has the Mission and Habitability Committee played in the implementation of the Dual Diagnosis Program?

11. What role does institutional management play on that committee?

12. What role has the Executive Leadership Committee played in the implementation of the Dual Diagnosis Program?

13. What role does institutional management play on that committee?

14. During the cross training institutional management staff was invited to participate in the Dual Diagnosis Program. Why has there been little involvement of release management staff in the Dual Diagnosis Program at each facility?

15. Do you foresee any expansion of the treatment role of release management staff on the Dual Diagnosis Units?

16. What role does the Division of Health Services play in the implementation of the Dual Diagnosis Program?

17. How do you monitor the implementation of the Dual Diagnosis Program?

18. How have you communicated with treatment staff on the Dual Diagnosis Unit?

19. Throughout the few months of this program, there has been concern about the low number of inmates participating in treatment at each Dual Diagnosis Site. What do you think accounts for the small number of referrals and low number of inmates participating in the Dual Diagnosis Program thus far?

20. How is the problem of low census being addressed by your office?

Correctional Classification Services Assistant Administrator (04/02/98)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your work experience here?

2. Describe your work experience in mental health treatment?

3. Describe your work experience in substance abuse treatment?

4. What has been your role in the implementation of the Dual Diagnosis Programs?

5. What role did you play in recruiting staff for the Dual Diagnosis Program?

6. During the implementing of the Dual Diagnosis Program at FDOC, from a release management perspective what personnel problems and difficulties have you experienced?

7. During the implementing of the Dual Diagnosis Program at FDOC, from a release management perspective what kind of direction and input have you provided to the Regional Office?

8. During the implementing of the Dual Diagnosis Program at FDOC, from a release management perspective what kind of direction and input have you provided to Jefferson and Zephyrhills Correctional Institutions?

9. Who is your supervisor? What kind of direction and input have you received from your supervisor and upper management in implementing the Dual Diagnosis Program?

10. What role has the Mission and Habitability Committee played in the implementation of the Dual Diagnosis Program?

11. What role does institutional management play on that committee?

12. What role has the Executive Leadership Committee played in the implementation of the Dual Diagnosis Program?

13. What role does institutional management play on that committee?

14. During the cross training institutional management staff was invited to participate in the Dual Diagnosis Program. Why has there been little involvement of release management staff in the Dual Diagnosis Program at each facility?

15. Do you foresee any expansion of the treatment role of release management staff on the Dual Diagnosis Units?

16. What role does the Division of Health Services play in the implementation of the Dual Diagnosis Program?

17. How do you monitor the implementation of the Dual Diagnosis Program?

18. How have you communicated with treatment staff on the Dual Diagnosis Unit?

19. Throughout the few months of this program, there has been concern about the low number of inmates participating in treatment at each Dual Diagnosis Site. What do you think accounts for the small number of referrals and low number of inmates participating in the Dual Diagnosis Program thus far?

20. How is the problem of low census being addressed by your office?

Chief of Health Services (04/05/98)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your work experience here?

2. What is your educational background?

3. Describe your work experience in substance abuse treatment?

4. Describe your work experience in mental health treatment?

5. What has been your role in the implementation of the Dual Diagnosis Programs?

6. What role did you play in recruiting staff for the Dual Diagnosis Program?

7. In recruiting staff for the Dual Diagnosis Units, what was the most important factor in selecting individuals?

8. Were you looking for specific types of prior experiences, a willingness to work with the dually-diagnosed, particular educational background, or was there nothing in particular that had been identified as more or less desirable in the choice of staff?

9. Did you find that some applicants lost interested in the job once they learned more about the proposed Dual Diagnosis Program?

10. What proportion of applicants lost interest in the job once they learned more about the proposed Dual Diagnosis Program?

11. When did you begin to recruit program staff for the Dual Diagnosis Program?

12. During the implementing of the Dual Diagnosis Program at FDOC, what personnel problems and difficulties have you experienced?

13. During the implementing of the Dual Diagnosis Program at FDOC, what kind of direction and input have you provided to the Regional Offices?

14. During the implementing of the Dual Diagnosis Program at FDOC, what kind of direction and input have you provided to Jefferson and Zephyrhills Correctional Institutions?

15. Who is your supervisor? What kind of direction and input have you received from your supervisor and upper management in implementing the Dual Diagnosis Program?

16. What role has the Mission and Habitability Committee played in the implementation of the Dual Diagnosis Program?

17. What role has the Executive Leadership Committee played in the implementation of the Dual Diagnosis Program?

18. How is the Dual Diagnosis Program different from other substance abuse and mental health programs provided at the Department of Corrections?

19. In general, what is difference between inmates on the Dual Diagnosis Unit and inmates in traditional mental health and substance abuse treatment programs at FDOC?

20. During the cross training security staff members were invited to participate in the Dual Diagnosis Program. Why has there been little involvement of security staff in the Dual Diagnosis Program at each facility?

21. Do you foresee any expansion of the treatment role of security staff on the Dual Diagnosis Units?

22. What role does the Division of Health Services play in the implementation of the Dual Diagnosis Program?

23. What methods are you using to monitor implementation?

24. How have you communicated with treatment staff on the Dual Diagnosis Unit?

25. The staff in the Dual Diagnosis Program appears to have more work experience in mental health than substance abuse treatment. How are you assured that integrated treatment is taking place in the programs?

26. Although the Dual Diagnosis Program has been described as a substance abuse program, there is no substance abuse treatment staff working in the programs. Why is there no substance abuse treatment staff assigned to the Dual Diagnosis Program?

27. Why isn't nursing staff assigned to the Dual Diagnosis Program?

28. Why isn't psychiatric staff assigned to the Dual Diagnosis Program?

29. Recently, the department decided to increase the number of patients at the Jefferson program from 40 to 60. What was the main reason for that decision?

30. During the management team meetings and teleconferences at least three separate plans to modify treatment space at Zephyrhills C. I have been initiated by the Bureau Chief of Substance Abuse Program Services. Could you describe those plans and explain what has become of them?

31. During the management team meetings on the Dual Diagnosis Program, staff indicated that there was a need to modify physical space and allocate additional resources at Jefferson C. I. and Zephyrhills C. I. to treat dually-diagnosed inmates. What role did your office play in resolving the problems of space, furniture, and equipment for the Dual Diagnosis Program Unit?

32. During the week of December 6, 1997, John Burke visited Zephyrhills C. I. and recommended that no physical modifications be made to the treatment site, describe how and why you participated in that process.

33. During the management team meeting there was discussion about providing Dual Diagnosis Program treatment during evening hours. Why isn't the program providing treatment during the evening hours?

34. During the first two months of the program Bob Trifiletti, the Dual Diagnosis Program Supervisor at Jefferson C. I., was without a telephone. Why was Bob without a telephone for so long?

35. Throughout the few months of this program, there has been concern about the low number of inmates participating in treatment at each Dual Diagnosis Site. What do you think accounts for the small number of referrals and low number of inmates participating in the Dual Diagnosis Program thus far?

36. How is the problem of low census being addressed by your office?

Bureau Chief of Health Services (04/06/98)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your work experience here?

2. Describe your work experience in substance abuse treatment?

3. Describe your work experience in mental health treatment?

4. What has been your main role in the implementation of the Dual Diagnosis Programs?

5. What role did you play in recruiting staff for the Dual Diagnosis Program?

6. In recruiting staff for the Dual Diagnosis Units, what was the most important factor in selecting individuals?

7. Were you looking for specific types of prior experiences, attitudes or educational, or was there nothing in particular that had been identified as more less desirable in the choice of staff?

8. What proportion of staff lost interest in the job once they had learned more about the proposed Dual Diagnosis Program?

9. During the implementing of the Dual Diagnosis Program at FDOC, what personnel problems and difficulties have you experienced?

10. During the implementing of the Dual Diagnosis Program at FDOC, what kind of direction and input have you provided to the Regional Office?

11. During the implementing of the Dual Diagnosis Program at FDOC, what kind of direction and input have you provided directly to Jefferson and Zephyrhills Correctional Institutions?

12. Who is your supervisor? What kind of direction and input have you received from your supervisor and upper management in implementing the Dual Diagnosis Program?

13. What role has the Mission and Habitability Committee played in the implementation of the Dual Diagnosis Program?

14. What role has the Executive Leadership Committee played in the implementation of the Dual Diagnosis Program?

15. How is the Dual Diagnosis Program different from other substance abuse and mental health programs provided at the Department of Corrections?

16. During the cross training security staff members were invited to participate in the Dual Diagnosis Program. Why has there been little involvement of security staff in the Dual Diagnosis Program at each facility?

17. What role does the Division of Health Services play in the implementation of the Dual Diagnosis Program?

18. How do you monitor the implementation of the Dual Diagnosis Program?

19. How have you communicated with treatment staff on the Dual Diagnosis Unit?

20. What are the differences between inmates on the Dual Diagnosis Unit and inmates in traditional mental health and substance abuse treatment programs at FDOC?

21. The staff in the Dual Diagnosis Program appears to have more work experience in mental health than substance abuse treatment. How are you assured that integrated treatment is taking place in the programs?

22. Why isn't nursing staff assigned to the Dual Diagnosis Program?

23. Why isn't psychiatric staff assigned to the Dual Diagnosis Program?

24. Recently, the department decided to increase the number of patients at the Jefferson program from 40 to 60. What are the main reasons for the expansion?

25. During the management team meetings, there was discussion about providing Dual Diagnosis Program treatment during evening hours. Why isn't the program providing treatment during the evening hours?

26. During the first two months of the program Bob Trifiletti, the Dual Diagnosis Program Supervisor, was without a telephone. Why was Bob without a telephone for so long?

27. Throughout the few months of this program, there has been concern about the low number of inmates participating in treatment at each Dual Diagnosis Site. What do you think accounts for the small number of referrals and low number of inmates participating in the Dual Diagnosis Program thus far?

28. How is the problem of low census being addressed by your office?

Regional Office Interviews:

Region I Director (12/09/97)

1. How long have your been with The Florida Department of Corrections (FDOC) and what has been your experience since being at FDOC?

2. When did you learn that the Dual Diagnosis Program would be implemented in your Region?

3. What role have you played in the implementation of the Dual Diagnosis Program?

4. What role has your staff played in the implementation of the Dual Diagnosis Program?

5. What personnel problems and difficulties have you experienced in implementing the Dual Diagnosis Program in you Region?

6. What kind of direction have you received from central office in implementing the Dual Diagnosis Program?

7. What role has the Executive Leadership Committee played in the implementation of the Dual Diagnosis Program?

8. What role has the Mission And Habitability Committee played in the implementation of the Dual Diagnosis Program?

9. What elements of the Dual Diagnosis Program have you been able to implement thus far?

10. During our management team meetings on the Dual Diagnosis Program, staff indicated that there was a lack of physical space and resources at Jefferson C. I. to treat the dually-diagnosed inmates. How has your staff resolved the problem of not having enough physical space and resources to treat dually-diagnosed inmates?

11. What effect has the Dual Diagnosis Program had on the duties and responsibilities of the Regional staff?

12. What effect has the Dual Diagnosis Program had on the overall organization structure at the regional level?

13. Why has there been more staff participation in cross-training by Region V than Region I?

14. Why has there been more staff participation in central office teleconferences by Region V than Region I?

Region I Director of Education & Job Training (12/09/97)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your experience since being at FDOC?

2. When did you learn that the Dual Diagnosis Program would be implemented in your Region?

3. What role have you played in the implementation of the Dual Diagnosis Program?

4. Who is your direct supervisor? What kind of direction and support have you received from your supervisor in implementing the Dual Diagnosis Program in your Region?

5. What kind of direction and support have you received from central office in implementing the Dual Diagnosis Program in your Region?

6. What kind of Substance Abuse Treatment issues and concerns do the Dual Diagnosis Program present?

7. Why isn't contract substance abuse staff involved with the Dual Diagnosis Program?

8. How is the Dual Diagnosis Program different from other substance abuse programs?

9. What personnel problems and difficulties have you experienced in establishing the Dual Diagnosis Program in your Region?

Region I Director of Health Care (12/16/97)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your experience since being at FDOC?

2. When did you learn that the Dual Diagnosis Program would be implemented in your Region?

3. What role have you played in the implementation of the Dual Diagnosis Program in your Region?

4. Who is your direct supervisor? What kind of direction and support have you received from your supervisor in implementing the Dual Diagnosis Program in your Region?

5. What kind of directions and support have you received from central office in implementing the Dual Diagnosis Program in your Region?

6. What kind of special health care issues and concerns does the Dual Diagnosis Program present?

7. Why isn't nursing staff assigned to the Dual Diagnosis Program?

8. Why aren't psychiatrists assigned to the Dual Diagnosis Program?

9. How is the Dual Diagnosis Program different from other Mental Health Programs?

10. How is the Dual Diagnosis Program different from other programs in Health Services?

Region I Mental Health Consultant (12/16/97)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your experience since being at FDOC?

2. When did you learn that the Dual Diagnosis Program would be implemented in your Region?

3. What role have you played in implementing of the Dual Diagnosis Program?

4. Since the implementation of the Dual Diagnosis Program, what personnel problems and difficulties have you experienced?

5. What kind of direction have you received from Central Office in implementing the Dual Diagnosis Program?

6. During our management team meetings on the Dual Diagnosis Program, staff indicated that there was a lack of physical space and resources at Jefferson to treat Dually-diagnosed inmates. How has your office resolved the problem of not having enough physical space and resources to treat dually-diagnosed inmates?

7. How do you communicate with the treatment staff of the Dual Diagnosis Program?

8. What kind of direction do you provide to the Dual Diagnosis Program staff?

9. How do you provide direction to the Dual Diagnosis Program staff?

Region I Substance Abuse Consultant (12/16/97)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your experience since being at FDOC?

2. When did you learn that the Dual Diagnosis Program would be implemented in your Region?

3. What role have you played in implementing of the Dual Diagnosis Program?

4. Since the implementation of the Dual Diagnosis Program, what personnel problems and difficulties have you experienced?

5. What kind of direction have you received from Central Office in implementing the Dual Diagnosis Program?

Region V Administrator (01/22/98)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your experience since being at FDOC?

2. When did you learn that the Dual Diagnosis Program would be implemented in your region?

3. As Regional Administrator, what is the nature of your contact with the Dual Diagnosis Program staff?

4. What contact do you have with institutional staff concerning the Dual Diagnosis Program?

5. What kind of direction do you receive from central office concerning the Dual Diagnosis Program?

6. During our management team meetings on the Dual Diagnosis Program, staff indicated that there was a lack of physical resources at Jefferson C. I. to treat Dually-diagnosed inmates. How has your office resolved the problem of not having enough resources to treat the dually-diagnosed inmates?

Region V Director (01/22/98)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your experience since being at FDOC?

2. When did you learn that the Dual Diagnosis Program would be implemented in your Region?

3. What role have you played in the implementation of the Dual Diagnosis Program?

4. What role has your staff played in the implementation of the Dual Diagnosis Program?

5. Since the implementation of the Dual Diagnosis Program, what personnel problems and difficulties have you experienced?

6. What kind of direction have you received from central office in implementing the Dual Diagnosis Program?

Region V Director of Education & Job Training (01/22/98)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your experience since being at FDOC?

2. When did you learn that the Dual Diagnosis Program would be implemented in your Region?

3. What role have you played in the implementation of the Dual Diagnosis Program?

4. Who is your direct supervisor? What kind of direction and support have you received from your supervisor in implementing the Dual Diagnosis Program in your Region?

5. What kind of direction and support have you received from central office in implementing the Dual Diagnosis Program in your Region?

6. What kind of Substance Abuse Treatment issues and concerns do the Dual Diagnosis Program present?

7. Why isn't contract substance abuse staff involved with the Dual Diagnosis Program?

8. How is the Dual Diagnosis Program different from other substance abuse programs?

9. Since the implementation of the Dual Diagnosis Program in your region, what personnel problems and difficulties have you experienced?

Region V Director of Health Care (01/22/98)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your experience since being at FDOC?

2. When did you learn that the Dual Diagnosis Program would be implemented in your Region?

3. What role have you played in the implementation of the Dual Diagnosis Program in your Region?

4. Who is your direct supervisor? What kind of direction and support have you received from your supervisor in implementing the Dual Diagnosis Program in your Region?

5. What kind of directions and support have you received from central office in implementing the Dual Diagnosis Program in your Region?

Region V Mental Health Consultant (01/22/98)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your experience since being at FDOC?

2. When did you learn that the Dual Diagnosis Program would be implemented in your Region?

3. What role have you played in implementing of the Dual Diagnosis Program?

4. What role did you play in recruiting staff for the Dual Diagnosis Program?

5. In recruiting staff for the Dual Diagnosis Unit, what was the most important factor in selecting individuals?

6. Were you looking for specific types of prior experiences, a willingness to work with the dually-diagnosed, particular educational background, or was there nothing in particular that had been identified as more less desirable in the choice of staff?

7. Did you find that some applicants lost interest in the job once they learned more about the proposed Dual Diagnosis Program?

8. What proportion of staff lost interest in the job once they learned more about the proposed Dual Diagnosis Program?

9. During the implementation of the Dual Diagnosis Program at FDOC, what personnel problems and difficulties have you experienced?

10. During the implementation of the Dual Diagnosis Program at FDOC, what kind of direction and input have you received from central office?

11. During the implementation of the Dual Diagnosis Program at FDOC, what kind of direction and input have you provided to Zephyrhills C. I.?

12. Who is your supervisor? What kind of direction and input have you received from your supervisor during the implementation of the Dual Diagnosis Program?

13. How different is the Dual Diagnosis Program from other substance abuse and mental health programs provided at the FDOC?

14. How have the cross-training helped in implementing the Dual Diagnosis Program?

15. During the cross-training security staff was invited to participate. Why has there been little involvement of security staff in the Dual Diagnosis Program at each facility?

16. How has the Security staff assisted the Dual Diagnosis Program in providing treatment to dually-diagnosed inmates?

17. How do you monitor the implementation of the Dual Diagnosis Program?

18. How do you communicate with treatment staff on the Dual Diagnosis Unit?

19. What are the differences between inmates on the Dual Diagnosis Unit and inmates in traditional mental health and substance abuse treatment programs at FDOC?

20. How has the role of the Bureau of Mental Health Services been different from the Bureau of Substance Abuse Programs in implementing the Dual Diagnosis Program?

21. The staff in the Dual Diagnosis Program appears to have more experience in mental health treatment than substance abuse treatment. How are you assured that integrated treatment is taking place in the programs?

22. Although the Dual Diagnosis Program has been described as a substance abuse program, there is no substance abuse treatment staff working in the programs. Why is there no substance abuse treatment staff assigned to the Dual Diagnosis Program?

23. Why isn't nursing staff assigned to the Dual Diagnosis Program?

24. Why isn't psychiatric staff assigned to the Dual Diagnosis Program?

25. During the management team meetings there was discussion about providing treatment during evening hours. What happened to the idea of the Dual Diagnosis Program providing treatment during the evening hours?

26. Throughout the few months of this program, there has been concern about the low number of inmates participating in treatment at each site. What do you think accounts for the small number of referrals and low number of inmates participating in the Dual Diagnosis Program thus far?

27. How has your office been directly involved in any efforts to increase the census or to encourage more referrals?

28. How are referrals made to the Dual Diagnosis Program?

29. How are Dually-diagnosed inmates screened and identified?

30. During our management team meetings on the Dual Diagnosis Program, staff indicated that there was a lack of physical space and resources at Zephyrhills C. I. to treat the dually-diagnosed inmates. How has your office resolved the problem of not having enough physical space and resources to treat dually-diagnosed inmates?

31. During the management team meetings and teleconferences there were three separate plans to modify treatment space at Zephyrhills C. I. Describe the plans to modify the treatment space at Zephyrhills C.I., and explain what happened to them?

32. What elements of the Dual Diagnosis Program do you regard as fully implemented?

33. During the week of December 6, 1997, John Burke recommended that no physical modifications be made to the treatment site at Zephyrhills C. I.. Describe how you participated in the decision to recommend that no physical modifications be made to the treatment site at Zephyrhills C.I.

34. How do you communicate with the treatment staff of the Dual Diagnosis Program?

35. How do you provide direction to the Dual Diagnosis Program staff?

36. What kind of direction do you provide to the Dual Diagnosis Program staff?

37. Who is ultimately responsible for implementing the Dual Diagnosis Program?

Region V Substance Abuse Consultant (01/22/98)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your experience since being at FDOC?

2. When did you learn that the Dual Diagnosis Program would be implemented in your Region?

3. What role have you played in implementing of the Dual Diagnosis Program?

4. Since the implementation of the Dual Diagnosis Program, what personnel problems and difficulties have you experienced?

5. What kind of direction have you received from Central Office in implementing the Dual Diagnosis Program?

6. During our management team meetings on the Dual Diagnosis Program, staff indicated that there was a lack of physical space and resources at Jefferson to treat Dually-diagnosed inmates. How has your office resolved the problem of not having enough physical space and resources to treat dually-diagnosed inmates?

7. How do you communicate with the treatment staff of the Dual Diagnosis Program?

8. What kind of direction do you provide to the Dual Diagnosis Program staff?

9. How do you provide direction to the Dual Diagnosis Program staff?

Jefferson Correctional Institution Interviews:

Senior Psychologist Dual Diagnosis Program (11/10/97)

1 When did you learn that The Dual Diagnosis Program would be implemented at your institution?

2. As Senior Psychologist for the Dual Diagnosis Program, what is your role?

3. When did you begin to recruit program staff for the Dual Diagnosis Program?

4. Your program currently shares space with already established substance abuse treatment programs at your institution. How is that arrangement going?

5. Why is it so difficult to communicate with you while you are on the compound?

6. How is the Dual Diagnosis Program more integrated than other mental health and substance abuse treatment programs at your institution?

7. What kind of treatment are you providing during the evening hours?

8. How has Security Staff responded to the Dual Diagnosis Program?

9. What elements of the Dual Diagnosis program have you been able to implement thus far?

9. What progress have you made thus far in recruiting and using peer facilitators?

11. What kind of direction and support have you received from institutional management and central office staff in implementing the Dual Diagnosis Program?

12. Since the implementation of the Dual Diagnosis Program, what personnel problems and difficulties have you experienced?

13. What do you think accounts for the small number of inmates that have been identified as appropriate for treatment in the Dual Diagnosis Program thus far?

14. How are Dually-diagnosed inmates identified differently than inmates who have received other kinds of mental health and substance abuse treatment?

15. What is the process by which inmates are referred to the Dual Diagnosis Program?

Dual Diagnosis Program Treatment Staff (11/10/97)

1. When did you learn that the Dual Diagnosis Program would be implemented at your institution?

2. How have the cross-training been helpful in working with the Dually-Diagnosed?

3. How are Dually-Diagnosed inmates screened and identified?

4. How are inmates being referred to the Dual Diagnosis Program?

5. How is security assisting staff with providing treatment to the Dually-Diagnosed?

6. Are there any other ways that Security Staff is called upon to work with or help staff of the Dual Diagnosis Unit?

7. How is the Dual Diagnosis Program different from existing mental health and substance abuse programs?

8. How are mental health holds being handled by the Dual Diagnosis Program?

9. What are the diagnostic criteria necessary for an inmate to enter the Dual Diagnosis Program?

10. How are Dually-diagnosed inmates identified differently than inmates receiving other kinds of mental health and substance abuse treatment?

11. How is the Dual Diagnosis Program more integrated than other mental health and substance abuse treatment programs at your institution?

12. Why do you think only a small number of inmates have been referred to the Dual Diagnosis Program?

13. What kind of direction do you receive from the Senior psychologist?

14. Would you describe your typical daily routine of activities?

Business Manager (12/03/97)

1. How long have you been with The Department of Corrections (FDOC) and what has been your work experience since being at FDOC?

2. When did you learn that the Dual Diagnosis Program would be implemented at your institution?

3. As business manager for this institution, what contact if any do, you have with the Dual Diagnosis Program?

4. What is your role in that contact?

5. Who is your direct supervisor? What kind of direction and support have you received from management at your institution and central office in providing resources to the Dual Diagnosis Program?

Superintendent (12/03/97)

1. How long have you been with The Department of Corrections (FDOC) and what has been your work experience since being at FDOC?

2. What was your role in the decision to implement the Dual Diagnosis Program at this institution?

3. What role did you play in recruiting program staff for the Dual Diagnosis Program?

4. Since establishing the Dual Diagnosis Program, what personnel problems and difficulties have you experienced?

5. What kind of direction and input have you received from the Regional Office in implementing the Dual Diagnosis Program.

6. During our management team meetings on the Dual Diagnosis Program, staff indicated that there was a lack of physical space and resources at Jefferson to treat the dually-diagnosed inmates. How has your institution resolved the problem of not having enough physical space and resources to treat the dually-diagnosed inmates?

7. How has the Dual Diagnosis Program affected the duties and responsibilities of security staff?

8. How has the Dual Diagnosis Program affected your overall organizational structure?

Corrections Staff (12/03/97)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your work experience since being at FDOC?

2. When did you learn that the Dual Diagnosis Unit would be implemented at your institution?

3. How has cross-training helped you deal with the dually-diagnosed inmates?

4. How have you participated in treating dually-diagnosed inmates?

5. How do you monitor inmates in the Dual Diagnosis Unit?

6. From your point of view, what are the main differences between inmates on the Dual Diagnosis Unit and other inmates at this institution?

7. Does the dually-diagnosed inmate create any new or unusual demands on Security Staff?

8. What security concerns are presented when peer facilitators are used in substance abuse treatment programs?

9. How do you communicate with the treatment staff of the Dual Diagnosis Unit?

Senior Psychologist Mental Health Program (01/06/98)

1. How long have you been with The Department of Corrections (FDOC) and what has been your work experience since being at FDOC?

2. When did you learn that The Dual Diagnosis Program would be implemented at your institution?

3. As Senior Psychologist for the Mental Health Program, what contact if any do you have with the Dual Diagnosis Program?

4. What is your role in that contact?

5. What effect has the Dual Diagnosis Program had on the existing Mental Health Program?

6. How has space been a problem for the Dual Diagnosis Program and Mental Health Programs?

7. How are referrals processed from Mental Health Services to the Dual Diagnosis Program?

8. Who is your direct supervisor? What kind of direction and support have you received from management at your institution, and central office in handling referrals to the Dual Diagnosis Program?

9. What personnel problems have you experienced with the Dual Diagnosis Program?

10. What other difficulties have you experienced with the Dual Diagnosis Program?

11. How is the Dual Diagnosis Program more integrated than other mental health and substance abuse treatment programs at your institution?

12. How has Security Staff responded to the Dual Diagnosis Program?

13. What do you think accounts for the small number of inmates that have been identified as appropriate for treatment in the Dual Diagnosis Program thus far?

14. How are Dually-diagnosed inmates identified differently than inmates who received other kinds of mental health and substance abuse treatment?

15. How have the cross-training prepared you for the Dual Diagnosis Program?

16. How does your staff participate in coordinating treatment with dually-diagnosed inmates?

17. How soon after inmates enter the Dual Diagnosis Program does treatment staff meet with institutional mental health staff regarding the development of comprehensive individualized treatment plans?

Assistant Superintendent (01/06/98)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your work experience since being at FDOC?

2. What was your role in the decision to implement the Dual Diagnosis Program at this institution?

3. What role did you play in recruiting program staff for the Dual Diagnosis Program?

4. What kind of personnel problems have you experienced while establishing the Dual Diagnosis Program at your facility?

5. What kind of direction and input did you received from the Regional Office in implementing the Dual Diagnosis Program.

6. During our management team meetings on the Dual Diagnosis Program, staff indicated that there was a lack of physical space and resources at Jefferson to treat the dually-diagnosed inmates. How has your institution resolved the problem of not having enough physical space and resources to treat the dually-diagnosed inmates?

7. How has the Dual Diagnosis Program affected the duties and responsibilities of security staff?

8. How has the Dual Diagnosis Program affected your overall organizational structure?

Senior Staff Substance Abuse Program (01/06/98)

1. How long have you been with The Department of Corrections (FDOC) and what has been your work experience since being at FDOC?

2. When did you learn that The Dual Diagnosis Program would be implemented at your institution?

3. As Senior Staff for the Substance Abuse Program, what contact if any do you have with the Dual Diagnosis Program?

4. What is your role in that contact?

5. What effect has the Dual Diagnosis Program had on the existing Substance Abuse Program?

6. How has space been a problem for the Dual Diagnosis Program and Substance Abuse Programs?

7. How are referrals processed from Substance Abuse Services to the Dual Diagnosis Program?

8. Who is your direct supervisor? What kind of direction and support have you received from management at your institution, and central office in handling referrals to the Dual Diagnosis Program?

9. What personnel problems have you experienced with the Dual Diagnosis Program?

10. What other difficulties have you experienced with the Dual Diagnosis Program?

11. How is the Dual Diagnosis Program more integrated than other mental health and substance abuse treatment programs at your institution?

12. How has Security Staff responded to the Dual Diagnosis Program?

13. What do you think accounts for the small number of inmates that have been identified as appropriate for treatment in the Dual Diagnosis Program thus far?

14. How are Dually-diagnosed inmates identified differently than inmates who received other kinds of mental health and substance abuse treatment?

15. How have the cross-training prepared you for the Dual Diagnosis Program?

16. How does your staff participate in coordinating treatment with dually-diagnosed inmates?

17. How soon after inmates enter the Dual Diagnosis Program does treatment staff meet with institutional substance abuse staff regarding the development of comprehensive individualized treatment plans?

Substance Abuse Treatment Staff (01/06/98)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your work experience since being at FDOC?

2. When did you learn that the Dual diagnosis Program would be implemented at your institution?

3. If you attended the cross-training, then how has it been helpful in working with Dually-diagnosed inmates?

4. How are Dually-diagnosed inmates screened and identified by substance abuse staff?

5. How are inmates being referred from the Substance Abuse Program to the Dual Diagnosis Program?

6. What are the ways in which Security Staff assists the Substance Abuse Program and the Dual Diagnosis Program in providing treatment to dually-diagnosed inmates?

7. How is the Dual Diagnosis Program different from already existing Substance Abuse Programs?

8. What are the necessary diagnostic criteria for an inmate to enter the Dual Diagnosis Program?

9. How are Dually-diagnosed inmates identified differently than inmates receiving other kinds of substance abuse services?

10. According to the experts, Dual Diagnosis Programs are to provide integrated mental health and substance abuse treatment. How is the Dual Diagnosis Program more integrated than existing Substance Abuse Programs?

11. Why do you think only a small number of inmates have been referred to the Dual Diagnosis Program?

12. Why haven't the inmates who have been referred to the program remained in treatment?

13. What kind of direction do you receive from your Senior Staff concerning the Dual Diagnosis Program?

Mental Health Treatment Staff (01/06/98)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your work experience since being at FDOC?

2. When did you learn that the Dual diagnosis Program would be implemented at your institution?

3. If you attended the cross-training, then how has it been helpful in working with Dually-diagnosed inmates?

4. How are Dually-diagnosed inmates screened and identified by mental health staff?

5. How are inmates being referred from the Mental Health program to the Dual Diagnosis Program?

6. What is the ways in which Security Staff assists the Mental Health Program and the Dual Diagnosis Program in providing treatment to dually-diagnosed inmates?

7. How is the Dual Diagnosis Program different from existing Mental Health Programs?

8. How are mental health holds being handled by the Dual Diagnosis Program?

9. What are the necessary diagnostic criteria for an inmate to enter the Dual Diagnosis Program?

10. How are Dually-diagnosed inmates identified differently than inmates receiving other kinds of mental health services?

11. According to the experts, Dual Diagnosis Programs are to provide integrated mental health and substance abuse treatment. How is the Dual Diagnosis Program more integrated than existing Mental Health Programs?

12. Why do you think only a small number of inmates have been referred to the Dual Diagnosis Program?

13. Why haven't the inmates who have been referred to the program remained in treatment?

14. What kind of direction do you receive from the Senior psychologists concerning the Dual Diagnosis Program?

Zephyrhills Correctional Institution Interviews:

Superintendent (11/18/97)

1. What was your role in the decision to implement the Dual Diagnosis Program at this institution?

2. What role did you play in recruiting program staff for the Dual Diagnosis Program?

3. Since establishing the Dual Diagnosis Program at your facility, what personnel problems and difficulties have you experienced?

4. What kind of direction and input have you received from the Regional Office in implementing the Dual Diagnosis Program.

5. During our management team meeting on the Dual Diagnosis Program, staff indicated that there was a need to modify physical space and allocate additional resources at Zephyrhills to treat the dually-diagnosed inmates. How has your institution resolved the problem of having adequate physical space and additional resources to treat the dually-diagnosed inmates?

6. How has the Dual Diagnosis Program affected the duties and responsibilities of security staff?

Senior Psychologist of Dual Diagnosis Program (11/18/97)

1. Describe your educational experience and training.

2. When did you learn that The Dual Diagnosis Program would be implemented at your institution?

3. As Senior Psychologist for the Dual Diagnosis Program, what is your role?

4. When did you begin to recruit program staff for the Dual Diagnosis Program?

5. How is the development of space for your program going at your institution?

6. Who is your direct supervisor? Has your supervisor provided you direction in the implementation of the Dual Diagnosis Program?

7. What elements of the Dual Diagnosis program have you been able to implement thus far?

8. How is the Dual Diagnosis Program more integrated than other mental health and substance abuse treatment programs at your institution?

9. What kind of treatment are you providing during the evening hours?

10. How has Security Staff responded to the Dual Diagnosis Program?

11. What progress have you made thus far in recruiting and using peer facilitators?

12. What kind of direction and support have you received from institutional management and central office in implementing the Dual Diagnosis Program?

13. What personnel problems and difficulties have you experienced in establishing the Dual Diagnosis Program at your facility?

14. What do you think accounts for the small number of inmates that have been identified as appropriate for treatment in the Dual Diagnosis Program thus far?

15. How are Dually-diagnosed inmates identified differently than inmates who have received other kinds of mental health and substance abuse treatment?

16. What is the process by which inmates are referred to the Dual Diagnosis Program?

17. How have the cross-training prepared you for the Dual Diagnosis Program?

18. How does the Dual Diagnosis Program's treatment staff participate in coordinating treatment?

19. How soon after inmates enter the Dual Diagnosis Program does treatment staff meet with institutional mental health staff regarding the development of comprehensive individualized treatment plans?

20. What is a mental health hold?

21. How are mental health holds being handled by the Dual Diagnosis Program?

Senior Psychologist Mental Health Program (11/18/97)

1. Describe your educational experience and training.

2. When did you learn that the Dual Diagnosis Program would be implemented at your institution?

3. As Senior Psychologist for the Mental Health Program, what contact if any do you have with the Dual Diagnosis Program?

4. What is your role in that contact?

5. What effect has the Dual Diagnosis Program had on the existing Mental Health Program?

6. How has space been a problem for the Dual Diagnosis Program and Mental Health Programs?

7. How are referrals processed from Mental Health Services to the Dual Diagnosis Program?

8. Who is your direct supervisor? What kind of direction and support have you received from management at your institution, and central office in handling referrals to the Dual Diagnosis Program?

9. What personnel problems have you experienced with the Dual Diagnosis Program?

10. What other difficulties have you experienced with the Dual Diagnosis Program?

11. How is the Dual Diagnosis Program more integrated than other mental health and substance abuse treatment programs at your institution?

12. How has Security Staff responded to the Dual Diagnosis Program?

13. What do you think accounts for the small number of inmates that have been identified as appropriate for treatment in the Dual Diagnosis Program thus far?

14. How are Dually-diagnosed inmates identified differently than inmates who received? other kinds of mental health and substance abuse treatment?

15. How have the cross-training prepared you for the Dual Diagnosis Program?

16. How does your staff participate in coordinating treatment with dually-diagnosed inmates?

17. How soon after inmates enter the Dual Diagnosis Program does treatment staff meet with institutional mental health staff regarding the development of comprehensive individualized treatment plans?

Senior Staff of Substance Abuse Program (11/18/97)

1. Describe your educational experience and training.

2. When did you learn that The Dual Diagnosis Program would be implemented at your institution?

3. As Senior Staff for the Substance Abuse Program, what contact if any do you have with the Dual Diagnosis Program?

4. What is your role in that contact?

5. What effect has the Dual Diagnosis Program had on the existing Substance Abuse Program?

6. How has space been a problem for the Dual Diagnosis Program and Substance Abuse Programs?

7. How are referrals processed from Substance Abuse Services to the Dual Diagnosis Program?

8. Who is your direct supervisor? What kind of direction and support have you received from management at your institution, and central office in handling referrals to the Dual Diagnosis Program?

9. What personnel problems have you experienced with the Dual Diagnosis Program?

10. What other difficulties have you experienced with the Dual Diagnosis Program?

11. How is the Dual Diagnosis Program more integrated than other mental health and substance abuse treatment programs at your institution?

12. How has Security Staff responded to the Dual Diagnosis Program?

13. What do you think accounts for the small number of inmates that have been identified as appropriate for treatment in the Dual Diagnosis Program thus far?

14. How are Dually-diagnosed inmates identified differently than inmates who received other kinds of mental health and substance abuse treatment?

15. How have the cross-training prepared you for the Dual Diagnosis Program?
16. How does your staff participate in coordinating treatment with dually-diagnosed inmates?

17. How soon after inmates enter the Dual Diagnosis Program does treatment staff meet with institutional substance abuse staff regarding the development of comprehensive individualized treatment plans?

Substance Abuse Treatment Staff (11/18/97)

1. Describe your educational experience and training.

2. When did you learn that the Dual diagnosis Program would be implemented at your institution?

3. If you attended the cross-training, then how has it been helpful in working with Dually-diagnosed inmates?

4. How are Dually-Diagnosed inmates screened and identified by substance abuse staff?

5. How are inmates being referred from the Substance Abuse Program to the Dual Diagnosis Program?

6. What are the ways in which Security Staff assists the Substance Abuse Program and the Dual Diagnosis Program in providing treatment to dually-diagnosed inmates?

7. How is the Dual Diagnosis Program different from already existing Substance Abuse Programs?

8. What are the necessary diagnostic criteria for an inmate to enter the Dual Diagnosis Program?

9. How are Dually-diagnosed inmates identified differently than inmates receiving other kinds of substance abuse services?

10. According to the experts, Dual Diagnosis Programs are to provide integrated mental health and substance abuse treatment. How is the Dual Diagnosis Program more integrated than existing Substance Abuse Programs?

11. Why do you think only a small number of inmates have been referred to the Dual Diagnosis Program?

12. Why haven't the inmates who have been referred to the program remained in treatment?

13. What kind of direction do you receive from your Senior Staff concerning the Dual Diagnosis Program?

Dual Diagnosis Treatment Staff (11/18/97)

1. Describe your educational experience and training.

2. When did you learn that the Dual diagnosis Program would be implemented at your institution?

3. How have the cross-training been helpful in working with dually-diagnosed inmates?

4. How are Dually-diagnosed inmates screened and identified?

5. How are inmates being referred to the Dual Diagnosis Program?

6. How is security assisting staff with providing treatment to dually-diagnosed inmates?

7. Are there any other ways that Security Staff is called upon to work with or help staff of the Dual Diagnosis Unit?

8. How is the Dual Diagnosis Program different from existing Mental Health Programs?

9. How are mental health holds being handled by the Dual Diagnosis Program?

10. What are the necessary diagnostic criteria for an inmate to enter the Dual Diagnosis Program?

11. How are Dually-diagnosed inmates identified differently than inmates receiving other kinds of mental health services?

12. According to the experts, Dual Diagnosis Programs are to provide integrated mental health and substance abuse treatment. How is the Dual Diagnosis Program more integrated than existing Mental Health Programs?

13. Why do you think only a small number of inmates have been referred to the Dual Diagnosis Program?

14. Why haven't the inmates who have been referred to the program remained in treatment?

15. What kind of direction do you receive from the Senior psychologists?

16. Would you describe your typical daily routine of activities?

Mental Health Treatment Staff (11/18/97)

1. Describe your educational experience and training.

2. When did you learn that the Dual diagnosis Program would be implemented at your institution?

3. If you attended the cross-training, then how has it been helpful in working with Dually-diagnosed inmates?

4. How are Dually-diagnosed inmates screened and identified by mental health staff?

5. How are inmates being referred from the Mental Health program to the Dual Diagnosis Program?

6. What is the ways in which Security Staff assists the Mental Health Program and the Dual Diagnosis Program in providing treatment to dually-diagnosed inmates?

7. How is the Dual Diagnosis Program different from existing Mental Health Programs?

8. How are mental health holds being handled by the Dual Diagnosis Program?

9. What are the necessary diagnostic criteria for an inmate to enter the Dual Diagnosis Program?

10. How are Dually-diagnosed inmates identified differently than inmates receiving other kinds of mental health services?

11. According to the experts, Dual Diagnosis Programs are to provide integrated mental health and substance abuse treatment. How is the Dual Diagnosis Program more integrated than existing Mental Health Programs?

12. Why do you think only a small number of inmates have been referred to the Dual Diagnosis Program?

13. Why haven't the inmates who have been referred to the program remained in treatment?

14. What kind of direction do you receive from the Senior psychologists concerning the Dual Diagnosis Program?

Corrections Staff (11/18/97)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your work experience since being at FDOC?

2. When did you learn that the Dual Diagnosis Unit would be implemented at your institution?

3. How has cross-training helped you deal with the dually-diagnosed inmates?

4. How have you participated in treating dually-diagnosed inmates?

5. How do you monitor inmates in the Dual Diagnosis Unit?

6. From your point of view, what are the main differences between inmates on the Dual Diagnosis Unit and other inmates at this institution?

7. Does the dually-diagnosed inmate create any new or unusual demands on Security Staff?

8. What security concerns are presented when peer facilitators are used in substance abuse treatment programs?

9. How do you communicate with the treatment staff of the Dual Diagnosis Unit.

Business Manager (01/21/98)

1. How long have you been with The Department of Corrections (FDOC) and what has been your work experience since being at FDOC?

2. When did you learn that the Dual Diagnosis Program would be implemented at your institution?

3. As business manager for this institution, what contact if any do, you have with the Dual Diagnosis Program?

4. What is your role in that contact?

5. Who is your direct supervisor? What kind of direction and support have you received from management at your institution and central office in providing resources to the Dual Diagnosis Program?

Assistant Superintendent (02/12/98)

1. How long have you been with The Florida Department of Corrections (FDOC) and what has been your work experience since being here?

2. When did you learn that the dual Diagnosis program would be implemented in your Institution?

3. What role have you played in implementing the Dual Diagnosis Program?

4. What role did you play in recruiting program staff for the Dual Diagnosis Program?

5. In recruiting staff for the Dual Diagnosis Unit, what were the most important factors in selecting individuals?

6. Were you looking for specific types of prior experiences, a willingness to work with the dually-diagnosed, particular educational background, or was there nothing in particular that had been identified as more or less desirable in the choice of staff?

7. Did you find that some applicants lost interest in the job once they learned more about the proposed Dual Diagnosis Program?

8. If yes, about what proportion of the staff lost interest in the job once they learned more about the proposed Dual Diagnosis Program?

9. Who is your supervisor? What kind of direction and input have your received from your supervisor during the implementation of the Dual Diagnosis Program?

10. During the implementation of the Dual Diagnosis Program, what personnel problems and difficulties have you experience?

11. During the implementation of the Dual Diagnosis Program, what kind of direction and input have you received from central office?

12. During the implementation of the Dual Diagnosis Program, what kind of direction and input have you received from your regional office?

13. During our management team meeting on the Dual Diagnosis Program, staff indicated that there was a need to modify physical space and allocate additional resources at Zephyrhills C. I. to treat the dually-diagnosed inmates. How has your institution resolved the problem of having adequate physical space and additional resources to treat the dually-diagnosed inmates?

14. How has the cross-training helped the implementation of the Dual Diagnosis Program?

15. How has the Dual Diagnosis Program affected the duties and responsibilities of security staff?

16. How has the Dual Diagnosis Program affected your overall organizational structure?

Ancillary Interviews:

Florida Mental Health Institute Consultant, University of South Florida (02/16/98)

1. How long have you been affiliated with the Florida Department of Corrections (FDOC) and what has been the nature of that affiliation?

2. When did you learn about the Dual Diagnosis Program?

3. When did you learn that the Dual Diagnosis Program would be implemented in the FDOC?

4. What role did you play in implementing the Dual Diagnosis Program at FDOC?

5. What role did you play in recruiting program staff for the Dual Diagnosis Program?

6. In recruiting staff for the Dual Diagnosis Unit, what was the most important factor in selecting individuals?

7. Were you looking for specific types of prior experiences, a willingness to work with the dually-diagnosed, particular educational background, or was there nothing in particular that had been identified as more or less desirable in the choice of staff?

8. Did you find some applicants lost interested in the job once they learned more about the proposed Dual Diagnosis Program?

9. What proportion of the staff lost interested in the job once they learned more about the proposed Dual Diagnosis Program?

10. During the implementation of the Dual Diagnosis Program, what kind of direction and input have you provided to Zephyrhills C. I. and Jefferson C. I.?

11. During the implementation of the Dual Diagnosis Program, what kind of direction and input have you provided to central office?

12. During the implementation of the Dual Diagnosis Program, what kind of direction and input have you provided to the regional offices?

13. During the management team meetings on the Dual Diagnosis Program, staff indicated that there was a need to modify physical space and allocate additional resources at Zephyrhills C. I. to treat the dually-diagnosed inmates. How has your office help resolve the problem of having adequate physical space and additional resources to treat the dually-diagnosed inmates?

14. How have the cross-training helped the implementation of the Dual Diagnosis Program?

15. How do you monitor the implementation of the Dual Diagnosis Program?

16. How do you communicate with treatment staff?

17. The staff in the Dual Diagnosis Program appears to have more experience in mental health treatment than substance abuse treatment. How are you assured that integrated treatment is taking place in the programs?

18. Although the Dual Diagnosis Program has been described as a substance abuse program, there is no substance abuse treatment staff working in the programs. Why do you think there no substance abuse treatment staff assigned to the Dual Diagnosis Program?

19. How has the role of the Office of Mental Health Services been different from the Bureau of Substance Abuse Programs in implementing the Dual Diagnosis Program?

20. Why do you think nursing staff is not assigned to the Dual Diagnosis Program?

21. Why do you think psychiatric staff is not assigned to the Dual Diagnosis Program?

22. How has your office been directly involved in any efforts to increase the census or to encourage more referrals?

23. How has your office been directly involved in any efforts to increase the census or to encourage more referrals?

24. During the management team meetings on the Dual Diagnosis Program, there was frequent discussion concerning the scheduling of groups for inmates. Describe how that scheduling is going at this point in the program?

25. During the management team meetings and teleconferences there were three separate plans to modify treatment space at Zephyrhills C. I., could you describe you involvement with the development of those plans?

26. What elements of the Dual Diagnosis Program do you regard as fully implemented?

27. The phase approach to treatment in this program has appeared to have been discarded? How do you feel this will affect the Dual Diagnosis Program?

28. During the management team meetings, there was considerable discussion about measuring treatment effectiveness through a series of proposed diagnostic tests, what is the current status of the proposed measures of treatment effectiveness?

Florida Department of Community Affairs (04/30/98)

1. How long have you been affiliated with the Florida Department of Corrections (FDOC) and what has been the nature of that affiliation?

2. When did you learn about the Dual Diagnosis Program?

3. When did you learn that the Dual Diagnosis Program would be implemented in the FDOC?

4. What role did you play in implementing the Dual Diagnosis Program at FDOC?

5. What role did you play in recruiting program staff for the Dual Diagnosis Program?

6. During the implementation of the Dual Diagnosis Program, what kind of direction and input have you provided to Zephyrhills C. I. and Jefferson C. I.?

7. During the implementation of the Dual Diagnosis Program, what kind of direction and input have you provided to central office?

8. During the implementation of the Dual Diagnosis Program, what kind of direction and input have you provided to the regional offices?

9. During the management team meetings on the Dual Diagnosis Program, staff indicated that there was a need to modify physical space and allocate additional resources at Zephyrhills C. I. to treat the dually-diagnosed inmates. How has your office help resolve the problem of having adequate physical space and additional resources to treat the dually-diagnosed inmates?

10. How have the cross-training helped the implementation of the Dual Diagnosis Program?

11. How do you monitor the implementation of the Dual Diagnosis Program?

12. How do you communicate with treatment staff?

13. The staff in the Dual Diagnosis Program appears to have more experience in mental health treatment than substance abuse treatment. How are you assured that integrated treatment is taking place in the programs?

14. Although the Dual Diagnosis Program has been described as a substance abuse program, there is no substance abuse treatment staff working in the programs. Why do you think there no substance abuse treatment staff assigned to the Dual Diagnosis Program?

15. How has the role of the Office of Mental Health Services been different from the Bureau of Substance Abuse Programs in implementing the Dual Diagnosis Program?

16. Why do you think nursing staff is not assigned to the Dual Diagnosis Program?

17. Why do you think psychiatric staff is not assigned to the Dual Diagnosis Program?

18. How has your office been directly involved in any efforts to increase the census or to encourage more referrals?

19. How has your office been directly involved in any efforts to increase the census or to encourage more referrals?

20. During the management team meetings on the Dual Diagnosis Program, there was frequent discussion concerning the scheduling of groups for inmates. Describe how that scheduling is going at this point in the program?

21. During the management team meetings and teleconferences there were three separate plans to modify treatment space at Zephyrhills C. I., could you describe you involvement with the development of those plans?

22. What elements of the Dual Diagnosis Program do you regard as fully implemented?

23. The phase approach to treatment in this program has appeared to have been discarded? How do you feel this will affect the Dual Diagnosis Program?

Second Round Interview Questions

Central Office Interviews:

Bureau Chief of Inmate Classification & Management (10/12/98); Assistant Secretary of Security & Informational Management (10/12/98); Bureau Chief of Security & Institutional Management (10/13/98); Deputy Assistant Secretary of Education and Job Training (10/22/98)

1. What salient organizational issues have affected the implementation of the Dual Diagnosis Program in your region?

2. What have you determined to be the strengths and weaknesses of the Dual Diagnosis Program?

3. What programmatic and/or treatment modifications would you recommend for the Dual Diagnosis Program?

Correctional Classification Services Administrator (10/12/98)

1. What salient organizational issues have affected the implementation of the Dual Diagnosis Program in your region?

2. What have you determined to be the strengths and weaknesses of the Dual Diagnosis Program?

3. What programmatic and/or treatment modifications would you recommend for the Dual Diagnosis Program?

4. Describe the nature of your contact and relationship with the Department of Children and Families' forensic staff?

5. Describe the transition or after care component the Dual Diagnosis Program staff has developed for inmates treated in the program?

Correctional Program Administrator of Substance Abuse Program Services (10/12/98); Operations & Management Consultant II (Fiscal) of Substance Abuse Program Services (10/13/98)

1. What salient organizational issues have affected the implementation of the Dual Diagnosis Program in your region?

2. What have you determined to be the strengths and weaknesses of the Dual Diagnosis Program?

3. What programmatic and/or treatment modifications would you recommend for the Dual Diagnosis Program?

4. What budgetary of funding modifications would you recommend to the Dual Diagnosis Program?

Director of Mental Health Services (10/12/98); Operations & Management Consultant II of Substance Abuse Program Services (10/14/98)

Treatment Staffing

1. How has treatment staff been lacking in this program?

2. What do you think accounts for the inadequate number of treatment staff in this program?

3. How has treatment staff turnover affected the implementation of the program?

4. What recommendations would you make to reduce treatment staff turnover?

Security Staffing

1. How has security staff been lacking in this program?

2. What do you think accounts for the inadequate number of security staff in this program?

3. How has security staff turnover affected the implementation of the program?

4. What recommendations would you make to reduce security staff turnover?

Program

1. What are the strengths of this program?

2. What are the weaknesses of this program?

3. What additional services would you recommend for this program?

4. What existing services would you enhance for this program?

5. What type of routine reports have you received from the treatment providers?

6. How would you modify this program?

Secretary (10/21/98)

1. What salient organizational issues have affected the implementation of the Dual Diagnosis Program in your region?

2. What programmatic and/or treatment modifications would you recommend for the Dual Diagnosis Program?

Regional Office Interviews:

Region I Director of Education & Job Training (09/09/98); Region I Director of Health Care (09/09/98); Region I Mental Health Consultant (09/09/98);Region I Substance Abuse Consultant (09/09/98); Region V Director (09/10/98); Region V Director of Education & Job Training (09/10/98); Region V Director of Health Care (09/10/98); Region V Mental Health Consultant (09/10/98); Region V Substance Abuse Consultant (09/10/98)

1. What salient organizational issues have affected the implementation of the Dual Diagnosis Program in your region?

2. What have you determined to be the strengths and weaknesses of the Dual Diagnosis Program?

3. What programmatic and/or treatment modifications would you recommend for the Dual Diagnosis Program?

4. What budgetary of funding modifications would you recommend to the Dual Diagnosis Program?

Jefferson Correctional Institution Interviews:

Substance Abuse Treatment Staff (05/14/98); Substance Abuse Treatment Staff (06/24/98); Senior Staff Substance Abuse Program (09/15/98)

1. Why do you think the Dual Diagnosis Program is being moved from Jefferson Correctional Institution (C.I.) to Broward C.I.?

2. What do you think accounts for the high turnover in treatment staff in the Dual Diagnosis Program?

3. What could have been done to alleviate the high turnover in treatment staff in the Dual Diagnosis Program?

4. What do you think accounts for the diminished role of security staff in the Dual Diagnosis Program?

5. How has the turnover in security staff, particularly in the dorm, affected the Dual Diagnosis Program?

6. What are the strengths and weaknesses of the Dual Diagnosis Program?

7. If the Dual Diagnosis Program were to remain at Jefferson C.I., what modifications would you make to the program?

8. What specific services would you enhance in this program?

9. What additional services would you provide in this program?

Corrections Staff (09/10/98)

1. How has security staff been lacking in this program?

2. What do you think accounts for the inadequate number of security staff in this program?

3. How has security staff turnover affected the implementation of the program?

4. What recommendations can you make to relieve security staff turnover?

5. What is the nature of the working relationship between security and the Dual Diagnosis Program staff?

6. Describe the training process for security.

7. What have been the salient security issues that have surfaced in the implementation of the program, and how were they resolved, if at all?

Zephyrhills Correctional Institution Interviews:

Superintendent (09/17/98); Assistant Superintendent (09/17/98); Business Manager (09/17/98)

1. What salient organizational issues have affected the implementation of the Dual Diagnosis Program in your region?

2. What have you determined to be the strengths and weaknesses of the Dual Diagnosis Program?

3. What programmatic and/or treatment modifications would you recommend for the Dual Diagnosis Program?

4. What budgetary of funding modifications would you recommend to the Dual Diagnosis Program?

Senior Psychologist of Dual Diagnosis Program (09/10/98); Dual Diagnosis Program Treatment Staff (09/10/98)

Treatment Staffing

5. How has treatment staff been lacking in this program?

6. What do you think accounts for the inadequate number of treatment staff in this program?

7. How has treatment staff turnover affected the implementation of the program?

8. What recommendations would you make to reduce treatment staff turnover?

Security Staffing

1. How has security staff been lacking in this program?

2. What do you think accounts for the inadequate number of security staff in this program?

3. How has security staff turnover affected the implementation of the program?

4. What recommendations would you make to reduce security staff turnover?

Program

1. What are the strengths of this program?

2. What are the weaknesses of this program?

3. What additional services would you recommend for this program?

4. What existing services would you enhance for this program?

5. What type of routine reports have you received from the treatment providers?

6. How would you modify this program?

7. How has the therapeutic community of the Dual Diagnosis Program been modified from a traditional therapeutic community?

8. Which program criteria have had the most effect on the program?

Treatment

1. Describe how peer facilitators are used in the program?

2. What is a Top-Of-the-House offender?

3. What are the criteria for inmates being phased up in the program?

4. What are the criteria for determining whether an inmate has completed the program?

5. Describe your process groups.

6. Describe your Dual Diagnosis Groups.

7. Describe your medication groups.

8. How do you track whether an inmate is attending group sessions?

9. What kind of programmatic support do inmates receive from other treatment programs?

10. Describe the between staff members in the Dual Diagnosis Program?

11. What are the advantages and disadvantages of treatment team meetings?

Disciplinary Infractions

1. Describe how disciplinary infractions are handled in the program?

2. Describe how peer facilitators are used in the program?

3. Under what conditions and circumstance may an inmate leave or discontinue treatment in the Dual Diagnosis Program?

4. What may delay an inmate leaving the treatment program promptly once they have been disciplinary dismissed?

Senior Psychologist Mental Health Program (09/29/98)

1. What do you think accounts for the high turnover in treatment staff in the Dual Diagnosis Program?

2. What could have been done to alleviate the high turnover in treatment staff in the Dual Diagnosis Program?

3. What do you think accounts for the diminished role of security staff in the Dual Diagnosis Program?

4. How has the turnover in security staff, particularly in the dorm, affected the Dual Diagnosis Program?

5. What are the strengths and weaknesses of the Dual Diagnosis Program?

6. What specific services would you enhance in this program?

7. What additional services would you provide in this program?

Ancillary Interviews:

Forensic Staff District II (09/28/98); Forensic Staff District VI (10/01/98);
Forensic Staff District VI (10/01/98)

1. What is the nature of your contact and relationship with the Florida Department of Corrections (FDOC)?

2. What has been your experience with inmates in the Dual Disordered Treatment Program?

3. What type of community-based after care services have you provided for inmates in the Dual Diagnosis Program?

4. Describe the nature of your contact with the Dual Diagnosis Program staff.

5. How have you dealt with issues of confidentiality in providing after care to inmates in the Dual Diagnosis Program?

6. What type of treatment and assessment information have the Dual Diagnosis Program staff shared with your office?

7. Describe what type of transitional care plan you have developed for inmates upon release from the Dual Diagnosis Program?

Florida Mental Health Institute Consultant University of South Florida (09/30/98)

1. What salient organizational issues have affected the implementation of the Dual Diagnosis Program in your region?

2. What have you determined to be the strengths and weaknesses of the Dual Diagnosis Program?

3. What programmatic and/or treatment modifications would you recommend for the Dual Diagnosis Program?

Florida Department of Community Affairs (11/09/98)

1. What salient organizational issues have affected the implementation of the Dual Diagnosis Program in your region?

2. What have you determined to be the strengths and weaknesses of the Dual Diagnosis Program?

3. What programmatic and/or treatment modifications would you recommend for the Dual Diagnosis Program?

4. What budgetary funding modifications would you recommend for the Dual Diagnosis Program?