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PROCESS EVALUATION OF SUMMIT HOUSE

A RESIDENTIAL SUBSTANCE ABUSE TREATMENT PROGRAM

OF THE NEW HAMPSHIRE DEPARTMENT OF CORRECTIONS

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FINAL REPORT Archive

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Suzanne McMurphy received her Masters of Social Service, Master of Law and Social Policy and Ph.D. in Social Policy from Bryn Mawr College. She has taught in the Social Work Departments of both the University of Vermont and the University of New Hampshire. She was previously a Fulbright Scholar in Sweden working with the National Council for Crime Prevention and the Swedish Ministry of Justice. She is currently the Principal Investigator of a number of evaluation projects including this NIJ sponsored process evaluation of substance abuse treatment programs in the New Hampshire, an outcome evaluation of the same program and an evaluation of the effect of drug testing and rehabilitation programs. Dr. McMurphy is also collaborating on several international projects on substance abuse and criminality including a 10-country assessment of residential treatment programs. Her research has been published in both Swedish and English.

William Butynski Ph.D - Project Director

Bill Butynski earned his PhD in psychology from the University of Vermont. He first served as a Research Associate on the Aspects Behavioral & Environmental in Traffic Safety (ABETS) Project at the University in 1969 where he began his research on the role of alcohol and other drugs in motor vehicle crashes. Since that time he has continuously been involved in planning, managing and evaluating programs related to the prevention and treatment of alcohol and other drug problems. A sampling of relevant positions he has held include Executive Director positions with the State of Vermont Alcohol and Drug Abuse Division, the Midwestern Area Alcohol Education and Training Program, and the National Association of State Alcohol and Drug Abuse Directors. He has served as a reviewer of alcohol and other drug grant applications for organizations ranging from the Robert Wood Johnson Foundation to the Substance Abuse and Mental Health Services Administration. Finally, he currently serves as an on-site visitor who evaluates Alcohol Impaired Driving Programs operated by various State Governors' Highway Safety Programs for the National Highway Traffic Safety Administration.

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Tim Ackerson received his MSSW from Columbia in 1975. He has worked for many years as a Clinical Social Worker and was a Director of Lutheran Child and Family Services of New Hampshire. In 1991 he became the Project Director at NH-Dartmouth Psychiatric Research Center NIMH/NIAAA funded study of Assertive Case Management for the Dually Diagnosed. Following the completion of the study, he was employed for 6 years by the NH Department of Corrections as the Programs Coordinator where he implemented the Correctional Options Demonstration grant and helped coordinate offender treatment programs. For the past 2 years he has worked as a research project coordinator at Treatment Research Institute in Philadelphia with various ONDCP funded studies on substance abuse.

Executive Summary

The National Institute of Justice (NIJ) awarded a grant, # 99RTVXK005, to the University of New Hampshire (UNH) for a process evaluation of the Summit House Residential Substance Abuse Treatment (RSAT) program within the New Hampshire (NH) Department of Corrections (DOC). This Executive Summary of that project consists of the following sections: Substance Abuse Problems Within the State of NH; Substance Abuse Treatment Needs of Prisoners, Nationally and In NH; The Substance Abuse Treatment Approach Within the NH Corrections Department; Research Purpose and Methods; Highlights from the Process Evaluation Project Findings; and Recommendations for Future Treatment of Alcohol and Drug Offenders Within NH.

Substance Abuse Problems Within the State of NH: The primary substance abuse problem within NH, like many rural states, is dependence and abuse related to alcohol. A NH Adult Household Needs Assessment Survey was conducted during the summer of 2000 and reported in May of 2001 by The Gallup Organization. The findings published within the State of NH Alcohol and Drug Plan in July of 2001 indicate that among the 1.2 million residents of the state, 28,898 individuals were abusing alcohol, while 58,827 were dependent upon alcohol. The findings for other principal drug problems were as follows: marijuana – 2,971 abusers and 5,355 persons dependent; cocaine – 258 abusers and 946 persons dependent; hallucinogens – 406 abusers and 859 persons dependent; and heroin – 363 persons dependent. It should be noted that the Needs Assessment Survey was conducted by telephone and although anonymity was provided to individual respondents, it is possible that some underreporting did occur, particularly related to the use of illicit drugs.

Substance Abuse Treatment Needs of Prisoners, Both Nationally and In NH: A variety of national studies and reports have concluded that alcohol and other drug problems have a major impact on public safety and crime. More specifically, the National Center on Addiction and Substance Abuse (CASA) at Columbia University reported in 1998 that substance abuse and addiction problems are related to the incarceration of approximately 80 % of the people behind bars (i.e., 1.4 million of the 1.7 million American men and women who are incarcerated). These estimates are in the same range as those provided by a number of governmental bodies such as the Federal Bureau of Prisons in 1989, the Government Accounting Office in 1991 and the Office of National Drug Control Policy in 2001. Also, given the impact of managed care and other efforts at deinstitutionalization of health and mental health patients over the past few decades, it appears that many individuals who may have received health care in other systems in the past, are now more likely to end up being incarcerated. This trend toward higher levels of incarceration in the United States has been reinforced by public attitudes that support determinate sentencing (i.e., specific mandatory minimum sentences) and increased surveillance of parolees and probationers which leads to more violations and reincarcerations of persons on parole and probation.

A recent study and analysis of correctional data in NH by Minard (2001) determined that "The action most likely to result in a state-prison term in New Hampshire today is a violation of a probation or a parole order" and that "A medical problem – drug and alcohol dependency – plays a critical role in many of the parole and probation violations that result in incarceration".

A needs assessment survey conducted by the NH DOC in 1990 estimated that 75% to 85% of all offenders within the NH system had substance abuse problems prior to their incarceration. These data are comparable to the national trends noted above. More recently, as part of this process evaluation of NH's RSAT program, the Addiction Severity Index (ASI) and other instruments were used to assess the substance abuse treatment needs of the offenders incarcerated at three sites within the NH DOC. Lifetime use of various substances for the treatment cohort of men at Concord State prison was as follows: Drinking to Intoxication, 9.4 years; Heroin, 2.0 years; Cocaine, 3.4 years; Cannabis, 9.6 years; and More Than One Substance, 9.9 years. Lifetime use of substances for the treatment cohort of men at the Lakes Region Correctional Facility in Laconia was as follows: Drinking to Intoxication, 7.5 years; Heroin, 0.75 years; Cocaine, 3.9 years; Cannabis, 8.5 years; and More Than One Substance, 8.1 years. Finally, lifetime use of substances for the treatment cohort of women at the Lakes Region Correctional Facility was as follows: Drinking to Intoxication, 5.9 years; Heroin, 3.1 years; Cocaine, 4.6 years; Cannabis, 5.3 years; and More Than One Substance, 6.2 years. Also, as measured by the ASI, well over 50% of all the men and women in the treatment cohorts indicated that they perceived that they had a "moderate" to "extreme" need for treatment. These offender perceptions were more than confirmed by the perceptions of the ASI interviewer who determined that 70% or more of the incarcerated men and women in each of the three treatment cohorts had a "moderate' to "extreme" need for substance abuse treatment services.

The Substance Abuse Treatment Approach Within the NH Corrections Department: The NH DOC established Summit House, an intensive residential alcohol and drug treatment program in 1991. In 1996, with the advent of additional grant funds available through the RSAT formula awards, the NH DOC enhanced and expanded the Summit House treatment program. The RSAT funds were used to enhance and increase the capacity of the 6-month intensive residential phase of the Summit House program, known as Phase I. In addition, the program was expanded to include both the NH State Prison for men in Concord and the Lakes Region Correctional Facility in Laconia – the latter facility has separate substance abuse treatment programs for men and women.

With the infusion of the RSAT monies and the creation of the Phase I intensive residential treatment component (i.e., a "modified" Therapeutic Community) at three sites, Summit House evolved and expanded into a 3-phase program. The phases of the program were designed to be developmental in nature, following inmates through their changes in custody level and into the community. The clinical personnel hired to staff the program through the 3 phases included a mix of recovering addicts and substance abuse treatment professionals, both males and females.

Phase I of the Summit House treatment program is the 6-month intensive "modified" therapeutic Community inside the walls. It is comprised of a 24-hour residential drug and alcohol treatment program located separately from the general prison population in order to minimize negative peer pressures from the general population that could adversely affect engagement in the treatment process. The program content is based on a social learning model that requires a safe locale and structured milieu which includes group and individual counseling, psycho-educational lectures and workshops, Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) groups, and GED preparation. Since 1996, the number of clients entering Phase I has continued to increase, most rapidly at the men's facility in Laconia. At the time of this evaluation, the total bed capacity for Phase I in Concord was 40, at the Laconia men's facility it was 96, and at the Laconia women's facility it was 20.

Phase II is a re-entry program outside the walls designed to prepare offenders to reenter the community. Phase II begins with the re-classification of the offender to minimum security with the continuation of some minimal (i.e., weekly) group counseling along with the availability of weekly AA/NA meetings. Some relapse prevention and practice of skills learned earlier occur, but the emphasis is on work in the outside community or on prison grounds. This phase lasts approximately 2 months and the offender must be involved in approved work or school during this period.

Phase III is focused on support, relapse prevention, and community safety. At the beginning of Phase III the offender is moved either to a Halfway House or to Administrative Home Confinement that includes electronic monitoring. While at the Halfway House the offender must work full time and save money in preparation for being released on parole. During this phase, skills learned in the previous 2 phases are reinforced and practiced in weekly group therapy sessions. Also, some continuing involvement with mutual aid and self-help groups such as AA and NA is encouraged. In addition, finalization of employment, aftercare services, and the parole plan occurs. Once the individual is released on parole, he or she is considered to have successfully completed Phase III and to be a graduate of the Summit House Program.

Research Purpose and Methods: The purpose of this process evaluation of the NH DOC Summit House substance abuse treatment program was to provide a comprehensive description of the theoretical framework, the content, the structure and the processes of the Summit House treatment intervention. Factors examined included: 1) treatment clients at baseline, during the interventions, and at completion of the program; 2) the substance and quality of the program interventions, including the program content, intensity, and length, as well as the numbers and quality of the staff that delivered the interventions; and 3) the overall organizational context in which the program and interventions occurred.

Four primary data gathering methods were utilized. These included the following: (1) in-person interviews with key administrative personnel at the NH DOC (2) in-depth interviews of Summit House clinical staff and administrative security staff – these interviews included both a standardized questionnaire (the MAPS-Unit form) and more

open questions designed to elicit more qualitative information; (3) examination of program documentation and direct observations of Summit House program operations during site visits; and (4) semi-structured interviews with clients just prior to their entry into Summit House, at each program stage, and upon completion of the program.

Although the original proposal design included only one full day of interviews and observations for each treatment phase, due to significant programmatic and facility changes that were implemented in the overall correctional system and in the operation of the Summit House program, the research team conducted additional visits to all 3 sites. Some of the major changes that occurred included: the implementation of a "smoke-free" facility policy by the NH DOC; significant staff changes at Summit House that were due in part to the opening of a new prison; structural program changes such as an increase in group therapy sessions, along with a decrease in individual counseling sessions; and restructuring of staff roles and changes in the number and content of community meetings. The research program staff implemented a total of at least 8 separate site visits to Phase I of Summit House – these visits do not count many other visits during which individual interviews were conducted with offenders. Additional onsite observations and interviews with clinical and correctional security staff were conducted at Phases II and III of the Summit House program.

Objective data were gathered from offenders, including not only the collection of baseline information on various domains before entry to Summit House, but also upon transitioning to each of the different program phases through graduation from Summit House. The Addiction Severity Index (ASI) was used to collect historical data, treatment needs, and severity data across the 7 domains of medical, employment, family and social relationships, drug abuse, alcohol abuse, criminal justice, and psychological. In addition, a new set of instruments entitled Monitoring Area and Phase System (MAPS) was used to gather information on treatment motivation. These instruments were used to assess the impact of the treatment intervention on client motivation to change, as well as to determine client satisfaction with the treatment that was provided.

Demographic, problem severity, and all other data were collected not only from the 3 Summit House treatment groups (i.e., 69 men at the Concord State Prison; 133 men at the Lakes Regional Correctional Facility in Laconia; and 35 women at the Lakes Region Correctional Facility in Laconia), but also for one comparison group of 81 men and one comparison group of 17 women who did not receive the treatment interventions. The comparison group was necessary because the current Process Evaluation was the first part of a longitudinal study of Summit House; the second part is made up of an outcome study assessing the impact of the program and the relationships between substance abuse, criminality and motivation that influence treatment effectiveness.

Highlights from the Process Evaluation Project Findings: The findings are organized according to four basic research areas. After the statement of each basic research area, specific findings relevant to that area are presented.

(1) A description of the guiding program philosophy, goals, and outcomes as they are understood and implemented by the staff across different program phases and facilities:

The clinical staff across all 3 Summit House facilities and across the 3 Phases of the program shared a similar guiding program philosophy. They view substance abuse as a chronic relapsing disorder. In order to effectively treat this disorder they feel that a safe and drug-free residential environment with a structured milieu that encourages inmates to acknowledge their addictive behaviors is required. By gaining and practicing new and effective coping skills in this "modified" therapeutic community (the modification is that staff, not clients, are responsible for enforcement of rules to ensure the safe environment) inmates will lead more productive lives and recidivism will be reduced. Abstinence is considered the only effective goal for all participants. Although this basic program philosophy and related goals and outcomes were found to be generally shared by all of the Summit House clinical staff, a number of the Correctional Officer security staff (particularly those in the Lakes Region Correctional Facility in Laconia) were less aware of or simply did not share the philosophy. Therefore, they were less effective in supporting the goals and outcomes of the Summit House program.

(2) A description of any site specific issues that affect program implementation; a description of gender issues that affect program implementation and/or content:

Staff turnover resulted in major program changes. For example, the original Director of Summit House was not only phased out of his role, but his position was redefined such that it no longer was responsible for overseeing all Substance Abuse Services in the Department. A new Coordinator was appointed for the Summit House program at the Lakes Region Correctional Facility in Laconia who, as might be expected, implemented a number of significant program changes – she expanded the number of group therapy sessions, but decreased the number of individual counseling sessions. Also, in response to higher level administrative decisions, the size of the Summit House program at Laconia was increased from 84 to 96 inmates. In addition, the Coordinator of the women's Summit House program in Laconia was replaced twice during the course of the process evaluation. In contrast, the Coordinator of the Summit House Program at Concord State Prison remained in place and thus program implementation at that site was more consistent and stable.

A new prison facility was opened in the northern part of the state. This affected all program sites, but especially the Lakes Region Correctional Facility in Laconia due to its geographical proximity to the new prison. Many senior Correctional Officer security staff left the existing facilities, particularly Laconia, in order to accept promotions or other reassignments to the new facility. Also, due to both a low unemployment rate (less than 2% at that time) and low salaries, it took time to fill a number of the open Correctional Officer security positions and more time to train them on the Summit House treatment philosophy.

Physical space issues varied at the different Summit House facilities. At each of the programs there was some physical separation of the Summit House population from the general prison population. The Phase I Summit House population of men at the Lakes Regional Correctional Facility in Laconia had a distinct building in which they are housed separately from other inmates, whereas the Phase I Summit House participants in Concord and the women's program in Laconia simply had a separate unit or ward. Physical space issues continue to occur when inmates at the different programs move from Phase I to Phase II. The Phase II program for men at Laconia does have a separate building, but the women are simply housed in a separate dormitory in the same building as Phase I women. Also, due to space limitation issues, in Concord when the Summit House men leave Phase I and move to Phase II, minimum security, they are housed with the prison's general population of inmates.

A new smoking policy was recently implemented such that the entire NH DOC became a "smoke free" environment. However, this policy was implemented differently at the different correctional institutions. Inmates caught smoking at the Lakes Region Correctional Facility in Laconia were more likely to experience more severe punishments and program "set backs" – smoking there is viewed as an addiction and/or banned criminal activity that warrants immediate punishment. Smoking at Concord appears to be tolerated more, particularly in Phases II and III where the staff feel that there are larger problems that need to be addressed.

Rules and regulations, although written out in volumes that comprise the NHDOC Policy and Procedures Directives, appear to be applied somewhat inconsistently, due to the power of interpretation left to individual staff. This may be related at least in part to the staff turnover issue addressed earlier. However, it is also related to the different responsibilities of staff in programs with complementary, but different, objectives. For example, inmates who are students in the college based Transformations program are encouraged by the college staff to interact "normally" with members of the opposite gender in order to gain social skills, to learn to work together in a business environment, etc. However, outside of the Transformations program these students are not supposed to even speak to a person of the opposite sex, and if a Correctional Officer observes such outside fraternization, they may be dismissed from participation in the Transformations program. Another example is that the Summit House group therapy sessions encourage emotional honesty, but if an inmate confronts a staff member for inappropriate behavior, this can be treated as insubordination.

Disability issues exist for Summit House and other inmates. For example, none of the 3 Halfway Houses can accommodate individuals who are physically disabled - there are no elevators, no ramps and no first floor sleeping rooms. Therefor, such inmates participate in Administrative Home Confinement, which usually means a longer and more difficult approval process. Another example relates to inmates who are eligible for Supplemental Security Income (SSI) for either physical and/or mental disabilities. Since SSI is discontinued when

someone is incarcerated, inmates cannot receive SSI until they are paroled. However, one condition of moving to Phase III of the Summit House Program (either to a Halfway House or to Administrative Home Confinement), is that the inmate obtain a job within 2 weeks and work 30 hours per week. If the inmate obtains a job, the inmate may no longer be eligible to receive SSI, whereas if the inmate does not obtain a job, the inmate may be sent back to prison due to not meeting the job requirements.

Gender issues emerged in relation to First Step, which is a highly structured modified boot camp experience with strict military style discipline and "in-your-face" confrontation. Before inmates can enter the Summit House program, they must go through a 60-day pre-treatment period that includes participation in and graduation from First Step. There is no evidence that supports the effectiveness of a First Step type program for either men or women. However, particularly for the Summit House women, most of whom have a history of emotional abuse (94%), physical abuse (91%), and/or sexual abuse (73%), the First Step experience may be not only unnecessary, but counterproductive.

(3) A description of the treatment program, including substantive content at each phase, along with information on the duration and intensity of treatment interventions, and information on program philosophy and content as implemented within each facility:

As noted earlier, the staff consider the 6 month long Phase I of Summit House to be a "Modified" Therapeutic Community. It consists of a mix of recovered and professional counselors who primarily provide group therapy, along with mutual aid support through AA and NA, plus psycho-educational lectures and workshops, and GED preparation as needed. The goal is total abstinence and recovery. This content is typical of many such programs within state correctional systems where the professional staff control the content and process. The "heart" of the program is the group therapy, but the impact of that modality appeared to vary according to the experience and competence of the individual counselors.

The level of individual counseling varied from 1 hour per week in the Concord facility to 1 hour every other week in the Laconia men's program – the level of individual therapy in that facility was reduced in order to allow more group therapy and to accommodate the program expansion from 84 to 96 men.

The mutual aid support provided by AA and related groups appeared to be reasonable and appropriate, but at least during the time of this process evaluation, the number of NA and drug oriented groups in the Laconia facility was not adequate – the clinical staff explained that insufficient numbers of community based volunteers were available who were willing to enter the prison to offer the drug oriented groups. Also, there were insufficient numbers of AA, NA and other recovery-oriented materials written in Spanish to meet the identified need.

The quality of the psycho-educational lectures and workshops that were offered varied according to the capabilities of the individual presenters. Also, although general outlines existed to define the content of the lectures, specific goals and objectives for inmate learning did not exist. Also, there was no standard assessment or measure of the inmates' mastery, or lack of it, of the content.

Phase II of the program begins after the inmate graduates from the 6 months of Phase I inside the walls and moves to a separate Minimum Security Unit outside the wire and walls. Phase II lasts for a minimum of 2 months and is focused on outside work in the community, with some fairly minimal continuing clinical support that includes one group therapy session per week. Also, the individual is expected to participate in one mutual aid group meeting per week (e.g., AA or NA). Given the intensity of Phase I, a number of the inmates in Phase II feel somewhat abandoned and that they do not receive sufficient ongoing clinical support.

Phase III consists of the inmate being moved to either a Halfway House facility and/or to Administrative Home Confinement where he or she must stay a minimum of 3 months. Within this Phase the inmate has one clinical group meeting per week with a new counselor, has some attention from a Sergeant Mentor, is expected to go to work out in the community, as well as to continue participation in mutual aid groups.

(4) A description of staff competence and training levels across program phases and sites, along with a discussion of staff impact on treatment program implementation at each facility:

The Summit House sites are affected by the strengths and personalities of the individuals directing and working in the individual programs, as well as the overall institutional philosophies and contexts. The Concord Summit House located within a mixed-security prison has more of a paramilitary style. Its strengths include strong leadership and stability for both staff and inmates. However, potential weaknesses include less willingness to listen to inmates and less openness to change. Greater contacts and interchange among the staff at the 3 different Summit House programs could be advantageous to all.

Given the reliance upon clinical groups as the major treatment modality throughout Summit House, some of the counselors could use increased training to enhance their group clinical skills. Also, consideration should be given to providing incentives to ensure that all of the Summit House clinical staff become Licensed Alcoholism and Drug Abuse Counselors (LADACs) – more staff are moving in this direction, but additional incentives would speed this process. In addition, more in-service and outside training workshop opportunities should be provided for all the staff (e.g., participation in the Correctional Institute offered by the New England Institute of Addiction Studies; attendance at the Annual Meeting of the Therapeutic Communities of America;). Finally, some cross

training should be designed and implemented for both the Summit House clinical staff and the Correctional Officer security staff.

Another critical staff performance and competence issue relates to the ratio of staff to inmates. Currently, each of the Summit House counselors is responsible for providing intensive group and individual counseling services, as well as educational services, to a minimum of 12 inmates in Phase I. In addition, these same counselors are expected to provide follow-up services to the inmates who have graduated from Phase I and reside in Phase II. Also, during the evenings, only one Correctional Officer is often responsible for providing security for all of the 96 inmates within the Men's Summit House program in Laconia.

Finally, the Coordinators of the Concord and Laconia Summit House programs meet weekly to share information and to discuss clinical issues. However, consideration should be given to the possibility of hiring a senior Licensed Alcoholism and Drug Abuse Counselor who could provide clinical supervision and ongoing consultation to these Coordinators on a weekly basis.

Recommendations for Future Treatment of Alcohol and Drug Offenders Within NH:
The process evaluation research team implemented numerous interviews with administrators, clinical and security staff, and inmates associated with the Summit House program in all 3 facilities, across all 3 phases of the program. In addition, the team conducted direct observations of program operations, examined program records, and collected data from other relevant sources, such as a review of the pertinent literature on the effectiveness of various substance abuse treatment approaches with offenders. As a result of a synthesis and analysis of all of these data, the research team developed a series of program recommendations for the consideration of the NH DOC as the agency works on an ongoing basis to improve and develop the best possible treatment program for offenders within NH. These recommendations should be considered tentative until data collection from the ongoing outcome evaluation of Summit House can be completed, analyzed, and synthesized. Also, it is our understanding that the NH DOC has undertaken its own internal review of substance abuse programs that will compare its programming with relevant research on those approaches that are most effective with correctional populations.

Following are the current recommendations from the process evaluation research team:

- Standardize the initial substance abuse assessments of offenders in order to provide more consistent data and better treatment planning.

- Conduct an evaluation of the boot camp oriented First Step pre-treatment entry program requirement to determine whether its advantages in fostering discipline are outweighed by its disadvantages in creating barriers to treatment. As an alternative to First Step, the NH DOC may wish to consider implementing a cognitive behavioral program that deals with criminogenic factors as a prerequisite to entry to Summit House.

- Further standardize the curriculum and therapeutic format of all of the Summit House programs in order to ensure that all offenders are receiving the same educational content and treatment.

- Design and implement a broader continuum of empirically based substance abuse treatment approaches within the NH DOC. Not all substance-abusing offenders require the level of intensity of the Summit House program. Science based treatment modules such as those available from the National Institute on Drug Abuse, the Treatment Research Institute, the Clinical Trials Network, and other sources should be examined and considered as to their applicability within the NH DOC.

- Implement additional ongoing pre and post testing of offenders curriculum mastery in substance abuse treatment programs within the NH DOC.

- Enhance the existing Summit House program model to include greater and more effective inmate participation in the daily operations and maintenance of the "Therapeutic Community".

- Provide more intensive aftercare services for substance abusers after they leave Phase I. The NH DOC should seriously consider collapsing and integrating Phases II and III of Summit House. They could be brought together as a work release Therapeutic Community along the lines of the Amity program in California and/or the Crest program in Delaware. The 6 months of Phase I in prison should be followed by a 6 month work release oriented Therapeutic Community that is out in the community. In addition, aftercare services should be significantly expanded to support the offenders during their parole period for at least 6 to 12 months after they leave the Therapeutic Community.

- Provide the Coordinators of Summit House with greater latitude to exercise clinical judgements as to how best to handle inmate behaviors.

- Continue and reinforce established relationships with AA, NA, and other mutual aid groups in order to insure offender involvement with these groups both in prison and out in the community.

- Reduce the caseloads of those Probation and Parole Officers who monitor Summit House graduates and provide more intensive and extensive training on substance abuse treatment and relapse prevention for all Probation and Parole Officers.

- Implement mandatory cross training for all clinical staff and security staff employed in Summit House programs.

- Hire an overall Coordinator or Director of Substance Abuse Services who can not only establish the overall direction for these services within the NH DOC, but also provide necessary clinical supervision for the various Summit House Coordinators.

- Increase fiscal support for Summit House programs so that the program can purchase necessary publications such as manualized treatment workbooks and recovery oriented materials in English and Spanish, and also provide increased salary and training support for staff.

- The initial Summit House priority should emphasize problem recognition and willingness to change before introducing the tools of change.

- Ensure that at least some bilingual Summit House counselors are available to serve the needs of Hispanic inmates.

- Renovate at least one of the Halfway Houses that are utilized by Summit House graduates so that it is accessible for those persons who are disabled.

- Consider placing greater program emphasis within the women's program on issues such as dealing with children, past victimization, "interpersonal criminogenic needs targets", and presentations and interactions that are more in tune with women's learning styles.

INTRODUCTION

This report summarizes the findings from a process evaluation of the Summit House program, a residential substance abuse treatment program within the New Hampshire Department of Corrections (NHDOC). The process evaluation, conducted from June 1999 through September 2001, comprises the first part of a longitudinal study of Summit House; the second part is made up of an outcome study assessing the impact of the program and the relationships between substance abuse, criminality and motivation that influence treatment effectiveness. This process evaluation focuses on the characteristics of the Summit House program including: treatment content and program structure across the three Summit House sites, quality of the program staff and training, and characteristics of the clients and a corresponding comparison group.

This report is targeted toward two audiences: The National Institute of Justice, to fulfill the requirements of the grant that funded this evaluation, and the NHDOC to inform policy and program developments for the Summit House program. Thus we attempted to include programmatic details and statistical analyses that would be informative to both of these audiences. We have organized this report into five sections: **Section One** describes the process evaluation methodology, data sources and instruments; **Section Two** summarizes the literature presenting the theoretical framework upon which the evaluation methodology, analyses and recommendations are based; **Section Three** describes the demographic and treatment characteristics of Summit House clients and analyzes the client and comparison group's need for treatment, motivation and changes during the treatment period; **Section Four** summarizes the findings of the process evaluation and is organized around four guiding research questions as outlined in the original proposal submitted to the National Institute of Justice; **Section Five** includes recommendations from the research team for addressing the issues identified in the findings and enhancement to the overall Summit House program.

Overview of the NHDOC Summit House Program

The New Hampshire Department of Corrections incarcerates more than 2,200 felons in three prisons, three halfway houses and in-home confinement (electronic monitoring). In addition, Field Services supervises 3,300 probation cases and 1,150 parole cases throughout the state. In the summer of 2000, a new 'hardened' medium security facility was opened in Berlin to house male inmates transferred from other NHDOC facilities and to ease the overcrowding at the Concord prison.

A needs survey conducted by the NHDOC in 1990 estimated that 75% to 85% of all offenders had substance abuse related problems prior to their incarceration. These data corresponded with national trends reported by the Federal Bureau of Prisons (1989), Government Accounting Office (GAO, 1991) and the National Center on Addiction and Substance Abuse (GAO, 1996). On the strength of these data, in 1991, NHDOC established Summit House, an intensive residential drug and alcohol treatment program. In 1996, with the advent of additional grant funds under the Residential Substance Abuse Treatment for State Prisoners (RSAT) formula awards, NHDOC was able to enhance and expand the Summit House Program. The RSAT funds were used to establish the 6-month intensive residential phase of the Summit House program—known as Phase I—and expand the program to both the New Hampshire State Prison for men in Concord and the Lakes Region Facility in Laconia. The Laconia Facility has separate programs for both men and women.

With the infusion of the RSAT funds and the creation of Phase I, Summit House evolved into a three-phase program comprising components identified in the literature as effective for substance abuse treatment in corrections (Inciardi, et al, 1997; Pan, et al, 1993; Wexler, 1992; DeLeon, 1991). The clinical personnel hired to staff all three of the Summit House phases included a mixture of recovering addicts and substance abuse professionals. The phases of the program were intended to be developmental in nature, following inmates through their changes in custody level and into the community.

Phase I of the program is the 6-month intensive 'modified' Therapeutic Community inside the walls, and is comprised of a 24-hour residential drug and alcohol program located separately from the general prison population to minimize the peer pressures that adversely affect engagement in the treatment process. The program content is based on a social learning model requiring a safe locale and structured milieu including group and individual counseling, psycho-educational lectures and workshops, AA/NA groups, and GED preparation. Since 1996, the number of clients entering Phase I has continued to increase, most rapidly at the Laconia men's facility. At the time of this evaluation, the total bed capacity for Phase I in Concord was 40, at the Laconia men's facility it was 96, and 20 at the Laconia's women's program.

Phase II is a re-entry program outside the walls that prepares offenders to enter the community. Phase II begins with the re-classification of the participant to minimum security with the continuation of some minimal (i.e., weekly) group counseling and AA/NA meetings. Relapse prevention and practice of earlier skills learned are included in the program, but the emphasis is on outside work on prison grounds or in the community. This phase lasts approximately 2 months and mandates that the offender is involved in approved work or school during this period.

Phase III is focused on support, relapse prevention and community safety. At the beginning of Phase III the offender moves to a Halfway House or Administrative Home Confinement (AHC – electronic monitoring) and this period of treatment lasts approximately 3 months. While at the halfway house all offenders must work full time and save money to prepare for their release on parole. During this phase skills learned in the previous phases are reinforced and practiced and finalization of employment, aftercare services and the parole plan takes place. With release on parole considered successful completion of Phase III, the inmate is considered a graduate of the Summit House Program.

Client eligibility for Summit House Program

Offenders are initially classified to attend Summit House during their first 30 days of incarceration when they are housed in the Reception and Diagnostic Unit (R&D) of the NHDOC. This recommendation comes from the Classification officer who, after reviewing the offender's record and interviewing the offender, makes a determination that: 1) the Mittimus states that the offender must complete Summit House as a requirement of the sentence; or 2) the offender's crime was a drug offense, an offense committed while under the influence of alcohol or drugs, or a crime committed to obtain money to buy drugs; or 3) the offender admitted during the interview to having a history of substance use. This recommendation becomes a part of the offender's pre-parole plan and a condition that must be completed for the offender to be considered for parole at the minimum parole date[1].

Prior to entering the Summit House Program, offenders must be within 2 years of their minimum parole date and must successfully complete a 60-day pre-treatment period that includes a highly structured modified boot camp called First Step. Inmates may attempt the First Step program any number of times but must graduate before moving on to the Summit House Program.

The First step program was not examined as part of this evaluation since it is not considered a component of the Summit House program. However, a number of issues did arise from the impact of this program on Summit House clients. These issues are noted throughout the report when relevant, and are addressed in the recommendations section.

[1] NH is an indeterminate sentencing state where the judge imposes a mandatory minimum and maximum for each crime. 100% of the mandatory minimum must be served unless the court issues a sentence modification of the original minimum order.

SECTION ONE: METHODOLOGY, DATA SOURCES AND INSTRUMENTS

The purpose of a process evaluation is to provide a comprehensive description of the theoretical framework, content, structure and processes of an intervention so that a complete picture of a program is generated (need methodology citation). In evaluation language, this is describing the 'black box' of an intervention so that later assessments of programmatic impact and effectiveness are informed by a comprehensive description of those factors from the intervention that contribute to or appear to have an affect on the outcomes. The types of factors typically examined in a process evaluation of an intervention include: a comprehensive description of clients who participate in the intervention at baseline, during exposure to the intervention and at completion; the substance and quality of the intervention content; the intensity and length of exposure to the content by the participants (the dosage effect); the quality and experience of the staff overseeing and administering the intervention; the context in which the intervention is applied including the larger organizational structure and policy; as well as other external factors that are observed to have an impact on the intervention such as other staff who come into contact with the program, gender relevance and physical structure. Once this picture is generated, a program can then be evaluated in terms of quality of content and structure, intervention intensity, implementation consistency, client/need appropriateness, staff competence, and organizational capacity.

To gain the most comprehensive picture of the Summit House program, four data-gathering methods and data sources were identified: 1) in-person interviews with key administrative personnel at NHDOC; 2) in-depth interviews of Summit House staff and administrative security staff; 3) examination of program documentation, site visits and observations of the Summit House program activities; and 4) interviews with clients just prior to entering the Summit House program, at each program stage and upon completion of the program.

Key administrative interviews

In-person interviews were conducted with several key NHDOC administrative sources to gather a picture of the Summit House program within the corrections system and policies and procedures that affect the Summit House program. These included the NHDOC Commissioner and Assistant Commissioner; Wardens for each of the sites and local prison administrative staff at each of the facilities. The entire research team participated in these interviews and recorded individual field notes that were later compiled and analyzed.

Staff interviews

In-depth interviews were conducted with every member of the Summit House Program treatment staff, including all three program Coordinators (as well as two subsequent coordinators for the women's program) all clinical staff and the sergeant mentors which are hybrid security staff providing support to the offenders and the program. Several Correctional Officers that provided security to the Summit House living and program units were also interviewed. Standardized data were gathered on the Summit House components by the individual program coordinators using the MAPS-Unit form. To gather standard data on staff background, history, experience and education, the research team used the staff component of the MAPS-Unit form. In addition, a set of interview questions was developed to guide the in-person interviews with staff and was used consistently for all interviews so that the data could be compared across the different program roles. Each site had a minimum of two sets of interviews, one large group interview when the evaluation project was introduced and individual interviews with various members of the research team. The identical questions were asked both in the group interviews and in the individual interviews for standardization and comparison. Field notes from these interviews were compiled and analyzed separately and then together by two of the research team members.

On-site program observations

During several of the site visits, the members of the research team also engaged in direct observation of actual program operations. These observations included staff meetings, educational workshops, group therapy sessions, community meetings and informal life on the units. We did not observe individual therapy sessions or disciplinary sessions. Research staff members involved in the site visits included Dr. Suzanne McMurphy, the Principal Investigator, Dr. William Butynski, the Project Director, Theimann (Tim) Ackerson, MSSW, a Clinical Consultant and Alice Caswell, MSW, clinical interviewer.

Although the original proposal included only one full day of interviews and observations for each treatment phase, the research team implemented additional visits to all three sites due to significant programmatic and facility changes that were being implemented either in the overall correctional system and/or in the design and operation of the Summit House Program during the time of the process evaluation. These changes included the implementation of a "smoke-free" facility policy; significant staff changes due in part to the opening of a new prison; structural program changes such as increases in the number of group therapy sessions; decreases in the number of individual counseling sessions for the participants; and restructuring of the role of staff and number of community meetings.

The dates of the site observation visits to Phase I of the Summit House Program, including both the Concord and Laconia men's and women's sites were October 19, 1999, November 21, 1999, December 14, 1999, December 21, 1999, December 28, 1999, January 19, 2000 and March 7, 2000. Because a large number of the treatment cohort remained in Phase I after all the sites visits were completed, an additional visit was made to the Lakes Region Facility (LRF) programs, both men's and women's programs, on January 26, 2001 to document any changes in programming during the previous six months.

The research team also spent one day in interviews and site observations with Phase II and Phase III Summit House clinical staff and correctional security staff. The same

interview questions were used for these interviews as with Phase I staff as well as several additional questions appropriate to the programmatic structure of Phase II and Phase III. The Laconia Phase II visit was conducted in May 15, 2000; the Concord visit was May 25, 2000. Phase III site visits were conducted throughout August 2000.

Client data sources and instruments

Data was gathered from the Summit House participants at baseline prior to entering Summit House, and upon transitioning to each of the different Phases[2]. The Addiction Severity Index (ASI) was used to gather comprehensive historical data at baseline and to assess the need for treatment and the severity of treatment needs across a number of domains prior to entering the Summit House program. A new set of instruments called Monitoring Area and Phase System (MAPS) was used to gather baseline information on treatment motivation and track the impact of the treatment program on client motivation to change as well as client satisfaction with treatment provided.

The ASI was administered to collect baseline historical data within two week of the offender entering the Summit House program. Along with the ASI, the MAPS-In (intake form) was administered to assess baseline motivation in each of the domain areas of the ASI. Within the first few days of entering Phase II and Phase III, the offender was interviewed using the MAPS-out (discharge form) which gathered information on the client's motivation to change at the end of each phase and his/her motivation for the upcoming Phase along with the satisfaction rating of the treatment services provided during the preceding phase. A final MAPS-out was given at the end of Phase III. A scheme showing the data collections phases is provided in Appendix **.

The ASI was used to collect baseline data as it provides a multi-dimensional approach for identifying life problems within seven areas: medical, employment, alcohol, drugs, legal, relational and mental health (McClellen, 1980). The ASI can be employed for repeated

[2] Additional interviews with the participants as well as other data collection efforts are currently underway for the Summit House Outcome Evaluation but are not described in this report.

measures of self and interviewer perceived severity in each of those seven domains. The ASI has become the most commonly used measure of substance abuse treatment effectiveness and has been validated in a variety of treatment settings and populations. It is widely used for its research capacity based upon the composite score index which is calculated for each individual and can be used as a follow-up score for assessing treatment progress as well as a normative comparison against other treatment groups. Recent research has resulted in an additional composite index, which identifies more specific clinical factors (McDermitt, et al. 1996).

The Monitoring Area and Phase System (MAPS) presents a model based upon specific client problem fields (Area), client stages of change (Phase) and conditions of treatment, i.e. staff competence, program resources, program treatment and goals, as well as interventions related to client's needs and stages of change (Oberg, et al. 1998). The uniqueness of this instrument is its multiple levels of use from baseline scoring, to treatment planning and matching, program monitoring and evaluation and program effectiveness. The conceptualization of the MAPS is based upon the Addiction Severity Index (McAllen, et al, 1980) and the Stages of Change theory developed by Prochaska & DiClemente (1993). The combination of the ASI and the theory on stages of change have been used before as a model for substance abuse treatment and assessment, but this is the first battery of instruments to standardize these two approaches into an integrated model (Campbell, 1997).

Two other administrative data sources will be necessary to complete the subsequent Outcome Evaluation of Summit House but were not available in time to be included in this Process evaluation report: 1) data from the administrative offender records for information on criminal history, drug abuse, technical violations and disciplinary actions while in prison and sanctions upon release; 2) data from the NHDOC parole board on returns to prison of Summit House participants and comparison to calculate recidivism. Data from the administrative records will need to be manually gathered from each parole office since the Probation and Parole management information system projected to be developed by this time has not yet been implemented. This is currently underway for the

Outcome evaluation but was not available to be used in the analyses for this process evaluation.

Summit House client treatment group and comparison group

To most effectively compare the experience of the offenders who participate in Summit House to offenders with similar needs who do not participate, a sample of Summit House participants were selected as well as a corresponding comparison group. Both groups of offenders were tracked through their time in the prison, with identical data being collected for both at baseline and upon completion of their time in prison prior to entering the community on parole[3].

Sample size, description and recruitment process

To recruit for the treatment sample, all new clients that were eligible to enter the Summit House program beginning in May of 1999 were approached to participate in the study. Members of the research team met with the eligible clients to explain the research project and to address any questions or concerns. They were introduced to the clinical interviewer and told to expect to be called to a private room to speak with her and make a decision about their participation in the study approximately 2 weeks after they had started the Summit House program. The team stressed that participation was completely voluntary and that no one, either in the Summit House program or in the NHDOC would know whether they chose to participate. The team also stressed that participating in the study would not affect their treatment in any way either positive or negative, nor would they receive any additional benefits as a result of participation "(e.g., monetary or otherwise)."

Recruitment continued for approximately 10 months for the men and 14 months for the women until the sample sizes were achieved: 202 for the men's treatment group and 80

[3] The only additional data collected on the Summit House participants was the interim MAPS-In and Out for the Phase II and Phase III. Because the comparison group did not participate in any other programs while in prison, there were no interim time periods appropriate for data collection.

for the comparison group; 34 for the women's treatment group and 17 for the comparison group.

While clients signed an inform-consent document at the initial interview, their verbal assent was sought at the beginning of each subsequent interview. During the treatment phase, only 1 man dropped out of the study. Because we had over sampled in the men's groups, we did not have to recruit additional clients during the treatment phase. We had a more difficult time meeting the sample size for the women. Because the woman were not moving into Phase II of the treatment program until sometimes a year after their entry into Phase I, there was a very small pool to recruit from in the beginning of the study. Secondly, several women refused to participate and ** dropped out during the study. After more than a year, we finally reached the minimum sample size of 35 women for the treatment group. When another client dropped out upon entry into the community, we became 1 short of the projected total.

The comparison group was identified through the NHDOC classification process as those offenders who met the criteria of having drug and alcohol treatment needs and a minimum parole date that was comparable to the treatment group[4]. All offenders eligible to be part of the comparison group received a letter indicating that they had met the eligibility criteria for being part of the study and that they would be contacted by the interviewer to inquire whether they were interested in participating. Because of the small number of people who met the comparison group criteria, recruitment for the men and the women went well into the study period and resulted in the need for a no-cost extension. The comparison sample size of 80 was met for the men, however, the majority of eligible women approached to be part of the study refused to participate. Thus we were only able to achieve a final sample size for the comparison group of 17 women, 3 short of the target number of 20.

[4] To be eligible for selection into the comparison group an offender had to be within 24 months of their minimum parole date.

SECTION TWO: LITERATURE OVERVIEW AND THEORETICAL FRAMEWORK

To guide the design of the evaluation and to provide a framework with which to evaluate the Summit House program and construct the recommendations, a review of the current scientific views on substance abuse programming in corrections was conducted and is summarized here.

Assessments of the quality and effectiveness of prison-based treatment for inmates with alcohol and/or other drug problems have changed significantly over the past quarter century. Lipton (1995) notes that the rather cynical but widespread belief in the mid 1970s that "nothing works" emerged at least in part from a study that he and two colleagues published in 1975, along with Martinson's well-known pronouncement in 1974. It was at a time when a major shift occurred from an era with a belief in rehabilitation to one that emphasized punishment and general deterrence. Martinson eventually recanted that pronouncement and, over the subsequent period of years Lipton (1998, 1995, and 1994) worked along with a number of other authors, such as Inciardi (1996, 1995 and 1993) and Wexler (1999, 1997 and 1993), to demonstrate that substance abuse treatment which begins in prison can have a number of important positive impacts, particularly if it is followed by appropriate aftercare services. These impacts can range from a reduction in crime, substance use and recidivism, to an increase in employment.

Beginning in the 1970s, and continuing over the following couple of decades, a number of federal agencies began providing increased levels of support for the treatment of substance abusers, as well as for research studies on those treatment programs which evolved. These studies have clearly demonstrated both the effectiveness and the limitations of treatment for persons with alcohol and/or other drug problems, in the overall population of substance abusers and also for those who have been or are currently within the criminal justice system (NIDA, 1999).

Several of these major national studies that analyzed the effectiveness of substance abuse treatment for the broad general population included the following: the Drug Abuse Reporting Program (DARP) implemented between 1969 and 1973 which conducted a one year post treatment follow-up of publicly funded substance abusers; the Treatment Outcome Prospective Study (TOPS) conducted between 1979 and 1981 that followed clients for up to five years after treatment; the Drug Abuse Treatment Outcome Study (DATOS) that followed clients admitted between 1991 and 1993 (Simpson and Brown, 1999); the California Drug and Alcohol Treatment Assessment (Gerstein et al, 1994) that was limited to California but did include large numbers of clients discharged from 1991 to 1992; and the National Treatment Improvement Evaluation Study (NTIES) whose results on the effects of treatment began being published in the late 1990s (Center for Substance Abuse Treatment, 1997; NTIES, 1997). Using data from these studies and other sources, in 1999 the National Institute on Drug Abuse (NIDA) summarized its experience in the treatment area and published "Principles of Effective Treatment – A Research-Based Guide" (NIDA, 1999).

Major results and findings from most of the treatment studies cited above include not only descriptive information, but also long term objective evaluative data relating to the effectiveness of different treatment modalities, including that of therapeutic communities. Since a modified therapeutic community constitutes the primary initial treatment approach used within New Hampshire's prison system, those and other findings are relevant to our process evaluation and outcome evaluation studies. The findings from the national studies have generally demonstrated that longer treatment results in less drug use, fewer predatory crimes, more full time employment and less welfare dependency (Office of National Drug Control Policy, 1998 and 1996; U.S. Department of Health and Human Services, 1995; and Condelli and Hubbard, 1994).

Over the past several years one of the major supporters and funders for process and outcome evaluations related to substance abuse treatment provided for persons incarcerated in state prisons has been the National Institute of Justice (NIJ). Although the Residential Substance Abuse Treatment (RSAT) Program experienced some startup

problems at the state level, particularly in those states without relevant preexisting substance abuse treatment programs within their prison system, State officials unanimously indicated that the program has expanded state capacity to provide drug treatment services for their inmates (Harrison and Martin, 2000). Particularly over the past 10 years, a relatively large number of research investigations and reviews have been produced which specifically described, delineated, studied and evaluated substance abuse treatment of inmates within the correctional system. These have ranged from studies on chronic drunk drivers (e.g., Applegate, Langworthy and Latessa, 1997) to broader studies and reviews of treatment outcomes for substance abusers who have been incarcerated for a broad range of different offenses (Lipton, 1998; Office of Justice Programs, 1998; Inciardi, 1993; Leukefeld and Tims, 1992).

There are many different reasons for the interest in both the overall substance abuse problem and in the treatment of substance abusers. Some of these reasons include recognition of the enormous economic costs associated with these problems as reported in a number of different national reports. Earlier this year the National Center on Addiction and Substance Abuse (CASA) at Columbia University published a detailed analysis of the impact and costs of substance abuse on state budgets. They determined that every American annually pays $277 in state taxes to "shovel up" and pay for the consequences of the problem (in state agency budgets such as Corrections, Medicaid, Public Safety and Welfare), but only pays $10 for direct prevention and treatment services (National CASA, 2001).

Another broad economic analysis of the overall national costs of alcohol and other drug problems included specific data on the costs associated with alcohol and drug related crimes. These costs totaled nearly $70 billion, including: $24.3 billion in crime costs; $23.4 billion in lost earnings related to incarceration; $19.2 billion in lost earnings related to the crime career; and $3.1 billion in lost earnings of the victims of crime (National Institute on Drug Abuse and National Institute on Alcohol Abuse and Alcoholism, 1998). Another estimate of the substantial substance abuse treatment and service related costs is provided in a report from the General Accounting Office (GAO, 1996). Finally, whereas

substance abuse treatment costs are in the range of $2,722 (for outpatient services) to $12,467 (for residential services) per person per year, the cost of incarceration averages $39,600 per person per year (Substance Abuse: The Nation's Number One Health Problem, 2001).

Beyond the major economic costs, another reason why there is concern with the substance abuse problem relates to public safety and crime. The National Center on Addiction and Substance Abuse (CASA) at Columbia University has reported that alcohol and other drug abuse and addiction problems are related to the incarceration of 80% (1.4 million) of the 1.7 million American men and women who are behind bars (National CASA, 1998). These data are similar to and/or in the range of other national governmental estimates from the Office of National Drug Control Policy (March 2001), the Government Accounting Office (GAO, 1991) and the Federal Bureau of Prisons (1989).

Not only did our U.S. taxpayers spend $30 billion to incarcerate offenders for alcohol and drug involved crimes in 1996, but in New Hampshire, as in many states, incarceration costs continue to increase as more prisons are built and offenders face mandatory minimum sentences due to truth in sentencing types of laws. As noted within a recently published study of corrections policies and costs in New Hampshire: "The cost of incarceration is one of the largest and fastest growing drivers of state government spending in New Hampshire" (Minard, 2001). Similar problems exist in many other states. Also, as noted earlier this year by the U.S. Office of Justice Programs (OJP) "Violent offenders and drug offenders account for almost 70 percent of prison population growth in the last decade" (OJP, 2001).

Over the past 10 to 15 years due to managed care and other changes in the health and mental health care systems, many hospitals, alcohol and drug treatment centers and mental health facilities have closed, significantly reduced their levels of services to persons living in poverty and/or have established fee structures that reduce service access to persons without means. These changes have led to a population shift such that

correctional systems generally, and prisons in particular, have more individuals with more serious psychiatric problems (Wexler, 1997). In addition, there is today a greater and more widespread recognition that many individuals, including offenders, have combined substance abuse and psychiatric (i.e., dual diagnosis) problems.

Through the use of the Addiction Severity Index (ASI) a number of researchers have taken a multi-dimensional approach that looks at addiction not in isolation, but in terms of identifying life problems within seven domains: medical, employment, alcohol, drugs, legal, relational, and mental health (McLellan, Luborsky, Woody and O'Brien, 1980). Over time, the ASI has become the most commonly used measure not only of substance abuse problem severity, but also of substance abuse treatment effectiveness, and has been used and validated with different populations in a variety of treatment settings (McLellan, Cacciola, Kushner, Peters, Smith, and Pettinati (1992). Also, some researchers have refined the use of the ASI and developed an additional composite index that identifies more specific clinical factors (McDermott, Altermann, Brown, Zaballero, Snider, and McKay, 1996).

In addition, many researchers have noted the need for special studies which focus on women offenders and their particular treatment and related needs both while in correctional facilities and while in aftercare following their return to the community (Tims, DeLeon and Jainchill, 1994; Wellish, Anglin and Prendergast, 1993). The process and outcome evaluations that are being conducted in New Hampshire include incarcerated populations of both men and women who are treated for substance abuse in separate but related programs.

A number of current theories postulate that readiness for and acceptance of treatment is related to a cognitive state of mind. Prochaska, DiClemente, and Norcross (1993) theorize that before successfully changing their addictive behaviors, individuals progress through five related but different stages. These stages include pre-contemplation, contemplation, preparation, action, and maintenance, with most persons recycling among stages several times before successfully resolving their addictive behaviors. Different

treatment approaches, processes, and interventions are more effective during particular stages. For example, consciousness raising and cognitive approaches are generally more appropriate during early stages, and stimulus control, reinforcement management and other behavioral approaches are more effective when used during later stages.

Several authors such as Annis, Schober, and Kelly (1996) and DiClemente and Hughes (1990) have recognized and brought attention to the importance of matching addiction treatment approaches to client readiness for change. Also, Campbell (1997) has used the Addiction Severity Index (ASI) along with the Prochaska et al. (1993) stages of change theory to assess and evaluate a residential substance abuse treatment program. In addition, Oberg, Gerdner, Sallmen, Jansson, and Segraeus (1998) have developed a battery of assessment instruments entitled MAPS (Monitoring Area Phase System) which incorporates stages of change concepts and is now being used across 10 European countries, as well as here in New Hampshire, to evaluate substance abuse treatment programs.

Even with the growing size of the incarcerated population in New Hampshire and in the nation, many Americans still do not feel safe. A fairly recent governmental report from the Bureau of Justice Statistics (BJS) provides an estimate similar to that offered within the National CASA (1998) report regarding the relationship of substance abuse problems to incarceration: approximately three-fourths of inmates are "alcohol- or drug-involved", including 51 percent of offenders who reported that they were under the influence of alcohol or other drugs at the actual time of the offense (BJS, 1999).

Over the last decade a number of research studies and reviews have been published that specifically assess and demonstrate the effectiveness of prison-based therapeutic communities in reducing drug use and/or recidivism (e.g., Pearson and Lipton, 1999; Siegel, Wang, Carlson, Falck, Rahman, and Fine, 1999; Wexler, DeLeon, Thomas, Kressel and Peters, 1999; Inciardi, Martin, Butzin, Hooper and Harrison, 1997; Hartmann, Wolk, Johnston and Colyer, 1997; Knight, Simpson, Chatham and Camacho, 1997; Inciardi, 1995; Wexler, Lipton, Falkin and Rosenblum, 1995; Tims, DeLeon and

Jainchill, 1994; Lipton, Falkin and Wexler, 1992; Wexler, Falkin and Lipton, 1990). These positive results have been interpreted to be primarily related to the specific impact of a therapeutic community for substance abusers that is located within the prison setting. For some time, "A Practitioner's Handbook" has been available to assist in the development, establishment and evaluation of substance abuse treatment programs based upon a model within prisons that is applicable to both male and female inmates (Wexler, 1993).

A recent meta-analytic review of evaluation research studies from 1968 to 1996 concluded that considerable evidence exists that corrections based therapeutic community treatment programs for drug abusers are effective in reducing recidivism (Pearson and Lipton, 1999). However, the results of the meta-analysis did not support the effectiveness of boot camps or of group counseling programs that are focused on substance abuse. Finally, although no firm conclusions could be drawn, several strategies or treatments were defined as promising and deserving further study. These include methadone maintenance treatment, 12-step programs, cognitive behavioral therapy, and substance abuse education.

Another recent study presented and discussed six major barriers to the development and implementation of effective drug treatment programs within correctional settings (Farabee, Prendegast, Cartier, Wexler, Knight and Anglin, 1999). A few of these barriers and possible solutions to the problems identified include the following: (1) insufficient and limited criteria to determine treatment need and inmate "dumping" into programs regardless of real need which can be rectified by using more comprehensive program admission criteria and involving treatment staff in the selection of inmates who are admitted into the program; (2) hiring and utilization of unqualified or insufficiently trained treatment staff which can be improved by offering higher wages for counselors and providing cross-training of correctional security and treatment staff; (3) too great a reliance on institutional sanctions as versus therapeutic sanctions which can in part be alleviated by allowing treatment staff to remove those inmates who violate rules of the treatment program; and (4) insufficient aftercare which can be improved by strengthening

the engagement of inmates with the program through a variety of strategies ranging from motivational interviewing, to offering more individual treatment sessions with offenders, to stipulating parole conditions that include frequent random urine testing, to establishing community based aftercare treatment centers and services that are designed to meet the continuing treatment needs of parolees. Another recent study examined the impact of the increasingly restrictive cigarette smoking policies that are being implemented in many prisons and jails (Lankenau, 2001). Smoking bans appear to transform fairly benign "gray markets" of cigarette use in prisons into much more problematic "black markets". Although the intent of such bans is positive, the actual results can be negative for both institutions and inmates.

Within much of the most recent research literature, many of the positive effects of substance abuse treatment (i.e., reductions in recidivism and drug use) are attributed to a multi-phase program (such as that in New Hampshire) that begins with the in-prison therapeutic community, but is then followed by a number of important additional aftercare services. Some of these critical aftercare services include supervised work release that establishes ties with existing relevant community resources such as 12-step programs, outpatient follow-up services and/or even a post-prison therapeutic community (e.g., Van Stelle and Moberg, 2000; Hiller, Knight and Simpson, 1999; Simpson, Wexler and Inciardi, 1999; Wexler, Melnick, Lowe and Peters, 1999; Lipton, 1998; Inciardi et al., 1997; Inciardi, 1996; Wolk and Hartman, 1996; Inciardi and Pottieger, 1996; Lipton, 1995; Lipton, 1994; Pan, 1993; Wexler and Lipton, 1993; Chavaria, 1992; Falkin, Wexler and Lipton, 1992; DeLeon, 1991; and Field, 1989).

Some of the most recent studies have found that the reduced recidivism rates at 12 and 24 month periods that are found for participants within in-prison therapeutic communities are not necessarily maintained at a significant level for a 36 month period. However, for offenders who complete both an in-prison therapeutic community and a community based follow-up that includes residential services (e.g., a therapeutic community), the positive impact on recidivism continues for at least a 36 month period (Knight, Simpson and Hiller, 1999; Martin, Butzin, Saum and Inciardi, 1999; Wexler, Melnick et al., 1999).

Also, the positive benefits are most likely to occur for those inmates who are involved with the most serious crime and drug problems (Knight et al., 1999), for those who complete secondary treatment services (Martin et al., 1999) and for those who are maintained in treatment and aftercare services for longer periods (Wexler, Melnick et al., 1999).

As the nation and states have concentrated upon building new prisons, they have often neglected the many critical issues related to prisoner reentry into the community. The importance of appropriate preparation and planning for prisoner reentry, along with the establishment of coordinated linkages with many relevant public and private community resources is highlighted in a recent report by Travis, Solomon and Waul (2001). It is clear that to sustain recovery from substance abuse and addiction problems and to prevent recidivism, offenders can benefit from close ties with a broad range of community services and supports (e.g., substance abuse treatment services; contacts with faith communities; family counseling services; transitional housing and work environments; ongoing contacts with 12-step programs).

Many research and evaluative studies of substance abuse treatment programs for inmates within correctional systems have been conducted over the last decade, often with support from the National Institute of Justice (NIJ). The positive results from many of these studies which demonstrate that substance abuse treatment can, and often does, reduce recidivism, have resulted in, or at least coincided with, a major societal shift that is again more supportive of rehabilitation. There is emerging a belief and understanding that certain types of treatment programs that begin within prisons can have beneficial results for inmates (by reducing their substance abuse problems), for overall public safety (by reducing crime due to offender recidivism), and for the economic good of both the inmates and the broader society (by reducing costs related to crime, as well as by increasing the employment, productivity and tax paying ability of former inmates) as they are successfully reintegrated within the community.

SECTION THREE: SUMMIT HOUSE CLIENT DEMOGRAPHICS, TREATMENT NEEDS, MOTIVATION AND CHANGE

This section provides a summary of the demographic characteristics, family, medical and mental health issues as well as treatment needs of the Summit House and comparison groups, broken out by site to provide more detailed information that may be of interest to the individual programs.

DEMOGRAPHICS

Age

The Laconia Men represented the youngest of all of the groups, both in average age and in absolute numbers. The Concord men represented the oldest group, having the greatest number of men above the age of 50. The women had a higher average age than the men's groups, however, the women tended to cluster more closely to the 30-40 year range than the men. The wide spread of ages may pose some problem for the treatment program as the participants may be in different developmental life stages and thus require differing strategies for engagement and problem solving approaches, implying the need for more individual work rather 'one size fits all' group work.

Laconia Men

The sample size recruited from the Laconia men's program totaled 133 clients. The mean age was 29.6 years, ranging from 19 to 53 years of age. Exactly 50% of the clients were 28 years of age or younger, 75% of the clients were 36 years of age or younger and 95% of the clients were 44 years of age or less. Only 6 people in the treatment group were between the ages of 45 and 53.

Concord Men

The sample size recruited from the Concord men's prison totaled 69 clients. The mean age was 34.4 years, ranging from 20 to 63 years of age. Approximately 50% of the

clients were 34 years or younger, 75% were 40 or younger and 95% were 53 or younger. Four clients were between the ages of 54 and 63.

Comparison Men

The sample size recruited for the Men's Comparison group totaled 81 clients. The mean age was 32.5 years, ranging from 18 to 65 years of age. Approximately 50% of the clients were 30 years or younger, 75% were 39 or younger and 95% were 53 or younger. Four clients were between the ages of 54 and 65.

	Laconia Men	Concord Men	Comparison Men
Average Age	29.6	34.4	32.5
Median Age	28	34	30
Range	19-53	20-63	18-65

Laconia Women

The sample size recruited for the Women's treatment group totaled 35 clients. The mean age was 32.1 years, ranging from 20 to 42 years of age. Exactly 50% of the clients were 32 years of age or younger, 75% of the clients were 38 years of age or younger and only 4 people in the treatment group were between the ages of 39 and 42.

Comparison Women

The sample size recruited for the Women's comparison group totaled 17 clients. The mean age was 34.1 years, ranging from 21 to 53 years of age. Exactly 50% of the clients were 35 years of age or younger, 75% of the clients were 39 years of age or younger and 8 people in the comparison group were between the ages of 40 and 53.

	Women Treatment	Women Comparison
Average Age	34.1	32.1
Median Age	35.5	32
Range	21-53	20-42

Race/Ethnicity

An over-representation of minority groups existed in all of the programs as compared to the general population of New Hampshire. The proportion of Black participants ranged from 12% to 6% compared to 0.7% in the general population. The proportion of Hispanic participants was approximately 10% while the population of Hispanic residents in New Hampshire is approximately 1.7%. The same is true for American Indians, while the proportion in the programs averaged 4%, only 0.2% are reported to be in the general population of New Hampshire. These differences may be a result of crimes committed by residents of surrounding states, such as Massachusetts, which has a higher population of Blacks and Hispanics. One major implication for the treatment programs, however, is the proportion of participants for whom English is not their first language. The evaluation found a number of Summit House clients for whom Spanish was their first, and sometimes only, language, while no accommodation existed in any of the Summit House programs. This issue is further addressed in the recommendation section.

Laconia Men

In the Laconia men's treatment group, 78% indicated they were white/non-Hispanic, 8.3% reported they were Black, 4% indicated they were American Indian, and 10% said they were Hispanic.

Concord Men

In the Concord treatment group sample, 83% indicated they were white/non-Hispanic, 4% reported they were Black, 4% indicated they were American Indian, and 9% said they were Hispanic.

Comparison Men

In the Comparison group sample, 82% indicated they were white/non-Hispanic, 6% reported they were Black, 5% indicated they were American Indian, and 7% said they were Hispanic.

	Laconia Men	Concord Men	Comparison Men	2000 Census NH population
White	78%	83%	82%	96%
Black	8%	4%	6%	0.7%
American Indian	4%	4%	5%	0.2%
Latino/Hispanic	10%	9%	7%	1.7%

Laconia Women

In the Women's treatment group sample, 79% indicated they were white/non-Hispanic, 12% reported they were Black, 0% indicated they were American Indian, and 9% said they were Hispanic.

Comparison Women

In the Women's comparison group sample, 82% indicated they were white/non-Hispanic, 0% reported they were Black, 6% indicated they were American Indian, and 12% said they were Hispanic.

	Women Treatment	Women Comparison
White	79%	82%
Black	12%	0%
American Indian	0%	6%
Latino/Hispanic	9%	12%

Employment and Education

The level of education and vocation training did not differ greatly between the Laconia and Concord men's treatment groups. Both had approximately 11.7 years of education with Concord having just slightly more participants having obtained a GED. While the Laconia men had slightly more technical training over their lifetime than the Concord

men, a greater number of Concord men had held a job for a longer length of time than those in Laconia. This is may be due to the age differences between the Concord and Laconia men. Interestingly, the women's treatment group looks very similar to the men's groups, in both average education level, post high-school education, technical training and employment history. In fact, the women's comparison group had the highest level of education of all of the groups. The women also had a number with higher education degrees, such as associates and master's degrees.

Laconia Men

For the Laconia treatment group, the average number of years of education was 11.7, ranging from 6 to 17 years with 73% of them attaining either a high school diploma or GED. Approximately 22% had some post-high school education. Approximately 30% had at least one year of technical or vocational training, 14% had 2 years of additional training and 7 people—or 5% reported having more than 2 years of training.

Prior to coming into prison, the longest length of time that a client in the Laconia treatment group had held a job ranged between less than one year to 30 years with an average of 4 years. Approximately 31% had held a job no longer than one year, 25% had held a job between 1 and 3 years, 24% had held a job between 3-5 years and 20% had held a job for more than 5 years. Approximately 2% reported never having worked prior to coming into prison.

Concord Men

For the Concord treatment group, the average number of years of education was 11.7, ranging from 6 to 18 years of total schooling with 80% of them attaining a high school diploma or GED. Approximately 26% had some post-high school education. Approximately 23% had at least one year of technical or vocational training, 12% had 2 years of additional training and 8 people—or 11%-- reported having more than 2 years of training.

Prior to coming into prison, the longest length of time that a client had held a job ranged from less than one year to 20 years with an average of 5 years. Approximately 27% had held a job no longer than one year, 23% had held a job between 1 and 3 years, 19% had held a job between 3-5 years and 28% had held a job for more than 5 years. Approximately 3% report never having worked prior to coming into prison.

	Laconia Men	Concord Men	Comparison Men
Years of Education			
Average	11.7	11.7	11.8
Median	12.0	12.0	12.0
Range	6-17	6-18	5-18
% 1 year or more technical training	49%	46%	37%
% Never having held a job longer than one year	31%	27%	27%
% Has never been employed	2%	3%	5%

Comparison Men

For the Comparison group, the average number of years of education was 11.8, ranging from 5 to 18 years with 72% of the clients having either a high school diploma or GED. Approximately 23% had some post-high school education. Approximately 37% had at least one year of technical or vocational training, 14% had 2 years of additional training and 11 people—or 12%-- reported having more than 2 years of training.

Prior to coming into prison, the longest length of time that a client in the Comparison group had held a job ranged between less than one year to 35 years with an average of 4 years. Approximately 27% had held a job no longer than one year, 33% had held a job between 1 and 3 years, 14% had held a job between 3-5 years and 26% had held a job for more than 5 years. Approximately 5% reported never having worked prior to coming into prison.

Laconia Women

For the Women's treatment group, the average number of years of education was 11.8, ranging from 0 to 19 years with 73% of the clients having either a high school diploma or GED. Approximately 24% had some post-high school education. Approximately 15% had at least one year of technical or vocational training, 9% had 2 years or more of additional training.

Prior to coming into prison, the longest length of time that a client in the Women's Treatment group had held a job ranged between less than one year to 20 years with an average of 3.4 years. Approximately 21% had held a job no longer than one year, 53% had held a job between 1 and 3 years, 9% had held a job between 3-5 years and 17% had held a job for more than 5 years. Approximately 9% reported never having worked prior to coming into prison.

Comparison Women

For the Women's Comparison group, the average number of years of education was 13.5, ranging from 12 to 16 years with 100% of the clients having either a high school diploma or GED. Approximately 76% had some post-high school education. Approximately 38% had at least one year of technical or vocational training, 6% had 2 years or more of additional training.

Prior to coming into prison, the longest length of time that a client in the Women's Comparison group had held a job ranged between less than one year to 15 years with an average of 4.6 years. Approximately 23% had held a job no longer than one year, 29% had held a job between 1 and 3 years, 18% had held a job between 3-5 years and 30% had held a job for more than 5 years. Approximately 6% reported never having worked prior to coming into prison.

FAMILY, MEDICAL AND PSYCHOLOGICAL HISTORY

Physical and Medical problems

As a whole, both the clients and the comparison group report a substantial history of hospitalizations, medical treatments and chronic illnesses. Approximately a third of the Laconia group and almost half of the Concord group report having a chronic illness and of those, approximately one-quarter take medication regularly to control the illness. For the women, the proportion is even greater, with more than 50% reporting having a chronic illness for which about one-third take regular medication. The more serious medical problems reported by offenders were Hepatitis C and hypertension related disorders. Over half of the treatment group, men and women, have been hospitalized at least once for an illness or accident (not including drug or alcohol related issues or pregnancies for the women). A small proportion had over 10 hospitalizations in each of the groups.

On the whole the inmates were dissatisfied with the medical care they received in prison. A number of participants that took medication regularly told the interviewer that they had been taken off their medications as soon as they entered the prison because prison officials told them that they were too expensive or switched to other less expensive medications that the offenders thought did not work as well. The offenders said that their medical complaints weren't taken seriously and that they were often told to "drink water" in response to colds, influenza or headaches. The interviewer documented several cases where underarm deodorant was prescribed for a skin infection and in one case, resulted in the inmate being taken to the hospital outside the facility. The offenders reported being told repeatedly that they were 'faking' their illnesses. In fact, a co-pay policy was developed by NHDOC whereby the inmates were required to pay from their canteen account in order to see a health practitioner. The co-pay was an attempt by the NHDOC to stop frivolous visits to the clinic and, in theory, only would be levied if the health care practitioner felt the inmate had no good reason for coming to sick call.

Laconia Men

The number of hospitalizations over a lifetime for a non-drug related physical problem for the Laconia Men's treatment group ranged from 0 (32%) to 20 (1.5%). The average was 2 hospitalizations with 90% of the treatment group having four or fewer hospitalizations over a lifetime. Six people had between 5 and 10 hospitalizations in their lifetime and six people had between 11 and 20 hospitalizations for non-drug related medical illnesses or accidents. Approximately 35% have a chronic illness and of those, 23% take medication to control the illness.

Concord Men

The number of hospitalizations over a lifetime for a non-drug related physical problem for the Concord treatment group ranged from 0 (19%) to 20 (4%). The average was 3.4 hospitalizations with 90% of the treatment group having ten or fewer hospitalizations over a lifetime. Six people had between 11 and 20 hospitalizations for non-drug related medical illnesses or accidents. Approximately 48% have a chronic illness and of those, 29% take medication to control the illness.

Comparison Men

The number of hospitalizations over a lifetime for a non-drug related physical problem for the Men's Comparison group ranged from 0 (36%) to 20 (3%). The average was 2.3 hospitalizations with 90% of the treatment group having seven or fewer hospitalizations over a lifetime. Seven people had between 8 and 20 hospitalizations in their lifetime for non-drug related medical illnesses or accidents. Approximately 32% have a chronic illness and of those, 24% take medication to control the illness.

Laconia Women

The number of hospitalizations over a lifetime for a non-drug related physical problem for the women's treatment group ranged from 0 (23%) to 20 (9%). The average was 4.0 hospitalizations with 91% of the treatment group having ten or fewer hospitalizations over a lifetime. Three people had 20 hospitalizations in their lifetime for non-drug

related medical illnesses or accidents. Approximately 60% have a chronic illness and of those, 37% take medication to control the illness.

Comparison Women

The number of hospitalizations over a lifetime for a non-drug related physical problem for the Women's Comparison group ranged from 0 (47%) to 6 (6%). The average was 1.5 hospitalizations with 90% of the treatment group having four or fewer hospitalizations over a lifetime. Approximately 53% have a chronic illness and of those, 35% take medication to control the illness.

Family History and Current relationships

The influence of families, both families of origin and current relationships has been found to be of great significance for the success of treatment programs (Dowden, 1999). Successful treatment programs are beginning to work with offenders not only around family dynamics that have influenced their current behavior, but also in regard to strengthening current relationships for recidivism prevention upon re-entry and reintegration into the community (Broekaert, 1998; Travis et al 2001).

The Summit House clients' history with their families is very mixed, with over 50% of the treatment group having either a mother or father with substance abuse, and at least 15% having at least one parent with mental health problems. Half of the men reported that they have a close relationship with someone in their family of origin: father, mother or siblings. A large majority have had at least one close relationship with a partner, however over half report having serious problems with a partner over their lifetime. The following is a more detailed discussion of these issues.

Marital Status and Dependents

Laconia Men

Of the Laconia treatment group, 71% have never been married, 12% are divorced, 4% are separated, 1 person was widowed and 12% are currently married. Prior to coming into prison, the average length of marriage was 6 years, ranging from less than one year to 18 years. The average length of separation was 1.5 years, ranging from slightly less than one year to 3 years. The average length of time for those divorced was 10 years with a range from less than one year to 19 years.

Of those that have never been married, 67% report being satisfied with their arrangements and 33% are dissatisfied with being single. Of those that are divorced or separated, approximately 60% report being satisfied with those arrangements. Of those that are married, 75% report being satisfied with their marriage.

Forty-six percent indicated that before coming into prison no one else relied on them for food or shelter, 35% reported that they were responsible for 1-2 other people, 18% said 3-4 additional people and 1 person reported being responsible for the food and shelter of 6 additional people.

A large proportion of the Laconia men (86%) report having had at least one close relationship with a sexual partner or spouse and of those who have children, (60% of the treatment group or 79 men) 82% report having a good relationship with at least one of their children. On the other hand, 64% report having had serious problems with a partner over their lifetime and approximately 10% said they had problems with their children.

Concord Men

For those in the Concord treatment group, 51% have never been married, 29% are divorced, 3% are separated, and 17% are currently married. Prior to coming into prison, the average length of marriage was 10 years, ranging from less than one year to 22 years.

All of those who were separated had been so for 1.5 years, and the average length of time for those divorced was 6.5 years ranging from less than one year to 24 years.

Of those that have never been married, 66% report being satisfied with those arrangements and 34% indicate they are dissatisfied with being single. Of those that were divorced, 55% indicate they are satisfied with this situation. Of those that are currently married 83% indicate that they are satisfied with their marriage.

Sixty-four percent indicated that before coming into prison no one else relied on them for food or shelter, 20% reported that they were responsible for 1-2 other people, 14% said 3-4 additional people and 1 person reported being responsible for the food and shelter of 5 additional people.

A large proportion of the Concord men (81%) report having had at least one close relationship with a sexual partner or spouse and of those who have children, (54% of the treatment group or 37 men) 73% report having a good relationship with at least one of their children. On the other hand, 51% report having had serious problems with a partner over their lifetime and approximately 5% said they had problems with their children.

Comparison Men

Of the Comparison group, 56% have never been married, 28% are divorced, 1% are separated, and 15% are currently married. Prior to coming into prison, the average length of marriage was 8 years, ranging from less than one year to 26 years. The average length of time for those divorced was 8 years with a range from less than one year to 16 years.

Of those that have never been married, 71% report being satisfied with their arrangements and 29% are dissatisfied with being single. Of those that are divorced or separated, approximately 61% report being satisfied with those arrangements. Of those that are married, 75% report being satisfied with their marriage.

Fifty-four percent indicated that before coming into prison no one else relied on them for food or shelter, 38% reported that they were responsible for 1-2 other people, 6% said 3 additional people and 2 persons reported being responsible for the food and shelter of 5 additional people.

A large proportion of the men's comparison group (84%) report having had at least one close relationship with a sexual partner or spouse and of those who have children, (60% of the Comparison group or 48 men) 88% report having a good relationship with at least one of their children. On the other hand, 62% report having had serious problems with a partner over their lifetime and approximately 5% said they had problems with their children.

Laconia Women

Of the women's treatment group, 38% have never been married, 15% are divorced, 15% are separated, and 32% are currently married. Prior to coming into prison, the average length of marriage was 8.4 years, ranging from less than one year to 28 years. The average length of time for those divorced was 2.8 years with a range from less than one year to 6 years.

Of those that have never been married, 85% report being satisfied with their arrangements and 15% are dissatisfied with being single. Of those that are divorced or separated, approximately 90% report being satisfied with those arrangements. Of those that are married, 91% report being satisfied with their marriage.

Thirty-eight percent indicated that before coming into prison no one else relied on them for food or shelter, 44% reported that they were responsible for 1-2 other people, 12% said 3 or 4 additional people and 2 persons reported being responsible for the food and shelter of 5 additional people.

A large proportion of the women's treatment group (85.3%) report having had at least one close relationship with a sexual partner or spouse and of those who have children,

(74% of the women's treatment group or 26 women) 79% report having a good relationship with at least one of their children. On the other hand, 77% report having had serious problems with a partner over their lifetime and approximately 24% said they had problems with their children.

Comparison Women

Of the women's comparison group, 35% have never been married, 47% are divorced, 6% are separated, 6% are widowed, and 6% are currently married. The length of time for those divorced was 2 years.

Of those that have never been married, 67% report being satisfied with their arrangements and 33% are dissatisfied with being single. Of those that are divorced or separated, 100% report being satisfied with those arrangements. The one inmate that is currently married was satisfied with being married.

Forty-seven percent indicated that before coming into prison no one else relied on them for food or shelter, 35% reported that they were responsible for 1-2 other people, and 35% said 3 or 4 additional people.

A large proportion of the comparison group women (88%) report having had at least one close relationship with a sexual partner or spouse and of those who have children, (71% of the women's comparison group or 12 women) 100% report having a good relationship with at least one of their children. On the other hand, 71% report having had serious problems with a partner over their lifetime and approximately 36% said they had problems with their children.

Family Relationships

Laconia Men

Approximately 25% of the men in the Laconia Treatment group reported that their mothers either had or currently have an alcohol problem and 11% reported their mothers

having a drug problem. Approximately 14% reported their mothers having mental health problems. Seventy percent of the clients report having a close long-lasting relationship with their mothers although 44% report having serious problems with their mothers at some point in their lifetime.

Approximately 52% of the men in the Laconia Treatment group reported that their fathers either had or currently have an alcohol problem and 18% reported their fathers having a drug problem. Approximately 16% reported their father having mental health problems. Slightly more than half of the clients report having a close long-lasting relationship with their fathers, however 54% report having serious problems with their fathers at some point in their lifetime.

Forty-seven percent had at least one brother with a history of alcohol problems and 29% report having a sister with an alcohol problem. Thirty-seven percent report having a brother with drug problems and 24% report have a sister with drug problems. Approximately 10% report a brother having mental health problems and 13% report having a sister with mental health problems. Seventy-six percent of the men report having a close relationship with at least one of their sisters or brothers and 43% report having serious problems with at least one of their siblings over their lifetime.

Concord Men

Approximately 31% of the men in the Concord Treatment group reported that their mothers either had or currently have an alcohol problem and 13% reported their mothers having a drug problem. Approximately 22% reported their mothers having mental health problems. Sixty-eight percent of the clients report having a close long-lasting relationship with their mothers although 45% report having serious problems with their mothers at some point in their lifetime.

Approximately 63% of the men in the Concord Treatment group reported that their fathers either had or currently have an alcohol problem and 18% reported their fathers having a drug problem. Approximately 20% reported their father having mental health

problems. Forty-three percent of the clients report having a close long-lasting relationship with their fathers, however 65% report having serious problems with their fathers at some point in their lifetime.

Fifty-nine percent had at least one brother with a history of alcohol problems and 32% report having a sister with an alcohol problem. Forty-eight percent report having a brother with drug problems and 29% report have a sister with drug problems. Approximately 20% report a brother having mental health problems and 11% report having a sister with mental health problems. Sixty-one percent of the men report having a close relationship with at least one of their sisters or brothers and 50% report having serious problems with at least one of their siblings over their lifetime.

Comparison Men

The Comparison client's history with their families does not differ significantly from the treatment group. Half of the men reporting state that they have had a close relationship with someone in their family, either their father, mother or siblings. A large majority have had at least one close relationship with a partner, however over half report having serious problems with a partner over their lifetime. The following is a more detailed discussion of the comparison group.

Approximately 24% of the men in the Comparison group reported that their mothers either had or currently have an alcohol problem and 14% reported their mothers having a drug problem. Approximately 26% reported their mothers having mental health problems. Seventy-nine percent of the clients report having a close long-lasting relationship with their mothers although 41% report having serious problems with their mothers at some point in their lifetime.

Approximately 38% of the men in the Comparison group reported that their fathers either had or currently have an alcohol problem and 16% reported their fathers having a drug problem. Approximately 14% reported their father having mental health problems. Slightly more than half of the clients report having a close long-lasting relationship with

their fathers, however 43% report having serious problems with their fathers at some point in their lifetime.

Forty-six percent had at least one brother with a history of alcohol problems and 20% report having a sister with an alcohol problem. Thirty-eight percent report having a brother with drug problems and 19% report have a sister with drug problems. Approximately 12% report a brother having mental health problems and 11% report having a sister with mental health problems. Eighty-two percent of the men report having a close relationship with at least one of their sisters or brothers and 49% report having serious problems with at least one of their siblings over their lifetime.

	Laconia Men			Concord Men			Comparison Men		
	Alcohol	Drugs	Mental Health	Alcohol	Drugs	Mental Health	Alcohol	Drugs	Mental Health
Mother	25%	11%	14%	31%	13%	22%	24%	14%	26%
Father	52%	18%	16%	63%	18%	20%	38%	16%	14%
Brother	47%	37%	10%	59%	48%	20%	46%	38%	12%
Sister	29%	24%	13%	32%	29%	11%	20%	19%	11%

Laconia Women

Approximately 32% of the women in the treatment group reported that their mothers either had or currently have an alcohol problem and 18% reported their mothers having a drug problem. Approximately 29% reported their mothers having mental health problems. Fifty-nine percent of the clients report having a close long-lasting relationship with their mothers although 65% report having serious problems with their mothers at some point in their lifetime.

Approximately 65% of the women in the Treatment group reported that their fathers either had or currently have an alcohol problem and 18% reported their fathers having a drug problem. Approximately 29% reported their father having mental health problems. Thirty-two percent of the clients report having a close long-lasting relationship with their

fathers, however 59% report having serious problems with their fathers at some point in their lifetime.

Sixty percent had at least one brother with a history of alcohol problems and 32% report having a sister with an alcohol problem. Forty-three percent report having a brother with drug problems and 41% report have a sister with drug problems. Approximately 30% report a brother having mental health problems and 36% report having a sister with mental health problems. Seventy-six percent of the women report having a close relationship with at least one of their sisters or brothers and 59% report having serious problems with at least one of their siblings over their lifetime.

Comparison women

Approximately 35% of the women in the Comparison group reported that their mothers either had or currently have an alcohol problem and 24% reported their mothers having a drug problem. Approximately 41% reported their mothers having mental health problems. Seventy-one percent of the clients report having a close long-lasting relationship with their mothers although 82% report having serious problems with their mothers at some point in their lifetime.

Approximately 65% of the women in the Comparison group reported that their fathers either had or currently have an alcohol problem and 18% reported their fathers having a drug problem. Approximately 29% reported their father having mental health problems. Thirty-two percent of the clients report having a close long-lasting relationship with their fathers, however 59% report having serious problems with their fathers at some point in their lifetime.

Fifty-eight percent had at least one brother with a history of alcohol problems and 22% report having a sister with an alcohol problem. Fifty percent report having a brother with drug problems and 22% report have a sister with drug problems. Approximately 43% report a brother having mental health problems and 22% report having a sister with mental health problems. Seventy-one percent of the women report having a close

relationship with at least one of their sisters or brothers and 59% report having serious problems with at least one of their siblings over their lifetime.

	Treatment Women			Comparison Women		
	Alcohol	Drugs	Mental Health	Alcohol	Drugs	Mental Health
Mother	32%	18%	29%	35%	24%	41%
Father	65%	18%	29%	65%	18%	29%
Brother	60%	43%	30%	58%	50%	43%
Sister	32%	41%	36%	22%	22%	22%

Social and Peer Relationship History

Laconia Men

Approximately three-fourths of the Laconia client group report having at least one close friendship over their lifetime. The Laconia men reported an average of 3.59 friends with 22% of them reporting that they did not have any friends. Thirty-eight percent report having had difficulty at some point in their lives getting along with friends. Approximately a third of the Laconia treatment sample reported having problems with their neighbors and 22% report having problems getting along with their co-workers.

Concord Men

Seventy-one percent of the Concord client group report having at least one close friendship over their lifetime. The Concord men reported an average of 3.35 friends with 29% of them reporting that they did not have any friends. Thirty-three percent report having had difficulty at some point in their lives getting along with friends. Twenty-five percent of the Concord treatment sample reported having problems with their neighbors and 20% report having problems getting along with their co-workers.

Comparison Men

Eighty-three percent of the Men's Comparison group report having at least one close friendship over their lifetime. The comparison men reported an average of 4.2 friends with 17% of them reporting that they did not have any friends. Thirty-eight percent report having had difficulty at some point in their lives getting along with friends. Thirty-two percent of the Concord treatment sample reported having problems with their neighbors and 27% report having problems getting along with their co-workers.

Laconia Women

Seventy-three percent of the Women's Treatment group report having at least one close friendship over their lifetime. The women reported an average of 2.1 friends with 27% of them reporting that they did not have any friends. Fifty percent report having had difficulty at some point in their lives getting along with friends. Twenty-four percent of the women's treatment sample reported having problems with their neighbors and 3% report having problems getting along with their co-workers.

Comparison Women

Eighty-two percent of the Women's Comparison group report having at least one close friendship over their lifetime. The women reported an average of 2.4 friends with 18% of them reporting that they did not have any friends. Thirty-five percent report having had difficulty at some point in their lives getting along with friends. Twenty-four percent of the women's treatment sample reported having problems with their neighbors and 18% report having problems getting along with their co-workers.

Physical, Sexual and Emotional Abuse History

The Summit House clients' report a substantial amount of abuse over their lifetime. Almost half of all the men, both treatment and comparison groups, report having been emotionally abused, while approximately one-third report physical abuse during their lifetimes. Nearly all of the women reported having been emotionally abused while more than 75% of them report physical and sexual abuse. The statistics reported by both the

men and women were profoundly greater than that found in the general population. The latest statistics from the National Child Abuse and Neglect Data System for 1999 report that the victim rate counting all types of maltreatment[5] for children 18 and under was 11.8%. The rate for females was 12.2% while that for males was 10.8%. Given the high levels of abuse reported by the Summit House participants and corresponding psychological ramifications, these findings should have substantial implications for the Summit House treatment program content and delivery. This also has implications for the affect of First Step, the boot-camp like program that precedes Summit House. Further discussion of the potential consequences of First Step and Summit House program content is included in the evaluation findings in Section Four.

Laconia Men

For the Laconia treatment group, 47% report having been emotionally abused, 35% report having been physically abused and 8.3% report having been sexually abused over their lifetime.

Concord Men

For the Concord treatment group, 58% report having been emotionally abused, 35% report having been physically abused and 25% report having been sexually abused over their lifetime.

Comparison Men

For the Comparison group, 49% report having been emotionally abused, 30% report having been physically abused and 16% report having been sexually abused over their lifetime.

[5] Including: Physical Abuse, Neglect, Medical Neglect, Sexual Abuse, Psychological Maltreatment, and Other unspecified abuse.(USDHHS Children's Bureau 1999)

	Laconia Men	Concord Men	Comparison Men
Emotional abuse	47%	58%	49%
Physical abuse	35%	35%	30%
Sexual abuse	8%	25%	16%

Laconia women

For the women's treatment group, 94% report having been emotionally abused, 91% report having been physically abused and 73% report having been sexually abused over their lifetime. Thirty-two percent of the women's treatment group reported being bothered a lot by their prior physical abuse while 36% report being bothered a lot by prior sexual abuse.

Comparison women

For the women's comparison group, 88% report having been emotionally abused, 77% report having been physically abused and 53% report having been sexually abused over their lifetime. Thirty-eight percent of the women's comparison group report being bothered a lot by their prior physical abuse while 33% reported being bothered a lot by their prior sexual abuse.

	Treatment Women	Comparison Women
Emotional abuse	94%	88%
Physical abuse	91%	77%
Sexual abuse	73%	53%

Mental Health Issues

The high level of co-existing mental health problems in the Summit House population, especially for the Concord Men and the Laconia women, should have had an impact on the type and delivery of substance abuse treatment for those programs. However, none of the Summit House programs had a specific component to deal with those offenders that

had a dual disorder, diagnosed with both emotional and substance use problems. Also psychotropic medication was generally discouraged by treatment staff who felt that even prescribed drugs hindered a participant's ability to achieve recovery. Most research indicates that there are methods specific to treat this population and must include treatment for both the substance abuse disorder and the psychological disorder concurrently (Sacks 2000).

Laconia Men

Approximately 16% (21) of the Laconia treatment group has been admitted at least once to a psychiatric hospital for inpatient mental health treatment. Thirty-five percent have at least one episode of outpatient treatment. Forty-five percent report having been seriously depressed over their lifetime and 52% have experienced serious anxiety and tension lasting over 2 weeks. Six percent of the Laconia men said they experienced hallucinations during their lifetime that were not attributed to substance use. Another 49% experienced trouble controlling violent behavior, 25% percent reported having suicidal thoughts and 16% report having tried to commit suicide at least once in their lifetime. Twenty-three percent report having taken medication for a psychiatric problem during their lifetime with 4% being prescribed medication during the prior 30 days.

Concord Men

Approximately 26% (19) of the Concord treatment group has been admitted at least once to a psychiatric hospital for inpatient mental health treatment. Fifty percent have at least one episode of outpatient treatment. Fifty-seven percent report having been seriously depressed over their lifetime and 65% have experienced serious anxiety and tension lasting over 2 weeks. Six percent of the Concord men said they experienced hallucinations during their lifetime that were not attributed to substance use. Another 58% experienced trouble controlling violent behavior, 46% percent reported having suicidal thoughts and 32% report having tried to commit suicide at least once in their lifetime. Fifty-two percent report having taken medication for a psychiatric problem during their lifetime with 7% being prescribed medication during the prior 30 days.

Comparison Men

Approximately 14% (11) of the Comparison group has been admitted at least once to a psychiatric hospital for inpatient mental health treatment. Fifty-two percent have at least one episode of outpatient treatment. Sixty-four percent report having been seriously depressed over their lifetime and 63% have experienced serious anxiety and tension lasting over 2 weeks. Twelve percent of the Comparison men said they experienced hallucinations during their lifetime that were not attributed to substance use. Another 47% experienced trouble controlling violent behavior, 31% percent reported having suicidal thoughts and 25% report having tried to commit suicide at least once in their lifetime. Forty percent report having taken medication for a psychiatric problem during their lifetime with 3% being prescribed medication during the prior 30 days.

	Laconia Men	Concord Men	Comparison Men
Psych. Inpatient	16%	26%	14%
Psych. Outpatient	35%	50%	52%
Depression Life	45%	57%	64%
Anxiety Life	52%	65%	63%
Hallucinations Life	6%	6%	12%
Violence Life	49%	58%	47%
Suicide Attempt	16%	32%	25%
Medication Life	23%	52%	40%

Laconia women

Approximately 35% (11) of the women's treatment group have been admitted at least once to a psychiatric hospital for inpatient mental health treatment. Sixty-two percent have at least one episode of outpatient treatment. Eighty-eight percent report having been seriously depressed over their lifetime and 77% have experienced serious anxiety and tension lasting over 2 weeks. Fifteen percent of the treatment women said they experienced hallucinations during their lifetime that were not attributed to substance use. Another 41% experienced trouble controlling violent behavior, 56% percent reported

having suicidal thoughts and 47% report having tried to commit suicide at least once in their lifetime. Forty-seven percent report having taken medication for a psychiatric problem during their lifetime with 15% being prescribed medication during the prior 30 days.

Comparison Women

Approximately 34% (6) of the women's comparison group has been admitted at least once to a psychiatric hospital for inpatient mental health treatment. Sixty percent have at least one episode of outpatient treatment. Eighty-eight percent report having been seriously depressed over their lifetime and 82% have experienced serious anxiety and tension lasting over 2 weeks. Twelve percent of the comparison women said they experienced hallucinations during their lifetime that were not attributed to substance use. Another 18% experienced trouble controlling violent behavior, 53% percent reported having suicidal thoughts and 41% report having tried to commit suicide at least once in their lifetime. Sixty-five percent report having taken medication for a psychiatric problem during their lifetime with no one being prescribed medication during the prior 30 days.

	Treatment Women	Comparison Women
Psych. Inpatient	35%	34%
Psych. Outpatient	62%	60%
Depression Life	88%	88%
Anxiety Life	77%	82%
Hallucinations Life	15%	12%
Violence Life	41%	18%
Suicide Attempt	47%	41%
Medication Life	47%	65%

CRIMINAL JUSTICE AND SUBSTANCE ABUSE HISTORY

Criminal Justice History

Because of the eligibility requirements of the Summit House program, the majority of offenders who participate have a history of chronic drug offenses, property offenses, simple assaults and driving violations. Those offenders with serious personal offenses, such as homicide, serious assault and robbery are screened out upon classification. In addition, sex offenders are not eligible to participate as a separate NHDOC program is available to these type of offenders. Nonetheless, over half of the group had been convicted for a previous offense and approximately 80% had been incarcerated before this current incarceration.

Laconia Men

Sixty-one percent of the Laconia men's group had been arrested and charged with drug offenses and 43% had been arrested and charged with a property offense during their lifetime. Approximately 50% of the Laconia men's group had 1 to 4 charges resulting in convictions over their lifetime while twenty-five percent had 8 or more charges resulting in convictions. Sixty-six percent of the men were convicted of 1 or more probation or parole violations and 44% had been charged with DWI over their lifetime. The Laconia men averaged 29 months of incarceration with a range of 0 to 300 months. Fifty percent of the group had been incarcerated for over 12 months and only 16% had never been incarcerated prior to their current incarceration.

Concord Men

Forty-five percent of the Concord men's group had been arrested and charged with drug offenses and 48% had been arrested and charged with a property offense during their lifetime. Approximately 50% of the Concord men's group had 1 to 4 charges resulting in convictions over their lifetime while twenty-five percent had ten or more charges resulting in convictions. Fifty-five percent of the men were convicted of 1 or more probation or parole violations and 46% had been charged with DWI over their lifetime.

The Concord men averaged 51 months of incarceration with a range of 0 to 288 months. Fifty-nine percent of the group had been incarcerated for over 12 months and only 13% had never been incarcerated prior to their current incarceration.

Comparison Men

Forty-one percent of the Comparison men's group had been arrested and charged with drug offenses and 39% had been arrested and charged with a property offense during their lifetime. Approximately 50% of the Comparison men's group had 1 to 4 charges resulting in convictions over their lifetime while twenty-five percent had nine or more charges resulting in convictions. Fifty-seven percent of the men were convicted of 1 or more probation or parole violations and 28% had been charged with DWI over their lifetime. The Comparison men averaged 28 months of incarceration with a range of 0 to 264 months. Fifty percent of the group had been incarcerated for over 12 months and only 16% had never been incarcerated prior to their current incarceration.

	Laconia Men	Concord Men	Comparison Men
Drug Charges	61%	45%	41%
Property Offenses	43%	48%	39%
Parole/Prob Violations	66%	55%	57%
Av. # Convictions	6.3 convictions	9.1 convictions	6.5 convictions
DWI	44%	46%	28%
Av # Mo. Incarcerated	29.1 months	51.1 months	28.2 months

Percentages reflect lifetime charges

Laconia Women

Fifty-three percent of the Treatment women's group had been arrested and charged with drug offenses and 17% had been arrested and charged with a property offense during their lifetime. Approximately 68% of the Treatment Women's group had 1 to 4 charges resulting in convictions over their lifetime while a third had five or more charges resulting in convictions. Sixty-two percent of the women were convicted of 1 or more probation or parole violations and 32% had been charged with DWI over their lifetime.

The Treatment women averaged 12.6 months of incarceration with a range of 0 to 96 months. Fifty percent of the group had been incarcerated for over 3 months and 35% had never been incarcerated prior to their current incarceration.

Comparison Women

Forty-one percent of the Comparison women's group had been arrested and charged with drug offenses and 18% had been arrested and charged with a property offense during their lifetime. Approximately 53% of the Comparison Women's group had 1 to 4 charges resulting in convictions over their lifetime while 25% had seven or more charges resulting in convictions. Fifty-three percent of the women were convicted of 1 or more probation or parole violations and 18% had been charged with DWI over their lifetime. The Comparison women averaged 4.7 months of incarceration with a range of 0 to 20 months. Fifty percent of the group had been incarcerated for over 1 month and 47% had never been incarcerated prior to their current incarceration.

	Treatment Women	Comparison Women
Drug Charges	53%	41%
Property Offenses	17%	18%
Parole/Prob Violations	62%	53%
Av. # Convictions	6.0 convictions	7.1 convictions
DWI	32%	18%
Av # Mo. Incarcerated	12.6 months	4.7 months

Percentages reflect lifetime charges

Drug and Alcohol History

The men's treatment groups report a long and varied history of lifetime substance use with the Concord men's group having the highest levels of use for all drugs with the exception of cocaine that was higher in Laconia. This breakdown can be explained by the older average age of the Concord cohort and the fact that cocaine is more a drug of choice for those individuals under age 30 and is reflected more with the age of the

Laconia men. Although the comparison group does not display as high a level of lifetime use as the treatment cohort, their use is still quite high in relation to the general population and still indicates a need for treatment.

	Laconia Men	Concord Men	Comparison Men
Drinking Intoxication	7.5 years	9.4 years	4.8 years
Heroin	.75 years	2.0 years	1.0 years
Cocaine	3.9 years	3.4 years	1.7 years
Cannabis	8.5 years	9.6 years	6.0 years
More than one substance	8.1 years	9.9 years	6.4 years

Lifetime Use in years

The women's treatment group had the highest lifetime level of any group, treatment or comparison, for both heroin and cocaine. In addition, the women's comparison group had higher levels of lifetime use than the men's comparison group in both alcohol and cocaine.

	Women's Treatment	Women's Comparison
Drinking Intoxication	5.9 years	5.9 years
Heroin	3.1 years	1.0 years
Cocaine	4.6 years	3.9 years
Cannabis	5.3 years	2.9 years
More than one substance	6.2 years	5.5 years

Lifetime Use in years

TREATMENT NEEDS AND MOTIVATION

The ASI provides the ability for the client to indicate their perceived need for treatment in each of the seven domain areas: medical, employment, family and social relationships, drug and alcohol abuse, criminal justice and psychological. At the end of each section,

the ASI asks the client to rate their need for treatment using five categories: 'not at all'; 'slightly'; 'moderately'; 'considerably'; 'extremely'. The ASI also allows for the computation of severity ratings that specify a level of treatment need as determined by the clinical interviewer. These severity ratings are calculated using an algorithm unique to each domain area and specific critical objective items from those sections. When the ASI is applied just prior to entering a treatment program, the client's perceived need for treatment together with the interviewer severity rating provide a baseline of the client's problem areas when examined individually. When examined across a group of offenders, these two ratings together provide a form of programmatic needs assessment, indicating the proportion of clients needing treatment in specific clinical areas that can be contrasted with the types of interventions available in a treatment program.

The following table examines each of the ASI domain areas and indicates the percentage of offenders who rate their perceived need for treatment in this area to be 'moderate' to 'extreme'. The second column lists the interviewer's proportion of offenders rated between 'moderate' to 'extreme' need for treatment.

	Laconia Men		Concord Men		Comparison Men	
ASI Domain	Offender	Interviewer	Offender	Interviewer	Offender	Interviewer
Medical	29%	28%	41%	32%	20%	25%
Employment	48%	53%	42%	54%	47%	58%
Alcohol	53%	71%	59%	71%	23%	41%
Drug	61%	74%	58%	70%	18%	47%
Legal	60%	83%	55%	87%	49%	89%
Family and Social	37%	50%	50%	62%	39%	54%
Psychiatric	48%	50%	67%	70%	39%	63%

The areas that both the Summit House clients the interviewer rate as having the highest proportion off offenders needing treatment are alcohol drug and legal domains, with the exception of psychiatric which is higher in Concord. An interesting finding is that the

comparison group men rate themselves as needing less treatment in every domain area than the Summit House men, even when the interviewer's severity rating is higher (e.g. employment, legal, psychiatric).

Women show a greater need for treatment in almost all of the domain areas, with a particularly higher proportion needing medical, family/social and psychiatric treatment than the men. There is less discrepancy between the comparison women and the Summit House women than the men, except in the area of alcohol and drugs.

	Treatment Women		Comparison Women	
ASI Domain	Offender	Interviewer	Offender	Interviewer
Medical	68%	59%	53%	47%
Employment	59%	62%	65%	65%
Alcohol	58%	70%	35%	53%
Drug	71%	76%	29%	35%
Legal	58%	73%	88%	88%
Family and Social	78%	91%	76%	82%
Psychiatric	88%	88%	88%	94%

Because these are baseline ratings prior to entering the treatment program, these higher ratings are not a result of program influence, but may reflect a greater awareness of their treatment needs. On the other hand, it could reflect a need to answer in a socially acceptable way, given that they are about to enter a treatment program. This is best examined by looking at the motivation for treatment scores with the MAPS.

The MAPS intake form assesses the clients' motivation to address problem areas each of the seven ASI domains as well as provides a baseline measure by which to measure their readiness to engage in treatment. The MAPS intake form together with the MAPS change allows for the examination of treatment impact as a client progresses through a treatment program. The MAPS discharge form provides a measure of treatment

effectiveness upon leaving the program and moving into the community. As described earlier, The MAPS tools assess clients' readiness for treatment according to Prochaska and DiClemente's stages of change. A client can be in any one of 5 stages of change when a treatment issue is identified: pre-contemplation, contemplation, preparation, action or maintenance. Each stage of change requires a different type of intervention to assist clients with more effective behaviors for addressing the problem area and move them on to higher stages of treatment. For example, clients in the pre-contemplation stage do not respond well to confrontational forms of intervention that only serves to push them away from treatment, but are more effectively engaged with education and information based interventions. On the other hand, confrontational interventions are more effective when engaging clients in the preparation stage to move toward taking an active role in their treatment and recovery. Clients can both progress and regress during a treatment program and the MAPS forms capture this movement.

Used in a process evaluation, a motivational assessment using the MAPS forms provide a description of the proportion of clients needing different types of intervention for most effective treatment content. In an Outcome Evaluation, the movements between stages can be analyzed in relation to those factors that predict positive motivational change and thus examine the level of treatment impact and effectiveness.

The following table shows the proportion of Summit House clients in the different stages of change for each of the domain areas of the ASI at baseline and upon completion of Phase I. [6]

[6] Since the entire sample has not yet completed the Summit House program, more sophisticated statistical techniques that predict the likelihood of regressing and progressing through the stages of change- such as latent transitional analysis-cannot be calculated until all the clients have progressed at least to Phase III. This type of analysis will be used in the Outcome Evaluation to evaluate treatment impact.

	Laconia Summit House Clients – Men Baseline, Phase I, II, III completion					
ASI Domain	Pre-contemplation	Contem-plation	Preparation	Action	Maintenance	No Relevant Problem
Medical						
Baseline (125)	0%	0%	1%	31%	10%	58%
Phase I (124)	0%	1%	0%	21%	29%	49%
Phase II (107)	0%	1%	0%	22%	35%	43%
Phase III (85)	0%	4%	0%	15%	38%	44%
Employ-ment						
Baseline (125)	0%	20%	50%	20%	0%	10%
Phase I (124)	1%	10%	30%	53%	1%	6%
Phase II (107)	0%	14%	8%	73%	1%	5%
Phase III (85)	0%	5%	2%	86%	4%	4%
Alcohol						
Baseline (125)	18%	19%	42%	3%	5%	12%
Phase I (124)	21%	18%	44%	2%	5%	11%
Phase II (107)	21%	14%	50%	0%	4%	12%
Phase III (85)	24%	14%	46%	0%	5%	12%
Drug						
Baseline (125)	14%	23%	39%	1%	9%	14%
Phase I (124)	14%	15%	48%	0%	9%	14%
Phase II (107)	13%	8%	56%	0%	8%	14%
Phase III (85)	17%	9%	53%	1%	8%	12%

	Laconia Summit House Clients – Men Baseline, Phase I, II, III completion					
ASI Domain[7]	Pre-contemplation	Contem-plation	Preparation	Action	Maintenance	No Relevant Problem
Legal						
Baseline (125)	1%	38%	61%	0%	0%	0%
Phase I (124)	1%	17%	82%	0%	0%	0%
Phase II (107)	2%	7%	92%	0%	0%	0%
Phase III (85)	2%	11%	85%	2%	0%	0%
Family/ Social						
Baseline (125)	0%	16%	33%	31%	16%	4%
Phase I (124)	0%	12%	14%	45%	25%	4%
Phase II (107)	0%	10%	8%	52%	24%	5%
Phase III (85)	0%	11%	4%	58%	22%	6%
Psycho-logical						
Baseline (125)	5%	22%	18%	35%	12%	8%
Phase I (124)	4%	9%	5%	58%	18%	7%
Phase II (107)	3%	6%	1%	62%	19%	10%
Phase III (85)	4%	5%	0%	67%	15%	9%

It is important to note that the results of these descriptive analyses are relevant for comparing the types of available program content to the needs of the offender based upon their stage of change. In other words, if a program has a set curriculum which is based on education and informative workshops, this type of content is most relevant to clients in the pre-contemplation and contemplation stage of change. If however, an analysis such as that shown above, indicates that the program has a large proportion of clients in a later stage of change, such as preparation or action, the program content needs to be more

[7] The numbers in parentheses represents the sample size used for calculating the percentages in each row.

clinical in order to support the insight and behavior change necessary for clients at the stage. In terms of drugs and alcohol treatment needs, at baseline, approximately 40% of Laconia Summit House participants are in the preparation stage, and about 37% are in pre-contemplation or contemplation. With the focus of the Laconia Summit House program on information workshops and group therapy, we would not expect this program to be as effective in moving clients to an action phase while in Phase I, although we would expect to see a movement of those offenders from pre-contemplation and contemplation to preparation.

By the end of Phase III, the Laconia program participants generally appear to have moved into the action stage, to more actively address their problems in employment, family/social and psychological areas. They do not seem to have moved as much in the areas of drug and alcohol, remaining in the preparation stage even upon entering the community. This may have implications for their ability to remain in recovery while on parole. However, some members of the research team feel strongly that while in prison, offenders do not have the opportunity to actively address their addiction, and therefore cannot move to an action or maintenance stage until returning to the community. If this theory is true, then the aftercare component of the Summit House program becomes extremely important for recovery.

If, however, a substance program located within a prison system can in fact successfully move clients to higher stages of change, i.e. action and maintenance, this places a significant amount of importance on the therapeutic work in Phase II and Phase III, to move clients from preparation into action and providing clients with the skills to be able to manage their drug and alcohol problems in the community. Given the current programming of the Summit House program, there is very little clinical work that takes place in Phase II and Phase III.

	Concord Summit House Clients – Men Baseline, Phase I, II, III completion					
ASI Domain	Pre-contemplation	Contem-plation	Preparation	Action	Maintenance	No Relevant Problem
Medical						
Baseline (63)	0%	2%	2%	35%	24%	38%
Phase I (63)	0%	2%	0%	30%	32%	37%
Phase II (56)	0%	0%	0%	30%	32%	38%
Phase III (43)	0%	0%	0%	30%	35%	35%
Employ-ment						
Baseline (63)	2%	21%	46%	24%	0%	8%
Phase I (63)	3%	11%	24%	56%	0%	6%
Phase II (56)	2%	7%	14%	71%	0%	5%
Phase III (43)	0%	2%	5%	93%	0%	0%
Alcohol						
Baseline (63)	16%	10%	44%	6%	5%	19%
Phase I (63)	10%	5%	57%	5%	2%	22%
Phase II (56)	9%	9%	54%	5%	4%	20%
Phase III (43)	2%	7%	61%	7%	0%	23%
Drug						
Baseline (63)	14%	13%	46%	10%	6%	11%
Phase I (63)	6%	6%	64%	5%	6%	13%
Phase II (56)	7%	11%	59%	7%	5%	11%
Phase III (43)	2%	9%	67%	9%	2%	9%

	Concord Summit House Clients – Men Baseline, Phase I, II, III completion					
ASI Domain[8]	Pre-contemplation	Contem-plation	Preparation	Action	Maintenance	No Relevant Problem
Legal						
Baseline (63)	3%	38%	54%	5%	0%	0%
Phase I (63)	0%	11%	86%	3%	0%	0%
Phase II (56)	0%	14%	86%	0%	0%	0%
Phase III (43)	0%	9%	88%	2%	0%	0%
Family/ Social						
Baseline (63)	5%	21%	37%	24%	10%	5%
Phase I (63)	0%	16%	14%	51%	18%	2%
Phase II (56)	0%	18%	4%	50%	25%	4%
Phase III (43)	0%	7%	5%	70%	16%	2%
Psycho-logical						
Baseline (63)	2%	21%	27%	38%	10%	3%
Phase I (63)	0%	6%	5%	76%	10%	3%
Phase II (56)	0%	9%	0%	75%	13%	4%
Phase III (43)	2%	0%	0%	84%	9%	5%

For the Concord Summit House clients, by the end of the intensive treatment Phase I, approximately 60% of the clients are in the stage of preparation in terms of addressing their drug and alcohol problems. Again, this makes the treatment available in Phase II and Phase III critical in continuing to build upon this momentum.

Even given the limitations of these descriptive analyses, it appears that both the Laconia and Concord Summit House programs have a greater proportion of their clients in the

[8] The numbers in parentheses represents the sample size used for calculating the percentages in each row.

stage of action in the employment, family/social and psychological domains upon completion of Phase I.

	Summit House Clients – Laconia Women Baseline, Phase I, II, III completion					
ASI Domain	Pre-contemplation	Contem-plation	Preparation	Action	Maintenance	No Relevant Problem
Medical						
Baseline (31)	0%	3%	0%	61%	10%	26%
Phase I (30)	0%	0%	0%	53%	23%	23%
Phase II (26)	0%	0%	0%	58%	15%	27%
Phase III (17)	0%	0%	0%	59%	24%	18%
Employ-ment						
Baseline (31)	3%	13%	42%	36%	0%	7%
Phase I (30)	0%	17%	17%	63%	0%	3%
Phase II (26)	4%	12%	12%	73%	0%	0%
Phase III (17)	0%	0%	12%	88%	0%	0%
Alcohol						
Baseline (31)	3%	10%	65%	7%	3%	13%
Phase I (30)	3%	0%	67%	10%	3%	17%
Phase II (26)	12%	0%	65%	8%	4%	12%
Phase III (17)	12%	0%	59%	18%	6%	6%
Drug						
Baseline (31)	3%	13%	61%	3%	3%	16%
Phase I (30)	0%	0%	80%	3%	0%	17%
Phase II (26)	12%	0%	65%	4%	0%	19%
Phase III (17)	6%	0%	77%	6%	0%	12%

	Summit House Clients – Laconia Women Baseline, Phase I, II, III completion					
ASI Domain[9]	Pre-contemplation	Contem-plation	Preparation	Action	Maintenance	No Relevant Problem
Legal						
Baseline (31)	0%	29%	71%	0%	0%	0%
Phase I (30)	3%	3%	93%	0%	0%	0%
Phase II (26)	0%	0%	100%	0%	0%	0%
Phase III (17)	0%	0%	88%	12%	0%	0%
Family/ Social						
Baseline (31)	0%	7%	19%	71%	3%	0%
Phase I (30)	0%	10%	7%	80%	3%	0%
Phase II (26)	0%	8%	8%	77%	8%	0%
Phase III (17)	0%	6%	6%	71%	18%	0%
Psycho-logical						
Baseline (31)	0%	13%	7%	74%	7%	0%
Phase I (30)	0%	0%	0%	90%	10%	0%
Phase II (26)	0%	0%	0%	96%	4%	0%
Phase III (17)	0%	0%	0%	94%	0%	6%

In contrast to the male Summit clients, the women were already in the stage of action regarding medical, family/social and psychological issues. This places more emphasis on Phase I to incorporate the necessary clinical interventions to support these women with their issues in these areas. Regarding drug and alcohol issues, the findings for the women are the same as for the men, given the large proportion in preparation at the end of Phase I that places additional emphasis on the interventions in Phase II and Phase III.

[9] The numbers in parentheses represents the sample size used for calculating the percentages in each row.

SECTION FOUR: SUMMARY OF SUMMIT HOUSE EVALUATION FINDINGS

1. A description of the guiding program philosophy, goals and outcomes as they are understood and implemented by the staff across different program phases and facilities.

Interviews with staff from all facilities provided a common description of the guiding program philosophy of Summit House as understood by the staff. This understanding was universal and showed little variance among staff at either the men's or one woman's program. This guiding program philosophy, as expressed by staff, included a belief that the provision of a safe, drug-free residential environment with a structured milieu encouraged inmates to acknowledge their addictive behaviors and that by gaining and practicing more effective coping skills, recidivism would be reduced and inmates would lead more productive lives in the future. Also expressed in the staff's philosophy was the view that substance abuse is a chronic relapsing disorder and abstinence is the only effective goal for all participants. This program philosophy was shared not only by clinical staff in Phase I, but also throughout each of the three phases of the program and at the different facilities.

As described in the original Summit House program manual, the goals of the Summit House Program are focused on recovery, abstinence and keeping the offender safely in his community upon release from prison. As stated in the manual, these goals are:

a) Provide the offender with an opportunity for self-improvement through a comprehensive residential substance abuse program. This allows the offender to cut through the cycle of addiction and obtain the tools to lead a substance free life.

b) Provide the offender a continuum of substance abuse services that begin with the Modified[10] Therapeutic Community but also follow them to the Minimum Security Unit (MSU), the Halfway Houses, and the first 12 weeks while under parole supervision.

[10] Staff considered the program to be a "modified" therapeutic community with the modification being that staff, not clients, are responsible for enforcement of rules and provision of the safe environment for

c) Incorporate individualized aftercare/relapse prevention plans into the offender's parole plans.

d) Create linkages with community resources to support the offender's abstinence through treatment, education and employment.

The outcomes desired by the Summit House Program staff included inmates who could utilize available self help resources, successfully reintegrate themselves into the larger outside society and lead more productive and healthy (i.e., drug free) lives out in the community. Furthermore, offenders were expected to not recidivate (i.e., in terms of substance use and/or crime) or at least do so at lower rates than similar inmates who did not participate in the Summit House program. The Summit House Program clinical staff members within each of the three program phases and each facility all voiced these as general shared outcomes.

While clinical program staff shared the philosophy, goals and outcomes of the Summit House program, the Correctional Officer security staff members were generally less aware of the treatment precepts and therefore were less effective in supporting the successful implementation of the Summit House program. Few, if any, of the Correctional Officer security staff had knowledge or an understanding of the program content and philosophy. Furthermore, on several occasions, some members of the research team observed Correctional officers at the Laconia facility using threats and coercive tactics with both the men and the women to gain information about purported illegal activities at the facility. Research team members heard security staff threaten inmates in a number of ways including loss of visitation privileges, calling child welfare to terminate their parental rights, sending inmates back to the men's prison in Concord or the women's prison in Goffstown, or that from now on they would be "watched" and if they ever broke a rule they would be severely dealt with by the security staff. These

treatment to take place. Program interventions to support this philosophy include group and individual counseling sessions, AA/NA, and other relevant mutual aid and self help groups.

actions by the security staff were harmful to the establishment of the therapeutic milieu and had the potential to destroy the trust necessary for self-disclosure in treatment. Through their actions, it was obvious to the research team that the security staff in Laconia were not a part of the treatment program, nor did they see that as one of their roles as a correctional officer, even while being assigned to the Summit House program.

Overall, the lack of commitment or education about the treatment setting was more evident in the Laconia facilities than the Concord site. Concord Summit House had the benefit of a veteran officer in charge of the First Step program, who was a part of the clinical team and took seriously the Correctional Officer's role as part of the therapeutic process. Through his own modeling of behavior and his training of the other officers who reported to him, the security staff at the Concord facility were more understanding and supportive of the Summit House philosophy and values.

An observation made by the project interviewer, that emerged both through her interviews with the Summit House participants and her own interactions with counseling and security staff, underscored the influence that Correctional Officers have in the Summit House program. As Summit House participants move through the program phases, the therapeutic influence of counselors steadily declines while the influence and authority of the correctional officer staff increases over time. When Summit House participants reach Phase II, the system is more concerned with "problem behavior" of inmates ready to be released to the community, rather than integration and relapse prevention. Moreover, when participants transition to Phase III, rather than bolster and strengthen the therapeutic process to assist program participants to transition from Phase III to the community, the program focus becomes more centered on discipline and rules of security rather "successful integration into society." From a systems perspective, this can be attributed to a lack of treatment staff outside of Phase I, but from a "departmental" perspective, the Summit House participants have been given the education and the skills and therefore, should be able to use them with only minimal counseling support. Since this increasing influence is often exercised by Correctional Officer staff having little or no understanding of the Summit House program or substance abuse treatment, program

participants are forced to try and "survive" the correctional system rather than be active participants in their treatment and recovery.

These problems may be due in part to high turnover rates found among Correctional Officer security staff—related to the opening of a new State Prison in northern New Hampshire. However, these problems are most likely due to the lack of sufficient training on the program philosophy and inmate treatment needs for Correctional Officer security staff, as well as their different responsibilities within the correctional system. Correctional Officers are primarily responsible for enforcing necessary correctional security measures, not for therapeutic interventions. However, those Correctional Officers who do understand and support the Summit House philosophy as they interact with inmates can and do have important positive impacts on the future lives of inmates. Also, those Correctional Officers who are either not familiar with the philosophy and goals of the Summit House Program and/or are inconsistent in their supervision of and interaction with inmates, can and do have a negative impact on the progress of Summit House participants through the program.

2. A description of any site specific issues that affect program implementation; a description of gender issues that affect program implementation and/or content.

Staff Turnover

A number of important site-specific issues that affect program implementation exist across the Summit House sites. For example, the individual who had been the Director and the driving force behind the creation and growth of the Summit House Program at both the Laconia and Concord facilities was phased out of his role in June 1999 by the Assistant Commissioner. Before his removal he had functioned as the Director of all Substance Abuse Services in the Department along with personally coordinating the Laconia programs and clinically supervising the coordinator of the Concord program. His comprehensive position was not replaced nor was a clinical supervisor ever obtained for the substance abuse staff in Summit House following his departure.

In July of 1999 a new coordinator of the Summit House Program at the Laconia was formally appointed. As might be expected, this new coordinator then implemented a variety of programmatic changes, e.g., she expanded the number of group therapy counseling sessions, but also decreased the amount of individual counseling time available to inmates. These changes were deemed necessary both because of the increased number of inmates entering the Laconia Summit House program (from 84 to 96 inmates), as well as a lack of available clinical staff due to several unfilled positions. Furthermore, the Coordinator of the women's program in Laconia was replaced twice during the Process evaluation, bringing a series of disruptions to the women's program.

In contrast, the coordinator of the Summit House Program at the Concord State Prison remained in place during this time period and thus program implementation at this site there was more consistent and stable.

Impact of New Facility

The opening of a new correctional facility in the northern part of New Hampshire has affected all of the program sites because many experienced Correctional Officer security staff were reassigned from their existing facilities to positions in the new facility - a significant number of these moves were accompanied by promotions for the Correctional Officers involved. Since the new facility is closer to the Laconia facility than to the Concord facility, proportionately more Correctional Officers have been drawn from staff related to the Summit House program in Laconia than from the Concord program. In Laconia, the Correctional staff lost all of its senior leaders and the remaining staff were often called upon to train new Correctional Officers and to work overtime to make up for the many vacancies unable to be filled with qualified individuals. The New Hampshire economy was quite good at that time with an unemployment rate less than 2%. The low salary of new Correctional Officers did not provide enough of an incentive to attract qualified individuals. This lack of experienced staff at the Laconia facility resulted in the Summit House counselors having to spend more time dealing with the correctional staff who didn't understand how the program operated and thus took time away from their

clinical interventions with the inmates. It also resulted in some unnecessary tension among inmates, counselors and security staff[11].

To speed up the opening of the Northern Correctional Facility (NCF) in Berlin during the summer of 2000, minimum-security inmates were sent from the Laconia facility to help get the NCF facility ready to accept the new inmate residents. Several of these worker inmates had been in Phase II of Summit House at Laconia when they were sent north. A unit manager at NCF who had previously been a Summit House counselor established a weekly group for these Phase II inmates so that they would eventually be able to move to Phase III. However, they were not able to attend any AA or NA groups and the inmates themselves worried about how their status in the Summit House program would be viewed by the Courts.

As the new NCF facility began to be populated with inmates from the other prison facilities, a program for inmates with substance abuse treatment needs evolved. Initially the program was to be a *true* therapeutic community modeled after Amity House in California. However, with the resignation of the Assistant Commissioner and the dismissal of the new warden at NCF, the main proponents of this approach, it was decided that another Summit House program would be replicated in Berlin. The Phase I program that eventually did develop was similar to the Summit House programs in both Concord and Laconia except that it did not require a successful completion of a First Step program prior to entry. This opened the way for several inmates in this Process Evaluation comparison group, who had not gained entry into the men's program at the Laconia or Concord facilities because they could not complete First Step, to transfer to Berlin and successfully complete Phase I of the Summit House program. This "innovation" or "deviation" in the NCF Summit House program was halted in the spring of 2001 and a First Step program was developed for NCF as a requirement of admission to the Summit House program, just as in Laconia and Concord.

[11] After a new Commissioner of Corrections was appointed in May 2000, this problem of low Correctional Officer salaries was recognized by the legislature. Salaries were increased in the Fall of 2000 which greatly helped the recruitment of new staff.

The evaluators see these as a regressive and ineffective program development in the Berlin facility. There is sufficient research on boot camps to suggest that people with childhood abuse histories may be re-victimized through the use of confrontational approaches such as that used in the First Step program. This then may prevent certain inmates from ever achieving successful completion of these types of programs. If successful completion is used as one of the main the criteria for entry into the Summit House program then a proportion of offenders who have substance abuse treatment needs will never be able to enter treatment while in prison.

Physical Space Issues

Due to different physical environment opportunities and constraints among the three program sites, the facility for Phase I in the Men's and Women's program in Laconia allows for physical separation from the non-program population. The Concord Phase I Summit House participants are physically closer in proximity to the general population, including those in maximum security who do not have substance abuse problems. However, even in the Concord program the Summit House participants are housed in a separate unit and away from the general population during Phase I. Furthermore, Laconia Phase II participants are also located in a separate building. This has been the stated preference at the Laconia Men's facility, but at times due to increased bed needs, other inmates have also been placed in the Phase II housing unit. In Concord due to the lack of bed space in minimum security, when inmates graduate from Phase I and move to Phase II, they are housed with the prison's general population of inmates, and thus they may be more likely to revert to the tougher and more negative attitude of the general prison population in order to survive. The coordinator of the Concord Summit House program was able to obtain an accommodation in the Spring of 2000 that allowed Summit House program participant so be housed together in separate wing of the minimum security unit (MSU).

Because of space issues at the women's program at LRF all inmates are housed in the same building but both Phase I and Phase II have their own dormitory room. Although

program participants are housed together, they have daily interaction with the other women housed in the unit, those that are waiting to enter First Step, or those that are in Minimum Security status. This doesn't seem to be as much of a problem as that in Phase II at MSU in Concord, but it still needs to be noted as a potential problem area.

At the Concord program, group space has always been a problem due to prison overcrowding. The community and educational groups for Phase I of Summit House are conducted in the inmate's dormitory living area, sitting alongside their bunks. Because of security reasons, bathrooms in these areas are completely open so that there is no privacy, especially when female staff members are leading groups. Inmates at the program have commented to the interviewer about the lack of air circulation and light in the Phase I dorm. Over the past year, however, treatment groups have been able to be conducted on the mental health unit, giving the program needed private space.

Impact of New Smoking Policy

The entire New Hampshire Correctional System recently became a "smoke free" environment. However, inmate-smoking infractions seem to be dealt with differently at the different facilities. For example, inmates who are caught smoking in the Laconia Facility appear to be more likely to experience more severe punishments, such as "set backs" in their program, than inmates located at the Concord State site. This appears to be due to a program philosophy at the Laconia site which views smoking either as an addiction or as a criminal behavior since it is a banned activity. Over time, these differences may dissipate, but at the moment there appear to be different facility reactions to this particular addiction problem, that is impacting inmate behavior, and potentially impacting the effectiveness of the Summit House programs at the different sites. As one female inmate told the interviewer, she felt that the no smoking edict contributed willingly and knowingly to "sneaky behaviors" which runs counter to the program's desire to rid the inmate of these. She felt that it was a type of "Catch 22" in which her addiction to cigarettes, which was not dealt with humanely or adequately, put her at a greater risk to fail. On the other hand, the Laconia Summit House staff feel that smoking

is clearly an addictive behavior and that obtaining and/or dealing cigarettes at the Laconia facility is not only manipulative and illegal, but also it is similar to the alcoholic and/or illicit drug addictive street behaviors that resulted in many of these individuals being convicted of their crimes in the first place. On the other hand, recent research has documented that the situational influence created by smoking bans led to a loss in an inmate's focus on treatment goals and strained inmate-custody staff relationships to the detriment of the treatment program (Linhorst et al, 2001).

The non-smoking rule is applied inconsistently across the Phase II and Phase III sites of the Summit House Program as well, according to the vigor with which the transgressors are pursued. At the minimum-security unit in Concord, for instance, staff have "bigger things to deal with," and usually turn a blind eye to smokers as long as they are not blatant in their actions. Smoking has been tolerated at work sites for inmates in Phase II as well as Phase III of the Concord program.

Phase II in Laconia is markedly different. Staff actively pursues any smoking behavior, sometimes to the extent of night raids and spot searches of inmates in outbuildings at the Laconia minimum security unit. In one instance, everyone in the vicinity of a bathroom where cigarette smoke was detected was written up for a disciplinary violation. Inmates in the Laconia Phase II program working off-site at the Veterans Administration nursing home or Gunstock recreational area are not allowed to smoke even if when offered cigarettes by the civilian members of the work crew. Again, the interpretation of this policy appears to be somewhat idiosyncratic based on the philosophy of the Laconia corrections staff person in charge.

Summit House smoking rules are "slightly different" (Summit House staff quote) than those posted in other units in the prison, but a vague no-smoking policy leaves much room for personal interpretation and enforcement. Having or selling tobacco or tobacco products constitutes a felony itself (introducing contraband), and could mean a new charge for the inmate. At a minimum this behavior results in a program setback, involving various sanctions and punishments, for example, on one case it resulted in an

offender being sent to the Secure Housing Unit--the maximum security part of the Concord prison—for an entire month.

Throughout the course of the process evaluation, the researchers informally documented the setbacks in program that occurred due to the violation of smoking policy. There were 32 setbacks at LRF Summit House (28 men, 4 women) due to disciplinary actions in violation of the smoking rules. In contrast, at the Concord Summit House program only one violation of the smoking policy needing disciplinary action occurred and did not result in a program setback. The comparison group had 2 setbacks, one male in Laconia and one male in Concord. This observation appears to reflect an inconsistency in application of the no smoking policy among all of the facilities, particularly between the Laconia and Concord Summit House programs, and if found to be true may undermine the therapeutic milieu of the Laconia program.

Gender Issues

The Coordinator of the Summit House program in Laconia for both the Men's and the Women's program was a woman, and for the majority of the Process Evaluation period, the Laconia men's program had six female counseling staff and only two male counselors. More recently, the staff composition has become more balanced; currently, the total Phase 1 staff at LRF includes 11 persons, four of whom are male. Since a number of the male Summit House participants reported having difficulty relating to women, having female counselors could be beneficial for the participants.

The Summit House Men's Program at the Concord State Prison has a male Coordinator and 3 counselors, one of whom is male and 2 are female. To be responsive to needing an effective gender balance, the Concord program has two women from a community domestic violence agency come into the program to talk on Domestic Violence and the inmates' relationships with women.

One security problem that arose during the process evaluation was the safety of the female Summit House staff while on the Phase I unit. Given the particular physical configuration of the Men's Program in Laconia, combined with the low levels of Correctional Officer security staff available to the Summit House programs, and the fact that many of the Summit House staff and security staff are relatively new to their positions, a concern was voiced among some personnel about the safety of the counseling staff, particularly the women.

The Summit House program in Laconia for women is much smaller than the men's program and currently has two counselors (the program had only one counselor for the first year of the process evaluation), both of whom are females. However, it does have two Correctional Officer Sergeant Mentors, one of whom is a male. In addition, the women's program is housed in a separate facility from the men's program. This creates some problems with parity of resources since the gender separation is necessary for a smooth running institution. The women do not get as much access to the library, GED classes, or the gymnasium as do the men, although recently women have been given one additional day per week to use the library and two additional times per week to access the gym. Furthermore, the women in Phase II are limited to the types of employment available to them and are not able to work off-site as many of the male inmate do.

Another important gender difference is the impact that First Step has on the female inmates. Since First Step is a modified boot camp experience with strict discipline and "in-your-face" confrontation, some of the women from abusive backgrounds found it intimidating and triggered earlier abuse experiences (Widom 1999, OJP 1999, UN 2000).[12] Initially, First Step for women was not required, but some concern arose that the Summit House program for women was not as "intensive" as for men, thus First Step was initiated for the women just prior to the beginning of the Process Evaluation.

[12] It should also be noted that men from abusive backgrounds also found the First Step program to trigger prior victimization experiences as well.

The First Step Program for the women replicated the First Step program for men, even though there is no evidence that supports the effectiveness for this type of program for either men or women. The clients told the interviewers that the military style discipline, marching and "in-your-face" confrontations were not viewed as helpful, but something that they needed to "play along with" in order to get into Summit House. Some men and women reported that the confrontational style of First Step scared them and brought up painful memories of prior abuse in their lives. Since First Step could not be modified for their specific needs, these offenders were unable to get through the program and thus could not enter Summit House for treatment. The First Step program at the Laconia site for both the Men and the Women was much more confrontational and military than was the program in Concord. In fact, some men who continuously failed to get through First Step in Laconia, requested that they be allowed to attend the Concord Summit House program because they felt they could get through the First Step Program in Concord.

Rules and Regulations

Rules and regulations, although written out in the volumes that comprise the NHDOC Policy and Procedures Directives, appear to be applied inconsistently, due to the power of interpretation left to individual staff. An excellent example of this inconsistency is an incident at Christmas time involving small gifts from inmates displayed openly under a tree and meant for everyone in the unit. Many staff, including the Sergeant Mentor assigned to this building, sanctioned this display. A lone correctional officer took exception to the display after it had displayed for some days, confiscated the tree and the gifts, and "wrote up" all inmates involved resulting in disciplinary actions for everyone. The inmates protested that other staff had condoned the display and that it was in a public area so nothing was being hidden. However, when all of the inmates were written up for disciplinary action, not one staff person came to their defense, and the disciplinary actions were applied. This is just one example of many in living units where inmates generally feel that punishment depends on personal likes or dislikes of the correctional staff and successfully completing the Summit House program is a combination of perseverance and luck.

Inmates also cite the difficulty of behaving in a consistent manner since expectations of "proper inmate behavior" vary among the correctional settings and with the understanding of the officers in charge. For instance, students in the college-based Transformations program are encouraged by the college staff to interact "normally" with members of the opposite gender thereby gaining social skills, learning to work together in a business environment, etc. However, they must not cross an invisible line and interact **too** much with one particular person of the opposite sex or even speak to that person if ever encountered outside of the Transformations program. Moreover, if this fraternization occurs, dismissal from Transformations often follows. In a similar vein, good manners are encouraged but an inmate who verbally apologized to another in the dining hall after dropping a fork received a disciplinary action for talking out loud. Likewise, disclosure and emotional honesty are encouraged, but seldom in relation to staff. If an inmate confronts a staff member for inappropriate behavior or other otherwise criticizes a staff member, this is treated as insubordination. Inmates cite these contradictions, inconsistencies, and idiosyncratic interpretation of rules as creating an atmosphere of secrecy and covert, if not deviant, behavior – something that the program purports to discourage in support of prosocial behavior, at least in theory.

On occasion, inmates are given basic information about the Summit program that are later found not to be true, or are discounted by the staff. One inmate reported to the interviewer that he was told he had to obtain his GED before entering Summit; while another staff member had told him that all he needed was his C3 (medium security) status. Another inmate was discharged from Summit because he could not keep up with his written work, although he had stated (verified by educational testing) that he could not read or write above a 2nd grade level. In contrast, other inmates were admitted and completed Summit House though they were functionally illiterate, and in some cases could not even speak English. The research interviewer spoke with four inmates who were functionally illiterate and three Hispanic inmates, all seven of whom "successfully" completed the Summit House program.

Disability Issues

A significant catch-22 exists for Summit House participants who are physically disabled. All three halfway houses (Phase III of Summit) cannot accommodate physically handicapped inmates, as there are no elevators, ramps or first floor sleeping rooms. Those Summit House participants with moderate to severe physical handicaps almost always have to participate in Administrative Home Confinement (AHC) rather than go to a halfway house. With the more difficult approval process for AHC, these inmates may stay in incarcerated in Phase II for a longer period of time than had they been able to take the option of a halfway house.

A second catch-22 exists for Summit House participants who are eligible for Supplemental Security Income (SSI) for either physical or mental disability. SSI is discontinued when an individual is incarcerated. Inmates cannot receive SSI until they are paroled, and cannot be in either in a halfway house nor on AHC—electronic monitoring. For those inmates who cannot work, SSI becomes their main source of income. However, one condition of moving to Phase III (either halfway house or AHC) is obtaining a job within 2 weeks of moving to the halfway house, and then working 30 hours per week. Individuals for whom SSI is their only means of income are caught in this catch-22. They have no means of support until they apply and receive SSI, however, they are not eligible to apply for SSI while in the halfway house and thus they cannot support themselves at the halfway house and meet the NHDOC requirements. The catch-22 is further exacerbated by the fact that they cannot be paroled to the community until they complete the requirements of Phase III for Summit House, which requires that they successfully complete AHC or the halfway house. One mentally and physically disabled inmate was caught in this loop twice, first getting set back to prison because he didn't get a job fast enough, and then when he was released again was denied SSI because he did manage to work a few hours in order to stay out of prison but as a result was then denied SSI as he was then not considered disabled.

3. A description of the treatment program, including substantive content at each phase, along with information on the duration and intensity of treatment interventions, and information on program philosophy and content as implemented within each facility.

As mentioned previously, staff reported that they consider Phase I of the Summit House program to consist of a "modified" Therapeutic Community approach. The modality of Phase I emphasizes group therapy with an eclectic mix of professional and recovering substance abuse counselors, relies on the AA and NA self help traditions and voluntary mutual aid support, and provides psycho-educational lectures and workshops, along with GED preparation as appropriate. A counselor at the Concord program explained it this way; "It's very easy to stay sober and drug free in prison because we don't serve wine with dinner, but our job is to prepare the inmate from the start to return to the community. We work for sobriety and total abstinence. Summit House works to help the inmates improve their lives, not just to take something away (their use of substances) but adding a positive element, recovery, to their life."

The structure of Phase I in both Concord and Laconia men's programs appears to be fairly typical of those types of modified Therapeutic Communities located within state correctional systems where the professional staff are in control of the content and process. For example, a male inmate's schedule on a typical Monday through Friday at the Laconia program is as follows: 5:45am – Wake Up; 6:15am – Breakfast; 7:00am – Count and House Jobs; 7:45am – Community Meeting; 9:00am – Count; 9:30am – Study Hall and School; 10:30am – Group Therapy; 12:00 noon – Lunch; 1:00pm – Count and House Jobs; 1:15pm – Lecture; 2:30pm – Group Therapy and/or Study Hall; 4:30pm – House Jobs; 5:00pm – Count; 5:15pm – Dinner; 7:00pm – AA or other self-help group; 8:15pm – Gym; 11:00pm – Count and Lights Out. Generally, most clinical counseling staff are available from 8:00am to 4:30pm, with lighter coverage to 7:00pm on weekdays. Clinical staff members are usually not available on weekends at either men's program, except on an emergency basis. While it would be beneficial to have at least minimal clinical staff availability during evenings and weekends so that counselors could respond

to inmates' individual crises as they arise, this change would require the hiring of additional clinical staff as well as security staff to cover increased activity.

The program includes a 24 week series of lectures, scheduled so that every inmate, irrespective of when he arrives, is exposed to the full series during his six-month minimum stay in Phase I.[13] The types of topics covered include: "The Disease of Addiction"; "Denial – How Did You Get Here?" "Relationships"; "Stress Management"; "Recovery Tools"; and "Life Skills". In addition, every inmate is exposed to a series of six workshops that are held once a week for four weeks. The themes of each of these workshops are: "Anger Management"; "Boundaries"; "Domestic Violence"; "Parenting"; "Expressive Therapy"; and "Relapse Prevention". Newer staff were paired with older staff as they assumed the responsibility to present these lectures and workshops. However, as might be anticipated, the content and quality of the various lectures and workshops varied considerably, depending upon the experience and skills of the individual presenter. The material for the lectures and workshops appeared to be taken from a variety of sources and no clear curriculum had been developed to guide newer staff when they had to present. A recent change in the program has resulted in assigning two staff persons with stronger presentation skills as the primary presenters for all of the lectures, allowing the other staff to concentrate more intensively on their clinical and counseling duties.

Phase I Program Observation Findings

Lectures

Prior to the change noted above in the Laconia program the researchers observed lectures at both the Concord and Laconia men's programs. At Laconia 22 Summit House participants attended a lecture on self-esteem, presented by one of the Summit House staff. The material was presented in a didactic manner with the counselor first reading a paragraph from a 12-step handout on self-esteem and then asking for volunteers to read.

[13] The Concord Program developed the framework of the 24-week lecture series and the workshops that was adopted by the Laconia Program in early 2000.

Much of the material available to the counselor for their presentations is taken from various articles and tracts copied from a variety of 12-step pamphlets or other treatment and recovery literature that pertain to the lecture topic. Many of the inmates were not engaged in the lecture and some asked questions or made comments, which implied that they had difficulty in understanding the concept and how it related to their addictions. Cognitive thinking exercises about self-esteem were used to encourage participation in the lecture, but it did not appear to hold the attention of the group. At the end of the lecture, participants are given Xeroxed handouts and homework questions to complete prior to the next lecture, however, the reading level of the handouts seemed higher than some people attending could master. The staff gauges the understanding of the lecture's content by the participant through homework assignments but admit there is no standard assessment or measure of the inmate's mastery of the content.

The lecture at the Concord program was given to 20 participants and was similar in content to Laconia with the exception that the inmates seemed to be more engaged in the lecture itself by asking questions and actively answering questions posed by the presenter. There also appeared to be more attention paid to the topic—self-esteem-and how it related to their addiction and recovery. The staff at Concord seemed to be more prepared and had clear learning objectives for their lecture. Handouts were also given in the lecture as well as homework assignments, which were different from those given in Laconia. The Concord program also has no method for assessing the program participants understanding of content.

When the researchers asked to see the curriculum for the lectures at Laconia, we were shown a file drawer where each lecture topic was filed separately. In each topic folder were various pamphlets, articles, handouts and exercises that a counselor could use in the lecture. Some topic files included a number of resources, while others had only a page or two outline of what the lecture might entail. There appeared to be no written curriculum with goals and objectives to insure the delivery of a standard content or means to link the content with their substance use. Each counselor was expected to be able to lecture on any of the 24 topics with the material available in the files.

In Concord, the Summit House program had developed a book of copied articles and handouts for the participants that corresponded to the 24 different lecture topics. The curriculum at Concord had a minimum of stated learning goals for each lecture but relied on each counselor to develop the lecture from the file materials each saw fit. Concord was somewhat more structured and organized than Laconia, but still did not standardize content or measure client understanding of content.

Workshops

The workshops were designed to take a single important topic and present on it for one full day, replacing lectures or other programming. The same topic would be presented in different forms over the course of one month, or four sessions. These workshops were more elaborate than the lectures, utilizing community speakers, other NHDOC staff, and videos that were more intensive on their focus of how the particular topic applied to the participant's life and addiction.

Although the research team planned to observe part of a workshop and set up the site visits to accomplish that objective, no workshops were held on the dates that the programs were visited. On each occasion, changes were made to the schedules at Laconia and Concord that resulted in cancellation of the workshops.

Clinical Groups

The "heart" of the program, according to the Summit House staff, was the clinical groups. This was the modality that the counselors used to work with the participant's clinical issues, to assist them in integrating the lecture and workshop materials, as well as reflect on how the issues raised had impacted their lives. The groups are also used to practice the skills taught in the lectures and to plan for their return to the community.

The research staff observed clinical groups at both Concord and Laconia men's groups and Laconia women's group. At Laconia, the clinical group consisted of 12 offenders and their primary counselor. The group had a large percentage of newer members. The counselor introduced a Hazelden pamphlet on Grandiosity, which the group took turns reading. After the group had finished reading the counselor asked if they either had questions about what grandiosity was or if they could describe how this pertained to their life. A few of the group were able to relate to this concept and tried to explain it to the others who were not able to relate grandiosity to themselves or their addiction. The counselor remained in charge of the group and directed the discussion, eliciting feedback and responses from the group. The counselor did not make use of the group process or facilitate its development, focusing as much on individual members rather than the group as a whole. The concept of grandiosity appeared too abstract for some members and the reading material was fairly complex. Although the counselor used a style that did not facilitate group processing and problem solving, the counselor did exhibit competent individual skills offering appropriate support and empathy. Serenity prayer ended the group.

Two clinical groups were observed in the Concord program, one with 9 members and one with 12 members plus the therapists. One of the groups observed was run in an organized, traditional manner where the therapist first wrote down names of who wanted to talk that day and then went in order. The themes revolved around the holidays and how drugs and alcohol had affected many of their Christmases both as children and adults. Also there was some discussion on how 2 of the group members had gotten into a misunderstanding, how it made them feel, and how they finally resolved it. The therapist would coax more talk from the members with interpretations and stepping up some "weak signals" so proper emphasis could be given them by the offender and the other group members. Comments about the past were related to the present and applied to their individual recovery. The counselor was competent, in charge, and kept the group moving. Serenity prayer ended the group.

The second group observed was run in a more dynamic, interactive manner. One person was very new to the program and struggling with integration issues. The counselor used the opportunity for the more senior participants to reflect on their earlier experiences in the program and work with the newcomer. Much of the discussion revolved around their feelings about the holidays and their preparation for getting through the upcoming weeks. The counselor allowed the group to lead the conversation, facilitating the application of the comments and insights to their recovery and encouraging everyone to speak. The counselor was clearly a trained group facilitator. Serenity prayer ended the group.

Since Summit House relies on the group process as the heart of their program, it is very important that the counselors be able to facilitate effective group process. While all of the counselors are expected to lead clinical groups, it was clear from the researchers observations that not all of the staff had the same level of group process experience or competence. As Summit House participants are not allowed to move into different clinical groups, those who have a less experienced group facilitator may be at a disadvantage, given the reliance of the program on this modality.

Individual Therapy (Phase 1)

Because of the sensitive nature of individual therapy and the client counselor relationship, the research team did not observe any individual sessions. At the start of the research project, all Summit House participants at Concord and Laconia received at least 1 hour of individual treatment every week. However, in May of 2000, the Laconia program decided to decrease the amount of individual treatment time to 1 hour every other week. This was done in order to place more emphasis on the group nature of the program. Many inmates decried this change. The Concord program continued its 1 hour of individual treatment a week as an important facet of their treatment.

Community Groups (Phase 1)

The research team observed community groups at the Concord and Laconia programs. At Laconia, the community meeting consisted of one half of the participants (48) in Phase I of Summit. The meeting was led by a different inmate each day and followed a set pattern of topical readings by other inmates in the group. After each reading any offender could respond with how the reading related to his own life situation. If any of the group members were graduating into Phase II, they would give a brief speech following this reading. Each member of the group would then provide a supportive statement to this member of the group moving on to Phase II. Finally, house issues and house business were addressed. All of the Summit House therapists attended these meetings and spoke during this housekeeping part. All meetings ended with the Serenity Prayer. The community meeting itself had little emotion, was quite perfunctory, and during the business session appeared overly concerned with petty issues. Since only half of the Summit program attended each community meeting, it was unclear to the research staff how the two groups of 48 participants each in Summit House could be a true community.

In Concord the observed community meeting focused on the group providing affirmation and feedback to two members who were moving into Phase II. Each of the 38 group members told the individuals how they saw their achievements and offered a few words of encouragement on what to pay attention to in their recovery outside the walls. Following this the daily spiritual topic reading book was passed around for each participant to read a passage. For the most part, participants were polite but not extremely involved unless they were close to the inmates who were moving on to Phase II. The community group met all the rules of a morning meeting including the coming together and closing rituals of standing serenity prayer, structured format, one person speaks at a time, task oriented, staying in present time. It lasted for one hour and the clinical staff person was a contributing member of the group. The community group at Concord included all Summit House staff and program participants. The meeting itself was more structured and focused than the community group at the Laconia program.

Overall, the duration and intensity of the treatment interventions during the six-month minimum period of Phase I of the Summit House Men's Program at the Laconia and

Concord appear to be reasonable and appropriate to programs where the emphasis is placed on group treatment and psycho-educational lectures. The programs are not, however, congruent with those programs that consider themselves to be therapeutic communities. Regarding the program as having an educational focus, however, one concern is the time allotted for study hall periods at Laconia that can comprise up to 3 hours of the inmate's program day. There appears to be only minimal supervision of inmates during this time. Some inmates appear to use the study halls productively to work on assignments given to them by their counselors, and/or use it to read recovery oriented or other useful educational materials. However, based on our direct observations of inmates during these study halls, at least some inmates, and possibly many, appear to use the time primarily to daydream or to engage in other non-productive behaviors. Inmates themselves when asked about the study halls, thought that the time was not productive for many of them. On the other hand, these periods are the only times that inmates can step outside the imposed structure of the program and use this time for self-directed recovery activities.

Additional problems across all Summit House programs include the lack of a sufficient quantity of recovery oriented reading materials for inmates, particularly those related to NA and to drugs other than alcohol. Furthermore, there are few recovery oriented materials written in Spanish, thus those inmates who cannot read English, but do read Spanish as a first language, generally do not have appropriate materials to read, learn from and study. This may be seen as a parity issue if these inmates are required to successfully complete Summit House as a requirement of their sentence and are unable to do so because of the language barrier or lack of materials in their native language. Moreover, if these inmates are merely moved through the program without fully engaging or understanding and yet 'successfully' complete Summit House, they are at greater risk of failure in the community.

The women's program at LRF initially differed somewhat from the men's in terms of the schedules, lectures and workshops. In June of 2000, however, substantial changes were made to align the women's program more closely with the content of the men's program.

The original head counselor of the women's program believed in a more spiritual and clinical approach with more inmate participation in the lectures and presentations. Some of the differences between the men's and women's programs were: daily meditation; spirituality work (angel, medicine and change cards); daily affirmations; 14 hours of clinical group work weekly (primarily over a concentrated two day period); weekly clinical group combined with the Phase II inmates; and mandatory exercise program. The closeness of this small (never more than 20 total) community appeared to intensify the experience for the women and on average they stayed in Phase I longer than the men. It was the initial head counselor's belief that women in Summit House had more issues than the men and needed more time in treatment to work them out. This was not the belief or style of the new Coordinator of the Laconia Summit House Programs. She wanted the women to have a program more similar to the men's moving through the correctional system in the same time and manner. She also felt that in the prior program women were being setback more often than the men, that the behavioral expectations for the women were more ambiguous, e.g. they were often not told what specific behaviors they needed to change, and the program was, at times, more punitive than therapeutic.

Phase II Program Observation Findings

Once the Summit House men graduate from Phase I, at the Laconia facility they are moved to a separate Minimum Security Unit outside the wire and walls. However, they continue to participate in Summit program related activities. Phase II lasts a minimum of two months with a focus on outside work in the community. During this period, the participants may leave the grounds to work in the community, or attend Transformations at the Laconia facility. They also receive some continuing clinical support. Their counselor from Phase I is scheduled to visit them in the Phase II facility for one weekly group session; they are expected to participate in AA or other self-help recovery group meetings one time per week; and a new counselor, as well as a Sergeant Mentor security staff person, are available in the new facility who serve all the men there, plus work on parole issues. Since the men are out all day, this has to take place in the late afternoon and evenings. Overall, this phase of the program appears to be less intensive clinically

than one would hope it would be. Apparently, after the intensity of Phase I, a number of the men feel somewhat abandoned and that they do not receive sufficient clinical support in Phase II. This problem exists relative to Phase II as it is implemented both at the Lakes Region Facility and at the Concord State Prison. It should be noted, however, that at our follow-up visit in January 2001, greater clinical support for Phase II was just being implemented at the Laconia facility.

Phase II at the men's program in Concord also takes place in the MSU but the program participants are mixed with the general population of inmates. Originally, the Summit House clinical staff at the NH State Prison in Concord was assisted in Phase II by three of the aftercare counselors. These aftercare counselors took over the primary treatment responsibility when the inmate moved from Phase II to Phase III to assist with the transition to the community and to free up Concord Summit House staff to focus on Phase I and First Step. This strengthened the clinical content of the Phase II program at Concord. The Assistant Commissioner halted this in the spring of 2000 and following that decision Phase II at NHSP had much less clinical support for the inmates.

Phase II at the women's program at LRF had some of the same problems as those of the men. There was a lack of intensity in treatment, with only one group a week for them. However, they had more access to individual sessions with the counselor since the women did not have the opportunity in Phase II to go off grounds to work as did the men. Since the women in Phase II worked at various jobs on the LRF grounds, the counselor was more accessible to them. Also, twice a week the Phase I and II women held joint community meetings to go over what was happening with them in the environment.

Phase III Program Observation Findings

To move to Phase III, the Summit House client must be within 6 months of their mandatory minimum sentence, however, they can petition a judge to modify their minimum date to facilitate moving to Phase III if they have a longer minimum sentence and have completed Phase II. Phase III consists of either a Halfway House facility and/or

to Administrative Home Confinement. The waiting list for the halfway house is sometimes as long as 5 months. An investigation for AHC is supposed to take approximately 30 days, however it often took much longer. At the Halfway House, the inmates receive attention from a new substance abuse counselor who engages them in one clinical group per week and from a Sergeant Mentor. Also, they are required to go out to work in the new community, and are encouraged to continue their self-help program through participation in AA or NA meetings. This program phase lasts a minimum of three months.

Length of Stay for Phase I, Phase II, Phase III

The RSAT funding for Phase I requires a minimum length of stay of 180 days. Approximately 5% (n=6) in Laconia Men's program completed Phase I in less than 180 days—on average 25 days early. This was most often due to offenders entering the college education program 'Transformations' which had a fixed semester schedule and required that they move into the minimum-security unit, Phase II of Summit House. Concord Men's program had two offenders who completed Phase I approximately 1 week early due to an opening in the minimum-security unit that they would lose if they were not immediately transferred.

In general, we calculated length of stay as the number of days that it took the participants to finish Phase I—from their first day of admission up until they entered Phase II. [14]

The Laconia men's group spent an average of 213 days in Phase I ranging from a low of 124 to a high of 853 days. The median was 184, with 46% of the men spending between 181 and 184 days in Phase I. The next 25% spent between 185 and 213 days in Phase I

[14] These numbers include time that was spent in setbacks, both within and outside of the program. Setbacks within the program imply that the offender remains in the program, but has additional time added to their 180 days in Phase I varying based upon the severity of the disciplinary action. For more severe disciplinary actions, offenders are setback outside of the program, where they return to general population and are required to remain disciplinary free for a period of time before they can apply to return to the program. In addition, they loose their 'place' in the program and must wait until there is an opening to reapply. Data on the types and severity of the setbacks, both within and outside the program, are currently being gathered for the Outcome Evaluation in order to evaluate how these affected treatment completion and treatment outcomes.

and 25% spent between 214 and 474 days. One participant took 853 days to complete Phase I of Summit House.

The Concord men's group spent an average of 248 days in Phase I ranging from a low of 166 to a high of 814 days. The median was 189, with 46% of the men spending between 181 and 189 days in Phase I. The next 25% spent between 190 and 207 days in Phase I and 25% spent between 211 and 692 days. One participant took 814 days to complete Phase I of Summit House.

The Laconia men's group spent an average of 91 days in Phase II ranging from a low of 20 to a high of 308 days. The median was 76, with 49% of the men spending between 50 and 76 days in Phase II. The next 25% spent between 77 and 108 days in Phase II and 25% spent between 111 and 308 days.

The Concord men's group spent an average of 95 days in Phase II ranging from a low of 28 to a high of 241 days. The median was 75, with 48% of the men spending between 44 and 73 days in Phase II. The next 25% spent between 76 and 125 days in Phase II and 25% spent between 133 and 241 days.

The Laconia men's group spent an average of 136 days in Phase III ranging from a low of 47 to a high of 609 days. The median was 102, with 46% of the men spending between 61 and 102 days in Phase II. The next 25% spent between 102 and 133 days in Phase III and 25% spent between 141 and 457 days. One participant took 609 days to complete Phase III of Summit House.

The Concord men's group spent an average of 134 days in Phase III ranging from a low of 33 to a high of 419 days. The median was 116, with 41% of the men spending between 59 and 116 days in Phase II. The next 25% spent between 118 and 162 days in Phase III and 25% spent between 166 and 256 days. One participant took 419 days to complete Phase III of Summit House.

Length of Stay (in days)	Laconia Men	Concord Men	Laconia Women
Phase I			
Expected LOS	180	180	180
Average	213	248	240
Median	184	189	198
Range	124-474*	166-692**	140-484
Phase II			
Expected LOS	60	60	60
Average	91	95	83
Median	76	75	63
Range	20-308	28-241	52-218
Phase III			
Expected LOS	90	90	90
Average	136	134	142
Median	102	116	98
Range	47-609	33-419	47-380

*This excludes one Laconia participant who took 853 days to complete Phase I.
**This excludes on Concord participant who took 814 days to complete Phase I.

A One Way Analysis of Variance (ANOVA) comparing length between the two men's program for each of the different phases, found that there was a statistically significant different in length of stay between the programs only for Phase I. This was statistically significant at the .05 level. time in Phase between Concord and Laconia was significant at the .05 level for Phase I only.

ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
Days in Phase I	Between Groups	44141.96	1	44141.960	3.963	.048
	Within Groups	1893317	170	11137.162		
	Total	1937459	171			
Days in Phase II	Between Groups	759.260	1	759.260	.387	.535
	Within Groups	311891.0	159	1961.578		
	Total	312650.2	160			
Days in Phase III	Between Groups	172.703	1	172.703	.020	.888
	Within Groups	1049223	122	8600.186		
	Total	1049395	123			

4. A description of staff competence and training levels across program phases and sites, along with a discussion of staff impact on treatment program implementation at each facility.

Staff Competence

As with any program, the Summit House sites are affected by the strengths and personalities of the individuals directing and/or working within the program, as well as the overall institutional philosophies and context. For example, the Summit House program at the Concord State Prison is located within a maximum-security prison. This program also has some strong administrative personalities within the Correctional Officer staff and appears (perhaps by design) to have more of a paramilitary style than the Summit House program located in the Lakes Region Facility in Laconia, which is not a maximum-security facility. Some of the potential advantages of the Concord program and/or of strong administrative personalities generally (some of these are also part of the staff at the Lakes Region Facility in Laconia) may be that they provide strong leadership, consistency, and stability for both staff and inmates. Expectations for the inmates as well as the staff are clear, consistent, and enforced. However, there may also be some disadvantages to this type of ongoing leadership. For example, there may be less willingness to listen to input and needs as expressed by inmates or other staff, as well as less openness to changes that could be constructive and positive in terms of Summit House program outcomes. It may be appropriate for the leaders of the different Summit House programs and other leaders within the correctional system to discuss the

advantages and disadvantages of different administrative styles and expectations as they relate to desired program outcomes.

In terms of staff impact on treatment program implementation, it is clear that staff experience and expertise are both critical to successful program implementation and operations at each of the other Summit House Program sites, facilities and phases of the program. Overall, most of the staff appeared to have basic competence in performing the specific program and/or security tasks that were observed. However, the research staff noted that many of the counselors needed increased training to enhance their group treatment skills, especially because the Summit House program requires so heavily on clinical groups as their main modality of treatment.

In examining differences in counseling staff that might have some affect on the programs themselves the research team looked at the number of years in the field, number of years at the unit, and educational attainment for the Phase I and II staff. The educational attainment was comparable for all programs with a split between those staff with BA degrees and those with Masters degrees except for one counselor at the LRF men's program with less than an associate's degree and the lead counselor at the women's program who had an RN degree. The average number of years in the field was 7.5 for LRF men's, 9.5 for Concord, and 12 for the women's program. Concord's average time for the staff on the unit was 2.6 years while the LRF average was just under 1 year. This difference in prison experience and institutional memory of the 2 program' staff may explain some of the differences in the programs that were observed by the researchers.

As noted a number of the staff members are new, do not have counseling degrees or certification as Licensed Alcoholism and Drug Abuse Counselors (LADAC). As of the most recent site visit, four of the 11 clinical staff at the Laconia facility were LADACs, with another three staff actively pursuing their certification. Also, as clinical positions become available, the Laconia Program Coordinator has modified the job description so that it now includes a requirement that applicants already be licensed or at least be working toward licensure. Consideration should be given to providing incentives such as

pay increases for those clinical staff that are or become licensed. Another less desirable option would be to simply require licensure after a certain period of time as a Summit House counselor. To assure a greater likelihood of staff competency and efficiency, all or most of the clinical staff should receive all necessary support so that they can be licensed as alcoholism and drug abuse counselors as soon as possible In addition, the budget item that supports travel and fees for clinical staff to attend relevant regional and national training opportunities should be increased. Most importantly, as a means of recruitment, staff retention and quality assurance, the Department of Corrections should investigate ways to either provide expanded in-servide training opportunities to obtain Continuing Education Units (CEUs) required for maintaining licensure, or pay for staff to attend these workshops offsite (e.g., staff participation in the Therapeutic Communities of America (TCA) Annual Meeting, in the Correctional Institute offered by the New England Institute of Addiction Studies, and/or staff visits to other long established and respected therapeutic communities in other states' correctional systems). Such increased staff competency and efficiency should lead to more effective programming for the inmates.

Another issue related to staff performance and competence is the ratio of staff to inmates. Currently each of the Summit House counselors is responsible not only for providing intensive group and individual counseling services, as well as educational services, to a minimum of 12 inmates residing in the Phase I Summit House Program, but also they are responsible for providing follow-up services to their inmates who have graduated and currently reside in Phase II of Summit House. Also, at certain times such as evenings, one Correctional Officer may be responsible for security for all of the 96 inmates within the Men's Summit House program. Such high inmate to staff ratios pose a variety of risks and they can lead to less than optimal staff performance. Some consideration should be given either to hiring more staff, or to serving fewer inmates, and to lowering the inmate to staff ratio, particularly at both Phase I and Phase II of the Men's Program at the Lakes Region Facility in Laconia.

Training specific to Summit House

In terms of areas of improvement relating to staff competence or training, one area that could benefit from immediate attention is the provision of more intensive training and programmatic information on inmate behavioral expectations, the Summit House philosophy, and treatment goals to the Correctional Officer security staff. Currently, both new Correctional Officer security staff and new clinical staff who serve Summit House inmates receive limited, basic training on relevant security matters and other issues related to working within a correctional institution. Even with this basic training the most frequent complaints from Summit House participants and clinical staff encountered by the research team were the problems created by Correctional Officer security staff (many of whom were new to the program) who were inconsistent in their treatment of inmates. The most expedient way to resolve the apparent problems is to provide more intensive and relevant training for the Correctional Officers in responding to different inmate infractions of rules, on the clinical group process, the 12 step mutual aid philosophy, and on the hopes and expectations for growth of inmates as they enter and move through the various phases of Summit House.

Also important, is the need for more discussions and ongoing joint training between Correctional officers and the clinical staff at Summit House. A better understanding and closer ongoing working relationship among the Correctional Officer security staff and the more treatment oriented clinical staff will benefit both staffs and facilitate growth and progress among the inmates. At Laconia the role confusion among some counselors was evidenced in our interviews. Some of them felt that they had to be "hard" on the inmates and that this made management of the inmates and groups easier, while others felt that doing anything of a disciplinary or security nature interfered with their "therapeutic relationship" with the inmates.

Another significant problem is the lack of clinical supervision available for the Summit House Coordinators. While the Program Coordinators do meet weekly with their counselors to discuss clinical issues and to provide appropriate supervision, they must rely on peer support for their own clinical supervision. Currently, the Coordinators of

the Summit House Programs at the Lakes Region Facility and at Concord State Prison meet together on a regular basis in order to provide clinical and programmatic support for one another. These meetings should be continued, as they are critical to the stability of the programs, the consistency of implementation and integral peer support for the Coordinators. However, a more ideal situation would be if a senior Licensed Alcoholism and Drug Abuse Counselor were available to provide weekly clinical supervision for both of them, or at least to be available to answer difficult clinical questions.

SECTION FIVE: RECOMMENDATIONS

The following recommendations are based on the observations of the research team during the process evaluation, the interviews with program staff, the analysis of the data, and the review of the current literature. Where appropriate, the recommendations will be supported with citations from the literature. As a research team we decided to include recommendations at this interim stage of the evaluation because we felt that it was our responsibility to initiate a dialogue to support NHDOC in developing and implementing the best possible treatment programs for inmates and staff in a correctional setting. We will be providing additional recommendations based upon the findings from the Outcome Evaluation 2002.

1. Standardize the initial substance abuse assessments of the offenders to provide consistent data and enhance the information gathered so that NHDOC can identify and plan for the treatment needs of the population early. This screening assessment should be undertaken during the initial R&D 30 day period and provide information to Classification on an offender's treatment need, level of treatment indicated, and a planned time to enter a program. A screening and assessment tool such as the ASI could be used during this period and also could be used to collect follow-up data after an offender is paroled. Not all offenders with substance use problems need the intensity of a Summit House program and should be assessed as to both their motivation for treatment along with what intensity of treatment is needed.[15]

   A standardized screening and assessment process would assist NHDOC in making treatment decisions that are better matched to the offender's needs and in this way focus the most intensive treatment services to the highest risk and need offenders. The American Society of Addiction Medicine has been at the forefront of

[15] According to Canadian researchers Paul Gendreau and Don Andrews, levels of service should be matched to the risk and needs level of the offender. Intensive services are necessary for a significant reduction in recidivism among high-risk offenders, but when applied to low-risk offenders, intensive services produce a minimal or negative result.

developing placement criteria following assessment of risks and needs that has been reported on in the literature (Gastfried et al 2000). These criteria would be useful to NHDOC in developing more appropriate screening processes as well as and programmatic developments.

2. Conduct an evaluation of First Step to see if it either assists entry into treatment or sets up artificial barriers to individuals with prior physical, emotional or sexual abuse history. Several studies have suggested that boot-camp like programs with similar structure and content as First Step, are in fact detrimental to offenders entering treatment programs who have prior histories of abuse (MacKenzie, 1996, 2000; Widom, 2000). Consider instead the completion of a 6 to 12-month cognitive behavioral program that deals with criminogenic factors as a prerequisite to entry. Vermont Department of Corrections (VTDOC) has this type of pre-treatment program that offenders participate in prior to entry into a therapeutic program. It has been evaluated internally and found to be effective by VTDOC (personal communication John Perry VTDOC 2001). This type of program addresses the risk factors that predict dropout from treatment or relapse after treatment. Cognitive-behavioral programs also increase offender motivation and make them more engaged in participating in treatment once the criminality issues are addressed (Hiller et al, 1999, Andrews 1990, Blankenship et al, 1999, Baro 1999).

   Furthermore, it is critical that the requirement of First Step for women be examined to see if it meets their needs or is creating further victimization and barriers to treatment given the profound levels of abuse reported by the female offenders: 94% prior emotional abuse; 91% prior physical abuse; and 74% prior sexual abuse.

3. Standardize the curriculum and therapeutic format of the Summit House programs so that all the offenders are receiving the same treatment and educational content as well as being assessed by staff in the same manner. One suggestion is to move

to a more manualized form of treatment, with standard program components such as the Relapse Prevention Module currently used by the Concord Summit House program. This move will ensure that the content is consistent and less influenced by the personal styles or expertise of the staff. Summit House staff should investigate appropriate treatment modules, shown to be empirically effective, in order to select those that fit best with NHDOC treatment philosophy and ensure staff buy-in to any new program content and/or structure.

4. To meet the needs of offenders with less intense substance abuse treatment needs, other empirically based treatment programs should be implemented so that a continuum of substance abuse treatment services exist within NHDOC. As mentioned previously, not all offenders need the level of intensity of the Summit House program, and resources could be more cost-effectively distributed by identifying more appropriate interventions for those offenders needing specialized treatment, i.e. DUI's and other motor vehicle offenses, those with abuse versus dependency problems, etc. Effective treatment modules exist and are available through a number of sources such as National Institute of Drug Abuse, Treatment Research Institute, Clinical Trials Network, etc.

5. Pre and post testing should be established for all treatment programs provided by NHDOC to measure offender comprehension of materials and successful completion of the program. In this way the treatment programs can document success of the individual offender and obtain an assessment of the programmatic effectiveness through which to base their base their decisions regarding graduating to the next phase of treatment. Of the 3 Summit House sites, Concord had the most standardized treatment and organized content for lectures and workshops. However, none of the programs tested for participant comprehension of the material or assessed the quality of their delivery of the programmatic content on a regular basis.

6. An alternative to making substantial changes to the program content is to enhance the program framework to become an authentic therapeutic community. Although Summit House staff report that they have a "Modified" Therapeutic Community, that classification of "modified" is not supported in the literature and Summit House lacks several substantial components of the recognized Therapeutic Community. The primary missing element is that the residents are not involved in the all aspects of the program from daily operation to administration and maintenance; it is not "community as method". In reality, Summit House appears to be a group and individual substance abuse treatment program with psycho-education set in a "therapeutic" milieu. These types of programs have not been found to have robust effects; they typically do not result in significant decreases in recidivism or drug use, as do true TCs or some of the researched cognitive behavioral programs. (Pearson & Lipton 1999; Melnick et al, 1999; Broekaert et al, 1998).

7. Aftercare services for the offenders in the community have been shown to have the greatest effect on decreasing recidivism and drug use following prison treatment programs. (Wexler, 1999) The NHDOC should consider collapsing Phase II and Phase III of Summit House together as a work release TC housed in the community like the Amity program in California or Crest program in Delaware. The 6 months of Phase I in prison could be followed by the 6-month work release TC, which could be structured as a true TC (see Martin, 1999 for the relevant content and structure of such a TC). As with the current Summit House program, offenders could receive a modification of their minimum sentence by attending the work release TC that would enhance their motivation to succeed.

   In addition, aftercare services in the community should then also be developed and/or expanded to support those offenders on parole in their home communities for at least 6 months to one year after leaving the TC. Such more intensive and significantly expanded aftercare services for Summit House graduates would respond directly to Minard's findings and recommendations that : "the best way to

reduce the number of people in the state's prisons may be to do more to help those on parole make the transition back to civil society. A medical problem-drug and alcohol dependency-plays a critical role in many of the parole and probation violations that result in incarceration. Additional research and policy making should focus on those challenges"(Minard, 2001, p.1).

Given that a large percentage of those who return to prison are for technical parole violations, programmatic changes such as these could be found to be cost-effective over the long run, if they successfully reduce the level of recidivism for such violations.

8. Inmates in the Summit House program are expected to follow all the NHDOC rules of inmate behavior along with the additional rules imposed by the Summit House program pertaining to their treatment. At times, offenders who disobey any of the Summit House or NHDOC rules of conduct are taken directly to a disciplinary hearing board by the security staff without any input by the treatment staff. If the safety of either staff or inmates is not compromised by the offending behavior of the inmate, then the Summit House Program Coordinators should be able to clinically deal with the participants' attitudes and behaviors and have the latitude to exempt the inmate from the prison disciplinary policy if there is a therapeutic reason (Farabee et al, 1999). To insure that the program environment is conducive to treatment the Coordinators should also be able to eject program participants who are disruptive, unmotivated, or not amenable to treatment as a clinical decision after all therapeutic and disciplinary actions have been attempted. With appropriate documentation based on sound clinical and administrative procedures laid down in NHDOC policy, participants would not have a "right" to continued treatment chances.

9. NHDOC needs to continue and reinforce established relationships with AA, NA & other 12-step/mutual aid groups to insure involvement with the offenders in prison and in the community. During the study we noted that AA groups and

especially NA groups were not held on a consistent basis due to the lack of community volunteers. NHDOC may need to look to inmate resources as well as consider other DOCs lifers or those with longer sentences as peer group leaders. We suggest that NHDOC use inmates not as counselors but as peer conveners of self-help groups to be able to offer these groups on a more regular basis.

10. In place of adding a longer aftercare period, or in addition to this programmatic shift, the other factor which will have an impact on recidivism and success in the community is smaller caseloads and better training in Substance Abuse treatment and relapse prevention for Probation and Parole Officers. A decade ago, most PPOs had training in the social sciences and saw the role of the officer as service oriented, the helping hand that assisted the offender with remaining in the community. For the past several years, nearly all of the PPO positions were filled through internal NHDOC applicants, most of who were correctional officers with strong security not program or service orientation. This change in orientation of Field Services has led to large and increased numbers of probation and parole violations usually for technical issues and not for new crimes.

    Through the integral role that the PPO plays in the Correctional system, they have a great influence on sentencing decisions through their pre-sentence investigations for the court, and on community tenure when an offender is on parole. Thus their understanding of substance abuse and treatment, effects their decisions regarding their recommendations to the court for sentencing and also when to "violate" and return to prison those alcohol and drug involved offenders who they supervise on parole. With parole violations accounting for nearly 50% of NHDOC prison admissions (Sunday Citizen 11/25/2001), the ability to better treat and manage in the community, paroled offenders with substance abuse problems would be a significant cost savings to the state.

11. Mandatory cross training for counselors and security staff employed in the Summit House programs. To create more consistency among security staff in

Summit House, the security post in programs should be enhanced through pay, promotion, training and/or some other status. A sergeant-mentor position was developed to give security staff more of a role in prison programs like Summit House but the position developed in such a way that their roles blurred with the counselors and created problems of authority and accountability. Instead, sergeant mentors are necessary to be a stable security presence and a positive role model who engage the offenders in thinking about their past and current behaviors but who are not professional drug and alcohol counselors.

12. Hire a Coordinator of Substance Abuse Services who can set the direction and philosophy of all the SA services in the NHDOC and also provide the necessary clinical supervision and direction to the Summit House Coordinators and staff. Since working in a prison environment is stressful and utilizes different skills than counselors use in the community, clinical supervision and direction is necessary for staff in the prison system to provide responsible treatment services to inmates (Farabee et al, 1999; Najavits et al, 2000).

13. Increase the funding for Summit House so that the program can afford to buy necessary treatment materials such as manualized treatment workbooks, obtain mandatory training to gain or maintain licensure and keep current with the research on treatment in correctional settings, and make salaries higher to attract and retain competent, credentialed individuals.

14. In Phase I of Summit House the early emphasis should be on problem recognition and willingness to change before introducing the tools that one can use to change. Since most of the offenders are not voluntary participants in Summit House, it is important to deal with this immediately and to move the external motivation/coercion to a more internal self-motivated stance.

15. Inmates who have a first language other than English may be at a disadvantage in the Summit House program. The largest group that this affects is the Hispanic

offenders. The only bilingual counselor was at LRF men's program, went to the women's program and left the department for the private sector in the summer of 2001. All programs lack materials in Spanish and thus there exists an issue of parity with regard to treatment services.

16. Halfway houses are not accessible for inmates with physical disabilities so this is not an option for offenders entering Phase III of Summit House. At least one halfway house should be fitted with a lift so that treatment is equitable for the disabled. The catch-22's identified in the research should be examined to identify ways to address these.

17. Since the women's program changed twice during our study, it is difficult to offer specific recommendations based on the current program. However, the literature supports that NHDOC place more program emphasis with women concerning children, past victimization, "interpersonal criminogenic needs targets", and presentations that are more in tune with women's learning styles (Henderson 1998; Dowden & Andrews, 1999; Shearer et al, 2001).

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