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Department of Criminal Justice

Arkansas Comprehensive Substance Abuse Treatment Program
Process Evaluation of the Modified Therapeutic Community (Tucker Unit)

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University of Arkansas at Little Rock

FINAL REPORT

Approved By: Laurie Bright per note below

March 2001

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Where excellence has many faces

Rpt. Content and quality are the ultimate responsibility of the report authors. My signature does not indicate agreement with the contents or quality of any report.

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Allan L. Patenaude, Ph.D.
Deborah L. Laufersweiler-Dwyer, Ph.D.

Primary Investigators
March, 2001

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Executive Summary

1. Introduction

A partnership was established between the Department of Criminal Justice, University of Arkansas at Little Rock (UALR) and the Arkansas Department of Correction (ADC) to study the current Modified Therapeutic Community Program operated at the Tucker Unit. This partnership was designed to facilitate entry into the field, identify and evaluate an appropriate screening instrument, evaluate the operations and perceptions of the program, and report any discontinuities between the idealized and actual program. This research project was sponsored by the National Institute of Justice under Grant #199IJCXK015.

This program was in its infancy and required the evaluation of several areas: (1) the identification of instrumentation which can be used by correctional staff to identify initial and ongoing inmate needs, (2) identification of those factors which are correlated with successful participants, and (3) a formative evaluation of the overall program. Early identification of substance abuse problems among inmates and effective, ongoing treatment intervention is essential. When the research began, this program was receiving its initial inmate cohort.

The research explored the extent and patterns of substance abuse among the sample client group as well as the effectiveness of the current treatment intervention. With regards to the effectiveness of the current interventions, participants were empowered to discuss their beliefs concerning whether the components of the Comprehensive Substance Abuse Treatment Program (CSATP) were meeting their needs and what, if any, changes they perceived as necessary to improve it.

2. Methodology

The data on program participants was gathered: (1) at intake into the ADC, (2) at intake into the treatment program, (3) during treatment, and (4) upon completion/discharge from the program. A single instrument was identified, using the Interactive Group Process (IGP), which would help establish factors related to offender selection, program participation, retention in the program, and successful completion of the program. The development of this instrument involved the reaching of consensus on key variables among both senior ADC managers and the researchers.

A number of site visits were conducted throughout the project. Direct observation of daily activities permitted the evaluators to explore that which Wholey (1994) termed the "entire program reality." The initial role of the evaluators was to observe the routine and minutiae of the daily program using known, non-participant observation techniques to

understand the program activities, inmate participants, and the program staff. Later site visits required this role to change as it involved both semi-structured group interviews and focus groups to: (1) understand participants' perspectives by understanding the particular context within which they act, (2) identify unanticipated phenomena, (3) understand the process by which events take place, (4) identify local causality, and (5) develop causal explanations (Geertz, 1973; Maxwell, 1992, 1996; Patton, 1990; Miles and Huberman, 1984).

Unlike many evaluation studies, the co-investigators served as tools which the program providers could use to improve their program and its delivery. Indeed, as the few discontinuities between the idealized program statement and the realities of the program became evident during this process evaluation, they were communicated to the ADC program manager and other senior managers. This open style of communication led to both changes in the program and awkward moments with program staff and inmates.

3. Project Findings

The revised SRF Initial Intake Instrument (SRF) and the Prison Inmate Inventory (PII) were used to identify treatment motivation, truthfulness, and additional dynamic characteristics not often considered in evaluation research. Hostility, problem recognition, and drug problems were identified as significant to treatment retention. When identifying factors related to individual failure within the program, hostility and self-efficacy were shown to be significant. Individuals with these characteristics should be identified early in the program so that specific care can be taken in addressing these factors to increase retention.

The program staff appeared to be exceptional in their conduct of group sessions. They handled problems stemming from individual issues, group dynamics, and substance abuse concerns with casual efficiency. The large amount and high quality of the information which the program staff shared with the inmates during the classroom sessions was impressive and exceeded that provided in some non-custodial programs. The duration of the classroom sessions was appropriate for the amount and intensity of the content being delivered.

The working relationships among members of the program staff appeared to be very good. There was a willingness to share ideas and work together towards common solutions to client problems and issues that affected the TC community as a whole. It was noted that the program staff generally appeared to be as professional when counseling individual inmates as they were in facilitating group discussions.

The therapeutic community is a valid and reliable approach to the treatment of both substance abuse and behavioral problems. Site visits and discussions with program providers, supervisors and managers provided a view of a program whose staff, for the

most part, had a "can-do" attitude and a genuine desire to help those inmates who genuinely wanted their assistance. One of the strengths which was also present among the program staff was a willingness to learn from others and to change wherever necessary.

There were several group interviews held to gather client perceptions of the TC program. The first set of interviews was with the inmate hierarchy. Despite the "party line" being provided to the evaluators, this group revealed a number of areas of improvement for the program. They also commented on the differences between the program participant who 'volunteered' and the one who was 'mandated' into the program by the Post-Prison Transfer Board (the paroling authority in Arkansas) and the effects that the latter group has had on the overall TC program.

The structure of the program was also discussed by the hierarchy members. Not only was the internal structure of the program discussed, but so, too, were external influences on the effective functioning of the program. One external influence was the correctional staff assigned to the barracks. The choice of staff and their orientation towards the TC program were viewed with concern. This was also identified in the participant survey. The one area of concern identified by the inmates in this survey mirrored their concerns within the interviews.

The second set of interviews involved any available TC participant who was not a member of the inmate hierarchy. These interviews revealed that most inmates perceived the program as a "good program", but one with a few structural problems. The difference between inmates who volunteered and those who were mandated into the program, for example, remains an issue of contention. Mandated inmates expressed both frustration and anger at what they perceived to be unfair practices by the Post-Prison Transfer Board. Another area of contention was the messengers or the sanctions court. There was a large amount of hostility towards the sanctions imposed by both the program staff and the inmates in sanctions court.

Former clients were the next group to be interviewed. They expressed an extremely high level of frustration and anger towards current and former TC participants. The members of the inmate hierarchy were the primary targets of this hostility followed by the sanction court, the program staff, and the mixing of volunteers and mandated inmates, respectively. The group participants did have suggestions for improving the program with the most common being the removal of the hierarchy and the separation of volunteers and mandated inmates into two separate TC programs.

The last set of interviews was done with selected members of the program staff, the ADC Program Manager, and correctional staff. The program staff identified with the philosophy and processes of the TC model. Although treatment was regarded as a short-term process within the highly structured TC environment, recovery was viewed as a

lifelong process both in and out of the correctional environment. Staff members highlighted the problem with mandated clients rather than volunteer clients.

Correctional officers were also interviewed about the program and its effects on their working environment. Most commented that the control which the peer counselors wielded that contributed to the smooth operation of the program and a lack of trouble with this barrack. They offered a few changes to improve the program including increased number of classes taught and the inclusion of correctional officers in the community.

Client files were reviewed to determine the level of standardization in reporting and the types of reporting that was being done by program leaders and the inmate hierarchy. The client files revealed a number of problematic aspects such as non-standardized approaches to completion, high levels of incompletion, and high potential for breaches of client confidentiality.

4. Recommendations

There are few substantive areas that have been identified as being in need of modification. Inmate participants have difficulty identifying with this TC program and feel a general need for improvement in the program. Time spent in the program did not appear to have an effect in this area. Program staff felt that they were not members of the community, but members at a distance with specific roles. Correctional staff were not perceived as members of the community.

a. Modifying the Influence of the Community Hierarchy

Concerns over the composition of the "community hierarchy" arose throughout the research. It was also felt that the hierarchy exercised too much power in the community and that it was wielded for personal rather community reasons. While confrontation is a necessary part of the therapeutic process, the negative aspects to this process must be identified and dealt with for the process to be successful in changing the inmates' long-term behavior and beliefs. Sanctions court was seen as an ineffective treatment activity and as a contravention of the ruling in *Estelle v. Ruiz* by many inmates.

b. Change the Selection Process

Both the program participants and the program staff expressed some concern that the Post-Prison Transfer Board practice of mandating inmates to complete this program as a requirement for parole eligibility is coercing treatment and changing the culture of the program. There is a need to examine the mixture of volunteers and mandated offenders within the program, for instance, should there be separate programs based on intake criteria? It is also recommended that the selection process be re-evaluated and consider whether a cohort or continuous-intake process is best for this program.

c. Work Assignments

In addition to the TC as a work assignment, every inmate was also required to work elsewhere within the Tucker Unit which is an area which needs to be explored further. The major concern, here, is whether the time spent in a work assignment permits putting into practice those skills which they are learning within the program or if the program should be shortened and time spent only within the therapy milieu.

d. Increase the Level of Computer Technology

The review of client files indicated a degree of inconsistency that can be addressed by controlling access to files. It is recommended that the TC program strongly consider the computerization of this filing system.

e. Increase Staffing Levels and Revise Staffing Patterns

Staffing can benefit by cross-training security personnel and providing a rotating shift such that both day and evening program activities will be supervised by staff. This would be consistent with a goal of maximizing an inmate's time in the CSATP program.

f. Increase Consistency in Rules Application

Changing reasons for removal from the program or inconsistent application of those same reasons were constant complaints heard during the evaluation; this area requires clarification and communication to the TC members.

g. Change Volunteer-Mandate Ratio

Relative to retaining inmates in the TC program, the instrument currently being used at initial intake to the ADC, the PII, is adequate at identifying drug and alcohol problems. The Revised TCU SRF Intake Instrument is recommended to determine treatment readiness and problem recognition for inmates being considered for the TC program. An effort must be made to create an equal ratio between mandates and volunteers.

h. Continue Monitoring of CSATP

Continued evaluation is necessary to determine the true effect this program is having on drug/alcohol dependent offenders in Arkansas. An outcome evaluation is the next step to complete the cycle of evaluation. Arkansas, however, must devote attention to after-care issues for the Therapeutic Community goals in subsequent institutional phases as well as within the community for the overall mission of this program to be met.

Chapter 1 - Introduction

1. Overview of the Research

a. Substance Abuse and Crime

In 1990, over one million arrests were made for the manufacture, sale and distribution of drugs concurrent with over three million arrests for alcohol-related offenses such as driving while intoxicated (DWI), public drunkenness, and disorderly conduct (National Institute of Justice, 1996). Research by Gropper (1985) and the National Institute of Justice (1994) has also shown that the majority of all persons arrested were under the influence of either alcohol or drugs at the time of their arrest. Recent data from the Drug Forecasting Unit (DUF) program at the National Institute of Justice (NIJ) consistently indicates between 50 and 85 percent of all arrestees test positive for drugs at the time of arrest. DUF reports also indicate that approximately 60 percent of all violent arrestees test positive for drugs at their time of arrest (National Institute of Justice, 1996).

Drugs and alcohol are also precipitators of violent crime. At least 50 percent of those arrested for a violent crime were under the influence of alcohol or drugs at the time they committed their offense. Additionally, National Institute of Justice (NIJ) research indicates that 50-60 percent of homicides and serious assaults may be precipitated by alcohol consumption on the part of the victim, the offender or both (NIJ, 1993). These figures are supported by self-report data from state prisons which also indicate that approximately 50 percent of inmates convicted of a violent offense were under the influence of alcohol and/or drugs at the time of their offense (Institute of Health Policy, 1993).

This evaluation adds to the extant literature on retention in drug treatment programs. Researchers have found that the length of stay in a treatment program often predicts successful outcomes (Simpson and Sells, 1982; DeLeon, 1991; Hubbard, Marsden, Rachal, Harwood, Cavanaugh, and Ginzburg, 1989). With the dollars dedicated to treatment extremely scarce, it is necessary to utilize these dollars on those candidates most likely to remain in the treatment program until its completion. What is in question are which factors best account for abusers remaining in therapeutic communities. Hiller, Knight and Simpson (1999) attempted to identify those factors most associated with the early dropout rate. Their research examined two specific variable domains. The first was those variables which exist within the treatment program and which identify a successful process. The second domain was those which help in predicting retention. Fixed (static) demographic variables have been found to have little predictive power (Condelli and DeLeon1993; Bell, Williams, Nelson, and Spence, 1994; Hiller, Knight and Simpson, 1999). There has been limited research on the dynamic predictors that would best indicate retention in a substance abuse treatment program. This research examined the effects of dynamic variables as well as the static variables on program retention.

b. Substance Abuse Treatment Programs in Prison Environments

According to Bureau of Justice Statistics (BJS) sponsored research, nearly 60 percent of inmates sentenced for burglary or robbery had also used drugs within the month prior to their arrest and 40 percent of those same inmates were under the under the influence at the time of their arrest. Furthermore, nearly 1-in-3 women incarcerated in 1991 were serving a sentence for drug offenses. This is a substantial rise from the 1-in-8 females incarcerated for drug offenses in 1986. Finally, 27 and 30 percent of those offenders imprisoned for robbery and burglary, respectively, reported that they committed the crime to obtain money to buy drugs (BJS, 1993).

During 1979, institutional (prison-based) substance abuse programs treated approximately 10,000 inmates or merely 4 percent of the national prison population (NIDA, 1981). Ten years later in 1989, substance abuse treatment programs treated approximately 60,000 inmates or 11 percent of the national prison population (Chaiken, 1989). According to Camp and Camp (1995), 41 reporting state correctional agencies indicated that 130,560 inmates had been treated by an institutional substance abuse treatment program of some type or another.

While there is a lack of continuous outcome evaluations on substance abuse programs within correctional environments, there is research which reports that substance abuse treatment programs can have a positive effect on inmate recidivism (Murray, 1992). The Drug Abuse Reporting Program (DARP), for example, included a six-year survey of 990 opiate users after their admission to a community-based substance abuse program. Sixty-one percent of participants in that study reported being drug-free for at least one year at the follow-up interview which indicates "significantly better long-term outcomes on criminality, use of non-opiate drugs and alcohol, and productive activities" (Simpson *et al.*, 1982). Lipton *et al.* (1990) noted that prison-based therapeutic communities show considerable success with substance abuse offenders, with over 40 percent self-reporting no illegal drug use or criminal involvement and an additional 30 percent improving their behavior beyond the pre-treatment status.

An evaluation of the Wharton Tract Narcotics Treatment Program in New Jersey revealed that program graduates were more successful at avoiding re-commitment after parole and at remaining arrest-free for longer periods of time than non-graduates. The difference between their treatment and control groups was significant on both measures. According to Lipton *et al.* (1995), the control group exhibited re-commitment and arrest-free rates of 30 and 34 percent, respectively, while the treatment group exhibited re-commitment and arrest-free rates of 18 and 51 percent, respectively!

In addition to the scarcity of outcome evaluation research conducted on correctional substance abuse treatment programs, there are even fewer process evaluations which have been either conducted or released. One process evaluation was conducted by the

California Department of Corrections (CDC) during 1992 on the Amity Right-Turn Program. That evaluation suggested that inmates housed in treatment units were involved in less serious and fewer disciplinary incidents than their peers housed among the general prison population. The CDC researchers also reported that the context of the treatment had some effect on both short-term and long-term inmate behavior (CDC, 1992).

Similarly, there has been little research (Smart, Allison, Cheung, Erikson, Shain, and Single, 1991; McLellan, Woody, Luborsky, O'Brien, and Druley, 1982) conducted to determine what factors can be correlated with successful completion of a substance abuse treatment program. There has been significant need to identify which factors affect a participant's ability to succeed within the milieu created by a therapeutic community. The identification of such factors would clearly increase the potential for effective correctional management of substance abusing-offenders within both the institutional and community environments.

The literature, such as it is, clearly shows a link between substance abuse and criminal behavior. Many offenders are substance abusers. They are often arrested, convicted and incarcerated having consumed alcohol or drugs at the time of their offense or committed the offense to get money to purchase drugs. There also appears to be strong support, both within the limited literature base and the large amount of anecdotal information, for the argument that substance abuse treatment programs can have a substantial positive effect on recidivism and drug-free lifestyles among those persons who complete such programs.

While correctional substance abuse treatment programs have been in existence for a number of years, there have been few process evaluations to support both the formulation of such programs and to identify the common factors in their success. This evaluation, in conjunction with national efforts, will contribute significantly to the extant literature concerning correctional substance abuse treatment programs and their respective successes and failures.

c. Therapeutic Communities in Prison Environments

Pioneered by British physician Maxwell Jones at the end of the Second World War, therapeutic communities (TCs) were designed as residential treatment régimes for patients with psychiatric disorders (Edwards, Arif, and Jaffe, 1983:148). Therapeutic communities would seek large-scale, social and psychological changes in their patients through activities which taught and promoted prosocial values. The general premise was that treatment staff could initiate these changes by empowering clients to contribute to their own therapy, and that of others, through a number of structured activities and the governance of the community. The formal structures and relationships found within most hospitals (i.e., downwards from doctors through nurses to the patient or client) were replaced with more open communication and problem-solving at the group level (Edwards, Arif, and Jaffe, 1983).

The successes enjoyed by the British therapeutic communities did not go unnoticed by treatment professionals in the United States. During 1958, former addict Charles Dederich established the first American therapeutic community, *Synanon*, in Santa Barbara, California, to assist abusers of illegal drugs with their recovery (Yablonski, 1967). In marked contrast to the British therapeutic community model which employed a cooperative approach, Dederich instituted confrontational group sessions, such as the so-called "Synanon Game", during which participants were empowered to say whatever they wanted to other members of the community.

While Synanon's methods were controversial, the therapeutic community model has nonetheless been integrated into many community- and prison-based substance abuse treatment programs since the early 1970s including, for example, the United States Penitentiary at Marion, Illinois and Arizona's state prison at Fort Grant during 1969 (Lipton, Falkin, and Wexler, 1992:23). Therapeutic communities have been extremely successful in both environments.

The therapeutic community model has been modified for use within correctional settings since that time. Many states (to include California, Florida, Texas, New York, Oregon, Delaware) have developed residential programs based on a modified therapeutic community model within which the treatment program: (1) is housed separately from the general prison population, (2) focuses on the inmates' substance abuse and related problems, and (3) lasts between six and twelve months (DeLeon, 1997; Lipton, 1997). Recognition of the value of this type of treatment intervention was given by the *Violent Crime Control and Law Enforcement Act* (1994) whereby the federal government created block funding to support those states who adopt "comprehensive approaches to substance abuse testing and treatment for offenders, including relapse prevention and aftercare services

Florida's prison-based therapeutic communities may be held as the typical prison-based therapeutic community model and description. In the Florida program:

> The TC treatment regimen uses self- and mutual-help approaches, peer pressure, and role-modeling in a structured environment to achieve the recovery goal. Peer pressure is seen as the catalyst that converts criticism and personal insight into positive change. High expectations and high commitment from both offenders and staff support this positive change. TCs provide a 24-hour-a-day learning experience in which individual changes in conduct, attitudes, and emotions are monitored and mutually reinforced in the daily regimen....
>
> The goals of a residential TC include producing a change in lifestyle, abstinence from substance abuse, elimination of antisocial activity, increased employability, and prosocial attitudes and values. The TC approach reinforces anticriminal modeling, promotes the understanding of social vs.

didactic learning, and stresses the developmental process that occurs in a social learning context (Bell *et al.*, 1992:114-115).

Thus, it is possible to see the dual legacies of Jones's original treatment philosophy and Dederich's *Synanon*-based approach intertwined within contemporary therapeutic communities.

The Arkansas Department of Correction currently operates two modified therapeutic communities, one at the Tucker Unit which is a nine-month, comprehensive program utilizing a residential mode of delivery and one at the Benton Unit which is six-months in length, program operating in conjunction with a work-release program. There is no separation of the inmate-clients based on their respective type of dependency (i.e., alcohol, cannabis, opioids, methamphetamines, etc.), as all participants receive the same recovery message. The lengths of time specified herein are the minimum durations for an inmate to successfully complete the TC program. All staff members had been certified as substance abuse counselors by the Arkansas Bureau of Alcohol and Drug Abuse Programs (BADAP) and received extensive, ongoing training. The ranks of the treatment staff also included a small, yet significant, number of recovering addicts. In addition, both programs receive inmate clients who have either volunteered to participate in the program or been mandated to complete it by the state's paroling authority, the Arkansas Post-Prison Transfer Board.

d. Does Coerced Treatment Really Matter?

One concern which arises within the treatment literature surrounds the effectiveness and appropriateness of treatment when the client or patient is either forced by a judicial order to submit and complete a treatment program or when his or her participation is the product of some form of coercion (such as the promise of early release from custody). Addictions researchers are, themselves, divided on the issue of coerced or forced treatment (*cf.* DeLeon, 1988; Gendreau, 1996; Harford, Ungerer, and Kinsella, 1976; Leukefeld and Tims, 1988). Their beliefs are polarized among those who hold that little benefit is realized from forced treatment of offenders who are not receptive to treatment and others who argue that few offenders will enter treatment without some form of external threat or motivation to do so. Unfortunately, for both researchers and practitioners, the jury remains undecided regarding the effectiveness of coerced treatment since there appear to be as many studies that point towards either the positive or negative aspects of coerced treatment as well as those studies which offer neutral or offer inconclusive findings (Anglin, Prendergast, and Farabee, 1998).

Similarly Anglin, Prendergast, and Farabee (1998) noted that the terminology employed by the addictions and criminal justice fields concerning coerced treatment is far from consistent. They reported that:

> "Coerced," "compulsory," "mandated," "involuntary," legal pressure," and "criminal justice referral" are all used in the literature, sometimes interchangeably within the same article. This would not be a problem if these terms were synonymous. But "coercion" is not a well-defined entity; it in fact represents a range of options of varying degrees of severity across the various stages of criminal justice processing. "Coercion" can be used to refer to such actions as a probation officer's recommendation to enter treatment, a drug court judge's offer of a choice between treatment or jail, a judge's requirement that the offender enter treatment as a condition of probation, or a correctional policy of sending inmates involuntarily to a prison treatment program in order to fill the beds. In other cases, a treatment client's merely being "involved with the criminal justice system" is sufficient for him to be brought under the umbrella of "coercion" (1998:4-5).

In the Arkansas system, "coercion" is a practice that is both pervasive and as poorly defined as those programs described by Anglin, Prendergast, and Farabee (1998). Those Arkansas inmates with an alcohol- or drug-related offense who come before the Post-Prison Transfer Board are routinely mandated into the program as a condition for parole eligibility. This means that not only are those inmates who have an addiction problem referred to the program, but so, too, are those inmates convicted of the manufacture, distribution, or sale of illicit alcohol or drugs! Both volunteer and mandated inmates participate in the same program, where they perceive differential treatment.

2. Research Project Description

This treatment program was in its infancy and required the evaluation of several areas: (1) the identification of instrumentation which can be used by correctional staff to identify initial and ongoing inmate needs, (2) identification of those factors which are correlated with successful participants, and (3) a formative evaluation of the overall program. Early identification of substance abuse problems among inmates and effective, ongoing treatment intervention is essential. When the research began, the program was receiving its initial inmate cohort.

The research explored the extent and patterns of substance abuse among the sample client group as well as the effectiveness of the current treatment intervention. With regards to the effectiveness of the current interventions, participants were empowered to discuss their beliefs concerning whether the components of the Comprehensive Substance Abuse Program (CSATP) were meeting their needs and what, if any, changes they perceived as necessary to improve it.

3. Project Goals

The history and recent expansion of substance abuse treatment programs

demonstrates the Arkansas Department of Correction's commitment to providing effective treatment intervention to this high-risk offender population, both inside and outside of a correctional institution. A thorough evaluation however, was required to ensure that the program offered in the therapeutic community was meeting the often conflicting needs of the individual offenders, the institution and the community.

The specific goals of this process evaluation included:

1. *Identification of valid screening criteria which identified substance abuse problems, both criminal and lifestyle, among state inmates.* These criteria provided the foundation for revisions to the current risk/needs assessment conducted at intake by correctional personnel.

2. *Identification of an effective risk/needs instrument which correctional and treatment personnel could use to assess initial and ongoing substance abuse treatment needs among state inmates.* This instrument was designed to be used to: (a) select those inmates who are most in need of substance abuse treatment, (b) select inmates who are most likely to successfully complete the CSATP, and (c) assess the ongoing progress of inmates participating in the CSATP within the institution.

3. *Measurement of the perceptions and participation of both inmates and treatment personnel in the creation and operation of an effective substance abuse treatment program.* These measurements were taken at each major stage in the program's development and early operation. Personal interviews and focus groups were conducted among both the inmates and treatment personnel. Data collected at scheduled intervals provided processual evaluations and indications of effectiveness and problem areas.

4. *Creation of a demographic database to assist correctional managers and treatment personnel in ADC and other states.* The collection of treatment-oriented data such as lifestyle, influence of family and peers, frustration, problem solving abilities or strategies, indicators, substance abuse history by type and level are variables which assisted both treatment personnel and researchers to better understand those criminogenic factors most likely to be both substance abuse related and treatable within a correctional milieu. Demographic variables were also collected for the purposes of projecting correctional populations, forecasting facility development and case management planning.

Table 1 outlines these proposed goals, the specific research questions and the data sources for the process evaluation and instrument development.

Table 1
Study Goals, Research Objectives and Data Sources

Study Goal	Research Objective	Data Source
1. Document the process of the Residential Substance Abuse Treatment Program (RSATP).	a. Has the project been implemented as planned?	Site visits; focus groups; interviews with key stakeholders
	b. Has the program followed the plan as suggested in the treatment protocol?	Site visits; focus groups with key stakeholders; interviews with key stakeholders
2. Document the offender participation in treatment through development of a RSATP data system.	a. What are the characteristics of program participants?	RSATP data file
	b. What are the characteristics of inmates that complete the program?	RSATP data file
	c. What are the characteristics of the inmates that do not complete the program?	RSATP data file
	d. What are the perceptions of the inmates of the treatment process, treatment staff, and participants?	RSATP survey
3. Identify an instrument that can be administered at intake to determine likelihood of retention in RSATP.	a. What are the characteristics of those individuals who complete RSATP and those who do not complete?	RSATP data file; intake instrument; key stakeholders and researchers
	b. What aspects of the instrument are best at identifying completion verses noncompletion?	RSATP data files; intake instrument

Chapter 2 - Background

1. Arkansas and the Arkansas Department of Correction (ADC)

According to the United States General Accounting Office (GAO), over 500,000 of the 680,000 state inmates nationwide may have substance abuse problems. The social and economic costs of this same problem in Arkansas, for example, is staggering according to the Arkansas Bureau of Alcohol and Drug Abuse Prevention (BADAP). As noted by the BADAP, the cost of incarcerating offenders due to substance abuse and criminal behavior was $39,740,032 during 1994 (BADAP, 1995).

Based on inmate self-reports and staff interviews/observations at intake, ADC estimates that 83 percent of all inmates have a profile indicative of substance abuse-related problems at the time of their incarceration. This figure reflects a crisis that surpasses the conditions identified by the National Task Force on Correctional Substance Abuse Strategies in their report, *Intervening with Substance-Abusing Offenders* (1991), which estimates that 80 percent of all state inmates are substance abusers. Approximately 55 percent of incoming inmates in Arkansas have admitted lifestyle problems associated with the abuse of alcohol or drugs and 42 percent admitted using alcohol or drugs at the time they committed their offences. Most of these same inmates have been identified and classified as frequent users. The pattern of substance abuse among Arkansas inmates prior to incarceration has been classified as "frequent" with the following drug-of-choice preferences: (1) alcohol, (2) marijuana, and (3) amphetamines (ADC, 1991). In addition, two-thirds of those same inmates indicated no prior history of substance abuse treatment of any kind!

2. History of Substance Abuse Treatment Programs in ADC

The Arkansas Department of Correction strongly adheres to a philosophy of treatment and rehabilitation for substance abusing offenders. Since 1980, the Department's operations have included a Substance Abuse Treatment Program (SATP).

SATP began at the Cummins Unit in September 1980. The program was made possible by grant funds from the Office of Alcohol and Drug Abuse Prevention. SATP at the Cummins Unit consisted of a 30-day, 12-step oriented treatment program conducted by inmate peer staff and supervised by a free world program manager. The inmates were released from their work assignments to attend classes from 7:00 a.m. to 10:00 p.m., five days per week. The first class had 31 members. During the first year, over 300 inmates completed the program.

A second residential program was opened at the Tucker Unit in the fall of 1982, with the mission of providing treatment to inmates eligible for release under the *Community*

Service Act (Act 378). In February 1983 another grant from the Office of Alcohol and Drug Abuse Prevention allowed SATP to develop a 28-day program at the Wrightsville Unit and the Women's Unit. In 1985, SATP opened in the Benton Unit to interface with the Benton Prerelease Program. By 1987, over 5,000 inmates had completed SATP.

Through the years, SATP has grown and diversified. Today, 15 different programs operate at 13 separate units. SATP has developed specialized programs, such as the Responsible Actions Program (REACT) at the Boot Camp at Wrightsville, Arkansas, a Dual Diagnosis Program in the Special Programs Unit (SPU) at the Diagnostic Unit, and additional work release programs at the Texarkana Regional Correctional Center in Texarkana, Arkansas and at the Mississippi County Work Release in Luxora, Arkansas.

In May of 1997 the Comprehensive Substance Abuse Treatment Modified Therapeutic Community Program at the Tucker Unit accepted the first participants in the six-month program made possible by federal funds from the Residential Substance Abuse Treatment for State Prisoners Grant Program. This program has been expanded to a minimum of nine months in length and now has beds for 120 participants. Another therapeutic community has been developed for work release at the Benton Unit. The first of 120 participants began the therapeutic community at Benton in September 1998.

3. ADC's Residential Substance Abuse Treatment Program

a. Missions and Goals

The current Comprehensive Substance Abuse Treatment Project (CSATP) has been built upon the lessons learned by other correctional jurisdictions which have employed therapeutic community programs, notably, Alabama, Florida, New York and Wisconsin. ADC has identified four goals for this nine-month program:

1. To build a model intake-assessment program that provides effective matching of inmate needs/problems with treatment/management methods and programs;

2. To create a therapeutic community dedicated to comprehensive substance abuse treatment services;

3. To ensure that treatment gains continue following therapeutic community care;

4. To establish a correctional case coordination outreach system that provides a community-based continuum of services for substance abusers released from prison (ADC, 1998).

b. Program Description

To accomplish these goals, ADC has designed a five-phase program: (1) Pre-treatment, (2) Primary Care, (3) Therapeutic Community, (4) Pre-Release, and (5) Community Care. The operational time-line is nine months per treatment cohort. Table 2 outlines these phases.

Possible admission to the CSATP/TC was assessed by an assessment team and a recommendation was given to Central Classification. At present, the ratio of mandated intakes to volunteers is 4 to 1. This is not what was hoped for at the beginning of the research. Many of these individuals have been mandated as a requirement for parole. In many of the inmates, treatment readiness may not convert to treatment success as a result of the being mandated to treatment rather than being voluntary.

If the diagnostic criteria is met by the individual, he is referred to CSATP/TC at the Tucker Unit for an interview. This is a male-only program operating. The potential program participant must meet the following criteria:

1. Class I, II, or III.
2. No major disciplinaries within the past 90 days.
3. Within 12 months of Parole Eligibility/Transfer Eligibility date and/or work release eligibility date (must have a minimum of 9 months time remaining in prison in order to be able to complete CSATP).
4. Must have a substance abuse history or previous diagnosis of same.
5. Must be willing to commit to a minimum of 9 months in the Therapeutic Community and to participate in treatment.
6. Must have initial 60 day institutional work assignment satisfied.
7. Habitual Sex Offenders or those convicted of crimes of a sexual nature involving children are not eligible for CSATP/TC and will be referred to the Department's Reducing Sexual Violence Program (RSVP) for treatment.

Table Three outlines the primary program goals and the goal achievement measures developed by treatment staff.

Table 2
Phases of the ADC Comprehensive Substance Abuse Treatement Program

Phase:	Description:
Phase I Pre-Treatment Orientation	Those clients who show a willingness to participate will move to Phase II and those who are not serious about treatment will be dropped. This Phase lasts a minimum of thirty (30) days and must be successfully completed before moving on to Phase II. A Staff committee takes in all factors in making this decision on each client. Each client is introduced to basic education on the 12 Steps in this Phase in preparation for Phase II. Phase I is also used as a re-orientation of the Comprehensive Substance Abuse Treatment Program (CSATP) participants who experience problems later in their program, getting into disciplinary problems or other behaviors which show the need for re-orientation.
Phase II Self-Development	This Phase lasts approximately five months. Primary focus is on addressing addiction/substance abuse issues and faulty thinking associated with criminal behavior. Successful completion of this Phase depends upon the client meeting goals and objectives of the comprehensive treatment plan and overall participation in the program activities. A staff committee decides completion success for advancement to Phase III.
Phase III Relapse Prevention	This Phase lasts a minimum of 90 days. Primary focus is on relapse prevention, thinking restructuring, values clarification, Positive Cognitive Restructuring (PCR) and personality development. Educational/Vocational issues are given attention in this Phase. Pre-release issues are dealt with by the Social Worker/Case Coordinator in preparation for Phase V (Community Care). Successful participants of Phase III advance to Pre-Release Continuing Care.
Phase IV Pre-Release Continuing Care	Aftercare is to ensure treatment gains are maintained during both continued incarceration status or community release status. If a person becomes parole eligible during Phase III or IV, the Case Coordinator/Social Worker and Treatment Staff will make recommendations to the Post Prison Transfer Board by way of submitting an Aftercare Plan.
Phase V Community Care	A treatment referral is made by the Case Coordinator/Social Worker based on what is seen as continuing care needs of the individual. The Social Worker/Case Coordinator is responsible for making sure participants receive the proper referrals outlined for them in their aftercare plans. This is to ensure the continuum of care and will last for 12 months from release date. Participants are to receive a full range of services based on their needs which will include: Outpatient Counseling and Groups, Residential Treatment, Classes for Living Correctly (CFLC), as well as public and private health/social services. The Parole Officer is an important part of the ex-offender's life and, therefore, his continued progress. The CSATP Program Social Worker will act only as a consulting agent about treatment issues and may request information about any alcohol/drug screens given. The Social Worker/Case Coordinator will make individual contact with the Therapeutic Community aftercare client every three months in person, if possible, or minimally will make a telephone contact with the client. The Social Worker/Case Coordinator will track the individual's progress for a 12 month period.

Table 3
RSAT Program Goals and Measures

Program Goals and Objectives	Program Goal Achievement Measures
Phase I -Expectations for Orientation Phase • Be on time for all groups and activities • Stay well groomed at all times • All assigned homework to be turned in on time (no excuses) • Be open and honest • Follow lines of communication • Perform duties to the best of your abilities • Follow all rules of the institution and the program • Be able to recite the Serenity Prayer, word for word, to the group leader before moving to Phase II • Study the handbook • Accept the authority of Peer Hierarchy and the Community Hierarchy • Write an essay on "Why Am I Here?" • Write your life story (minimum 8 pages, maximum 15 pages) • Perform your institutional work assignment one-half days (am or pm) to the best of your ability, as this will be an important part of your adjustment to appropriate work ethics • Pass orientation phase, final test on what has been taught in classes and from the rules handbook (Rules Test) • Perform ten (10) minute one-to-one with all clients in the barracks • Recite life story	Phase 1- Criteria to Advance to Phase II • Complete minimum of 30 days in Phase I • Complete all classes, seminars and videos indicated on orientation checklists • Pass rules test • Write life story • Recite Serenity Prayer from memory • Essay on "Why Am I Here?" • Complete ten (10) minute one-to-one with all clients in the barracks • Recite Life Story
Phase II - Self Development Expectations • Be on time for all groups and activities and participate in them • Meet the goals and objectives set forth in your comprehensive treatment plan • Give a 10 minute seminar on (1) "My Faulty Thinking" and (2) "Values Clarification" • Follow the rules of both the Encounter and Support Groups • All homework is turned in on time (no excuses) • Essay on " Who Am I and What Do I Want?" • Assigned job role involvement in good standing	Phase II - Crieteria for Advancement to Phase III • Complete all classes, lectures and videos • Display discipline, responsibility for actions and impulse management • Participation in all group settings and activities • Goals and objectives of your treatment plan reasonably met • Homework completed and turned in on time (no excuses) • Essay and two seminar/lectures done • Pass final test to be given by the Group Leader and approval for advancement given • Assigned job role involvement to be in good standing

Table 3 (Continued)
RSAT Program Goals and Measures

Program Goals and Objectives	Program Goal Achievement Measures
Phase III - Therapeutic Community Demonstration Phase/Citizenship • Clients will demonstrate at all times prompt attention to taking responsibility for their actions (following rules and regulations) • Will display knowledge from previous Phases and act on this knowledge • Interact in a positive way in group setting. Mature thinking will be expected, actions follow • Having EARNED this status, client will model for Phase I and Phase II clients proper attitude, thinking and actions. Peer Role Leaders will be called upon to speak and interact for the good order of the Therapeutic Community • Proper demonstration of desirable qualities of citizenship will be noted to the Post Prison Transfer Board (Parole Board) • All treatment homework will be completed and turned in on time • If relapses in thinking/actions display evidence of old behaviors, the individual may be sent back to Phase I, or in extreme cases, discharged from the program	Phase III - Criteria for Graduation from Phase III to Pre-Release Status • Demonstration of self-improvement in all areas • Display positive mental attitude • Participation in personal program of change (Attitude and Actions) • Daily display of ability to follow rules without being constantly reminded • ACTIVE Group Participation • All assignments completed and turned in NOTE: All Phase III areas will be observed and noted in clients' file by staff. Recommendations will be forwarded to the Social Worker/case Coordinator who will monitor Pre-release Continuing Status.
Note: Achievement measures are not indicated within this table as each inmate is evaluated on an individual basis.	

c. Program Staffing

The Tucker Unit RSATP has nine primary staff members. They also have one correctional officer assigned to the program. In addition to freeworld staff, there are also 13 peer mentors or elders in the program. The staff includes 3 women, 6 men, with 4 being White and 5 African American. In the past year there has only been a 10 percent turnover which was simply the transfer of one treatment staff member. The staffing pattern includes:

- Program Coordinator (80 percent administrative, 20 percent on treatment issues)
- Program Leaders (100 percent of time on treatment issues)

- Transitional Counselor (80 percent on treatment issues, 20 percent administrative issues)
- Correctional officer (100 percent safety and security)
- Peer Mentors and/or Elders (50 percent treatment-oriented behaviors, 50 percent ADC responsibilities)

Job descriptions for each of the freeworld staff can be found in Appendix 2.

In closing this section, it should be noted that information concerning the certification and educational levels of the freeworld counseling staff was unavailable at the time of this evaluation. It was observed, however, that the counseling staff spends at least 40 hours annually to comply with training standards set by the American Correctional Association (ACA) minimal standards and additional training to comply with state mandated (BADAP) standards for substance abuse counselors.

Chapter 3 - Methodology

1. Introduction

Data for this process evaluation was collected at multiple levels via several measurement tools. An understanding of individual and group dynamics is important within a process evaluation in two respects. First, it provides opportunities for the identification of those conditions which either promote or hinder interaction by and between treatment personnel and program participants. Second, it provides opportunities for evaluators to increase their understanding of the treatment group/cohort and its response to program activities (Myers, 1998). Data on implementation of Phase I-IV (see Chapter 2 page 9) activities were obtained through observation, semi-structured interviews, focus groups conducted by evaluation staff, and a participant survey. A random sampling procedure was used to schedule the sessions to be observed so that all sessions were observed at least once throughout the grant period. Observers completed structured forms noting whether key curriculum topics were covered and whether modifications were made during the observed session. The protocol can be found in Edmundson *et al.* (1994).

Specific data collection activities sought to identify the scheduled and actual activities of each phase, those values and meanings which the participants and treatment personnel attach to each phase, the perceived effectiveness of the treatment, and possible alternatives which might increase the effectiveness of the intervention. Information from program participants were obtained using two different formats: surveys and focus groups. The following discussions present the methodologies employed throughout the study and the rationales which underlie those choices.

2. Scope of the Current Research

The data on program participants was gathered: (1) at intake into the ADC, (2) at intake into the treatment program, (3) during treatment, and (4) upon completion/discharge from the program. A single instrument was identified to help establish factors related to offender selection, program participation, retention in the program, and successful completion of the program. This instrument was based upon standardized measures drawn from: the *Alcohol and Drug Abuse Minimum Federal Client Data Set (MFCDS), DSM-IV* (section on substance abuse and dependency), *Expected Treatment Outcome Scales, Computerized Level of Service Inventory (CLSI), the Addictions Severity Index (ASI)* and *TCU Self Report Form (SRF) Initial Assessment Instrument;* these instruments have proven reliability and validity and are currently used by several correctional agencies across North America.

The identification of a new instrument was essential to the Arkansas Department of Correction. The ADC began collecting substance abuse data using the ASI. This proved

to be problematic and ADC was given a waiver from Arkansas Bureau of Alcohol and Drug Abuse Counselling to develop and implement an instrument better suited to their needs. At the present time, this consists of twenty questions developed from the DSM IV. Although adequate at the present for determining the intake needs, this instrument was lacking in identifying those factors related to severity of problem, readiness for treatment, the appropriate treatment program, and retention in the program. The instrument identified for this research effort not only identified those with problems, but addressed those factors which could help in assessing likelihood of completing the program and outcomes after program completion. This is essential for continuing research on evaluating impact and outcomes of this program.

3. A Triangulated Approach to the Research

Research in the field of corrections is rarely easy nor uncomplicated. The three constituent groups, inmates, correctional staff and administration, share a distrust for outside evaluators since none can completely control what the evaluator will discover and report (*cf.* Jackson, 1987; Jurik, 1985, Larivière and Robinson, 1996; Robinson *et al.*, 1990, Wright and Saylor, 1992). Evaluators studied these groups using one or more methodologies which may be classified as either a qualitative or quantitative approach.

The differences between these approaches may be simplified to a distinction between words and numbers, but to do so would ignore the strengths and variations which are found amongst the methods within these two methodological approaches. This attempt at simplification may be due, in part, to the fact that many authors of methodology textbooks tend to equate field research with qualitative research and the conversion of observations into machine-readable form by assigning numerical values to them for the purpose of statistical manipulation and analysis with quantitative research (Babbie, 1989; Bailey, 1982; Marshall and Rossman, 1989; Nachmias and Nachmias, 1987; True, 1989). Such simplistic definitions ignore the fact that each approach "is governed by its own classics, its own preferred forms of representation, interpretation, and textual evaluation" (Becker, 1986:134-135). Quantitative approaches to social science seek to understand systems and patterns of behavior using *a priori* definitions and other impersonal factors supplied by the evaluator as significant movers of human behavior whereas qualitative approaches seek the participants' definitions and personal understandings of systems and patterns of behavior to find explanations for that behavior (Pelto and Pelto, 1978:62).

While both of these research approaches produce distinct types of information, they should not be used in isolation (even though the situation will often dictate the methodological choice) as each approach possesses its own inherent strengths (Nachmias and Nachmias, 1987). Curriculum specialist Valerie Janesick (1994) noted that evaluators may choose from four distinct forms of triangulation, including:

1. Data triangulation: the use of a variety of data sources in the study;

2. Investigator triangulation: the use of several different researchers or evaluators;
3. Theory triangulation: the use of multiple perspectives to interpret a single set of data;
4. Methodological triangulation: the use of multiple methods to study a single problem (1994:214-215).

Typically, methodological triangulation has been favored by evaluators who employed the strengths of one or more methods or approaches to offset the weaknesses of another method or approach. To this end, this study offers a triangulated study. It has employed both investigator and methodological triangulation. In the former, the two co-investigators monitored the overall research project while completing separate components of the study. The latter, methodological triangulation, was accomplished through the use of a study-specific assessment instrument which was administered at different stages throughout the study, group and individual interviews, and site visits.

a. Development of Intake Assessment Instrument

To develop our measure of retention and treatment outcome, we used the Interactive Group Process (IGP) to identify the desired instrument. Due to the recent development of several retention instruments, the development of a new instrument was seen as duplicative. However, due to the uniqueness of the Arkansas population the revision of existing instruments to fit the needs of both the correctional population and treatment staff was essential. This process involved four steps: (1) a literature search of relevant instruments using the ancestry approach and library abstracting services, which revealed the Addiction Severity Index (ASI), the Diagnostic Interview Schedule (DIS), the Family Environment Scale (FES), the Substance Use Disorder: Alcohol Type Specification, TCU Intake Assessment Instrument, and Lifestyle Screening Instrument (LSI); (2) interviews with ADC personnel to identify variables they believed predict outcome, identify retention and are needed for administrative purposes; (3) a meeting to reach consensus on the most important variables; and (4) revision. The result was the development of an instrument which meets the needs of those working in the RSAT program and the research project.

Several factors were considered when identifying an appropriate instrument for the long-term residential component of the ADC substance abuse treatment programs. First was the length of time required to administer the instrument. Several of the available instruments require several hours to administer resulting in fatigue of the interviewer and subject. In a correctional setting this is important. Many of the subjects involved in the research lack the education needed to remain focused in a lengthy interview. Second, the attempt to collect extensive data, of which only a part bears directly on the research questions, may avert attention from the data essential for the research questions. The ASI

does not include important variables known to affect treatment retention. The Alcohol Type Specification does not contain specific questions relating to peer criminality, number of weeks in treatment or history of abuse. These variables have been identified as predictors of outcomes of drug treatment and retention. Third, at follow-up, a lengthy instrument may not be practical because some subjects will be found in places not suited for prolonged interviews.

Although a major objective of this research was to develop an instrument designed to identify retention factors, time and participant resources made this unnecessary. An assessment protocol had recently been developed by Texas Christian University (TCU) as part of a community-based treatment evaluation project titled "Improving Drug Abuse Treatment, Assessment, and Research" (DATAR). As part of this assessment protocol, a 95-item self-report instrument was developed by TCU designed to assess psychosocial functioning and treatment motivation at intake. This instrument had been used with a variety of community and institution based samples, including prisoners. It was identified by the evaluators and stakeholders as being the most acceptable for use with the Arkansas treatment population. However, several changes were made to the instrument. These included rewording the questions from third to first person, changing the wording for a less educated population, changing the way in which questions were grouped and changing terminology to words more appropriate for the Arkansas prison population. In addition, several questions were eliminated or added as based on their relevance to treatment staff.

Stakeholders felt that these changes were necessary for a number of reasons. First was the wording from third to first person. Many of the treatment staff felt that inmates must be "made to own their problem". In changing the wording many felt that this would promote this major goal of CSATP. Secondly, although the majority of participants are high school graduates, the standards of education for many of these individuals, puts them at lower levels of comprehension according to treatment staff. Treatment staff felt some phrases and meanings would not be understood by the present RSATP participants. Wording was changed to accommodate the level of understanding of the average program participant. Thirdly, the original instrument questions were grouped in large blocks of negative and positive question. The treatment staff felt that the inmates would be overwhelmed by large blocks of negative questions. As a result questions were mixed negative and positive.

Although the majority of the changes were simply cosmetic and the instrument had already been demonstrated reliable, a test-retest was used to determine the reliability of the revised instrument. Due to lack of qualified staff or peer counselors, inmates were asked to take the test and given a retest one week later. This was done for an initial sample of 30 subjects. The data was entered into computer files and verified by a second independent entry. The percentage of exact agreements was calculated. An intra-class correlation was examined to determine reliability. The result was the development of the hybrid instrument used in this evaluation.

Validity of the instrument was assessed in several ways. Face and content validity were established by the staff at ADC in comparison with existing instruments. Clinical histories and institutional intake data were examined to determine if subjects under report or over report on certain variables as a measure of concurrent validity. Construct and predictive validity were examined using a pretest of the instrument on inmates.

Research on factors associated with retention has determined that static demographic variables such as gender, age, and race/ethnicity are not associated with retention (Condelli and DeLeon, Bell William, Neson and Spense ,1994). During development of the instrument for intake into the RSATP, static demographic variables were not considered. These were collected centrally and therefore did not need to be included in the instrument.

b. Site Visits

Qualitative research, as mentioned previously, seeks to gather information and make meaning of the data gathered using the understandings and realities of the people engaged in the behavior or phenomena. Anthropologists Arthur Vidich and Stanford Lyman (1994:23) put this in more academic terms when they noted that qualitative research has "the analysis and understanding of the patterned conduct and social practices of society" as it's mission. Sociologists Norman Denzin and Yvonna Lincoln (1994:6) offer the range of qualitative approaches to research, noting that "qualitative researchers use ethnographic prose, historical narratives, first-person accounts, still photographs, life histories, fictionalized facts, and biographical and autobiographical materials among others."

A number of site visits were conducted by one of the co-investigators and a number of graduate students during the project. Here, the central role of the observer was stressed since:

> ...the evaluator is viewed as the measurement instrument. Qualitative evaluators are intimately involved in data collection so that they can react to the observations made. Such reactions may involve adjusting the focus of the evaluation (Posavac and Carey, 1997:217).

Direct observation of daily activities permitted the evaluators to explore that which Wholey (1994) termed the "entire program reality." The role of the evaluator was to observe the routine and minutiae of the daily program. The evaluators employed the "known, non-participant observer" technique as they observed both the program activities and the program staff.

In the former activity (activity observation), the evaluators were introduced to program providers and inmates, sat away from the groups, and made no effort to be

involved in or otherwise influence the group during the site visits. Their role was to assess the content and mood of the session as well as any deviation from the daily schedule. During the latter activity (staff observation), the evaluators were also provided with a schedule of the planned activities for the day and then proceeded to 'shadow' an individual staff member for that day. Their role in this activity was to assess the amount of time spent in various activities with an emphasis on the split between administrative and clinical activities.

c. Semi-Structured Group Interviews

In contrast to the unobtrusive site visits for observational data, the semi-structured group interviews were both obtrusive and exploratory in nature. Group interviews and focus groups are often used interchangeably. Both techniques fall within the broad range of qualitative research methods and employ first-person accounts to study human groups. Sociologist David Morgan notes that the hallmark of these methods is "...the explicit use of the group interaction to produce data and insights that would be less accessible without the interaction found in a group" (1988:12). A decade later, Morgan refined his definition of what constitutes a focus group as seen in the following three statements:

> Focus groups are group interviews. A moderator guides the interview while a small group discusses the topics that the interviewer raises. What the participants in the group say during the discussions are the essential data in focus groups. Typically, there are six to eight participants who come from similar backgrounds, and the moderator is a well-trained professional who works from a predetermined set of discussion topics (Morgan, 1998:1).

> Focus groups as fundamentally a way of listening to people and learning from them. Focus groups open up lines of communication. This is most obvious within the group itself, where there is continual communication between the moderator and the participants, as well as participants themselves. Just as important, however, is a larger process of communication that connects the worlds of the research team and the participants (Morgan, 1998:9).

> Focus groups are created by a research team for a well-defined purpose. Even when the groups are primarily exploratory, they are still focused on the research team's interests. In essence, focus groups are special occasions devoted to gathering data on specific topics. A fair amount of planning goes into focus groups. The research team determines not only what the questions will be but also who will attend the group. Rather than attempting to observe behavior as it naturally occurs, focus groups create concentrated conversations that might never occur in the "real world" (Morgan, 1998:31).

The strengths of both semi-structured group interviews and focus groups include:

1. Understanding participant's perspective: this approach offers the evaluator the opportunity to assist the participants in understanding the events, situations and actions in which they are involved and to convey that reality to the evaluator and his or her team (Geertz, 1973; Maxwell, 1992);

2. Understanding the particular context within which the participants act: unlike other methods, focus groups can identify how events occur, the context of that occurrence, and the meanings which participants attach to them (Maxwell, 1996);

3. Identifying unanticipated phenomena: this method permits participants and evaluators to explore both previous and current events in order to attach new meanings and sources of influence to them (Maxwell, 1992, 1996);

4. Understanding the process by which events take place: unlike quantitative research, focus groups can explore and identify those activities which contribute to a specific outcome (Patton, 1990); and,

5. Identifying local causality and developing causal explanations: focus groups, along with other qualitative methods permit evaluators to develop causal statements based on " the actual events and process that led to a specific outcome" (Miles and Huberman, 1984:132).

The conduct of the semi-structured, group interviews involved one of the co-investigators along with two graduate students arriving in the program barracks to facilitate and record a group interview, respectively. The groups generally consisted of twenty to thirty inmates and would begin with an introduction of the evaluators, and an explanation of the purpose of the evaluation as well as when and to whom a final report would be completed. The format ensured that the inmates understood that the evaluators were seeking to understand the program in it's entirety, including: (1) good activities or aspects of the program, (2) bad or negative aspects of the program, (3) areas which need more emphasis, and (4) areas which need to be dropped from the program. It was also important that the inmates were empowered to say whatever they felt necessary regarding the program and their perceptions of it. To this end, the inmates were given assurances that what they discussed would be reported in an anonymous manner such as "an inmate stated" and "another inmate noted", and so forth.

d. Semi-Structured Individual Interviews

Members of the treatment staff and the ADC Program Manager were interviewed individually. This obtrusive method employed a semi-structured interview guide that was

constructed with the assistance of one of the stakeholders. The following questions are typical of those asked of the program staff:

1. What are the cardinal rules in the program as far as inmate behavior?

2. If I am an inmate, how do I become aware of these rules and how I am expected to behave in the program?

3. What happens to me if I break the rules or don't behave as I'm expected to behave?

4. What is "sanctions court" and how does it work?

5. Are any staff involved in sanctions court and, if so, how?

6. What is the strongest part of the program?

7. What are the weaknesses of the program?

8. Is it necessary for staff to be considered members of the community?

9. Do you feel that you receive adequate training?

10. What would you like to change in the program?

Based on the depth of the response, changes in physical or verbal language, etc., the staff respondent would be asked for further explanation or a related question. Whenever the staff respondent wished to make a statement concerning an area that was not yet covered, they were encouraged to do so. It was emphasized that although the interviewer had a number of questions that needed to be answered, the respondent was free to say whatever he or she wished to say about the program and its operations.

e. Review of Inmate Program Files

Six inmate program files were randomly selected from among the 'closed' program files held by ADC. 'Closed' files were selected over active case files in order to reduce any disruption in the program's daily operations. Recently, academicians have focused on the wealth of information within correctional client records (Castle, 1986; Finkler, 1982). These records may be examined to produce a fuller understanding of a correctional agency as well as those specific programs operating within it.

Such information moves past the data gathered on sentence type and length, gender, ethnicity and age, to information concerning the offender and general populations.

Using both descriptive and statistical formats, these reports offer information about the programs which individuals or groups of inmates utilize, the effectiveness of certain treatment interventions, and the changes in both offenders and their home community as recorded through parole and pre-release reports. The information contained in the latter category of reports, for example, may be examined *ex poste facto* to determine the successful conditions for parole and, since they contain similar data (categories and information) to that found within Pre-Sentence Reports (PSRs), to confirm any change among local conditions. In the context of this evaluation, inmate program files offered a window on the activities of the program, it's program staff, and the inmates within the various stages of the Therapeutic Community. One aspect of particular interest was the amount and type of paperwork required by both ADC and the Bureau of Alcohol and Drug Abuse Programs (BADAP) and the impact of this paperwork on direct client activities.

4. Goals of the Current Evaluation

Among the stated goals of this evaluation, which included:

Study Goal #1: Documentation of treatment program process,

Study Goal #2: Document offender participation through the development of a RSATP data system,

Study Goal #3: Identifying an instrument for risk/needs assessment,

were a number of unstated or implicit goals held by the evaluators.

Posavac and Carey (1997:230) noted that "Regardless of how an evaluator goes about gathering program information, evaluations are not completed without reporting to the stakeholders." Among the unstated goals of this process evaluation were to report program information to ADC senior managers as soon as it was practical to do so. The purpose of this liaison function was to assist ADC in identifying areas of concern and to suggest changes immediately rather than to wait for a final report.

One of the difficulties encountered throughout this evaluation was balancing the need for program information with the need to maintain the trust of the program staff and inmates. While entry into the field and unrestricted access were granted by the ADC program manager and the Senior Management Team, the investigators were required to continually work at gaining the trust of the program coordinator, individual staff members, and program inmates. This was difficult at times due to the orientation of the co-investigators who served as tools which the program providers could use to improve their program and its delivery. Indeed, as the few discontinuities between the idealized program statement and the realities of the program became evident during this process evaluation, they were communicated to the ADC program manager and other senior managers. This

open style of communication led to both changes in the program and awkward moments with program staff and inmates.

Chapter 4 - Project Findings

1. The Quantitative Data

Typically, methodological triangulation has been favored by researchers who employed the strengths of one or more methods or approaches to offset the weaknesses of another method or approach. To this end, the *Arkansas Comprehensive Substance Abuse Treatment Program Process Evaluation* offers a triangulated study. It has employed both investigator and methodological triangulation. The first area involved the collection and analysis of the quantitative data. This data was analyzed frequently allowing for a feedback loop to be established between the stakeholders and the researchers. The following describes what was discovered during the analysis of the CSATP participant database, the SRF Intake Instrument and the participant surveys.

a. A Typical Therapeutic Community Inmate

Before analyzing the data collected from the inmates who entered during the specified research period, a picture of the "typical" TC community member was developed. It is recognized that not all inmates were willing to participate in the research and not all inmates that entered the program were captured.

Table 4
Demographic Characteristics of the Research Population

Variable	Frequency	Percent	Valid Percent	Cumulative Percent
Age				
18 - 25	20	10.7	10.7	10.7
26 - 32	58	31.0	31.0	41.7
33 - 65	109	58.3	58.3	100.0
Race/Ethnicity				
White	115	61.5	61.5	61.5
Black	71	38.0	38.0	99.5
Asian	1	0.5	0.5	100.0
Marital Status				
Single	91	48.7	48.7	61.5
Married	86	46.0	46.0	99.5
Divorced/Separated/Widowed	10	5.4	5.4	100.0
Education				
11 years or less	93	49.7	49.7	49.7
Highschool grad	75	40.1	40.1	89.8
Some college	19	10.2	10.2	100.0

In addition, there were a number of inmates who were already in TC and it was

necessary to determine whether their profiles were significantly different from the inmates that participated in the research. Tables 4 and 5 illustrate the sociodemographic characteristics, and criminality variables of these inmates. As can be seen, there are no significant differences between the general TC population and those who were captured for analysis in this research.

Table 5
Criminal Characteristics of the Research Population

Variable	Frequency	Percent	Valid Percent	Cumulative Percent
Age at First Arrest				
Under 18	117	62.6	62.6	62.6
18 or older	70	37.4	37.4	100.0
Felony Arrests				
1 to 4	121	64.7	64.7	65.1
5 or more	65	34.8	34.8	100.0
Missing	1	100	100	
Alcohol Arrests				39.6
Zero arrests	74	39.6	39.6	73.8
1 to 4 arrests	64	34.2	34.2	82.9
5 to 9 arrests	17	9.1	9.1	100.0
10 or more arrests	32	17.1	17.1	
Drug Arrests				
Zero arrests	60	32.1	32.1	32.1
1 to 4 arrests	111	59.4	59.4	91.4
5 to 9 arrests	13	7.0	7.0	98.4
10 or more arrests	3	1.6	1.6	100.0
DUI/DWI Arrests				
Zero arrests	88	47.1	47.1	47.1
1 to 4 arrests	79	42.2	42.2	89.3
5 to 9 arrests	11	5.9	5.9	95.2
10 or more arrests	9	4.8	4.8	100.0
Years in Prison				
Zero years	4	2.1	2.1	2.1
1 to 4years	65	34.8	34.8	36.9
5 to 9 years	74	39.6	39.6	76.5
10 or more	44	23.5	23.5	100.0
Probation Revocations				
No revocations	90	48.1	48.1	48.1
One revocation	77	41.2	41.2	89.3
More than one	20	10.7	10.7	100.0
Parole Revocations				
No revocations	38	20.3	20.3	20.3
One Revocation	56	29.9	29.9	50.3
More than one	93	49.7	49.7	100.0

b. Profiles Developed from the Intake Assessments

The initial survey was given to 197 inmates. Data were collected from inmates incarcerated in the Arkansas Department of Correction between September 1999 to September 2000. The therapeutic community was and still is available to only male inmates. Ten surveys were removed from the data set once it was identified that these inmates had been removed from the program for administrative reasons unrelated to performance in the program. Noncompleters/dropouts were divided further into the following categories: violated the rules of the therapeutic community, violated rules of ADC (received a disciplinary), and refused treatment.

Social history indicators showed that the population was 38.0 percent African American, 61.5 percent White and 0.5 percent Asian. Of the population in the initial group, the levels of education varied. About 49.7 percent had less than a high school diploma, 40.1 percent had a high school degree and 9.9 percent had attended some college. The marital status of those participating in the program included 48.7 percent single, 46 percent married, and 5.4 percent divorced, widowed or separated. In terms of criminal history, the majority of the participants had received their first arrest prior to their 18 th birthday (62.9 percent). The majority of participants had previously been placed on probation and had that probation revoked (51.3 percent). The majority of inmates (52.7 percent) had four or more felony arrests. In addition, 79.7 percent had been revoked from parole one or more times. When participants were asked about drug and alcohol arrest, 60.4 percent reported being arrested one or more times for alcohol and 67.9 percent had reported one or more drug arrests (Tables 4 and 5).

During the initial intake interviews to ADC, sociodemographic variables, drug abuse history and criminal history were collected. In addition, the inmates' *Prison Intake Inventory* (PII) scores were retrieved from central records to establish the violence, antisocial, risk, alcohol, drug, judgement, and distress/stress coping scales (Table 6). These scales were used in the analysis to determine if possible relationships existed between scores on these scales and retention in the therapeutic community.

Additionally, the ratings from the SRF Instrument scales were utilized in determining whether the inmates could be classified as low risk, medium risk, high risk or maximum risk. The most important scales to this research were the psychosocial and treatment motivation scales. These included items such as: problem recognition, desire for help, treatment readiness, and external pressures.

Table 7 identifies the SRF psychosocial functioning, the social functioning and the motivation for treatment scales of those dropped from the program compared to completers. No significant differences were identified between those who completed and those who dropped from the program.

Table 6
Prison Inmate Inventory (PII) Scores by Completed and Dropout Status

PII Scales	Completed		Dropped		Total Population	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Adjustment						
Invalid	26	74.3	9	25.7	35	18.7
Low Risk	36	81.8	8	18.2	44	23.5
Medium Risk	33	68.8	15	31.3	48	25.7
Problem Risk	31	73.8	11	26.2	42	22.5
Maximum Risk	11	61.1	7	38.9	18	9.6
Alcohol Problems						
Invalid	26	74.3	9	25.7	35	18.7
Low Risk	27	62.8	16	37.2	43	23.0
Medium Risk	23	67.6	11	32.4	34	18.2
Problem Risk	36	80.0	9	20.0	45	24.1
Maximum Risk	25	83.3	5	16.7	30	16.0
Drug Problems						
Invalid	26	74.3	26	74.3	35	18.7
Low Risk	9	25.7	9	25.7	16	8.6
Medium Risk	10	62.5	28	80.0	21	11.2
Problem Risk	6	37.5	7	20.0	98	52.4
Maximum Risk	15	71.4	34	66.7	17	9.1
Antisocial Problems						
Invalid	6	28.6	17	33.3	35	18.7
Low Risk	72	73.5	26	72.2	35	18.7
Medium Risk	26	26.5	10	27.8	51	27.3
Problem Risk	14	82.4	23	76.7	36	19.0
Maximum Risk	3	17.6	7	23.3	30	16.0
Violence Problems						
Invalid	26	74.3	9	25.7	35	18.7
Low Risk	47	73.4	17	26.6	64	34.2
Medium Risk	27	84.4	11	15.6	32	17.1
Problem Risk	18	66.7	9	33.3	27	14.4
Maximum Risk	19	65.5	10	34.5	29	15.5
Distress Problems						
Invalid	26	74.3	9	25.7	35	18.7
Low Risk	25	73.5	9	25.6	34	18.2
Medium Risk	32	74.4	11	25.6	43	23.0
Problem Risk	25	80.6	6	19.4	31	16.6
Maximum Risk	9	65.9	15	34.1	44	23.5
Judgement Problems						
Invalid	26	74.3	9	25.7	35	18.7
Low Risk	24	82.2	5	17.2	29	15.5
Medium Risk	18	75.0	6	25.0	24	12.8
Problem Risk	26	60.5	17	39.5	43	23.0
Maximum Risk	43	76.8	13	23.2	56	29.9
Self-esteem Problems						
Invalid	26	74.3	9	25.7	35	18.7
Low Risk	45	77.6	13	22.4	58	31.0
Medium Risk	27	75.0	9	25.0	36	19.3
Problem Risk	32	71.1	13	28.9	45	24.1
Maximum Risk	7	53.8	6	46.2	13	7.0
Stress Problems						
Invalid	26	74.3	9	22.5	35	18.7
Low Risk	31	77.5	12	26.7	40	21.4
Medium Risk	33	73.3	12	26.7	45	24.1
Problem Risk	25	67.6	12	32.4	37	19.8
Maximum Risk	22	73.3	8	26.7	30	16.0

Table 7
Self-Report Form (SRF) Intake Scores by Completed and Dropout Status

SRF Scales	Completers		Dropped Out		Total Population	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Problem Recognition						
Low Risk	19	70.4	8	29.6	27	15.2
Medium Risk	64	80.0	16	20.0	80	44.9
High Risk	31	72.1	12	27.9	43	24.2
Maximum Risk	15	53.6	13	46.4	28	15.7
Desire for help						
Low Risk	5	71.5	2	28.6	7	3.9
Medium Risk	79	74.5	27	25.5	106	58.6
High Risk	42	72.4	16	27.6	58	32.0
Maximum Risk	6	60.0	4	40.0	10	5.5
Treatment Readiness						
Low Risk	0	0.0	0	0.0	0	0.0
Medium Risk	62	76.5	19	23.5	81	44.0
High Risk	71	52.6	29	29.0	100	54.3
Maximum Risk	2	66.7	1	33.3	3	1.6
External Pressures						
Low Risk	2	40.0	3	60.0	5	2.8
Medium Risk	54	72.0	21	28.0	75	41.4
High Risk	63	74.1	22	25.9	85	47.0
Maximum Risk	12	75.0	4	25.0	16	8.8
Self Esteem						
Low Risk	1	100.0	0	0.0	1	0.5
Medium Risk	21	67.7	10	32.3	31	16.9
High Risk	100	72.5	38	27.5	138	75.4
Maximum Risk	11	84.6	2	15.4	13	7.1
Depression						
Low Risk	1	100.0	0	0.0	1	0.5
Medium Risk	25	71.4	10	28.6	35	19.2
High Risk	51	75.0	17	25.0	68	37.4
Maximum Risk	57	73.1	21	26.9	78	42.9
Anxiety						
Low Risk	0	0.0	0	0.0	0	0.0
Medium Risk	25	75.8	8	24.2	33	17.8
High Risk	65	73.0	24	27.0	89	48.1
Maximum Risk	45	71.4	18	28.6	63	34.1
Decision Making						
Low Risk	0	0.0	0	0.0	0	0.0
Medium Risk	54	69.2	24	30.8	78	42.6
High Risk	80	76.2	25	23.8	105	57.4
Maximum Risk	0	0.0	0	0.0	0	0.0
Self Efficacy						
Low Risk	1	100.0	0	0.0	1	0.5
Medium Risk	24	64.9	13	35.1	37	20.1
High Risk	104	76.5	32	23.5	136	73.9
Maximum Risk	5	5.0	5	50.0	10	5.4
Childhood Problems						
Low Risk	5	100.0	0	0.0	5	2.7
Medium Risk	60	68.2	28	31.8	88	48.1
High Risk	65	76.5	20	23.5	85	46.4
Maximum Risk	4	80.0	1	20.0	5	2.7

Table 7 (cont'd)
Self-Report Form (SRF) Intake Scores by Completed and Dropout Status

SRF Scales	Completers		Dropped Out		Total Population	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Hostility						
Low Risk	0	0.0	0	0.0	0	0.0
Medium Risk	18	78.3	5	21.7	23	12.6
High Risk	59	67.8	28	32.2	87	47.5
Maximum Risk	56	76.7	17	23.3	73	39.9
Risk Taking						
Low Risk	0	0.0	0	0.0	0	0.0
Medium Risk	20	64.5	11	35.5	31	17.1
High Risk	107	74.5	35	24.6	142	78.5
Maximum Risk	6	75.0	2	25.0	8	4.4
Social Conformity						
Low Risk	2	66.7	1	33.3	3	1.6
Medium Risk	72	69.9	31	30.1	103	55.4
High Risk	62	78.5	17	21.5	79	42.5
Maximum Risk	0	0.0	1	100.0	1	0.5

The population was further divided into those who succeeded and those who failed and by the reason for that failure. A total of 50 (26.7 percent) were identified as dropouts or noncompleters. Of those, 26 percent were dropped for a violation of the ADC rules, 30 percent were dropped for a violation of the TC rules, and 44 percent simply refused treatment. It should be noted that in the sample studied only 3.7 percent were volunteers and the remaining 96.3 percent were mandated to the program by the prison parole board as a condition of parole. The implication for the results will be discussed in *Chapter 5 - Summary and Conclusions*. Tables 8 and 9 illustrate the characteristics for those who were dropped from treatment by reason.

Table 8
Demographic Characteristics of the Population by Reason for Discharge

Variable	Disciplinary Charge		Refused Treatment		TC Rule Violation	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Age						
1 to 25	2	33.3	2	33.3	2	33.3
26 to 32	5	22.7	9	40.9	8	36.4
33 to 65	6	27.3	11	50.0	5	22.7
Race/Ethnicity						
White	7	25.0	12	42.9	9	32.1
African-American	6	27.3	10	45.5	6	27.3
Marital Status						
Single	5	20.0	14	56.0	6	24.0
Married	8	32.0	8	32.0	9	36.0
Education						
11 years or less	5	21.7	13	56.5	5	21.7
High School Graduate	7	28.0	9	36.0	9	36.0
Some College	1	50.0	0	0.0	1	50.0

Table 9
Criminal Characteristics of the Population by Reason for Discharge

Variable	Disciplinary Charge		Refused Treatment		TC Rule Violation	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Age at First Arrest						
Under 18 years	9	25.0	17	47.2	10	27.8
18 years or older	4	28.6	5	35.7	5	35.7
Felony Arrests						
1 to 4 felony arrests	10	29.4	16	47.1	8	23.5
5 or more felony arrests	3	20.0	5	33.3	7	46.7
Alcohol Arrests						
Zero arrests	10	40.0	6	24.0	9	36.0
1 to 4 arrests	2	15.4	8	61.5	3	23.1
5 to 9 arrests	0	0.0	4	80.0	1	20.0
10 or more arrests	1	14.3	4	57.1	2	28.6
Drug Arrests						
Zero arrests	7	36.8	6	42.1	4	21.1
1 to 4 arrests	5	20.0	11	44.0	9	36.0
5 to 9 arrests	1	20.0	3	60.0	1	20.0
10 or more arrests	1	100.0	0	0.0	0	0.0
DUI/DWI Arrests						
Zero arrests	10	34.5	19	34.5	9	31.0
1 to 4 arrests	2	11.8	9	52.9	6	35.2
5 to 9 arrests	0	0.0	0	0.0	3	100.0
10 or more arrests	1	100.0	0	0.0	0	0.0
Years in Prison						
1 to 4 years	4	22.2	5	27.8	9	50.0
5 to 9 years	6	30.0	8	40.0	6	30.0
10 years or more	3	25.0	9	75.0	0	0.0
Probation Revocations						
No revocations	8	36.4	11	50.0	3	13.6
1 revocation	4	18.2	10	45.5	8	36.4
More than 1 revocation	1	16.7	1	16.7	4	66.7
Parole Revocations						
No revocations	4	50.0	2	25.0	2	25.0
One revocation	4	22.2	8	44.4	6	33.3
More than 1 revocation	5	20.8	12	50.0	7	29.2

Additional analysis was conducted on the scoring for specific scale items for those who were removed from the program. Tables 10 and 11 show the breakdown by scale and reason for removal. Chi-square was used to determine statistically significance differences between reason for dropout and risk levels as identified by the PII scales and SRF scales. A 5 percent level of probability was used as a minimum for acceptable differences of significance. There were several relationships identified. The first three significant relationships were from the SRF Intake Instrument. These were hostility (χ^2= 10.153, 4*df*, p = .05), self efficacy (χ^2= 15.882, 4*df*, p = .05), and problem recognition (χ^2= 18.339, 6*df*, p = .05). The final significant relationship was drug problems (χ^2= 15.410, 8*df*, p = .05) as measured by the PII.

Table 10
Demographic and Criminal Characteristics of those Completing TC and Dropouts

Variable	Completed Program Frequency	Completed Program Percent	Dropped from Program Frequency	Dropped from Program Percent	Total Population Frequency	Total Population Percent
Age						
1 to 25	14	70.0	6	30.0	20	100.0
26 to 32	36	62.1	22	37.9	58	100.0
33 to 65	87	79.8	22	20.2	109	100.0
Race/Ethnicity						
White	87	75.7	28	24.3	115	100.0
African-American	49	69.0	22	31.0	71	100.0
Asian	1	100.0	0	0.0	1	100.0
Marital Status						
Single	66	72.5	25	27.5	91	100.0
Married	61	70.9	25	29.1	86	100.0
Separated/Divorced	10	100.0	0	0.0	10	100.0
Education						
11 years or less	70	75.3	23	24.7	93	100.0
High School Graduate	50	66.7	25	33.3	75	100.0
Some College	17	89.5	2	10.5	19	100.0
Age at First Arrest						
Under 18 years	81	69.2	36	30.8	117	100.0
18 years or older	56	80.0	14	20.0	70	100.0
Felony Arrests						
1 to 4 felony arrests	87	71.9	34	28.1	121	100.0
5 or more felony arrests	50	76.9	15	23.1	65	100.0
Alcohol Arrests						
Zero arrests	49	66.2	25	33.8	74	100.0
1 to 4 arrests	51	79.7	13	20.3	64	100.0
5 to 9 arrests	12	70.6	5	29.4	17	100.0
10 or more arrests	25	78.1	7	21.9	32	100.0
Drug Arrests						
Zero arrests	41	68.3	19	31.7	60	100.0
1 to 4 arrests	86	77.5	25	22.5	111	100.0
5 to 9 arrests	8	61.5	5	38.5	13	100.0
10 or more arrests	2	66.7	1	33.3	3	100.0
DUI/DWI Arrests						
Zero arrests	59	67.0	29	33.0	88	100.0
1 to 4 arrests	62	78.5	17	21.5	79	100.0
5 to 9 arrests	8	72.7	3	27.3	11	100.0
10 or more arrests	8	88.9	1	11.1	9	100.0
Years in Prison						
Less than 1 year	4	100.0	0	0.0	4	100.0
1 to 4 years	47	72.3	18	27.7	65	100.0
5 to 9 years	54	73.0	20	27.0	74	100.0
10 years or more	32	72.7	12	27.3	44	100.0
Probation Revocations						
No revocations	68	75.6	22	24.4	90	100.0
1 revocation	55	71.4	22	28.6	77	100.0
More than 1 revocation	14	70.0	6	30.0	20	100.0
Parole Revocations						
No revocations	30	78.9	8	21.1	38	100.0
One revocation	38	67.9	18	32.1	56	100.0
More than 1 revocation	60	74.2	24	25.8	93	100.0

Additional tests were also performed to determine the strength of the relationship.

Only two of the four relationships showed significant strengths. These included hostility and self efficacy. *Tau b* was used to determine the direction and strength of association. In the relationship between risk level on the hostility scale and reason for dropping from the TC program, those who were removed for disciplinaries were much more likely than others to score maximum risk on the hostility scale. Many of the factors relating to the hostility scale are dynamic in nature. These individuals should be identified early in the program so that specific care can be taken in addressing these factors to increase retention.

The second relationship that showed a significant strength of association was self efficacy. Those individuals who felt they had little control over their environment or were less than willing to take responsibilities for the problems in their life were also more likely to be dropped from the TC program as a result of disciplinaries. Again, these individuals should be identified early in the program so that special efforts can be made to address the issues of responsibility to increase retention. It should be noted that many of the factors on the self efficacy scale are addressed in the TC curriculum, however, they are often taught or handled in the last six months of the nine month program. The majority of the individuals in this category were removed during the first three months.

c. Factors Affecting Program Retention

i. Analytic Strategy

First, we examined simple relationships between discharge status (completer or dropout) and a set of variables comprised of sociodemographic background, criminal history, and psychosocial and treatment motivation ratings. The outcome criteria was a dichotomously scored measure (0=completer, 1= dropout) based on treatment discharge information that was collected by ADC. Further analysis was done on those removed from the program. A series of exploratory Pearson Correlations was performed to see what relationship existed. Those variables found to be significantly related to treatment outcome and reason for removal were then loaded into a multivariate model using stepwise linear regression procedure (for a detailed description of a similar model building strategy, see Walker,1999). This allowed for the determination of which variables represented the best set of predictors for those who dropped out and whether or not the instrument used would be valuable in identifying those individuals in the future.

ii. Univariate Comparisons

Sociodemographic Variables: Relatively few social history indicators distinguished completers from dropouts. Whether the offender dropped out or remained in the program was related to offenders age (r = -.191, p<.01) and whether they were mandated to treatment (r = -.199.34, p<.01). As was noted earlier, the percentage of mandated inmates was 97 percent. Discussion on the level of mandated and volunteer inmates will be addressed later.

Criminal History Variables: There were no significant relationships found between completers or dropouts and criminal history. When the reason for leaving was examined, it was related to the number of probation revocations the inmate had received (r =.334, p<.05),

Psychosocial and Treatment Motivation Ratings: There were no relationships identified between those who completed treatment or those who dropped out and the SRF scales. When exploring the reasons for dropping out, several relationships proved significant. Self efficiency (r = -.309, p<.05), childhood problems (r = -.347, p<.05),and hostility (r = -.324, p<.05), were all found to be negatively related to the reason for removal from treatment. The PII scale for violence (r =.287, p<.05) was found to be positively related to the reason for removal from treatment.

iii. Multivariate model

A stepwise linear regression was not applicable to examining completer verses dropout status due to the lack of significant correlations. However, a stepwise regression was used for the reason for removal from CSATP. This was performed to determine if there could be some program components that may be utilized to keep certain types of dropouts in the program, thereby increasing retention.

All independent variables found to be statistically significant were included. These were: violence scale, self efficiency, childhood problems and hostility. Because the focus was on dynamic predictors which could be addressed in treatment, probation revocations were excluded from the model. In addition, because of its strong association with treatment retention in the literature (hiller et al., 1999), treatment readiness was included in this model. The final results indicated that although other variables correlated, childhood problems and self efficacy were the dominant predictors of failure in the TC program as seen in Table 11. Each of these scales have dynamic characteristics that could be addressed during the early stages of treatment to increase retention.

Table 11
Stepwise Regression Results - Models 1 and 2

	b	*SE*	*F*	*R*
Model 1 - Predictor				
Intercept	3.237	.482		
Childhood Violence	-.488	.192	6.450 *	.347
Model 2 - Predictor				
Intercept	4.136	.482		
Childhood Violence	-.434	.188		
Self Efficacy	*-.362*	*.177*	*5.539* **	

* $p \leq .05$ DF Reg = 1, DF Res = 47 ** $p \leq .05$ DF Reg = 2, DF Res = 46

d. Participant Survey

A brief survey on inmate satisfaction for the CSATP survey (see Appendix 3) required inmates to provide their perceptions of the program attributes. The questions addressed program structure, program sessions and peer support. The survey was pilot tested on a small sample of individuals and then administered by peer mentors, when the participants reached the identified half-way point in the CSATP. A total of 121 surveys were completed. Several areas showed high levels of inmate disagreement. The first area included trust of treatment staff, other clients, and the development of friendships within the treatment program. Over half of the inmates (55 percent) stated that they disagreed with the associated statements. The second area identified problems with the program staff. A series of questions asked inmates if they felt the treatment staff cared about their problems and were helpful and whether the security staff cared and were helpful. When the questions were divided into two groups, treatment staff and security staff, it was clear that the dissatisfaction of the inmates was with the security personnel, not treatment staff. The last area found significant was the program structure, in particular the program sessions. The majority of inmates (57 percent) felt that they did not need more individual counseling, group counseling or lecture classes.

e. Summary of the Quantitative Data

Several attributes were found to be related to the reason individuals were removed from the TC program. The majority of these inmates were removed during the first three months of treatment. In addition, those removed at a later date showed continuing patterns of behavior directly related to the attributes previously described. Most of the attributes identified were dynamic, rather than static, and could be addressed therapeutically to help improve program retention and possibly program outcomes.

Although treatment readiness has been found to be a predictor of remaining in community-based TCs, it showed no significance in this study. The number of individuals mandated to the program may have been the reason for this discrepancy. Whether ready for treatment or not these individuals knew that their release was dependant on the completion of the program.

2. Introduction to the Qualitative Data

Shortly after the funding for this evaluation was awarded, the program staff and the inmate hierarchy were given an approximation of the purpose of the research, how it would be conducted, and their respective cooperation was solicited. There was a small amount of anxiety present during these meetings, a common occurrence with most correctional research, so it was also not perceived to be a problem. As with prison life in general, perceptions are reality for inmates, staff members, and evaluators. The actual events occurring within the prison may be different from how they are perceived, but these

perceptions are generally acted upon as if they were real. Some members of the program staff, for example, exhibited concern about the evaluation which bordered on fear. They reacted to this fear by attempting to:

1. Delay the evaluators entry into the unit;

2. Attempt to influence the evaluator's perceptions of the program and corrections as a whole;

3. Influence the conduct of the evaluation through selective access;

4. Delay or restrict access to inmate program files and other program materials.

The impact of these activities were neutralized through contact with the senior ADC managers. Finally, there were changes among the graduate students involved in this evaluation, but they did not present any serious problem to completing the evaluation and the level anxiety among members of the program staff did not appear to change.

For the purpose of this evaluation, the generic phrases "staff member" and/or "program staff" were employed interchangeably to describe the free-world staff employed by ADC to operate this program. It provides anonymity and avoids otherwise unwieldy sentence structure.

The terminology employed in the program may require slight modification to be consistent with the requirements of the funding agency and the Therapeutic Community itself. These difficulties are minor and may easily be corrected. The terms "peer counselor", "peer mentor", "peer elder", as well as "expediter", "department head", and others are cumbersome and reflective of a hierarchical structure, which needs to be "flattened."

a. Site Visit Observations

While site visits occurred throughout the evaluation period, the majority of such visits took place during the period between February and May, 2000. As referred previously, the program staff were initially anxious about the evaluation and the presence of outside evaluators in their area. The level of anxiety continued to increase, however, and became a constant factor in the site visits and staff interviews.

There were two major activities undertaken as part of the site visits, namely: activity observation and staff observation. During the former activity, the evaluators were introduced to the program staff and inmates and explained the purpose of the evaluation. Throughout this activity, the evaluators sat apart from the group and observed its activities.

There were agency goals exist that impacted on the manner in which this program operated. The Arkansas Department of Correction (ADC) has a goal to the maximize inmate participation in work programs (ADC, 2000). To that end, ADC policy ensures that every inmate who is medically capable works at an assigned task and the participants in the Therapeutic Community are no exception to this policy. Thus, the same TC program activities are delivered twice daily to accommodate inmate work schedules and permitted evaluators additional opportunities to observe program activities.

The evaluators were repeatedly impressed by the large amount of high quality information which the program staff shared with the inmates during the classroom sessions. The information provided to the inmates in the Therapeutic Community at Tucker exceeds that provided in non-custodial programs in some areas. The duration of the classroom sessions was appropriate for the amount and intensity of the content being delivered. Anecdotal information revealed that this was not always the case and that the current program is the result of the staff members working together to make the TC a model program.

The program staff appeared to be exceptional in their conduct of group sessions. They handled problems stemming from individual issues, group dynamics, and substance abuse concerns with casual efficiency. There was only one witnessed instance where the facilitation of the group appeared less than excellent. An "issues group" had dealt effectively with the interpersonal conflict between two inmates, yet, this same group was allowed to proceed. During this time, other inmates continued to point out areas of contention between the two original inmates and the previous conflict began to re-emerge. This is not uncommon as inmates in such groups will often continue pointing out the defects in the original participants in order to keep the discussion from focusing on themselves.

Observation of group sessions was stressed by the program supervisor. Indeed, it appeared that it was his desire that the evaluators need to observe whichever group session was either underway or about to start. This situation was corrected eventually and the evaluators were able to observe individual staff members and to conduct semi-structured, group interviews with inmates in the program.

In order to understand the daily routine from the perspective of the program staff, graduate students were assigned a staff member to 'shadow' on different occasions. The purpose of this activity was to gain an understanding of the processes which they affect in the TC program and the split between administrative and clinical duties as well as to observe any deviation from the daily schedule.

Based on the observations of the graduate student "shadows", a general picture of the program staff and their routine activities emerged. A typical weekday begins around 05:00 depending upon the inmate's work assignment (e.g., kitchen workers arise at 04:30

hrs) followed by morning ablutions, and breakfast. Approximately half of the TC inmate population had its work assignment scheduled for the morning while the other half was involved in the treatment program and worked during the afternoon.

The first group session of the day began at 07:00 hrs under the leadership of one or more members of the inmate hierarchy. The typical Monday-Friday schedule can be described as:

07:00 - 08:00	Mon. - Thurs.: Inmate-led Rules Group Fri.: Inmate-led Summary Group
08:00 - 09:00	Mon. - Thurs.: Inmate-led Design for Living Group Fri.: Inmate-generated, staff-led Summary Group
09:00 - 11:00	Mon. & Tues.: Staff-led Encounter / Issues Group Wed. - Thurs.: Inmate-led Chop Shop / Discussion Group Fri.: Educational films

This schedule was mirrored during the afternoon for inmates with morning work assignments and began at approximately 13:00 hrs. and continues past 15:30 hrs. when the program staff depart the unit. It generally included:

13:00 - 14:00	Mon., Wed. & Thurs.: Inmate-led Design for Living Group Tue.: Staff-led Encounter / Issues Group Fri. - Inmate-led Summary Group
14:00 - 15:00	Mon. & Wed. Staff-led Encounter / Issues Group Tues: Inmate-led Chop Shop / Discussion Group Thurs.: Inmate-led Rules Group Fri.: Inmate-generated, Staff-led Summary Group
15:00 - 17:00	Mon. - Thurs.: Inmate-led Rules Group Fri.: Inmate-generated, Staff-led Summary Group

In addition to these activities, there were also group sessions or activities scheduled during three evenings per week.

Although some staff members arrived earlier, it was common for staff members to arrive in the TC barracks between 08:00 and 09:00 hrs. daily. Shortly after arrival in the barracks, the program staff reviewed the occurrences of the previous twenty-four hours to determine what problems had arisen and plan practical approaches to address them. They were assisted in this matter by the "peer elders" (members of inmate hierarchy) who reported any problems that occurred since 15:30 hrs. the previous day when the program

staff left for the day. According to one observation report:

> At this time, councilors in the respective barracks will discuss, among themselves, possible solutions to any problems the community might be having, whether it be about certain individuals or the group at large. This is the majority of the counselor's job - to observe and fix problems in the community. Every counselor I spoke with told me that the inmates are responsible for their own treatment; the counselors act only as guides. Peer elders act as an important tool for the counselors. They give very helpful insight into the mood and goings-on of the community.

After the shift meeting, staff members had the option of either attending the 09:00-11:00 group, brainstorming solutions to community problems with fellow staff members, counseling individual inmates, or attending to their respective administrative duties. According to one observation report, this choice was generally dictated by the presence of any problems or conflict in the community. The same observer noted that "I found that the only time counselors sat in on the group was if there was a problem with the community or if there was some issues that the counselor needed to address. They primarily let the group take care of its own problems and progress."

The working relationships between program staff appeared to be very good. This was evidenced by the willingness to share ideas and work together towards common solutions to client problems and issues that affected the TC community as a whole. While professional disagreements may have existed concerning treatment approaches, there were no reported instances of anger or hostility on the part of one staff member towards a colleague.

Administrative duties ranged from completing weekly progress reports to reviewing treatment plans, reviewing the decisions of the TC Sanctions Court, and assuming the duties of the Program Supervisor in his absence. Although client files are discussed in another section of this report (*4.2.5 Review of Client Files*), the program staff were unanimous in their beliefs that there was too much paperwork involved in the TC program. The "paperwork" requires staff to review weekend reports of the community, weekly progress reports on individuals, monthly progress reports on individuals, and any reports of inappropriate behavior by the 20-25 inmates that were typically on each of their caseloads. It is important to note that staff departures increased some caseloads to 40-plus inmates.

The program staff generally appeared to be as professional when counseling individual inmates as they were in facilitating group discussions. When problems or issues did arise among the inmates, the program staff took the specific inmate aside for individual counseling which always occurred in private. The actions of one program staff member are illustrative of this point:

> There were several inmates written up for smoking, which had recently become against the rules. After lunch, [the staff member] spent most of the afternoon discussing the situation with the inmates one on one. He explained that, as a rule, he would talk to each inmate and give him the chance to "own up" to his behavior. If the inmates do accept responsibility, then he will discuss the matter with them and get a verbal agreement from the inmate that they will not commit the offense again. If the client does not accept the responsibility, then [the staff member] will put the client on a Behavior Contract, which is basically a written warning. According to [the staff member], once an inmate is put on a behavior contract, which usually lasts 45 days, if the client breaks the same rule during this time there is a good chance the inmate will be removed from the program.

Another observation report noted the exasperation in the voice of one program staff member when he or she stated "We are just chasing paper and talking to inmates about themselves and their problems."

An inmate whose behavior was judged to be inappropriate might receive either a "verbal pull-up" (verbal warning) from another inmate or a "written pull-up" (written notification) to appear before an inmate-run "Sanctions Court." Sanctions court usually occured during the evening hours after the program staff have departed or during weekends. According to one staff member, sanctions court:

> ...involves only inmates. It's just a paper saving device for us. There are no counselors needed in it. It is cut and dry. They have a list of inappropriate behaviors down one side and a list of recommended sanctions. They write down the behavior and the sanction and give it to [the staff member]. We don't make the decision, they do, we just sign the form. We monitor them to make sure they are doing it right. We have to make sure that they go by the book. I have only seen sanctions added once by the community. Personal issues and agendas come up from time to time, they are convicts, and sometimes we want to invalidate their decision.

The list of sanctions available to the Sanctions Court include:

- Behavior contracts: a written contract between the inmate and the staff; it outlines behaviors and consequences;
- Essays: the length may vary from 3 to 15 pages and is designed to assist the inmate to identify negative behaviors and seek solutions to them;
- Extra duties: inmates are assigned maintenance work in the barracks to create a sense of responsibility;

- Focus group: inmates negative behaviors are confronted in the group; the inmate sits quietly and receives the criticism;
- Individual confrontation: inmates are confronted by an elder, role model, or staff member to bring negative behavior to the surface;
- No talk contract: client is placed on total silence status except to respond to staff members or questions in groups;
- "Thank You" contract: inmates precede every interaction with the phrase "Thank you, I will get right on top of that";
- Room restriction: the inmate is restricted to his room during non-program and/or non-work periods;
- Seminar: inmates verbalize the nature of their negative behavior to the community as a whole;
- Tight house: the entire community is required to remain in their respective rooms and silently reflect on their negative behaviors;
- Time out: inmates are required to sit in a designated area in total silence for a specified period of time;
- Community one-on-one sign sheet: inmates are required to have a one-on-one session with every community member who, then, signs off on the session.

Generally, the sanctions range from a verbal reprimand to a behavior contract. These sanctions may escalate through a written essay of 3-15 pages, instructions not to talk for a number of days, to the wearing of a signs and/or a "dunce" hat (discontinued), and so forth.

The program staff at the Therapeutic Community (Tucker Unit) incorporated several aspects of a free-world" therapeutic community which have questionable value within a correctional environment. Such practices need to be either modified for correctional use or discontinued entirely.

The first questionable aspect was "tight house." A tight house period in a residential treatment facility employing a therapeutic community model is a short-term intervention. It is designed to:

1. Remove a client hierarchy which has become corrupt (in the treatment sense);

2. Provide clients with time to reflect based upon restricted movement and/or interactions; and,

3. Provide the program staff with time to restructure or replace the client hierarchy.

Observation reports and data from the group interviews indicated that the tight house practice involved the inmates sitting silently on a chair that faced the wall for up to two weeks, during which time no treatment activities took place! This practice was reported to the program manager who ordered it discontinued immediately. The same activity was also an individual-level sanction for inappropriate behavior and has been discontinued.

Another questionable sanction was to have the inmate wear a "dunce" hat and signs. According to one program staff member "We do have signs. The one on the front is the behavior and on the back is a positive statement" yet, a member of the correctional staff contradicted this statement who noted that he or she had recently seen a sign with "My name is Kenneth. I am an only child. I am spoiled" written on it. Upon hearing of these practices, the program manager ordered the "dunce hat" practice discontinued and the modification of the signs to contain only behavioral reminders to be worn only in the TC barracks.

The therapeutic community is a valid and reliable approach to the treatment of both substance abuse and behavioral problems. Site visits and discussions with program providers, supervisors and managers provided a view of a program whose staff, for the most part, had a "can-do" attitude and a genuine desire to help those inmates who genuinely wanted their assistance. One of the strengths, which was also present among the program staff, was a willingness to learn from others and to change wherever necessary.

b. Group Interviews - Current Clients

There were several group interviews held to gather client perceptions of the TC program. One interview involved only the inmate hierarchy while the subsequent group interviews involved the remaining community members. Membership in the latter group interviews with current clients was non-exclusionary with the exception of the hierarchy members, who were excluded from the area in which the interviews were held.

i. Peer Staff (Inmate Hierarchy)

Members of the inmate hierarchy comprised the first group interview. They were chosen for their low number and the opportunity to ease the graduate students into the group interview process. A general theme emerged throughout these interviews, namely:

"this program saved my life, I'm in it for personal reasons as well as to help."

Throughout the interview, the peer staff repeated all of the comments one expects to hear from a sponsor in an Alcoholic Anonymous (A.A.) or Narcotics Anonymous (N.A.) meeting or from a person about to graduate from a residential treatment program. The stock phrases (such as "This is one of the greatest things to happen to me." "it has probably saved my life." and "If I had got out before this program, I would have been back. This program is in me. You get it within yourself. When I get out, I will do the things I have done in this program") were spoken with the fervor of recent converts. Interestingly, the group tended to take it's lead from two speakers who, as the other interviews would reveal, exercised both power and leadership in the program.

Despite the "party line" being provided to the evaluators, this group identified a number of areas for improvement of the program. The participants revealed that they perceived the orientation barracks process superior to the continuous, direct intake process which was being employed. "The old way," they said, "two guys met you at the door and you got caught up to speed real quick. "Today, the setup is cyclical, it causes people to be at different stages throughout the program."

They also commented on the differences between the program participant who 'volunteered' and the one who was 'mandated' into the program by the Post-Prison Transfer Board (the paroling authority in Arkansas which is also referred to as the "Board", "Parole Board" or "PTTB") and the effects that the latter group has had on the overall TC program. They noted:

> Mandates reduce the number of volunteer slots open. We draw from other units and mandates get first dibs.
>
> They [mandates] make the process harder. Mandates are harder. They have a more "prove it to me" type of attitude. "I will prove you wrong."
>
> Don't have the parole board send them on a 9 month course when they only have 6 months left to go. Half of the beds are filled by the parole board. By the time that we get him [a mandated inmate], he's back to the way he was before he was all nice to the parole board.

The structure of the program was also discussed by the hierarchy members. Many felt that the ADC policy of every inmate having a work assignment was interfering with the TC program. Two members noted:

> I don't like the way they split the day into AM and PM. We went to four groups a day just to get chow time in. Some clients get AM, some PM, this splits the community. There is also a confidentiality problem because of this

> and having to have an outside job. We are trying to build trust but someone outside is experimenting with us.
>
> It should be a 18 month program... maybe 12 months... we could identify what's wrong in the first 6 months, have 6 months to plan a solution, and 6 months to implement it. We have to tinker to get things right. We don't have a time frame, but we need a rules meeting every week, the same with criminal thinking sessions, there are some areas we could expand and others we could reduce.

Not only was the internal structure of the program discussed, but so, too, were external influences on the effective functioning of the program. One such external influence was the correctional staff assigned to the barracks. The choice of staff and their orientation towards the TC program were viewed with concern.

> Good help is hard to train. We need more staff, we have good staff now. A definite set of officers would be good. There are some that do not need to be here. It is difficult to confront their behavior. We need good stable officers trying to reinforce what we are doing here.
>
> One of the problems is consistency. The changing of the officers. Most of the time, officers are understanding of what you are trying to do, but they send a lot of mixed messages. This causes a lot of shit for me to clean up. Some officers allow things to occur and we can't confront them about it. This is a serious problem.
>
> We can get a different officer every day. Lots of officers are the biggest crooks in prison. They can be culprits. It is difficult to contain this behavior. There is lots of inaction and action that we have no control over. There is a lack of consistency among the guards.

Although the orientation of the individual correctional officer can, and does, have an influence on the smooth running of the program, these comments (especially the last one) could also be interpreted as the hierarchy claiming that "we have no control over" wanting to ensure that they remain the driving force in the therapeutic community and barracks.

There is a lot which the inmate hierarchy has to offer the therapeutic community. Indeed, they are essential to the effective operation of such a program whether it operates within or outside of a prison environment. However, care has to be taken to ensure that the hierarchy remains focused on the overall goal of the program or it should be removed and its members returned to the general pool of participants (this could be a routine occurrence). We need to remember the words of one member of the current hierarchy who commented "I'm in it for personal reasons as well as to help."

ii. Program Participants

Members of the subsequent group interviews were comprised of any available TC participant who was not a member of the inmate hierarchy. Willingness to participate in the group interviews and to honestly share their experiences and concerns were the key criteria. Like the previous interview with the inmate hierarchy, a number of themes emerged, including "this is a good program, but..."

The program is perceived as a good program, but one with a few structural problems. One inmate may have described it best as "the message is good, but there are problems with the messenger." Most inmates described that they were receiving some good from the TC program:

> This is my third time in the program. The first time I was pissed off by being mandated. The second time I tried, but it was hard. This time it is hard, difficult... the program works. This time I am getting something out of it. After the previous times, I had taken a little of what I had learned to general population. I got something out of the last two times as well as this time. The program works.

> I like a lot of the stuff. I have gotten a lot of educational stuff, the free your mind class. I like the educational stuff and the workload, the twelve steps, and such. A lot of the stuff is how much I want to put into it.

> The program has a lot of good information. They give us information on how the mind works, transmitters, and different ways you can treat your addiction, like behavior modification.

An issue related to the good qualities of the program is the delay or waiting period prior to admittance into it. Several inmates commented on this particular issue:

> I was mandated through a parole violation. I have good time, but I am still here through 2002. There is a lot of good in the program, but it took me 10 months to get in. Look around, there ar ten empty beds today, but it took me almost a year to get in?? That's bullshit.

> I waited 8 months to get in here. When I walked in there were was 8 empty beds. There are a lot of good points. This program really makes you look at yourself. You know I understand that this is a prison. There are a lot of things to keep you from coming back.

> I was recommended by the parole board... that means mandated. It took me three months to get in. The parole board didn't tell me I had to wait. There

> were empty beds in here! I want to know why? I could be out in January, but I still have 4 months of TC left. The monthly count is down and there are empty beds here all the time.

This appears to be both a real and perceived concern because, on two occasions, the evaluators counted 12 and 20 empty beds, respectively, in one barracks alone. The issue of bed spaces versus waiting for an assignment to the TC is best comprehended, however, by taking the approach that: (1) the TC at the Tucker Unit is an ADC-wide resource, (2) requests from both volunteer and board-mandated requests are difficult to coordinate and balance, and (3) that the board mandated inmates are a priority placement over volunteers.

The difference between inmates who volunteered and those who were mandated into the program remains an issue of contention. Many related that they felt coerced into taking the program. These concerns may be seen in the following comments:

> When I was at [another unit] I was mandated by the parole board. I had to sign a volunteer statement... I never volunteered, they made sign a statement that I was volunteering to take this program or I couldn't be it. It took me a year to get here so I signed it.

> I was mandated. I didn't sign a paper. Two months later I was in. You can sign the paper or do the time. They shipped me to the program.

> The board mandates you, but makes you sign a form that you volunteer. Why mandate you if you have only a few months left to be in prison. They should mandate you early so you don't have to stay longer than if you were paroled.

Mandated inmates expressed both frustration and anger at what they perceived to be unfair practices by the Post-Prison Transfer Board. This anger is also directed at the TC program:

> They treat us like new borns. If they are mandated, a person should not be kicked out because they have a bad attitude. I volunteered. I didn't want to be mandated, this is a convict mentality. I already have it done if I am mandated. There are people who have been in the program for 7 months and then been kicked out. I understand the chair [time out] but I can't understand how they can kick us out if they require us to do it.

> I am mandated. I was kicked out last year. It took me a whole year to get back. That woman said when beds were open, people at the other units would have to respond, but the other units say they haven't heard from Tucker. [A program staff member] has good information, but I don't think I am

> getting anything out of it if because I don't care. Because they are forcing me to listen to this. I don't want to quit, but I don't think the board should impose these kinds of stipulations on me.
>
> I'll be here for 45 more days. My parole officer signed me up to do this. I am up on a 10 month parole violation. I waited 5 months to get in. They mandated me. I will be here until November.

As reported in the previous section, many of the inmates in the current TC inmate population regard the program favorably, but not so the messengers, the sanctions court, or the inmate hierarchy. Regarding the inmate hierarchy, several current clients repeated the frustrations expressed by the former program participants, including:

> I have seen people kicked out for bullshit reasons. I'm out in a year, so I don't need to do this. I don't see how they can play with other's freedom. I can see for fighting but no missing a meeting. The state is doing this [CSATP] to get money, but the nit-picking here. When the counselors go home, some of the stuff we are told, we don't know if it comes from the counselor [program staff]. I flatten in August. I feel that if they want me here for the money. Sometimes the peer mentors [inmate hierarchy] make up rules as they go along.
>
> One thing I don't understand is one convict over another convict. I think it's a bunch of shit! It is a bunch of criminals picking at each other and we're being taught by baby rapists and faggots. I can't look past that.
>
> I don't like this inmate police. It pisses me off. You have to be a rat or a snitch. I don't like the inmate police. To survive in this program you must turn into a rat. Somebody is going to do something horrible.
>
> Well, um, I'm 28 days from going home. The program has it's good points and good info. I am mandated. I had to hold down my anger. All this is good, but running around trying to tell people how they are wrong. When I think of treatment, I think of people talking to you. We are sick and we know we are. I broke rules that could have got me kicked out when we were in tight house.

There was also a large amount of hostility towards the sanctions imposed by both the program staff and the inmates in sanctions court.

> See our sanction board [he points a whiteboard on the wall] look at the people being forced to write essays, not talk for three days. A month or so ago we all sat in chairs facing the wall all day long. This was because we

laughed at an inmate doing the bunny hop. We were all told to do this. The people were laughing at a certain individual. The next day, we all sat in a chair for one week facing the wall all day long. I don't agree with inmates telling other inmates what to do.

If I give my word against a WPU [written pull-up] and they don't accept it, they are saying my word is not worth much. A witness statement has no pull. There's no understanding there.

An issue of honesty in group and individual counseling was explored, based in part on the comments about inmates having control over other inmates and perceptions of differential handling by program staff. Rather than discuss what the program participants had to say, both good and bad, about individuals, they were asked "How truthful or honest can you be in group?" This question was usually followed by loud laughter and comments such as:

I can't be that honest!

What I tell them is a bunch of shit. I don't tell them shit. I lie to these guys everyday. If I tell them the truth it will be down the hall [into other barracks]. Confidentiality is shit!

I am truthful and honest. I just hold stuff back. I hold back personal stuff like my addiction...like why I was doing things. What I say is the truth just, most of it, doesn't come out.

There's a lot of selective journalism. Some things I don't say. Its not like seeing a psychiatrist. Here, I will tell them only what the f**ck they want to hear and go on. I tell them what I have to tell them to go home.

You can only be as honest as what you want to be known down the hall. If you don't give a shit, its no big deal. Its up to you. You can only be so honest.

I think as far as some parts of life, I'll put out there, but some personal stuff I won't. You keep your mouth shut or you get into trouble. The really deep personal shit I don't put out.

I lie my ass off. We've had mentors that have f**ked chickens, like Brother [inmate hierarchy member], I'm not going to put that kind of shit out there. Petty squabbles consume the time in groups. Some things can't get out. They will nail me for negative behavior. I'm here to fix negative behavior. I am here for behavior modification. They will throw you out for negative behavior, but that's why I'm here.

It was discovered that the current program participants had issues with the selection process (volunteering versus mandating), the time spent waiting for a bed space when it is perceived that 10-20 beds were generally available, the inmate hierarchy, and the sanctions imposed for non-compliance with the program's rules. The inability to be honest in the program does not appear to be a major inmate concern, but rather a concern for the program staff and ADC management.

c. Group Interviews - Former Clients

A semi-structured, group interview of former clients was held at the library of the Tucker Unit. There was only one attempt to gather data from these individuals and no attempt was made to discriminate on the basis of success or failure in the program.

This was the most difficult interview of the entire evaluation. Just prior to the interviews, one of the co-investigators was confronted by a member of the program staff and questioned on the fairness of the evaluation. The effect of this confrontation was a twenty minute delay in starting the group interview and a reduction in the allotted time. Additional difficulties were encountered throughout the group interview including the presence of two current peer counselors who were subsequently removed from the group and an extremely high level of frustration and anger among the former TC participants. Indeed, these emotions were present in the verbalized comments, body language, and on-going departures of the interview participants. The members of the inmate hierarchy were the primary targets of this hostility followed by sanction court, the program staff, and the mixing of volunteers and mandated inmates, respectively.

According to the participants, the inmate hierarchy is best described as a power elite with it's members' interests being their foremost consideration. Many felt that this same power elite was sanctioned by the program staff. Several inmates commented on this issue, stating:

> They ain't doing nothing right. One inmate has control over another. Brother [hierarchy member] is like a cop. He'll turn anybody in on anything. He's a convict just like we are!
>
> Brother [hierarchy member] intimidates... free world staff gives him enough power to terminate inmates. If [hierarchy member] doesn't like a guy, all he has to do is have a focus group. He will persuade others in the group to turn on him and he'll get them kicked out.
>
> I did six months in there. I made them kick me out. Lot of sick individuals like Brother [hierarchy member] and [hierarchy member]. Councilors sit around all day and do paperwork. They cause friction to see how someone can handle it.

> I've been kicked out of the program three times. I was trying to do good. So-and-So [a hierarchy member] has life. He doesn't want to see any of us leave the prison. Inmates shouldn't be over other inmates. They don't want you to succeed.
>
> So much bullshit around you... so much shit goin' on down. You can't concentrate on the good. They force you to snitch and if you don't they snitch on you for not doing it...gets you so stressed. There's racial shit down there. That is why I'm not there now.
>
> There are peer councilors who are sexual offenders. That is not suppose to happen. How can they tell me how to run my life?

Sanctions court was a particular point of irritation with nearly all of the participants in the interview. Inconsistency and favoritism on the part of the hierarchy members of the court accompanied by acquiescence on the part of the program staff were the most commonly heard responses. Interestingly, they felt so strongly that the evaluators needed to understand the sanction court that several inmates role-played how they perceived sanctions court to operate. Some of their comments on the operation of sanctions court included:

> They make you wear signs. They made me wear a sign that said "jackass." This is bad; it gives you low self-esteem. Inmates having authority over you is not right. And sharing something in group, you don't want to share some things. Sometimes it can end up down the hall. How can you trust it?
>
> One time a guy was wearing a hat for a sanction, there were people touring the place. The councilors got on to the inmates wearing hats and sent them up to the office while the group of people went through.
>
> It occurs on Sundays and no free world staff is around then. On Monday, they are given the punishment. This is with no defending yourself. They might give you 48 hours to do something. A sanction can be, "We're gonna give him 20 pages on it."
>
> This program is too stressful. You don't get a chance to defend yourself. After a sanction is given, then you can appeal. Why I quit, what killed me, was how stressful it was.

The TC program and the program staff were the next major targets of the groups' anger. It was generally believed that the information provided in the program was very good, but the messengers were bad. Many felt that the TC program offered good information and lessons:

> The program has good principles. It is designed work for people who want to work out their problems.
>
> A lot of good information. Not enough time spent on it. They want you to write people up. They manipulated us to write more. That put me into resentment.
>
> It teaches you those things if you have the time. That person is gonna push your buttons and get up inside of your head... If you let someone talk to you like that, you're a lame ass.

However, the real or perceived behavior of the program staff and inmate hierarchy has reduced the impact of the program. Many inmates noted:

> Program ain't shit. The councilors aren't nothing, they have ain't done anything. How can you relate to us? I have an attitude problem myself. Because someone didn't like [another inmate], he got kicked out. Counselors [the inmate hierarchy] will tell you to write people up, or they write you up.
>
> I was there 47 days and didn't see the councilor once. You're supposed to be there to help yourself not the whole group. They give you the information and then they take it away from you later on.
>
> I was kicked out the first time. The second time, I left. I saw the counselors very rarely. They let inmates run their shit and they sit up in their office. Them cats'll flick you.
>
> I worked as a [peer] councilor for a year. A lot of the stuff they say is true. The confidentiality is not there. I had access to all of the files. If I had wanted to do something, I could have. It's easy to get the keys to all of the inmates' information. I was put out of the program for [an activity]. I came back a month later. I believe the program is deteriorated. The councilors are not in control now. They can pull people up. [Staff member A], [Staff member B] ,they don't do groups. Only [staff member C] is the only one I have seen in educational groups. There are some double standards. The program is run by lifers. It is normal to protect your job. I've seen a lot of white councilors come and go. It gets hard to watch things. I think there are some things that need to be changed.
>
> I got a lot of stuff out of RET [Rational Emotive Therapy] program. So I could recognize the things leading up to an adrenaline surge. Sometimes the knit-picking helped. I would try to remove myself from it but it wouldn't work.

> Someone is always there watching. After the bad they bring the good out of you, but they don't. I only saw them (councilors) when I was in trouble. Other than that I saw them once in two months.

The group participants did have suggestions for improving the program. One of the most common suggestions concerned the separation of volunteers and mandated inmates into two separate TC programs.

> They should split the mandates and volunteers. Mandates should get training on the outside, to get help there. Send them to a halfway house.

> If you could come up with a mix between here and Benton. More free world staff and split up the treatment. Part in prison and part out in a halfway house. You could interact with your family on the outside. This is still to much of a prison setting.

> Six months in here - four on the streets or whatever or more like four and a half here and four and a half at Benton or in a halfway house so you can be with your family. If we could get money prior to being out of prison, otherwise we are just dropped off at the bus stop with $50 in our hands. People got to live somehow. ADC is suppose to help—correct us! All they care about is the prison upkeep. When you come into the program, you shouldn't have anyone up over you. Let you use the knowledge you receive for your benefit if you want to.

It can be seen that while the former client group had a lot of anger and frustration concerning how the program operated, they also had some practical advice on how to correct those conditions which caused these emotions. Nonetheless, their perceptions of the abdication of staff responsibility, the hierarchy as a power elite, a belief that the program had forgotten to build up the person after they have been torn down, increased staff members, and the potential for a TC program in a community-based environment offer validation of similar perceptions held by other groups.[1]

d. Interviews with Selected Staff Members

Selected members of the program staff, the ADC Program Manager, and correctional staff were interviewed individually, using a semi-structured interview guide that was constructed with the assistance of one of the ADC stakeholders. Additional questions were forthcoming whenever a point required clarification or further depth was desired by

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[1] At the current time, there is minimal institutional aftercare for TC members who have completed the program (infrequent AA and NA meetings).

the evaluator. Finally, the staff members were empowered to ask questions of their own choosing about the evaluation.

The program staff identified with the philosophy and processes of this TC program. Their personal and professional beliefs were also consistent with the TC perspective commonly found in both free-world and correctional therapeutic communities. They noted that while there is a common addictive personality type and that substance abusers have common behavioral problems, that the medical model of addiction as a disease is also present in the program. "Both are true" stated one staff member, "we teach a concept, we explain peer pressure and choices. I think there is a balance." Another staff member explained that the inmates recognize the effect that alcohol and drugs have had on their bodies and their lifestyles by commenting:

> It's a disease that affects your brain. You had a problem before you started drinking or doing drugs. The drugs are just the symptom. There are different degrees to the illness, but its basically the same: what you're using, how long, and such. There are different drugs out there today than there used to be; they are really doing some poison out there today. Some of these guys are really scrambled, their brain does not work correctly... you can talk to them and tell that they do not know what is going on, the drugs have done that to them. It is really scary.

Although treatment is regarded as a short-term process in the highly structured TC environment, recovery is viewed as a lifelong process both in and out of the correctional environment. "We try to teach abstinence and pro-social values," claimed one staff member, who further noted:

> That's the basis of your recovery, honesty. It is difficult to achieve higher levels of sobriety and self-actualization without it, especially in the face of outside influences that keep that desirable. Cigarettes, for example, are against ADC policy now, but they play their little games to get them and often deny it. Once we find the cigarettes, its too late because they prevent honesty from occurring.

Another staff member noted:

> The program shows pro-social conduct and is just a start. We have consequences for wrong decisions. We use educational experiences. If they cuss a person, they will do a 10 minute speech or 10 page paper on that topic. It's a start of their acceptance to feel good about themselves. We don't have near the problem I though we going to have in this area. I've been real impressed with how the inmates deal with issues.

This latter individual also claimed there had been changes which had not been for the betterment of the program. One such change has involved the Arkansas Post-Prison Transfer Board which changed it's practices of mandating offenders into the program when there was a history of alcohol and/or drug abuse in the inmate's criminal history. One staff member exclaimed "I hate the mandates. Before the mandates we had it a little easier, especially on issues of denial." Another staff member commented on the change from a predominantly-voluntary client group to one which is a predominantly-coerced (mandated) population.

> The biggest part of the problem is board mandated. They are not the same as before. With 75 percent of our clients being mandated, a lot of them don't feel they have problem which makes the program more difficult to run. I think this is a very good program, it has a lot of information to pass on and is structured good.

Yet another staff member commented on the impact of the inmate mandated into the program:

> We had to change our mentality. It made us change and take more of a straight line approach since one guy can hurt another's chance of success if he doesn't like him. We have also slowed down on kicking people out [of the program]. Before we had 80 percent getting kicked out for dirty urine while only eight left in the last year for that. It was a problem since we also had some staff who would not kick one person who they had a good relationship with until after 3, 4, or 5 dirty urines while they'd kick another person out for only one dirty urine test if that person was someone who gave them a little bit of grief.

Over the past few years, the Arkansas Department of Correction has increased both it's focus on treatment and the amount of resources necessary to treat addictive behaviors (see *2.2 History of Substance Abuse Treatment Program in ADC*). This emphasis on treatment and necessary resources was clearly outlined in ADC's Administrative Policies and Administrative Regulations and has the support of the Director and his Senior Management Team.

When asked if there was adequate structure, resources, and framework to define and support the therapeutic community, staff members were unanimous in claiming that ADC supported the TC program better than other programs, but that it still had some work to do in that area. One staff member noted "we don't have aftercare, but we do have a good budget here and we have plenty of supplies." while a co-worker proudly stated that "Its hard to compare the Arkansas of today to the past when we didn't have anything, some A.A. and not much else. You can compare any state to Arkansas now, and we will be in the running."

When asked about the written policies and procedures under which the TC program operates and the roles of both clients and staff within it, staff members were quite open about the program. They identified the cardinal rules under which the program operates and stated that they were listed in the Client Handbook. They noted that violence, sexual acting outing/behavior, and refusal or failure to respond to treatment were the only reasons why a person would be expelled from the program. Unfortunately, those same cardinal rules as listed on page 26 of the Client Handbook contain only one offense that will receive a mandatory discharge from the program (fighting) while all other rule violations are discretionary on the part of the program staff. The exact terminology employed is "Fighting will result in discharge" and "Violations will be referred to staff." One staff member noted that the behaviors which could cause an inmate to be removed from the program include "fighting, breaking confidentiality, repeated behavior contracts for the same bad behavior, a threat or threatening, aggressive behavior." That staff member went on to discuss this concern, stating:

> It varies. Very few stay in the program if they threaten people. Dirty urine is another problem. Even though that is not abnormal with inmates coming in from other units. Repeated failure to follow the structure...it depends on the seriousness of what they did. Its not automatic to be kicked out. I try to talk with them as individuals. Someone who did something stupid near the end would probably be extended by a few months whereas an inmate who is new may be kicked out for the same offense. You have to deal with these guys individually and I think they do a good job.

Another staff member noted that an inmate would be likely removed for:

> any physical contact, if you threaten someone you could be removed. It depends on how it happened.... if you get two behavior contracts - not responding to treatment - you could be removed. Its progressive. We expect bad behavior so when you do something wrong, we have to give you time to turn it around.

This exercise of discretion has led to perceptions of favoritism among current and previous program participants.

The staff were generally content with the program as it is currently operated. They noted that any program could be improved and that theirs was no different. The structure of the program itself was universally regarded as one of the program's pillars of strength. The high quality and amount of staff training and the program information were seen as the remaining pillars. Other program resources were regarded as adequate by the staff. Although the television sets were reported as too small for group presentations and that computers and computer generated reports would be appreciated, the program staff claimed that if additional staff members were available that their paper work would be reduced and increase time could be spent with inmates. It is not clear how the amount of

paperwork would be reduced unless the additional staff performed clerical rather than clinical duties! The program length was universally regarded as adequate, but that an additional three to six months would optimize the program.

The program was weakest in terms of aftercare and follow-up. This is not to demean the individuals involved in these activities, but merely to note that large amounts of effort and resources were still needed to provide what the staff perceived as adequate levels of service. There appeared to be a lack of ADC community-based programs that deal with substance abusers after their release according to staff members. Claims of not being directly connected to service providers in the free-world community and being regarded as outsiders, rather than as partners, by community agencies were also problems. Consistency was reported as one of the weaknesses in the TC program. Staff members noted that the overall prison environment was the source of the inconsistency and that inconsistency among the correctional officers assigned to the unit might be part of the problem. There were correctional officers, they noted, that wanted to be part of the program, utilize the house rules and procedures rather Warden's Court for behavior problems, and who would benefit the program should they be assigned permanently to the TC barracks.

The locus of control issue was explored with staff members. While one staff member was adamant that the community controls the program:

> The community controls it. That is the idea behind a therapeutic community. The stronger the community, the less that I have to be involved. I can become a visitor, I come to say 'hey' and collect a check. On the other hand, if you have new guys that don't want to fit in, I have to be the bad guy. It is my responsibility to do something,

another was just as adamant in claiming that control of the program was in the hands of staff members:

> No way! They [the inmates] don't control anything. They are like our eyes and ears when we are not there. We have some peer counselors who have a purity of purpose and serve as role models and mentors. The inmates pick up on that. Those who understand the process, I respect them for that.

Similarly, the notion of staff members being perceived as members of the community and subject to community rules was polarized. One staff member felt that "the inmate has to feel authority in the staff member, that gives you some separation. If they have a problem, they can fill out a request form to see me or they can go to my boss about me, but I'm accessible to inmates and staff." Another staff member noted that he or she "should be a very minute part of it. In a healthy community, I should do very little. This happens somewhere in the process. Staff and inmates vary on this question. I tell them the community should handle most of its problems."

The comments from correctional staff were informative and added another perspective to this evaluation. The inmate hierarchy was seen as having too much power. According to one correctional staff member, "mentors who have a problem with an inmate would go to the counselor and tell them that the client is acting badly and get them kicked out." It was claimed that program staff needed to handle aggressive inmates better:

> The more aggressive attitudes the program handles wrong. Instead of sanctioning the way they do, counselors need to be present. Counselors need to be present all of the time. They're off in the office all of the time...if you're alone, then someone else can teach a class, but five counselors at a time like this? I'll give you an example of what happens, one time one of the peer counselors started teaching Islamic beliefs which is not part of the program. They are given the power to do so. The free world staff should have more control.

Similarly, it was the control which the peer counselors wielded that contributes to the smooth operation of the program. This correctional staff member commented on the lack of trouble with this barrack, noting:

> Give me a whole barracks, any other barracks - I'll take this barracks every time. They are wonderful. I can do drug specimens here easily. Another barracks and I am screaming and stuff to get them to cooperate. This comes from the peer mentors not the free world staff. There won't be one word from them [the inmates in this barrack] especially if the peer counselor is helping.

The correctional staff regarded the program as needing few changes to improve the quality of the services provided to inmates. The first change would be to increase the number of classes taught by the program staff as an effort to increase their presence in the program. Second, it was noted that correctional officers should play an expanded role in the TC program:

> They need to know and be trained by the counselors, so they don't mess up the program. It is our duty. A lot of counselors know what is going on in the barracks. CO's [correctional officers] have one of the biggest jobs in the program - not to cause chaos. Instead of us dealing with some disciplinaries [disciplinary offences], the program should handle it with us as part of the program.

The program staff and to a lesser degree, the inmates, identified with the philosophy and processes of the program. There were a number of discontinuities, however, between the idealized program goals, objectives, and activities and the reality of the TC program. Some of these same discontinuities might be removed with minimal effort. With program activities scheduled for three nights per week, it might be advisable to create a rotating shift

schedule (day and evening shifts from 07:00 to 21:00) for staff members. Another practical solution might involve the creation of a new hierarchy with less staff dependence on it[2].

e. Review of Client Files

Six randomly selected, inactive case files were examined as part of this evaluation. These files were maintained separately from the comprehensive ADC file on each inmate, which made the review easier to complete.

The first impression was that the files did not contain the same information in every instance. For instance, the TC Form Checklist was not present in each file which made the reviewers wonder which forms were completed or not. Those forms, which were present, were generally complete and comprehensive. In some cases, the handwriting was difficult to decipher and the reviewer was left wondering about the content.

The client files were revealing in a number of ways. One revelation concerned the practice of tight house which was as not frequently used as the evaluators first believed it to be. Tight house was generally limited to a week or so of lost treatment time which would be added on to the time the inmate spent in the program.

It was also discovered that if the inmates regular counselor was away from the unit for illness or training, the weekly progress summary would typically contain the notation "Client's counselor out sick - client status is stable and participates in community." This commentary begs the question of whether a serious condition might remain unreported if the regular counselor was absent and unable to update the file.

The "Significant Observations" section of the weekly progress summaries were often contradictory, or appeared so to an outsider. Comments such as:

> Client staying to himself and appears to be participating in all the groups. Client does all homework assignments and turns in on time. Client working on goal three and objective one and appears to be willing to make change,

do not appear to be logically consistent for an inmate involved in the Rational Emotive and Free Your Mind groups. Similarly, there does not appear to be an implicit or explicit rationale for the methods listed in the Comprehensive Treatment Plan forms. While the objective was clear and concise, the entries under "method", such as "Group 5x Week" or "3 page essay", did not indicate why this method was appropriate. The goals, objectives,

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[2] Some inmates and others have stated that 'dependance' is not the correct phrase since the program staff have abdicated many of their roles in the community.

and methods are more accurately described as activities. The problem may be either the program staff are over familiar with the forms and are writing in a shorthand which they and other insiders understood, or the physical space limitations of the form. Either way, the program would benefit from additional information.

Finally, it was not clear from the files whether the inmate, the program staff, or a third person completed the Group File Summaries. The evaluators noticed mixtures of handwriting and ink colors on most forms. This was followed by switching between the first and third persons. Examples of this phenomena include "Presently I listened to all that was said" and "Remaining respectful toward authority. Properly being able to address other's behavior (Pull Ups"). Although the file entry is signed off by the program staff, it was not clear who had access to the files or who was providing the file entries. This begs the question of file confidentiality which was raised throughout the group interviews.

f. Summary

As noted earlier, the therapeutic community is a valid and reliable approach to the treatment of both substance abuse and behavioral problems. This method has proven itself to be effective in both free-world and correctional environments. Site visits and discussions with program providers, supervisors and managers provided a view of a program whose staff possess a willingness to learn from others and to change wherever necessary.

Therapeutic community inmates were divided into the following three groups for the purposes of this evaluation: (1) current participants, (2) current inmate hierarchy members, and (3) former clients. The current inmates participating in the program had issues with the selection process (volunteering versus mandating), the time spent waiting for a bed space when it is perceived that 10-20 beds are generally available, the inmate hierarchy, and the sanctions imposed for non-compliance with the program's rules. The inmate hierarchy presented an interesting cross section of long-serving inmates with a myriad background of offences and substance abuse histories. Although essential to the overall program, this particular hierarchy needs to remain focused on the overall goal of the program or it should be removed and its members returned to the general pool of participants (this could be a routine occurrence). We need to remember the words of one member of the current hierarchy who commented "I'm in it for personal reasons as well as to help." Former TC participants, both completers and non-completers, expressed a large amount of anger and frustration concerning how the program operated, perceptions of the abdication of staff responsibility, the hierarchy as a power elite, a belief that the program has forgotten to build up the person after they have been torn down, increased staff members, and the potential for a TC program in a community-based environment offer validation of similar perceptions held by other groups.

Selected staff members offered their perspectives on the program, the inmate clients and hierarchy, and the direction for the future. They identified with the philosophy and processes of the program while noting a number of discontinuities, however, between the idealized program goals, objectives, and activities and the reality of the TC program.

5. Summary and Conclusions

1. Summary

It was found that the TC program operates from a solid theoretical and practical understanding of the unique qualities which a therapeutic community should bring to substance abuse treatment and recovery. The underlying philosophy is that substance abuse and criminal behavior are the result of lifestyle choices, the treatment program is a short-term intervention which provides the inmate with tools to employ, and that addiction is a lifetime condition in which recovery is a developmental and experiential learning activity. The TC program is structured to promote prosocial values and decision making (honesty to self and others, responsibility to self and others, etc.). Both clients and program staff accept that there are common personalty and behavioral traits which lead to substance abuse and/or criminality and that abstinence is a prerequisite to the ongoing process of recovery.

The operation and administration of the therapeutic community are fully supported by ADC as an agency. This support is evident in clear and specific administrative orders and regulations, program policies, adequate public funding, and ongoing staff training which have led to external accreditation by the Arkansas Bureau of Alcohol and Drug Abuse Programs. The length of the current program, a minimum of nine months, is adequate for the information and treatment provided. There is a difference of opinion concerning the optimal length of the program as inmate participants have suggested 4.5 months, hierarchy members mentioned 12 months, and program staff suggested12-18 months. The literature suggests that longer program duration equates to a longer mean time before recidivism occurs.

The following discussion summarizes the quantitative and qualitative findings of the evaluators. Efforts have been made to reduce duplication in the presentation of inmate and staff concerns wherever possible.

a. Therapeutic Community Environment

The program environment contains Barracks 7 and 8. These barracks are self-contained and separated by a common corridor which runs the length of the Tucker Unit's main building; they are located at one end of the corridor. Like other barracks, TC participants take full charge for the maintenance and cleanliness of the program environment and, between the two barracks, have been awarded the monthly "Best Barracks Award" more than any other barracks at the Tucker Unit. The Tucker Unit is accredited by the American Correctional Association (ACA).

Program information, including sanctions, are posted on large whiteboards for all to read. A large whiteboard listing the TC hierarchy and membership is maintained within the program office in each barrack. Inmates may mix freely with the general prison population during work assignments and outdoor recreation periods.

b. Organization of the Therapeutic Community Program

Eligibility and scheduling for the TC program is a concern. Both the program participants and the program staff expressed some concern that the Post-Prison Transfer Board practice of mandating inmates to complete this program as a requirement for parole eligibility is coercive treatment and changes the culture of the program. The TC program does not admit inmates serving time for sexual offences. In addition to the TC as a work assignment, every inmate also has another work assignment in the unit. Each inmate is assessed using the instrument devised for this evaluation, receives a written treatment plan which is updated monthly on the basis of weekly assessments and the needs of the phases of the program. Inmate program files are maintained separate from their ADC or comprehensive file. Concern was expressed over the confidentiality of inmate records with numerous inmates alleging that the community hierarchy has access to them.

The phases of the program are well known to each inmate in the program. The philosophy, practices, and policies of the modified therapeutic community are contained within the 59 page CSATP Client Handbook. The handbook is issued to all inmates as part of their orientation phase (Phase I) and contains descriptions of each phase and the conditions for successfully completing them. The rules for conduct are also explained in this handbook.

Groups are the primary method of addressing the socialization, treatment, and psychological needs of the program participants. Staff members interact with inmates on a daily basis within group sessions and at least bi-weekly for individual counseling. This has not always been the case according to a large number of inmates, some of whom claim that they had not seen their counselor in over three months; this practice has been corrected. The TC program stresses experiential learning, decision making skills, and anger management skills. Meditation is also a form of meaningful ritual within the program. The final phase of the program combines relapse therapy with minimal pre-release training.

The process of change within the TC involves inmates confronting each other's behavior and attitudes. While this is an essential component of a therapeutic community, there are negative aspects to this process such as those mentioned in Chapter 5, including: telling only what the inmate believes that others want to hear, placing limits on disclosure, breaking of confidentiality, accusations of snitching outside the program, and so forth. Indeed, the program has been called a "school for snitching" by former inmates! A large number of inmates revealed that they perceive the program staff and inmate hierarchy as moving them through the stages of compliance and conformity within the

program, but failing to provide opportunities for either commitment or integration; positive feedback and reinforcement appears to missing according to many inmates ("they tear us down, but forget to build us back up again").

Changing reasons for removal from the program or inconsistent application of those same reasons were a constant complaint heard during the evaluation; this area requires clarification and communication to the TC members. Wherever practical, it appears that the program staff prefer to handle TC rule violations and minor ADC offences through the sanctions court or by individual staff members.

The TC program is exploring options for community-based and institutional aftercare. This includes Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) meetings as well as the relapse prevention and pre-release training currently offered.

c. Program Participant Demographics

Demographic variables showed a research population very similar to the "Typical TC inmate". The research population was 38% African American, 61.5% White and .5% Asian. Of the population in the initial group, the levels of education varied. About 49.7% had less than a high school degree, 40.1% had a high school degree and 9.9% had attended some college. The marital status of those participating in the program included 48.7% single, 46% married, and 5.4% divorced, widowed or separated. In terms of criminal history, the majority of the participants had received their first arrest prior to their 18th birthday (62.9%). The majority of participants had previously been placed on probation and had that probation revoked (51.3%). The majority of inmates, (52.7%) had four or more felony arrests. In addition, 79.7% had been revoked from parole one or more times. When participants were asked about drug and alcohol arrest, 60.4% had been arrested one or more times for alcohol and 67.9% had one or more drug arrests.

Two instruments were used to identify treatment motivation, truthfulness and additional dynamic characteristics not often considered in evaluation research. These two instruments were the revised SRF Initial Intake Instrument and the Prison Inmate Inventory (PII). Analysis was conducted on the scoring of scale items for those who were removed from the program. Chi-square was used to determine statistically significant differences between reason for dropout and risk levels as identified by the PII and SRF scales. A 5% level of probability was used as a minimum for acceptable differences of significance. There were several relationships identified. The first three significant relationships were from the SRF Intake Instrument. These were hostility (χ^2= 10.153, 4*df*, p = .05), self efficacy (χ^2= 15.882, 4*df*, p = .05), and problem recognition (χ^2= 18.339, 6*df*, p = .05). The final significant relationship was drug problems (χ^2= 15.410, 8*df*, p = .05) as measured by the PII.

The population was further divided into those who succeeded and those who failed and by the reason for that failure. A total of 50 (26.7%) were identified as dropouts or noncompleters. Of that, 26% were dropped for a violation of the ADC rules, 30% for a violation of the TC rules and 44% simply refused treatment. It should be noted that in our sample, only 3.7% were volunteers, the remaining 96.3% were mandated to the program by the prison parole board as a condition of parole.

Tests were performed to determine the strength of the relationships. Only two of the four relationships showed significant strengths. These included hostility and self efficacy. In the relationship between risk level on the hostility scale and reason for dropping from the TC program, those who were removed for disciplinaries were much more likely than others to score maximum risk on the hostility scale. Many of the factors relating to the hostility scale are dynamic in nature. These individuals should be identified early in the program so that specific care can be taken in addressing these factors to increase retention.

The second relationship that showed a significant strength of association was self efficacy. Those individuals who felt they had little control over their environment or were less than willing to take responsibilities for the problems in their life were also more likely to be dropped from the TC program as a result of disciplinaries. Again, these individuals should be identified early in the program so that special efforts can be made to address the issues of responsibility to increase retention. Many of the factors within the self efficacy scale are addressed in the TC curriculum, however, they are often taught or handled in the last six months of the nine month program. The majority of the individuals in this category were removed within the first three months.

Regarding retaining inmates in the TC program, the instrument currently being used at initial intake to the ADC, the PII, is adequate at identifying drug and alcohol problems. The Revised TCU SRF Intake Instrument is recommended to determine treatment readiness and problem recognition for inmates being considered for the TC program. High scores can be used to identify those inmates likely to be discharged from the program.

d. Program Staff and Staffing Concerns

A number of interviews were completed with selected members of the program staff, the ADC Program Manager, and correctional staff. The program staff identified not only the philosophy and processes of the program, but also their own beliefs as being consistent with the TC perspective commonly found in free-world and correctional therapeutic communities. They noted that, while there is a common addictive personality type and substance abusers have common behavioral problems, the medical model of addiction as a disease is also present in the program. Although treatment is regarded as a short-term process in the highly structured TC environment, recovery is viewed as a lifelong process both in and out of the correctional environment. Staff members highlighted the problem with mandated clients rather than volunteer clients.

Staffing is consistent with the philosophy of a therapeutic community and includes recovering addicts and at least one individual who has completed a therapeutic community program as part of his or her own recovery. The relationship between the program staff and the program supervisor has been described as excellent even though the latter's time is split between the therapeutic communities at the Tucker and Benton units. The program staff are well trained and certified in addictions treatment by the Arkansas Bureau of Alcohol and Drug Abuse Programs. Recently, training has involved a minimum of two days per month in workshops away from the unit.

The program staff appeared to be exceptional in their conduct of group sessions. They handled problems stemming from individual issues, group dynamics, and substance abuse concerns with casual efficiency. There was only one instance witnessed by the evaluators where the facilitation of the group appeared less than excellent. An "issues group" had dealt effectively with the interpersonal conflict between two inmates, yet, this same group was allowed to proceed. During this time, other inmates continued to point out areas of contention between the two original inmates and the previous conflict began to re-emerge. It should be noted that this is not uncommon as inmates in such groups will often continue pointing out the defects in the original participants in order to keep the discussion from focusing on themselves.

The evaluators were repeatedly impressed by the large amount and high quality of the information which the program staff shared with the inmates during the classroom sessions. According to one of the evaluators (who has training in substance abuse counseling), the information provided to the inmates in the Therapeutic Community at Tucker exceeds that provided in non-custodial programs in some areas. The duration of the classroom sessions were appropriate for the amount and intensity of the content being delivered. Anecdotal information revealed that this has not always been the case and that the current program is the result of the staff members pulling together to make the TC a model program.

The working relationships among members of the program staff appear to be very good. This is evidenced in the willingness to share ideas and work together towards common solutions to client problems and issues that affect the TC community as a whole. While professional disagreements may exist concerning treatment approaches, there were no reported instances of anger or hostility on the part of one staff member towards a colleague. It was noted that the program staff generally appeared to be as professional when counseling individual inmates as they were in facilitating group discussions. When problems or issues did arise among the inmates, the program staff would take the specific inmates aside for individual counseling which always occurred in private (although not necessarily out of the hearing of other inmates as particular staff members were identified as speaking very loudly and/or yelling which negated any confidentiality).

Site visits and discussions with program providers, supervisors and managers provided a view of a program whose staff, for the most part, had a "can-do" attitude and a genuine desire to help those inmates who genuinely want their assistance. One of the strengths which was also present among the program staff was a willingness to learn from others and to change whenever necessary.

When asked if there was adequate structure, resources, and framework to define and support the therapeutic community, staff members were unanimous in claiming that ADC supported the TC program better than other programs, but that it still has some work to do in that area. When asked about the written policies and procedures under which the TC program operates and the roles of both clients and staff within it, staff members were quite open about the program. They identified the cardinal rules under which the program operates and stated that they were listed in the Client Handbook. They noted that violence, sexual acting outing/behavior, and refusal or failure to respond to treatment were the only reasons why a person would be expelled from the program. Unfortunately, the cardinal rules as listed on page 26 of the Client Handbook contain only one offense that will receive a mandatory discharge from the program (fighting) while all other rule violations are discretionary on the part of the program staff. This exercise of discretion has led to perceptions of favoritism among current and previous program participants.

At least two of the program staff have previous experience as a correctional officer or correctional supervisor. While the staffing numbers are adequate for this program, it appears that the staffing patterns should be changed to provide rotating shift coverage during both days and evenings when program activities are also available; this would be consistent with a goal of maximizing an inmate's time in the CSATP program.

Correctional officers were also interviewed about the program and its effects on their working environment. Security personnel (i.e., correctional officers) are neither cross-trained nor involved in the TC program. Most commented that the control which the peer counselors wield contributes to the smooth operation of the program and a lack of trouble with this barrack. The correctional staff regarded the program as needing few changes to improve the quality of the services provided to inmates. The first change would be to increase the number of classes taught by the program staff as an effort to increase their presence in the program. Second, it was noted that correctional officers should play an expanded role in the TC program.

e. Inmate Perceptions of the Program

There were several group interviews held to gather client perceptions of the TC program. The first set of interviews was with the inmate hierarchy. A general theme emerged from these interviews, namely: "this program saved my life, I'm in it for personal reasons as well as to help." Throughout the interview, the peer staff repeated all of the comments one expects to hear from a sponsor in an Alcoholic Anonymous (A.A.) or

Narcotics Anonymous (N.A.) meeting or from a person about to graduate from a residential treatment program. The stock phrases (such as "This is one of the greatest things to happen to me", "it has probably saved my life", and "If I had got out before this program, I would have been back. This program is in me. You get it within yourself. When I get out, I will do the things I have done in this program") were spoken with the fervor of a recent convert. Interestingly, the group tended to take it's lead from two speakers who, as the other interviews would reveal, exercised both power and leadership in the program.

Despite the "party line" being provided to the evaluators, this group revealed a number of areas of improvement for the program. The participants revealed that they perceived the orientation barracks process superior to the continuous, direct intake process employed today. "The old way," they said, "two guys met you at the door and you got caught up to speed real quick. "Today, the setup is cyclical, it causes people to be at different stages throughout the program." They also commented on the differences between the program participant who 'volunteered' and the one who was 'mandated' into the program by the Post-Prison Transfer Board (the paroling authority in Arkansas) and the effects that the latter group has had on the overall TC program.

The structure of the program was also discussed by the hierarchy members. Many felt that the ADC policy of every inmate having a work assignment was interfering with the TC program. Not only was the internal structure of the program discussed, but so, too, were external influences on the effective functioning of the program. One external influence was the correctional staff assigned to the barracks. The choice of staff and their orientation towards the TC program were viewed with concern. This was also identified in the participant survey. This is significant, in that this was the one area that was consistently repeated in both the interviews and the participant survey.

The second set of interviews involved any available TC participant who was not a member of the inmate hierarchy. These interviews revealed that most inmates perceived the program as a "good program", but one with a few structural problems. One specific issue identified was the delay or waiting period prior to admittance it. This appears to be both a real and perceived concern since, on two occasions, the evaluators counted 12 and 20 empty beds in one barracks alone. The issue of bed spaces versus waiting for an assignment to the TC is best comprehended, however, by taking the approach that: (1) the TC at the Tucker Unit is an ADC-wide resource, (2) requests from both volunteer and board-mandated requests are difficult to coordinate and balance, and (3) that board mandated inmates are a priority placement over volunteers..

The difference between inmates who volunteered and those who were mandated into the program remains an issue of contention. Many participants commented that they felt coerced into taking the program. Mandated inmates expressed both frustration and anger at what they perceived to be unfair practices by the Post-Prison Transfer Board.

Another area of contention was the messengers or the sanctions court. Regarding the inmate hierarchy, several current clients repeated the frustrations expressed by the former program participants. There was also a large amount of hostility towards the sanctions imposed by both the program staff and the inmates in sanctions court.

Former clients were the final group of inmates to be interviewed. They expressed an extremely high level of frustration and anger among the former TC participants. Indeed, these emotions were present in the verbalized comments, body language, and on going departures of the interview participants. The members of the inmate hierarchy were the primary targets of this hostility followed by sanction court, the program staff, and the mixing of volunteers and mandated inmates, respectively. However, the real or perceived behavior of the program staff and inmate hierarchy has reduced the impact of the program. The group participants did have suggestions for improving the program. One of the most common suggestions concerned the separation of volunteers and mandated inmates into two separate TC programs.

f. Managing Inmate Behavior

Concerns over the composition of the "community hierarchy" arose throughout the group interviews, indeed, it was not uncommon to hear the names of specific lifers and sex offenders on the hierarchy mentioned along with comments about them being inappropriate to teach prosocial behaviors for successful living in the free world. It was also felt that the hierarchy exercised too much power in the community and that it was wielded for personal, rather community, reasons. The routing of all requests to see a counselor through the hierarchy, sometimes four or five members, was most often reported as a cause of disaffection. The "community hierarchy" of peer counselors, peer mentors, and peer elders, presented opposite viewpoints and identified strongly with this program.

Although the community is the primary change agent, the hierarchy appears to be relied upon too heavily by the program staff to confront negative behavior, provide positive role models, promote the self-disclosure of personal issues, and impose sanctions for non-compliance. Many inmates reported that this was a reason why they were often less than honest in group sessions and often told other community members and the program staff what they believed the others wanted to here. According to a large number of inmates interviewed during this evaluation, sanctions court has been described as an ineffective treatment activity and as a contravention of the ruling in *Estelle v. Ruiz*. The line between role model and another inmate wielding power has become indistinguishable in this instance. Here, it is important to note that how a situation is perceived is often more real to inmates than the reality of that same situation.

In relation to the management of inmates, an inmate whose behavior was judged to be inappropriate might receive either a "verbal pull-up" (verbal warning) from another inmate or a "written pull-up" (written notification) to appear before an inmate-run "Sanctions

Court." Sanctions court usually occurred during the evening hours after the program staff have departed or during weekends. Generally, the sanctions range from a verbal reprimand to a behavior contract, a written essay of 3-15 pages, instructions not to talk for a number of days, to the wearing of a sign and/or a "dunce" hat (discontinued), and so forth.

The program staff at the Therapeutic Community (Tucker Unit) incorporated several aspects of a "free-world" therapeutic community which have questionable value within a correctional environment. Such practices need to be either modified for correctional use or discontinued entirely. One questionable aspect is "tight house." A tight house period in a residential treatment facility employing a therapeutic community model is a short-term intervention. It is designed to:

1. Remove a client hierarchy which has become corrupt (in the treatment sense);
2. Provide clients with time to reflect based upon restricted movement and/or interactions; and,
3. Provide the program staff with time to restructure or replace the client hierarchy.

Observation reports and data from the group interviews indicate that the tight house practice involved the inmates sitting silently on a chair that faced the wall for up to two weeks, during which time no treatment activities took place! This practice was reported to the program manager who ordered it discontinued immediately. The same activity was also an individual-level sanction for inappropriate behavior and has been discontinued.

Another sanction involved a questionable practice, namely the wearing of "dunce" hats and signs by inmates. According to one program staff member, "We do have signs. The one on the front is the behavior and on the back is a positive statement", yet, a member of the correctional staff contradicted this statement noting that he or she had recently seen a sign with "My name is Kenneth. I am an only child. I am spoiled" written on it. Upon hearing of these practices, the program manager also ordered "dunce hat" practice discontinued and the modification of the signs to contain only behavioral reminders and to be worn only within the TC barracks.

Additional comments indicated that the process of confronting negative behaviors and reporting them to staff has been problematic for inmates in their work assignments. Many inmates reported that they were often the first persons accused of being informants whenever a problem arose and the TC program was regarded as a "school for snitches." Strict confidentiality between inmates in the TC program and the general population has not been observed and this has caused problems for former TC participants.

g. Client Files and Record Keeping

Client files were reviewed to determine the level of standardization in reporting and the types of reporting that was being done by program leaders and the inmate hierarchy. The first impression was that the files did not contain the same information in every instance. Standardized TC Forms were not present in each file which made the reviewers wonder which forms were completed or not. Also, files were handwritten, often making it difficult to understand what had been documented. The need for computerization was identified as a method to prepare the forms electronically and to create a more comprehensive database for later outcome evaluations.

The client files revealed a number of problematic aspects of the program. These included the use of sanctions which were believed to have been "discontinued", the weekly progress summaries, the significant observations section and the group files summaries. The researcher found the entries to be inconsistent, written by a number of individuals (without any indication of who that individual was, ie. inmate, inmate hierarchy or program staff). Although the file entry was signed off by the program staff, it is not clear who has access to the files or who was providing the file entries. This begs the question of file confidentiality which was raised throughout the group interviews.

2. Conclusions and Recommendations

The Comprehensive Substance Abuse Treatment Program (CSATP) operating as a modified therapeutic community at the Tucker Unit meets most of the general criteria for effective therapeutic communities in both the free world and correctional environments. There are few substantive areas that need to be modified. Participant perceptions account for the majority of concerns.

Inmate participants have difficulty identifying with this TC program and feel a general need for improvement in the program. Time spent in the program did not appear to have an effect in this area. Program staff feel that they are not members of the community, but members at a distance with specific roles. Correctional staff are not perceived as members of the community.

The community meets on a regular basis to discuss problems or issues which affect the community as a whole. Similarly, the program staff also have regular staff meetings to discuss clinical concerns. It is unclear, however, how frequently these meetings are held as each of the interviewed staff members gave a different schedule ranging from weekly to biweekly and once every three weeks. The infrequent nature of the staff meetings may be understood in light of the ongoing, daily sharing of information , according to one staff member. Efforts are undertaken to correct problems as they occur.

In terms of weaknesses, the program is weakest in terms of aftercare and follow-up. This is not to demean the individuals involved in these activities, but merely to note that large amounts of effort and resources are still needed to provide what the staff perceive as adequate levels of service. There appears to be a lack of ADC community-based programs that deal with substance abusers after their release according to staff members.

There are few substantive areas that have been identified as being in need of modification. Inmate participants have difficulty identifying with this TC program and feel a general need for improvement in the program. Time spent in the program did not appear to have an effect in this area. Program staff feel that they are not members of the community, but members at a distance with specific roles. Correctional staff are not perceived as members of the community.

a. Modifying the Influence of the Community Hierarchy

i. Restrict the number of months a program graduate may serve as a member of the community hierarchy to a maximum of 12-24 months;
ii. Rotate hierarchy positions on a regular basis, e.g., 3 or 6 months per position;
iii. Restrict the operation of sanctions court to times when treatment staff members are present;
iv. Require the physical presence of a treatment staff member during all sanction court operations.

b. Change the Participant Selection Process

i. Restrict the number and percentage of mandated participants in the program; See Sections f.i and f.ii for further information;
ii. Utilize both the PII scales and SRF scales to identify weak areas for all inmates;
iii. Utilize both the PII scales and SRF scales to structure treatment needs;
iv. Restructure work assignments and schedule to be within the TC unit rather than outside the community.

c. Increase the Level of Computer Technology

i. Client case must be prepared electronically (via computer) and saved in a program specific database with possible uploading to the comprehensive ADC inmate database;
ii. Access to program client files must to be restricted to treatment and/or administrative staff members; computerization would facilitate this policy change.
iii. Minimum needs for computerization of the current program requires 2 PC-style computers per unit with one additional 2 PC-style computer for the program supervisor (5 computers total);

d. Increase Staffing Levels and Revise Staffing Patterns

i. Current staffing levels should be increased by two to three positions; one of these positions should be an administrative support position;

ii. Staffing patterns must be revised to include two, eight-hour rotating shifts to ensure that program staff members supervise both day and evening program activities (if the program activity is important enough to occur during the evening, it is important enough to be supervised by a member of the treatment staff);

iii. The involvement of correctional staff members should to be involved in the program and options to accomplish this should be explored explored.

e. Increase Consistency in the Application of Rules

i. Reasons for removal from the program must be consistent with those listed in the Client Handbook;

ii. Reasonable due process must be afforded to clients being considered for removal from the program;

iii. Removal from the program must be reviewed by the program supervisor and the SATP co-ordinator prior to removal;

iv. Rules must apply equally to both clients and hierarchy members (logic would dictate that hierarchy members should be held to a higher standard than clients).

f. Change Volunteer-Mandate Ratio

i. Methods to address the imbalance in the ratio of mandated and voluntary participants in the program must be explored;

ii. Initial intake instruments must be used to determine suitability for the program and those mandated inmates deemed not suitable for the program must be referred back to the Post-Prison Transfer Board for other consideration;

iii. Dual treatment programs, one for mandated and volunteer participants, respectively, should be explored.

g. Aftercare Provisions for Clients

i. Additional resources must be allocated to the relapse prevention/pre-release component of the current program;

ii. Adequate institutional after-care must be allocated developed;

iii. Institution-community liaison must be increased to ensure adequate communication of information between the CSATP program and the Department of Community Corrections and other agencies;

iv. Community after-care programs must be increased to provide transition and support for program graduates and to ensure that the goals in Phases IV and V of the CSATP are met.

h. Continue Monitoring of CSATP

i. The current process evaluation of the CSATP should continue over the next 2-3 years to assist in identifying areas for change and offering independent alternatives; Additional funding may be required to support this activity;

ii. An outcome evaluation must be conducted during the sixth year of the program to permit a cohort study of the effectiveness of the program;

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Tables

Table 1
All TC Participants (Benton/Tucker Units)

Sociodemographic Variables	Frequency	Percent	Cumulative Percent
Age			
1 to 25	77	14.3	14.3
26 to 32	144	26.8	41.1
33 to 75	317	58.9	100.0
Race			
White	306	56.9	56.9
Black	230	42.8	99.6
Hispanic	1	0.2	99.8
Asian	1	0.2	100.0
Marital Status	258	48.0	48.0
Single	246	45.7	93.7
Married	22	4.1	97.8
Divorced/Separated/Widowed	12	2.3	99.3
Education			
1 to 11	248	46.1	46.1
12 - High School Graduation	233	43.3	89.4
Some college	55	10.2	99.6
	2	0.4	100.0
Criminal History Variables			
Present Charge			
Property Offense	190	35.3	35.3
Drug Offense	219	40.7	76.0
DWI/DUI	12	2.2	78.3
Sex Offense	1	0.2	78.4
Violent Offense	115	21.4	99.8
Escape	1	0.2	100.0
Age at First Arrest			
Under 18	308	57.2	57.2
18 or older	230	42.8	100.0
Life-time felony arrests			
Zero prior felony arrests	1	0.2	0.2
1 to 4 arrests	381	70.8	70.9
5 or more felony arrests	156	29.0	100.0
Probation Revocations			
Zero	285	53.0	53.0
One revocation	195	36.2	89.2
Two or more	58	10.8	100.0

Table 1 (cont'd)
All TC Participants (Benton/Tucker Units)

	Frequency	Percent	Cumulative Percent
Parole Revocations			
Zero	206	38.3	38.3
One revocation	155	28.8	67.1
Two or more	177	32.9	100.0
Number of Years in Prison			
Zero years in prison	11	2.0	2.0
1 to 4 years	267	49.6	51.7
5 to 9 years	179	33.3	84.9
10 or more	81	15.1	100.0
Alcohol Arrests			
Zero arrests	246	45.7	45.7
1 to 4 arrests	182	33.8	79.6
5 to 9 arrests	47	8.7	88.3
10 or more arrests	63	11.7	100.0
Drug Arrests			
Zero arrests	163	30.3	30.3
1 to 4 arrests	331	61.5	91.8
5 to 9 arrests	34	6.3	98.1
10 or more arrests	10	1.9	100.0
DUI Arrests			
Zero arrests	286	53.2	53.2
1 to 4 arrests	202	37.5	90.7
5 to 9 arrests	30	5.6	96.3
10 or more arrests	20	3.7	100.0

Table 2
Characteristics of the Research Population

		Frequency	Percent	Cumulative %
Age	1 to 25	20	10.7	10.7
	26 to 32	58	31.0	41.7
	33 to 65	109	58.3	100.0
Race	White	115	61.5	61.5
	Black	71	38.0	99.5
	Asian	1	.5	100.0
Marital Status	Single	91	48.7	61.5
	Married	86	46.0	99.5
	Divorced/Separated/Widow	10	5.4	100.0
Parole Revocations				
	No revocations	38	20.3	20.3
	One Revocation	56	29.9	50.3
	More than one	93	49.7	100.0
Probation Revocations				
	No revocations	90	48.1	48.1
	One revocation	77	41.2	89.3
	More than one	20	10.7	100.0
Felony Arrests	1 to 4	121	64.7	64.7
	5 or more	65	34.8	99.5
	Missing	1	0.5	100.0
Years in Prison	Zero years	4	2.1	2.1
	1 to 4years	65	34.8	36.9
	5 to 9 years	74	39.6	76.5
	10 or more	44	23.5	100.0
Age at First Arrest	Under 18	117	62.6	62.6
	18 or older	70	37.4	100.0
Education	11 years or less	93	49.7	49.7
	Highschool grad	75	40.1	89.8
	Some college	19	10.2	100.0
Alcohol Arrests	Zero arrests	74	39.6	39.6
	1 to 4 arrests	64	34.2	73.8
	5 to 9 arrests	17	9.1	82.9
	10 or more arrests	32	17.1	100.0
Drug Arrests	Zero arrests	60	32.1	32.1
	1 to 4 arrests	111	59.4	91.4
	5 to 9 arrests	13	7.0	98.4
	10 or more arrests	3	1.6	100.0
DUI/DWI Arrests	Zero arrests	88	47.1	47.1
	1 to 4 arrests	79	42.2	89.3
	5 to 9 arrests	11	5.9	95.2
	10 or more arrests	9	4.8	100.0

Table 3
Characteristics of those Completing TC and Dropouts

Participant Characteristics	Not dropped		Dropped		Total Participants	
	Number	Percent	Number	Percent	Number	Percent
Type charge						
Property Offence	51	70.8	21	29.2	72	100.0
Drug Offence	50	78.1	14	21.9	64	100.0
DWI/DUI	3	50.0	3	50.0	6	100.0
Violent Offence	33	73.3	12	26.7	45	100.0
Age						
1 to 25	14	70.0	6	30.0	20	100.0
26 to 32	36	62.1	22	37.9	58	100.0
33 or above	87	79.8	22	20.2	109	100.0
Race						
White	87	75.7	28	24.3	115	100.0
African-American	49	69.0	22	31.0	71	100.0
Asian	1	100.0	0	0.0	1	100.0
Marital Status						
Single	66	72.5	25	27.5	91	100.0
Married	61	70.9	25	29.1	86	100.0
Divorced/Separated/Widowed	10	100.0	0	0.0	10	100.0
Years in Prison						
Zero years	4	100.0	0	0.0	4	100.0
1 to 4 years	47	72.3	18	27.7	65	100.0
5 to 9 years	54	73.0	20	27.0	74	100.0
10 or more	32	72.7	12	27.3	44	100.0
Age at first arrest						
Under 18	81	69.2	36	30.8	117	100.0
18 or over	56	80.0	14	20.0	70	100.0
Felony arrests						
1 to 4 felony arrests	87	71.9	34	28.1	121	100.0
5 or more felony arrests	50	76.9	15	23.1	65	100.0
Probation Revocations						
No revocations	68	75.6	22	24.4	90	100.0
One revocation	55	71.4	22	28.6	77	100.0
more than one revocation	14	70.0	6	30.0	20	100.0
Parole Revocations						
no revocations	30	78.9	8	21.1	38	100.0
one revocation	38	67.9	18	32.1	56	100.0
more than one revocation	60	74.2	24	25.8	93	100.0
Alcohol Arrests						
Zero arrests	49	66.2	25	33.8	74	100.0
1 to 4 arrests	51	79.7	13	20.3	64	100.0
5 to 9 arrests	12	70.6	5	29.4	17	100.0
10 or more	25	78.1	7	21.9	32	100.0

Table 3 (cont'd)
Characteristics of those Completing TC and Dropouts

Participant Characteristics	Not Dropped		Dropped		Total Participants	
	Number	Percent	Number	Percent	Number	Percent
Drug Arrests						
Zero arrests	41	68.3	19	31.7	60	100.0
1 to 4 arrests	86	77.5	25	22.5	111	100.0
5 to 9 arrests	8	61.7	5	38.5	13	100.0
10 or more	2	66.7	1	33.3	3	100.0
DUI Arrests						
Zero arrests	59	67.0	29	33.0	88	100.0
1 to 4 arrests	62	78.5	17	21.5	79	100.0
5 to 9 arrests	8	72.7	3	27.3	11	100.0
10 or more	8	88.9	1	11.1	9	100.0
Education						
11 years or less	70	75.3	23	24.7	93	100.0
highschool grad	50	66.7	25	33.3	75	100.0
some college	17	89.5	2	10.5	19	100.0

Table 4
Prison Inmate Inventory (PII) Scores by Completed and Dropout Status

PII Scale Items	Completed		Dropped		Total (% of total population)	
	Number	Percent	Number	Percent	Number	Percent
Adjustment						
Invalid	26	74.3	9	25.7	35	18.7
Low Risk	26	81.8	8	18.2	44	23.5
Medium Risk	33	68.8	15	31.3	48	25.7
Problem Risk	31	73.8	11	26.2	42	22.5
Maximum Risk	11	61.1	7	38.9	18	9.6
Alcohol Problems						
Invalid	26	74.3	9	25.7	35	18.7
Low Risk	27	62.8	16	37.2	43	23.0
Medium Risk	23	67.6	11	32.4	34	18.2
Problem Risk	36	80.0	9	20.0	45	24.1
Maximum Risk	25	83.3	5	16.7	30	16.0
Drug Problems						
Invalid	26	74.3	9	25.7	35	18.7
Low Risk	10	62.5	6	37.5	16	8.6
Medium Risk	15	71.4	6	28.6	21	11.2
Problem Risk	72	73.5	26	26.5	98	52.4
Maximum Risk	14	82.4	3	17.6	17	9.1
Antisocial Problems						
Invalid	26	74.3	9	25.7	35	18.7
Low Risk	28	80.0	7	20.0	35	18.7
Medium Risk	34	66.7	17	33.3	51	27.3
Problem Risk	36	72.2	10	27.8	36	19.0
Maximum Risk	23	76.7	7	23.3	30	16.0
Violence Problems						
Invalid	26	74.3	9	25.7	35	18.7
Low Risk	47	73.4	17	26.6	64	34.2
Medium Risk	27	84.4	11	15.6	32	17.1
Problem Risk	18	66.7	9	33.3	27	14.4
Maximum Risk	19	65.5	10	34.5	29	15.5
Distress Problems						
Invalid	26	74.3	9	25.7	35	18.7
Low Risk	25	73.5	9	25.6	34	18.2
Medium Risk	32	74.4	11	25.6	43	23.0
Problem Risk	25	80.6	6	19.4	31	16.6
Maximum Risk	29	65.9	15	34.1	44	23.5
Judgement Problems						
Invalid	26	74.3	9	25.7	35	18.7
Low Risk	24	82.2	5	17.2	29	15.5
Medium Risk	18	75.0	6	25.0	24	12.8
Problem Risk	26	60.5	17	29.5	43	23.0
Maximum Risk	43	76.8	13	23.2	56	29.9

Table 4 (cont'd)
Prison Inmate Inventory (PII) Scores by Completed and Dropout Status

PII Scale Items	Completed		Dropped		Total (% of total population)	
	Number	Percent	Number	Percent	Number	Percent
Self-Esteem Problems						
Invalid	26	74.3	9	25.7	35	18.7
Low Risk	45	77.6	13	22.4	58	31.0
Medium Risk	27	75.0	9	25.0	36	19.3
Problem Risk	32	71.1	13	28.9	45	24.1
Maximum Risk	7	52.8	6	46.2	13	7.0
Stress Problems						
Invalid	26	74.3	9	25.7	35	18.7
Low Risk	31	77.5	9	22.5	40	21.4
Medium Risk	33	3.3	12	26.7	45	24.1
Problem Risk	25	67.6	12	32.4	37	19.8
Maximum Risk	22	73.3	8	26.7	30	16.0

Table 5
Self Report Form (SRF) Scale Scores by Completed and Dropout Status

SRF Scale Items	Completed		Dropped		Total (% of total population)	
	Number	Percent	Number	Percent	Number	Percent
Problem Recognition						
Low Risk	19	70.4	8	29.6	27	15.2
Medium Risk	64	80.0	16	20.0	80	44.9
Problem Risk	31	72.1	12	27.9	43	24.2
Maximum Risk	15	53.6	13	46.4	28	15.7
Desire for Help						
Low Risk	5	71.5	2	28.6	7	3.9
Medium Risk	79	74.5	27	25.5	106	58.6
Problem Risk	42	72.4	16	27.6	58	32.0
Maximum Risk	6	60.0	4	40.0	10	5.5
Treatment Readiness						
Low Risk	0	0.0	0	0.0	0	0.0
Medium Risk	62	76.5	19	23.5	81	44.0
Problem Risk	71	52.6	29	29.0	100	54.3
Maximum Risk	2	66.7	1	33.3	3	1.6
External Pressuress						
Low Risk	2	40.0	3	60.0	5	2.8
Medium Risk	54	72.0	21	28.0	75	41.4
Problem Risk	63	74.1	22	25.9	85	47.0
Maximum Risk	12	75.0	4	25.0	16	8.8
Self Esteem						
Low Risk	1	100.0	0	0.0	1	0.5
Medium Risk	21	67.7	10	32.3	31	16.9
Problem Risk	100	72.5	38	27.5	138	75.4
Maximum Risk	11	84.6	2	15.4	13	7.1
Depression						
Low Risk	1	100.0	0	0.0	1	0.5
Medium Risk	25	71.4	10	28.6	35	19.2
Problem Risk	51	75.0	17	25.0	68	37.4
Maximum Risk	57	73.1	21	26.9	78	42.9
Anxiety						
Low Risk	0	0.0	0	0.0	0	0.0
Medium Risk	25	75.8	8	24.2	33	17.8
Problem Risk	64	73.0	2	27.0	89	48.1
Maximum Risk	45	71.4	18	28.6	63	34.1
Decision Making						
Low Risk	0	0.0	0	0.0	0	0.0
Medium Risk	54	69.2	24	30.8	78	42.6
Problem Risk	80	76.2	25	23.8	105	57.4
Maximum Risk	0	0.0	0	0.0	0	0.0

Table 5 (cont'd)
Self Report Form (SRF) Scale Scores by Completed and Dropout Status

SRF Scale Items	Completed		Dropped		Total (% of total population)	
	Number	Percent	Number	Percent	Number	Percent
Self Efficacy						
Low Risk	1	100.0	0	0.0	1	0.5
Medium Risk	24	64.9	13	35.1	37	20.1
Problem Risk	104	76.5	32	23.5	136	73.9
Maximum Risk	5	50.0	5	50.0	10	5.4
Childhood Porblems						
Low Risk	5	100.0	0	0.0	5	2.7
Medium Risk	60	68.2	28	31.8	88	48.1
Problem Risk	65	76.5	20	23.5	85	46.4
Maximum Risk	4	80.0	1	20.0	5	2.7
Hostility						
Low Risk	0	0.0	0	0.0	0	0.0
Medium Risk	18	78.3	5	21.7	23	12.6
Problem Risk	59	67.8	28	32.2	87	47.5
Maximum Risk	56	76.7	17	23.3	73	3.9
Risk Taking						
Low Risk	0	0.0	0	0.0	0	0.0
Medium Risk	20	64.5	11	35.5	31	17.1
Problem Risk	107	74.5	35	24.6	142	78.5
Maximum Risk	6	75.0	2	25.0	8	4.4
Social Conformity						
Low Risk	2	66.7	1	33.3	3	1.6
Medium Risk	72	69.9	31	30.1	103	55.4
Problem Risk	62	78.5	17	21.5	79	42.5
Maximum Risk	0	0.0	1	100.0	1	0.5

Table 6
Characteristics of the Population by Reason for Discharge

Characteristics		Disciplinary		Refused Treatment		TC Rule Violation	
		Number	Percent	Number	Percent	Number	Percent
Age	1 to 25	2	33.3	2	33.3	2	33.3
	26 to 32	5	22.7	9	40.9	8	36.4
	33 to 65	6	27.3	11	50.0	5	22.7
Race							
	White	7	25.0	12	42.9	9	32.1
	African American	6	27.3	10	45.5	6	27.3
Marital Status							
	Single	5	20.0	14	56.0	6	24.0
	Married	8	32.0	8	32.0	9	36.0
Education							
	11 years or less	5	21.7	13	56.5	5	21.7
	Highschool Grad	7	28.0	9	36.0	9	36.0
	Some College	1	50.0	0	0.0	1	50.0
Age at First Arrest							
	Under 18	9	25.0	17	47.2	10	27.8
	18 or over	4	28.6	5	35.7	5	35.7
Felony Arrests							
	1 to 4 felony arrest	10	29.4	16	47.1	8	23.8
	5 or more felony arrests	3	20.0	5	33.3	7	35.7
Probation Revocations							
	No revocations	8	36.4	11	50.0	3	13.6
	One revocation	4	18.2	10	45.5	8	36.4
	More than one revocation	1	16.7	1	16.7	4	66.7
Parole revocations							
	No revocations	4	50.0	2	25.0	2	25.0
	One revocation	4	22.2	8	44.4	6	33.3
	More than one revocation	5	20.8	12	50.0	7	29.2
Alcohol Arrests							
	0 arrests	10	40.0	6	24.0	9	36.0
	1 to 4 arrests	2	15.4	8	61.5	3	23.1
	5 to 9 arrests	0	0.0	4	80.0	1	20.0
	10 or more arrests	1	14.3	4	57.1	2	28.6

Table 6 (cont'd)
Characteristics of the Population by Reason for Discharge

Characteristics	Disciplinary		Refused Treatment		TC Rule Violation	
	Number	Percent	Number	Percent	Number	Percent
Drug Arrests						
0 arrests	7	36.8	6	42.1	4	21.1
1 to 4 arrests	5	20.0	11	44.0	9	36.0
5 to 9 arrests	1	20.0	3	60.0	1	20.0
10 or more arrests	1	100.0	0	0.0	0	0.0
DUI Arrests						
0 arrests	10	34.5	10	34.5	9	31.0
1 to 4 arrests	2	11.8	9	52.9	6	35.5
5 to 9 arrests	0	0.0	0	0.0	3	100.0
10 or more arrests	1	100.0	0	0.0	0	0.0
Years in Prison						
1 to 4 years	4	22.2	5	27.8	9	50.0
5 to 9 years	6	30.0	8	40.0	6	30.0
10 or more years	3	25.0	9	75.0	0	0.0

Table 7
Prison Inmate Inventory (PII) Scores by Reason for Discharge

PII Scale Items		Disciplinary Infraction		Refused Treatment		TC Rule Violation		Total (% of total population)	
		Num.	Percent	Num.	Percent	Num.	Percent	Num.	Percent
Adjustment	Invalid	3	33.3	5	55.6	1	11.1	9	18.0
	Low Risk	1	12.5	3	37.5	4	50.0	8	16.0
	Medium Risk	5	33.3	5	33.3	5	33.3	15	30.0
	Problem Risk	4	36.4	7	63.6	0	0.0	11	22.0
	Maximum Risk	0	0.0	2	28.6	5	71.4	7	14.0
Alcohol Problems	Invalid	3	33.3	5	55.6	1	11.1	9	18.0
	Low Risk	6	37.5	4	26.0	6	37.5	16	32.0
	Medium Risk	3	27.3	4	36.4	4	36.4	11	22.0
	Problem Risk	1	11.1	5	55.6	3	33.3	9	18.0
	Maximum Risk	0	0.0	4	80.0	1	20.0	5	10.0
Drug Problems	Invalid	3	33.3	5	55.6	1	11.1	9	18.0
	Low Risk	3	50.0	2	33.3	1	16.7	6	12.0
	Medium Risk	0	0.0	2	33.3	4	66.7	6	12.0
	Problem Risk	7	26.9	13	50.0	6	23.1	26	52.0
	Maximum Risk	0	0.0	0	0.0	3	100.0	3	6.0
Antisocial Problems	Invalid	3	33.3	5	55.6	1	11.1	9	18.0
	Low Risk	4	57.1	0	0.0	3	42.9	7	14.0
	Medium Risk	2	11.8	9	52.9	6	35.3	17	34.0
	Problem Risk	2	20.0	5	50.0	3	30.0	10	20.0
	Maximum Risk	2	28.6	3	42.9	2	28.6	7	14.0
Violence Problems	Invalid	3	33.3	5	55.6	1	11.1	9	18.0
	Low Risk	7	41.2	5	2.4	3	29.4	17	34.0
	Medium Risk	1	20.0	3	60.0	4	20.0	5	10.0
	Problem Risk	0	0.0	6	66.7	3	33.3	9	18.0
	Maximum Risk	2	20.0	3	30.0	4	50.0	10	20.0
Distress Problems	Invalid	3	33.3	5	55.6	1	11.1	9	18.0
	Low Risk	4	44.4	2	22.2	3	33.3	9	18.0
	Medium Risk	0	0.0	7	63.6	4	3.4	11	22.0
	Problem Risk	3	50.0	0	0.0	3	50.0	6	12.0
	Maximum Risk	3	20.0	8	53.3	4	26.7	15	30.0
Judgement Problems	Invalid	3	33.3	5	55.6	1	11.1	9	18.0
	Low Risk	1	20.0	1	20.0	3	60.0	5	10.0
	Medium Risk	3	50.0	2	33.3	1	16.7	6	12.0
	Problem Risk	4	23.5	8	47.1	5	29.4	17	34.0
	Maximum Risk	2	15.4	6	46.2	5	38.5	13	26.0
Self-Esteem Problems	Invalid	3	33.3	5	55.6	1	11.1	9	18.0
	Low Risk	3	23.1	4	30.8	6	46.2	13	26.0
	Medium Risk	3	33.3	4	44.4	2	22.2	9	18.0
	Problem Risk	3	23.1	7	53.8	3	23.1	13	26.0
	Maximum Risk	1	16.7	2	33.3	3	50.0	6	12.0
Stress Problems	Invalid	3	33.3	5	55.6	1	11.1	9	18.0
	Low Risk	4	44.4	2	22.2	3	33.3	9	18.0
	Medium Risk	3	25.0	5	41.7	4	33.3	12	24.0
	Problem Risk	2	16.7	5	41.7	5	41.7	12	24.0
	Maximum Risk	1	12.5	5	62.5	2	25.0	8	16.0

Table 8
Self Report Form (SRF) Scores by Reason for Discharge

SRF Scale Items	Disciplinary Infraction		Refused Treatment		TC Rule Violation		Total (% of total population)	
	Num.	Percent	Num.	Percent	Num.	Percent	Num.	Percent
Problem Recognition								
Low Risk	1	12.5	5	62.5	2	25.0	8	16.3
Medium Risk	1	6.3	7	43.8	8	50.0	16	32.7
High Risk	8	66.7	2	16.7	2	16.7	12	24.5
Maximum Risk	2	15.4	8	61.5	3	23.1	13	26.5
Desire for help								
Low Risk	0	0.0	2	100.0	0	0.0	2	4.1
Medium Risk	5	18.5	10	37.0	12	44.4	27	55.1
High Risk	6	37.5	7	43.8	3	18.8	16	32.7
Maximum Risk	1	25.0	3	75.0	0	0.0	4	8.2
Treatment Readiness								
Low Risk	0	0.0	0	0.0	0	0.0	0	0.0
Medium Risk	4	21.1	9	47.4	6	31.6	19	38.8
High Risk	8	27.6	13	44.8	8	27.6	29	59.2
Maximum Risk	0	0.0	0	0.0	1	100.0	4	8.2
External Pressures								
Low Risk	1	33.3	1	33.3	1	33.3	3	6.0
Medium Risk	3	14.3	11	52.4	7	33.3	21	42.0
High Risk	7	31.8	8	36.4	7	31.8	22	44.0
Maximum Risk	2	50.0	2	50.0	0	0.0	4	8.0
Self Esteem								
Low Risk	0	0.0	0	0.0	0	0.0	1	0.5
Medium Risk	1	10.0	6	60.0	3	30.0	31	16.9
High Risk	5	29.4	7	41.2	5	29.4	138	75.4
Maximum Risk	6	28.6	8	38.1	7	33.3	13	7.1
Depression								
Low Risk	0	0.0	0	0.0	0	0.0	0	0.0
Medium Risk	1	10.0	6	60.0	3	30.0	10	20.0
High Risk	10	26.3	7	42.1	12	31.6	38	76.0
Maximum Risk	2	100.0	8	0.0	0	0.0	2	4.0
Anxiety								
Low Risk	0	0.0	0	0.0	0	0.0	0	0.0
Medium Risk	1	12.5	6	75.0	1	12.5	8	16.0
High Risk	5	20.8	8	33.3	11	45.8	24	48.0
Maximum Risk	7	38.9	8	44.4	3	16.7	18	36.0
Decision Making								
Low Risk	0	0.0	0	0.0	0	0.0	0	0.0
Medium Risk	7	29.2	12	50.0	5	20.8	24	49.0
High Risk	6	24.0	9	36.0	10	40.0	25	51.0
Maximum Risk	0	0.0	0	0.0	0	0.0	0	0.0
Self Efficacy								
Low Risk	0	0.0	0	0.0	0	0.0	0	0.0
Medium Risk	0	0.0	10	76.9	3	23.1	13	26.0
High Risk	9	28.1	11	34.4	12	37.5	32	64.0
Maximum Risk	4	80.0	1	20.0	0	0.0	5	10.0

Table 8 (cont'd)
Self Report Form (SRF) Scores by Reason for Discharge

SRF Scale Items	Disciplinary Infraction		Refused Treatment		TC Rule Violation		Total (% of total population)	
	No.	Percent	No.	Percent	No.	Percent	No.	Percent
Childhood Problems								
Low Risk	0	0.0	0	0.0	0	0.0	0	0.0
Medium Risk	5	17.9	10	35.7	13	46.4	28	57.1
High Risk	8	40.0	10	50.0	2	10.0	20	40.8
Maximum Risk	0	0.0	1	100.0	0	0.0	1	2.0
Hostility								
Low Risk	0	0.0	0	0.0	0	0.0	0	0.0
Medium Risk	1	20.0	0	0.0	4	30.0	5	10.0
High Risk	5	17.9	15	53.6	6	28.6	28	56.0
Maximum Risk	7	41.2	7	41.2	3	17.6	17	34.0
Risk Taking								
Low Risk	0	0.0	0	0.0	0	0.0	0	0.0
Medium Risk	3	27.3	5	45.5	3	27.3	11	22.9
High Risk	8	22.9	16	45.7	11	31.4	35	72.9
Maximum Risk	1	50.0	0	0.0	1	50.0	2	4.2
Social Conformity								
Low Risk	0	0.0	1	100.0	0	0.0	1	2.0
Medium Risk	7	22.6	14	45.2	10	32.3	21	62.0
High Risk	6	35.3	6	35.3	5	29.4	17	34.0
Maximum Risk	0	0.0	1	100.0	0	0.0	1	2.0

Appendices

Appendix A - TC unit forms and documents

Appendix B - Staff Job Descriptions

Appendix C - Prison Inmate Inventory

Appendix D - Intake Assessment Instrument

Appendix E - Participant Survey

Appendix F - Scale Development for Intake Instrument

Appendix G - Scale Development for Participant Survey

Appendix H - Daily Schedule

Appendix I - Research Team Members

Appendix J - TC Books and Materials

Appendix K - Phase Schedule

Appendix A - TC Unit Forms and Documents

Phase Completion Form

Client Name: _____ ADC#_____

Admit Date: _____ Primary Counselor _____

Begin Phase 1_____ Completed Phase 1_____

ORIENTATION PHASE
Mandatory Expectations: (To be completed before Phase transition)

- ☐ Recite Serenity Prayer
- ☐ Why Am I Here? Essay
- ☐ Homework Assignments completed to date
- ☐ Rules Test
- ☐ Life Story (8-15 pages)
- ☐ 30 days minimum completed
- ☐ One-to-One Contact Form completed

Has client achieved treatment objective(s) / goal(s) for this phase? ____Yes ____No
If no, explain why not _____

_____ _____
Group Leader Signature Date

Self Development Phase
Begin Phase 2 _____ Completed Phase 2_____

- ☐ Who Am I/What Do I Want? Essay
- ☐ All Homework completed tod date?
- ☐ Faulty Thinking/Values Clarification

Has client achieved treatment objective(s) / goal(s) for this phase? ____Yes ____No
If no, explain why not _____

_____ _____
Group Leader Signature Date

Begin Phase 3 _____ Completed Phase 3_____

Mandatory Requirements:

- ☐ Behaves responsibly
- ☐ Aftercare Plan completed
- ☐ Active group participation
- ☐ Interacts well
- ☐ All homework assignments completed
- ☐ Daily display of following rules without being reminded

Has client achieved treatment objective(s) / goal(s) for this phase? ____Yes ____No
If no, explain why not _____

☐ Client completed treatment successfully ☐ Client's treatment extended (If yes, why?)

_____

_____ _____
Primary Counselor Date

_____ _____
Transition Counselor Date

Comprehensive Treatment Plan

Client Name: _____ ADC# _____

Date Plan Initiated: _____

Client Assets: _____

_____

_____

Client Liabilities: _____

_____

_____

Problem #1: _____

_____

Goal #1: _____

_____

OBJECTIVE	METHOD	TARGET DATE	STAFF

Problem #2: _____

_____

Goal #2: _____

_____

OBJECTIVE	METHOD	TARGET DATE	STAFF

Problem #3: _____

_____

Goal #3: _____

_____

OBJECTIVE	METHOD	TARGET DATE	STAFF

Problem #4: _____

_____

Goal #4: _____

_____

OBJECTIVE	METHOD	TARGET DATE	STAFF

I HAVE WORKED WITH MY ASSIGNED COUNSELOR TO DEVELOP THE ABOVE TREATMENT PLAN. I AGREE TO COMPLETE ALL OBJECTIVES BY THE TARGET DATES.

Client's Signature: _____ Date: _____

Counselor's Signature: _____ Date: _____

C.A.D.C. Signature: _____ Date: _____

ADC / SATP
TREATMENT PLAN REVIEW
(TO BE PERFORMED NO LATER THAN EVERY 30 DAYS)

Client's Name: _____ ADC#: _____

Date of Review: _____

ASSESSMENT OF CLIENT'S RESPONSE TO GOALS / OBJECTIVES :

GOAL #1: _____

_____

_____

HAS THIS GOAL BEEN ACHIEVED? _____ EXTENDED TO: _____

GOAL #2: _____

_____

_____

HAS THIS GOAL BEEN ACHIEVED? _____ EXTENDED TO: _____

GOAL #3: _____

_____

_____

HAS THIS GOAL BEEN ACHIEVED? _____ EXTENDED TO: _____

GOAL #4: _____

_____

_____

HAS THIS GOAL BEEN ACHIEVED? _____ EXTENDED TO: _____

Client's Signature: _____

Date: _____

Counselor's Signature: _____

Date: _____

C.A.D.C. Signature Reviewing: _____

Date: _____

Appendix B - Staff Job Descriptions

SUBSTANCE ABUSE PROGRAM COORDINATOR

CLASS SUMMARY

The Substance Abuse Program Coordinator works under general direction and is responsible for overseeing and providing direction for the substance abuse treatment programs in penal institutions. This position is governed by state and federal laws and agency policy.

EXAMPLES OF WORK

1. Supervises a medium-sized professional staff by interviewing and recommending selection of applicants, training or arranging for training, resolving work problems, and evaluating the performance of incumbents.
2. Monitors and coordinates substance abuse treatment programs involving the selection and training of inmate peer counselors, providing information to program leaders relative to referral resources, educational programs, and making recommendations to resolve specific problems.
3. Conducts periodic meetings with program leaders to discuss and resolve common problems, issues of policy, security, and other subjects, and to cross feed information.
4. Performs periodic case file review with each program leader to assess the adequacy of documentation and to insure that policies and procedures are followed.
5. Reviews program reports received from program leaders for adequacy and compiles information and prepares overall program report for presentation to the Board of Correction.
6. Maintains liaison with, and makes presentations to. community support groups and various provider organizations to promote participation in post-release treatment and follow-up programs.
7. Performs related responsibilities as required or assigned.

WORKING RELATIONSHIPS

The Substance Abuse Program Coordinator has regular contact with other agency personnel, various community referral agencies, law enforcement personnel, members of the inmate population, and the general public.

SPECIAL JOB DIMENSIONS

Constant exposure to the possibility of personal injury or verbal abuse when dealing with the inmate population is required and may occasionally be required to participate in searches for escapees.

KNOWLEDGES, ABILITIES, AND SKILLS.

- Knowledge of supervisory practices and procedures.
- Knowledge of the psycho-social behavior of incarcerated individuals and substance abusers.

- Knowledge of substance abuse counseling methods, techniques, and programs.
- Knowledge of agency security systems and operations.
- Ability to provide guidance to substance abuse counselors.
- Ability to plan, organize, and oversee the work of subordinates.
- Ability to maintain records.
- Ability to prepare and present oral and written information and reports.

MINIMUM QUALIFICATIONS

The formal education equivalent of a bachelor's degree in social work, sociology, psychology, or a related field; plus two years' experience in community services counseling, including one year in a leadership or supervisory capacity.

Other job related education and/or experience may be substituted for-all or part of these basic requirements upon approval of the Qualifications Review Committee.

SUBSTANCE ABUSE PROGRAM LEADER

CLASS SUMMARY

The Substance Abuse Program Leader works under general direction and is responsible for selecting and supervising inmate peer counselors in the substance abuse treatment program. This position is governed by state and federal laws and agency policy.

EXAMPLES OF WORK

1. Interviews, selects, and instructs inmate peer counselors and provides continual supervision and guidance in solving substance abuse related problems of inmates.
2. Interviews applicants; screens files, and approves inmate applications for substance abuse treatment program and assigns client to peer counselor.
3. Orients clients to, program activities and requirements, gathers intake information, develops treatment plans, and schedules program activities.
4. Conducts classes on substance abuse recovery stressing living skills and reinforcing positive mental attitudes.
5. Prepares lesson plans, writes progress notes, maintains case histories and mental health charts, and writes reports.
6. Participates as a member of the classification committee and attends inmate classification meetings.
7. Monitors program effectiveness following up on inmates who have completed the program at various intervals. Writes report of findings and recommends program changes as necessary.
8. May prepare and present talks to various groups on substance abuse programs and may conduct tours of penal facilities.
9. Performs related responsibilities as required or assigned.

WORKING RELATIONSHIPS

The Substance Abuse Program leader has regular contact with other agency personnel, the inmate population, civic groups, and members of the general public.

SPECIAL JOB DIMENSIONS

Constant on-call duty and possible exposure to injury and verbal abuse is required in dealing with the inmate population. Occasionally may be required to participate in searches for escapees.

KNOWLEDGES, ABILITIES, AND SKILLS

- Knowledge of behavior patterns and attitudes of incarcerated individuals and substance abusers.
- Knowledge of substance abuse treatment programs.
- Knowledge of interviewing and counseling methods and techniques.
- Knowledge of agency security systems and operations.
- Ability to select, train, and supervise inmate peer counselors.

- Ability to prepare lesson plans and conduct classes.
- Ability to maintain records and prepare reports.
- Ability to detect substance abuse among inmates.

MINIMUM QUALIFICATIONS

The formal education equivalent of a bachelor's degree in social work, sociology, psychology, or a related field; plus two years' experience in community services counseling.

Other job related education and/or experience may be substituted for all or part of these basic requirements upon approval of the Qualifications Review Committee.

MANAGEMENT PROJECT ANALYST I

EXAMPLES OF WORK

1. Conducts special studies such as systems and cost analysis, feasibility and effectiveness of agency/institution programs, and the identification of and solution to problem areas. Assists in the development of project goals and objectives.
2. Plans, organizes, and schedules project/program implementation phases and procedures and develops monitoring and reporting systems to measure project effectiveness.
3. Evaluates existing programs by gathering information, reviewing files, researching policy, directives, and regulations, conducting surveys and interviews, and contacting agencies/institutions in other states concerning their programs.
4. Analyzes project/program data and prepares reports explaining findings and recommendations.
5. Presents findings to management staff using graphs, charts, narratives, and statistical reports.
6. Develops or revises agency/institution policies, procedures, programs, and directives based on research findings. Develops handbooks and manuals for participant use and conducts workshops to educate personnel on new systems, policy, and procedures.
7. Evaluates project/program effectiveness after implementation by personal observation, conducting interviews, and reviewing data and reports.
8. Coordinates activities within the unit to maximize unit efficiency.
9. Performs related responsibilities as required or assigned.

WORKING RELATIONSHIPS

The Management Project Analyst I has regular contact with agency/institution personnel, the general public, and state and federal agencies.

KNOWLEDGES, ABILITIES, AND SKILLS

- Knowledge of the principles and techniques of organizational and systems analysis.
- Knowledge of planning, research, and analysis techniques and procedures.
- Ability to interpret and apply state and federal laws and regulations governing specialized area of work.
- Ability to plan and execute systems and perform organizational analysis and feasibility studies.
- Ability to plan and organize comprehensive reports of project findings and write and develop manual and handbooks.
- Ability to organize and conduct meetings and workshops.

MINIMUM QUALIFICATIONS

The formal education equivalent of bachelor's degree in public administration, general business, personnel management, or a related field; plus one year of experience in

planning, research, or a related field.

Other job related education and/or experience may be substituted for all or part of these basic requirements upon approval of the Qualifications Review Committee.

SOCIAL WORKER II

CLASS SUMMARY

The Social Worker II works under general direction and is responsible for supervising social work and counseling activities, providing technical assistance, and developing program plans. This position is governed by state and federal laws and agency/institution policy.

EXAMPLES OF WORK

1. Supervises a small professional staff by interviewing and recommending for hire, assigning and reviewing work, training new employees, and evaluating the performance of incumbents.
2. Provides technical assistance to staff and clients by offering consultation concerning specific requests, explaining laws and regulations, and monitoring for problems.
3. Develops program plans by determining goals and objectives, assessing programs, and making recommendations for policy and procedure changes in conjunction with other staff.
4. Interviews clients to obtain background information and social history and administers psychosocial, diagnostic, and behavioral assessments and makes recommendations for admission.
5. Develops, implements, and monitors client treatment plans individually or as a member of a diagnostic evaluation team.
6. Conducts individual or group counseling sessions to aid clients' social, emotional, psychological, and physical growth and increase client's self-esteem.
7. Establishes, provides, and monitors in-service training for staff by assessing needs, developing, and instructing in new procedures.
8. Prepares and analyzes reports including case work progress notes, logs of activities, and documentation of sessions.
9. Refers clients to other sources of help and follows up on clients' progress.
10. Performs related responsibilities as required or assigned.

WORKING RELATIONSHIPS

The Social Worker II has regular contact with clients, local and state agencies, law enforcement officials, agency/institution personnel, and the general public.

SPECIAL JOB DIMENSIONS

Frequent contact with mentally ill and/or potentially violent patients or residents is required.

KNOWLEDGES, ABILITIES, AND SKILLS

Knowledge of state laws and agency policies governing specific program area.
Knowledge of principles and practices of counseling and social work.
Knowledge of agency, community, and state human service resources.
Ability to plan, organize, and direct the work of others.

Ability to interview, obtain, evaluate, and diagnose information related to problems and services needed.
Ability to provide treatment, guidance, and counseling to clients.
Ability to serve as a social advocate for clients by providing information and evaluating and monitoring treatment plans.

MINIMUM QUALIFICATIONS

Licensed as a Licensed Social Worker, Licensed Master Social Worker, or a Licensed Certified Social Worker by the Arkansas Social Work Licensing Board as established by Act 791 of 1981; plus two years' experience as a social worker.

Other job related education and/or experience may be substituted for all or part of these basic requirements upon approval of the Qualifications Review Committee.

Appendix C - Prison Inmate Inventory

PRISON INMATE INVENTORY

The **Prison Inmate Inventory (PII)** is designed for inmate risk assessment and needs identification. PII reports help determine risk, establish supervision levels, and readiness for classification or status changes.

TEN PII SCALES

I. TRUTHFULNESS SCALE: measures truthfulness of the inmate while completing the test. Identifies guarded and self-protective inmates who minimize problems or attempt to fake results.

II. VIOLENCE SCALE: measures use of physical force to injure, damage or destroy. Identifies inmates that are dangerous to self and others.

III. ANTISOCIAL SCALE: measures antisocial behavior, e.g., lying, uncaring, irresponsible, unsocial, emotionally blunted, needless conning, etc.

IV. RISK SCALE: assesses client risk. Given the inmate's history, the scale establishes their risk of continuing the same problem-prone behavior.

V. SELF ESTEEM SCALE: describes the person one believes oneself to be. This scale gives a sense of inmate dignity and feelings of self-worth.

VI. ALCOHOL SCALE: measures inmate's alcohol proneness and alcohol-related problems.

VII. DRUGS SCALE: measures inmate's drug abuse proneness and drug-related problems.

VIII. JUDGMENT SCALE: inmate risk increases as their judgment decreases. Judgment involves understanding and affects decision making.

IX. DISTRESS SCALE: incorporates measures of anxiety and depression. Distress is the most common reason for counseling.

X. STRESS COPING ABILITIES: stress exacerbates other emotional, attitudinal and behavioral problems.

UNIQUE PII FEATURES

TRUTHFULNESS SCALE: an important advancement in testing because it measures how truthful the inmate was while completing the test. The Truthfulness Scale identifies self-protective, guarded and defensive inmates attempting to deny, minimize their problems or even fake their answers.

TRUTH-CORRECTED SCORES: correlations between the Truthfulness Scale and all other scales establish the error variance associated with untruthfulness. This error variance is then applied to each scale score, resulting in **Truth-Corrected Scores**. Raw scores may only reflect what the inmate wants you to know. **Truth-Corrected Scores reveal what the inmate is trying to hide.**

PRISON INMATE INVENTORY

The **Prison Inmate Inventory (PII)** is a brief, easily administered and automated (computer scored) test designed for inmate risk and needs assessment. It contains 219 items and can be completed in 45 minutes to an hour. The Prison Inmate Inventory helps determine inmate risk and readiness for classification or status changes. The PII can be re-administered at six month intervals.

PII QUESTIONS & ANSWERS

1. How truthful was the inmate when tested? In the past, many people were "turned off" by tests because they were too easy to fake. The PII has a built-in Truthfulness Scale designed to identify inmate denial or untruthfulness and detect faking.

2. If the inmate lies, how do you get accurate information? Truth-corrected scores are more accurate than raw scores. Raw scores reflect what the inmate wants you to know. Truth-corrected scores reveal what the inmate is trying to hide.

3. Why are the ten Prison Inmate Inventory scales important? In addition to establishing inmate truthfulness and substance abuse involvement, it is important to know inmates self-esteem, judgment, distress and violence potential, as well as antisocial tendencies and inmate risk.

The Prison Inmate Inventory (PII) is completed by the inmate individually or in group testing settings. PII diskettes contain all of the software needed to score tests and generate reports. This means that reports can be available within 3 minutes of test completion--on site--where decisions must be made in a timely manner. This procedure eliminates tedious, time consuming and error prone hand scoring. Inmate screening is faster and more accurate.

The Prison Inmate Inventory (PII) is competitively priced and cost per test can be even lower when ordered in substantial quantities. **Test booklets, training manuals, support services, ongoing research and annual summary reports are included free.** We're so sure you'll like the PII, that we

offer a money back guarantee.

*****

If you are interested in reviewing a PII example report you should click on the PII Example Report link.

PII Example Report

To review an example report click on this link

Although reports are highly individualized, the PII example report is representative of this tests report format. Our clients say these reports are concise - yet comprehensive, and easy to read.

PRISON INMATE INVENTORY

* * * * * * * * * * * * *

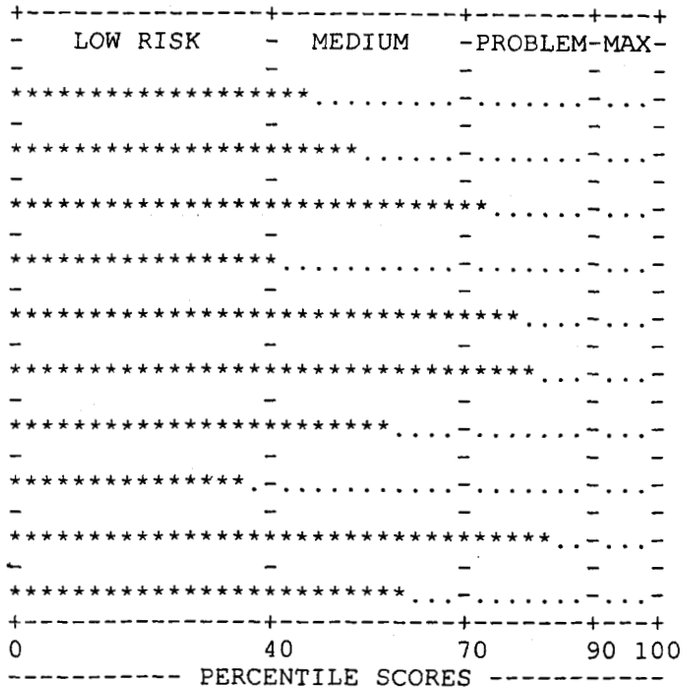
NAME: Mr. Example
ID# : 000-00-0000
AGE : 21 SEX: Male
ETHNICITY/RACE: Caucasian
HIGHEST GRADE ATTAINED: 12

CONFIDENTIAL REPORT

MARITAL STATUS: Married
DATE OF BIRTH : 01/01/1977
DATE SCORED : 12/11/1998

Prison Inmate Inventory or PII results are confidential and should be considered working hypotheses. No diagnosis or decision should be based solely upon PII results. The PII is to be used in conjunction with experienced staff judgment and review of available records.

MEASURES	%ile	PII PROFILE
TRUTHFULNESS	47	
ADJUSTMENT	54	
ALCOHOL	74	
DRUG	41	
ANTISOCIAL	78	
VIOLENCE	81	
DISTRESS	58	
JUDGMENT	35	
SELF-ESTEEM	83	
STRESS COPING	62	



ADDITIONAL INFORMATION PROVIDED BY INMATE

Age at first arrest.....	17	Years in jail and prison.....	1
Felony arrests.....	1	Alcohol-related arrests.....	3
Times on probation.....	1	Drug-related arrests.....	1
Probation revocations.....	0	Jail/Prison escape attempts.....	0
Total number of arrests.....	5	Months left to serve.....	4

PII RESPONSES

1- 50	FTTTFFTTFF	FFTTFFTTTT	FTTTTFTTFT	TFTFFFFTTF	TTTFFFTTTF
51-100	TTFTFFTTTF	FTTTTFTTFF	TTTTTTFFTF	FTTTTTFT22	3121213212
101-150	3212211212	2223131231	3112221143	4343414343	3443422232
151-161	2232212132	3			

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* * SUMMARY PARAGRAPHS EXPLAINING INMATE'S ATTAINED SCALE SCORES * *

TRUTHFULNESS SCALE: MEDIUM RISK RANGE RISK PERCENTILE:47
This PII profile is accurate. However, there is a tendency for this inmate to deny common problems and to portray self in an overly favorable light. Specific questions will usually be answered more accurately than open-ended questions. This is an accurate PII profile and other scale scores are accurate. This inmate was generally truthful.

ADJUSTMENT SCALE: MEDIUM RISK RANGE RISK PERCENTILE:54
Medium Adjustment Scale scorers (40 to 69th percentile) may manifest some attitudinal or adjustment difficulties while in prison, yet a pattern of maladjustment is not established. Under normal prison conditions this inmate would be largely problem free. Attitude and adjustment problems do not present as focal issues. This is a medium Adjustment Risk Scale score and problematic inmate adjustment problems are not anticipated. Other PII scale scores should be reviewed. This inmate should exhibit a relatively trouble free incarceration status.

ALCOHOL SCALE: PROBLEM RISK RANGE RISK PERCENTILE:74
Alcohol abuse is indicated and may be a focal issue. An established pattern is evident, or this inmate is recovering (alcohol problem, but has stopped drinking). RECOMMENDATIONS: Counseling and/or Alcoholics Anonymous (AA) could be helpful. Relapse is possible. With regard to alcohol, this is a problem risk score.

DRUG SCALE: MEDIUM RISK RANGE RISK PERCENTILE:41
Drug (marijuana, cocaine, crack, amphetamines, barbiturates and heroin) involvement is indicated, however, an established pattern of abuse is not evident. RECOMMENDATIONS: Prior drug-related convictions would warrant consideration of an education program or attendance at Narcotics Anonymous or Cocaine Anonymous meetings. With regard to the Drug Scale, this is a medium risk score.

ANTISOCIAL SCALE: PROBLEM RISK RANGE RISK PERCENTILE:78
An established pattern of antisocial behavior is evident. Problem risk scorers often have difficulty maintaining responsible relationships and loyalties. They are often callous, irresponsible, distressed and lack empathy. Many are boastful, deceitful, antisocial and given to tantrums. Poor work histories are common. This is a problem risk (70 to 89th percentile) Antisocial Scale score.

VIOLENCE SCALE: PROBLEM RISK RANGE RISK PERCENTILE:81
Violent tendencies are evident. Problem risk scorers are often characterized by inconsiderateness, harshness, unruliness and explosiveness. They are often controlling, abusive and can be violent. Jealousy, substance abuse and perceived stress could exacerbate violent behavior. With regard to the Violence Scale, this is a problem risk score.

DISTRESS SCALE: MEDIUM RISK RANGE RISK PERCENTILE:58
Periods of anxiety and depression are reported. Environmental (incarceration) stress and interpersonal conflict can be contributing factors. Distress may be dissipated during anger, physical exercise, eating or sleep. This inmate is not overwhelmed by distress. With regard to distress, this is a medium risk score.

JUDGMENT SCALE: LOW RISK RANGE RISK PERCENTILE:35
This inmate has sound judgment. Judgment incorporates understanding and comprehension. This inmate understands the difference between "right" and "wrong" and is capable of guilt or remorse. Inmate risk

increases as judgment decreases. This inmate's judgment is sound. This is a low risk Judgment Scale score.

SELF-ESTEEM SCALE: PROBLEM RISK RANGE RISK PERCENTILE:83

This inmate's self-esteem is negative. This person devalues himself or herself, feels inadequate and lacks confidence. Such persons are often moody, worrisome and insecure. Although negative self-esteem is indicated, it may not be the most significant focal area of difficulty. This is a problem risk Self-Esteem Scale score.

STRESS COPING SCALE: MEDIUM RISK RANGE RISK PERCENTILE:62

Stress coping abilities are not well established, however, stress does not present as a focal issue. Stress-related problems are characterized by irritability, instability and interpersonal conflict. Coping with stress is a process of adaptation. Symptoms of stress can be psychological or physiological and can include anxiety, depression, irritability, substance abuse and moodiness. With regard to stress coping abilities, this is a medium risk score.

* * * * *

SIGNIFICANT ITEMS: The answers are the inmate's actual responses. And, they represent direct admissions or unusual responses, which may help in understanding the inmate's situation. Note that these answers reflect the inmate's opinions, with all their biases and predispositions.

ALCOHOL

2. Is concerned about drinking
7. More than a little problem
13. Might have a drinking problem
39. Worry of a problem after prison
58. Will attend AA after prison
73. Treated for a drinking problem

DRUGS

18. Before prison used drugs a lot
27. Drug use threatened happiness
64. Drug use concern after prison

ANTISOCIAL

23. Many antisocial behaviors
31. People think is antisocial
47. People think ideas antisocial
54. Needless lying and conning
79. People say inmate is antisocial
83. Concern about being antisocial

VIOLENCE

3. More angry & violent than most
8. Often cannot control temper
22. Usually tries to get even
51. Feels justified hurting someone
59. Admits is a violent person
68. Has threatened or hurt others
74. More dangerous than most people
87. Denies is a nonviolent person

SECTION 3: The inmate's answers to multiple choice items are printed below. It should be noted that these answers represent the inmate's opinion--with all of its biases. These multiple choice answers allow comparison of the inmate's subjective opinions with objective and empirically based scale scores.

127. Will complain to authorities
128. Last year: disciplinary action
129. No job or trouble problems
131. Denies suicidal or homicidal
133. No family/relationship prob.
135. No disciplinary action(6 mon.)
137. No substance abuse programs
139. No inmate/officers problems
140. Drinking a mild problem
141. Not sure if needs alcohol help
142. No drinking or drug problem
143. Not a recovering sub. abuser
144. Drug use a mild problem
145. No need for drug treatment

RECOMMENDATIONS AND/OR COMMENTS: _____

STAFF MEMBER SIGNATURE BADGE NUMBER OR ID# DATE (TEST #1)

Appendix D - Intake Assessment Instrument

Instructions: Circle the answer that shows how much you agree or disagree each item describes you or the way [redacted] have been feeling lately.

1. My drug use is a problem for me	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
2. I like to take chances	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
3. People are important to me	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
4. I skipped school while growing up	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
5. I feel sad or depressed	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
6. I feel honesty is required in every situation	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
7. I need help in dealing with my drug use	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
8. I consider how my actions will affect others	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
[redacted] I have too many responsibilities now to be in this treatment program	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
10. I have much to be proud of	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
11. My drug use has been more trouble than its worth	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
12. In general I am satisfied with myself	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
13. I like the "fast" life	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
14. I took things that did not belong to me when I was young	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
[redacted]5. My stay in prison could be longer if I am not in treatment	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree

16. I feel mistreated by other people — Strongly Agree Agree Not sure Disagree Strongly Disagree

17. I have thoughts of committing suicide — Strongly Agree Agree Not sure Disagree Strongly Disagree

18. I have trouble sitting still for long — Strongly Agree Agree Not sure Disagree Strongly Disagree

19. My drug use has caused problems in the past — Strongly Agree Agree Not sure Disagree Strongly Disagree

20. I plan ahead — Strongly Agree Agree Not sure Disagree Strongly Disagree

21. I like others to feel afraid of me — Strongly Agree Agree Not sure Disagree Strongly Disagree

22. I have trouble following rules and laws — Strongly Agree Agree Not sure Disagree Strongly Disagree

23. This treatment program seems too demanding for me — Strongly Agree Agree Not sure Disagree Strongly Disagree

24. I feel lonely — Strongly Agree Agree Not sure Disagree Strongly Disagree

25. I like friends who are wild — Strongly Agree Agree Not sure Disagree Strongly Disagree

26. My drug use has caused problems in thinking or doing my work — Strongly Agree Agree Not sure Disagree Strongly Disagree

27. I had good support from my parents while growing up — Strongly Agree Agree Not sure Disagree Strongly Disagree

28. I like to do things that are strange and exciting — Strongly Agree Agree Not sure Disagree Strongly Disagree

29. I need immediate help for my drug use — Strongly Agree Agree Not sure Disagree Strongly Disagree

30. I feel like a failure — Strongly Agree Agree Not sure Disagree Strongly Disagree

31. I have trouble sleeping — Strongly Agree Agree Not sure Disagree Strongly Disagree

32. I feel a lot of pressure to be in treatment — Strongly Agree Agree Not sure Disagree Strongly Disagree

33. I depend on "things" more than "people" — Strongly Agree Agree Not sure Disagree Strongly Disagree

34. My drug use has caused problems with my friends or family — Strongly Agree | Agree | Not sure | Disagree | Strongly Disagree

35. I had feelings of anger during my childhood — Strongly Agree | Agree | Not sure | Disagree | Strongly Disagree

36. I feel my life is worth living — Strongly Agree | Agree | Not sure | Disagree | Strongly Disagree

37. This treatment may be my last chance to solve my drug problems — Strongly Agree | Agree | Not sure | Disagree | Strongly Disagree

38. I have urges to fight or hurt others — Strongly Agree | Agree | Not sure | Disagree | Strongly Disagree

39. I avoid anything dangerous — Strongly Agree | Agree | Not sure | Disagree | Strongly Disagree

40. I think about what might happen before I act — Strongly Agree | Agree | Not sure | Disagree | Strongly Disagree

41. I am tired of the problems caused by my drugs — Strongly Agree | Agree | Not sure | Disagree | Strongly Disagree

42. I feel I am basically no good — Strongly Agree | Agree | Not sure | Disagree | Strongly Disagree

43. This kind of treatment program will be very helpful to me — Strongly Agree | Agree | Not sure | Disagree | Strongly Disagree

44. I have a bad temper — Strongly Agree | Agree | Not sure | Disagree | Strongly Disagree

45. I have trouble making decisions — Strongly Agree | Agree | Not sure | Disagree | Strongly Disagree

46. My drug use has caused problems in finding or keeping a job — Strongly Agree | Agree | Not sure | Disagree | Strongly Disagree

47. I have kept the same friends for a long time — Strongly Agree | Agree | Not sure | Disagree | Strongly Disagree

48. I have had legal problems that require me to be in treatment — Strongly Agree | Agree | Not sure | Disagree | Strongly Disagree

49. I think of several different ways to solve problems	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
50. I plan to stay in this treatment program for awhile.	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
51. I got involved in arguments and fights while growing up	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
52. I feel anxious or nervous	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
53. I am willing to give up my friends and hangouts to solve my drug problem	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
54. I approach problems by looking at all the choices	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
55. My temper gets me into fights or other trouble	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
56. I make decisions without thinking about what could happen	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
57. While a teenager, I got in trouble with school authorities or the police	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
58. I can quit using drugs without any help	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
59. I have trouble concentrating or remembering things	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
60. My drug use has caused problems with my health	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
61. I usually feel tired or run down	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
62. I have problems keeping a job	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree

63. I am in this treatment program because someone else made me come — Strongly Agree Agree Not sure Disagree Strongly Disagree

64. I make good decisions — Strongly Agree Agree Not sure Disagree Strongly Disagree

65. I often feel helpless in dealing with the problems of life — Strongly Agree Agree Not sure Disagree Strongly Disagree

66.1 felt good about myself while growing up — Strongly Agree Agree Not sure Disagree Strongly Disagree

67. I feel afraid of certain things, like crowds, elevators or going out alone — Strongly Agree Agree Not sure Disagree Strongly Disagree

68. I am concerned about my legal problems — Strongly Agree Agree Not sure Disagree Strongly Disagree

69. I only do things that feel safe — Strongly Agree Agree Not sure Disagree Strongly Disagree

70. My life has gone out of control — Strongly Agree Agree Not sure Disagree Strongly Disagree

71. I get mad at other people easily — Strongly Agree Agree Not sure Disagree Strongly Disagree

72. My religious beliefs are very important to me — Strongly Agree Agree Not sure Disagree Strongly Disagree

73. There is little I can do to change many of the important things in my life — Strongly Agree Agree Not sure Disagree Strongly Disagree

74. My drug use has made my life become worse and worse — Strongly Agree Agree Not sure Disagree Strongly Disagree

75. I wish I had more respect for myself — Strongly Agree Agree Not sure Disagree Strongly Disagree

76. I worry or get moody a lot — Strongly Agree Agree Not sure Disagree Strongly Disagree

77. This treatment program can really help me — Strongly Agree Agree Not sure Disagree Strongly Disagree

78. I feel tightness or tension in my muscles	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
79. I have little control over the things that happen to me	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
80. Taking care of my family is very important to me	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
81. I think about what caused my current problems	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
82. My drug use is going to cause my death if I don't get help	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
83. I feel I am unimportant to others	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
84. I feel a lot of anger inside me	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
85. I want to get my life straightened out	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
86. There is really no way I can solve some of the problems I have	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
87. I have carried weapons, like knives or guns	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
88. I feel tense or wired	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
89. I was emotionally or physically abused when I was young	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
90. I want to be in a drug treatment program	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
91. I am very careful and cautious	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
92. I have family members who want me to be in treatment	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree

93. Sometimes I feel that I am being pushed around in life	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
94. What happens to me in the future mostly depends on me	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
95. I can do just about anything I really set my mind to do	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree

Appendix E - Participant Survey

EVAVLUATION OF SELF AND TREATMENT

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

1. You feel and show concern for others during group counseling . ..... Strongly Agree Agree Not Sure Disagree Strongly Disagree

2. Your counselors are easy to talk to . ..... Strongly Agree Agree Not Sure Disagree Strongly Disagree

3. You trust the treatment staff . ..... Strongly Agree Agree Not Sure Disagree Strongly Disagree

4. Your counselors help you develop confidence in yourself. . Strongly Agree Agree Not Sure Disagree Strongly Disagree

5. You have developed positive trusting friendships while at this program . ..... Strongly Agree Agree Not Sure Disagree Strongly Disagree

6. Your counselors are well organized and prepared for each counseling session . ..... Strongly Agree Agree Not Sure Disagree Strongly Disagree

7. The treatment staff cares about you and your problems . ..... Strongly Agree Agree Not Sure Disagree Strongly Disagree

8. You have made progress with your drug/alcohol problems . ..... Strongly Agree Agree Not Sure Disagree Strongly Disagree

9. Your counselors develop treatment plans with reasonable objectives for you . ..... Strongly Agree Agree Not Sure Disagree Strongly Disagree

10. The treatment staff is helpful to you . ..... Strongly Agree Agree Not Sure Disagree Strongly Disagree

11. You have made progress with your emotional or psychological issues . ..... Strongly Agree Agree Not Sure Disagree Strongly Disagree

12. Your conselors keep you focused on solving specific problems . ..... Strongly Agree Agree Not Sure Disagree Strongly Disagree

13. The security staff cares about you and your problems . ..... Strongly Agree Agree Not Sure Disagree Strongly Disagree

14. You have made progress toward your treatment goals . ..... Strongly Agree Agree Not Sure Disagree Strongly Disagree

15. Your counselors remember important details from your earlier sessions . ..... Strongly Agree Agree Not Sure Disagree Strongly Disagree

16. The security staff is helpful to you . ..... Strongly Agree Agree Not Sure Disagree Strongly Disagree

17. Your conselors help you make changes in your life . ..... Strongly Agree Agree Not Sure Disagree Strongly Disagree

18. You accept being confronted by others during group ..... Strongly Agree Agree Not Sure Disagree Strongly Disagree

19. Your counselors speak in a way that you understand . ..... Strongly Agree Agree Not Sure Disagree Strongly Disagree

20. You accept being confronted by others during group counseling . ..... Strongly Agree Agree Not Sure Disagree Strongly Disagree

21. Your counselors speak in a way that you understand . ..... Strongly Agree Agree Not Sure Disagree Strongly Disagree

22. You confront others about their real feelings during group counseling . ..... Strongly Agree Agree Not Sure Disagree Strongly Disagree

23. Your counselors respect you and your opinions . ..... Strongly Agree Agree Not Sure Disagree Strongly Disagree

24. You are willing to talk about your feelings during group counseling . ..... Strongly Agree Agree Not Sure Disagree Strongly Disagree

25. Your counselors understand your situation and problems. . Strongly Agree Agree Not Sure Disagree Strongly Disagree

26. You say things to show support and understanding to others during group counseling . ..... Strongly Agree Agree Not Sure Disagree Strongly Disagree

27. You trust your counselors. Strongly Agree Agree Not Sure Disagree Strongly Disagree

28. You give honest feedback to others during group counseling . ..... Strongly Agree Agree Not Sure Disagree Strongly Disagree

29. Your counselors help you to view problems/situations realistically . ..... Strongly Agree Agree Not Sure Disagree Strongly Disagree

30. You have made progress in understanding your feelings and how they can influence behavior . ..... Strongly Agree Agree Not Sure Disagree Strongly Disagree

31. Your counselors focus your thinking and planning . ..... Strongly Agree Agree Not Sure Disagree Strongly Disagree

32. You trust other clients in this program . ..... Strongly Agree Agree Not Sure Disagree Strongly Disagree

33. Your counselors make you feel foolish or ashamed . ..... Strongly Agree Agree Not Sure Disagree Strongly Disagree

34. Your counselors teach you useful ways to solve your problems . ..... Strongly Agree Agree Not Sure Disagree Strongly Disagree

35. You are motivated and encouraged by your counselors. Strongly Agree Agree Not Sure Disagree Strongly Disagree

36. You trust the security staff . ..... Strongly Agree Agree Not Sure Disagree Strongly Disagree

37. Meetings and activities are well organized . ..... Strongly Agree Agree Not Sure Disagree Strongly Disagree

EVALUATION OF SELF AND TREATMENT

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

38. You need more individual counseling	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
39.. The morning meetings are productive and useful	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
40. Other clients at this program care about you and your problems	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
41. House rules and tools are fair and appropriate	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
42. Other clients at this program are helpful to you.	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
43. The evening meetings are productive and useful	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
44. You are similar (or like) other clients of this program.	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
45. You need more group counseling	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
46. The authority structure among residents is fair and useful	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
47. There is a sense of family (or community) in this program	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
48. Work assignments are fair and useful	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
49. You need more lecture classes	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
50. Privileges are appropriate and given soon after they are earned	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

Appendix F - Scale Development for Participant Survey

Ratings of Treatment Process

Participation in Treatment

"TC Client Progress Scales" adapted from De Leon, G. (1997). [Client Self-Rated Progress Checklist. New York: Center for Therapeutic Community Research.]

a. Therapeutic Engagement (TE)

1. You feel and show concern for others during group counseling.
18. You accept being confronted by others during group counseling.
20. You confront others about their real feelings during group counseling.
22. You are willing to talk about your feelings during group counseling.
24. You say things to give support and understanding to others during group counseling.
26. You give honest feedback to others during group counseling.

b. Personal Progress (PP)

8. You have made progress with your drug/alcohol problems.
11. You have made progress with your emotional or psychological issues.
14. You have made progress toward your treatment program goals.
28. You have made progress in understanding your feelings and how they can influence behavior.

c. Trust Group (TG)

3. You trust the treatment staff.
5. You have developed positive trusting friendships while at this program.
30. You trust other clients in this program.
34. You trust the security staff.

d. Program Staff (PSF)

69. The treatment staff cares about you and your problems.
72. The treatment staff is helpful to you.
75. The security staff cares about you and your problems.
78. The security staff is helpful to you.

Counselor Attitude and Behavior

e. Counselor Rapport (CR)

2. Your counselors are easy to talk to.
19. Your counselors speak in a way that you understand.
21. Your counselors respect you and your opinions.

23. Your counselors understand your situation and problems.
25. You trust your counselors.
27. Your counselors help you view problems/situations realistically.
29. Your counselors focus your thinking and planning.
31. Your counselors make you feel foolish or ashamed.

f. Counselor Competence (CC)

4. Your counselors help you develop confidence in yourself.
6. Your counselors are well organized and prepared for each counseling session.
9. Your counselors develop treatment plans with reasonable objectives for you.
12. Your counselors keep you focused on solving specific problems.
15. Your counselors remember important details from your earlier sessions.
17. Your counselors help you make changes in your life.
32. Your counselors teach you useful ways to solve your problems.
33. You are motivated and encouraged by your counselors.

Section C. Ratings of Program Attributes

"Client Rating of Program" adapted from De Leon, G. (1994). [Client Self-Rated Progress Checklist and Client Rating of Program. New York: Center for Therapeutic Community Research.]

g. Program Structure (PS)

1. Meetings and activities are well organized.
3. The morning meetings are productive and useful.
5. House rules and tools are fair and appropriate.
7. The evening meetings are productive and useful.
10. The authority structure among residents is fair and useful.
12. Work assignments are fair and useful.
14. Privileges are appropriate and given soon after they are earned.

h. Program Sessions (SES)

2. You need more individual counseling.
9. You need more group counseling.
13. You need more lecture classes.

i. Peer Support (SUP)

4. Other clients at this program care about you and your problems.
6. Other clients at this program are helpful to you.
8. You are similar to (or like) other clients of this program.
11. There is a sense of family (or community) in this program.

Appendix G - Scale Development for SRF Intake Instrument

Item-scoring Guide for Evaluation of Self and Treatment (TCU Correctional Residential Forms/AR Revision)

Section A. Ratings of Self - Psychological Functioning Scales

a. Self Esteem (SE)

10. I have much to be proud of.
12. In general, I am satisfied with myself.
30. I feel like a failure.
42. I feel I am basically no good.
75. I wish I had more respect for myself.
83. I feel I am unimportant to others.

b. Depression (DP)

5. I feel sad or depressed.
17. I have thoughts of committing suicide.
24. I feel lonely.
36. I feel life is worth living.
61. I feel extra tired or run down.
76. I worry or get moody a lot.

c. Anxiety (AX)

18. I have trouble sitting still for long.
31. I have trouble sleeping.
52. I feel anxious or nervous.
59. I have trouble concentrating or remembering things.
67. I feel afraid of certain things, like elevators, crowds, or going out alone.
88. I feel tense or wired.
78. I feel tightness or tension in my muscles.

D. Self Efficacy (PM)

"Pearlin Mastery Scale," taken from Pearlin, L., and Schooler, C. (1978). [The Structure of Coping. Journal of Health and Social Behavior, 19, 2-21.]

79. I have little control over the things that happen to me.
86. There is really no way I can solve some of the problems I have.
73. There is little I can do to change many of the important things in my life.
65. I often feel helpless in dealing with the problems of life.
93. Sometimes I feel that I am being pushed around in life.
94. What happens to me in the future mostly depends on me.
95. I can do just about anything I really set my mind to do.

d. Decision Making (DM)

8. I consider how my actions will affect others.
20. I plan ahead.
40. I think about what might happen before I act.
45. I have trouble making decisions.
49. I think of several different ways to solve a problem.
54. I approach problems by looking at all the choices.
56. I make decisions without thinking about what could happen.
64. I make good decisions.
81. I think about what causes my current problems.

Social Functioning Scales

e. Hostility (HS)

16. I feel mistreated by other people.
21. I like others to feel afraid of me.
38. I have urges to fight or hurt others.
44. I have a bad temper.
55. My temper gets me into fights or other trouble.
71. I get mad at other people easily.
87. I have carried weapons, like knives or guns.
84. I feel a lot of anger inside me.

f. Risk Taking (RT)

2. I like to take chances.
13. I like the "fast" life.
25. I like friends who are wild.
28. I like to do things that are strange or exciting.
39. I avoid anything dangerous.
69. I only do things that feel safe.
91. I am very careful and cautious.

g. Social Conformity (SC)

3. People are important to me.
6. I feel honesty is required in every situation.
22. I have trouble following rules and laws.
33. I depend on "things" more than "people".
47. I have kept the same friends for a long time.
43. I have problems keeping a job.
72. My religious beliefs are very important in my life.
80. Taking care of my family is very important.

Treatment Motivation Scales

h. Treatment Readiness (TR)

9. I have too many outside responsibilities now to be in this treatment program.
23. This treatment program seems too demanding for me.
37. This treatment may be my last chance to solve my drug problems.
43. This kind of treatment program will be very helpful to me.
50. I plan to stay in this treatment program for awhile.
63. I am in this treatment program because someone else made me come.
77. This treatment program can really help me.
90. I want to be in a drug treatment program.

i. External Pressures (EP)

15. My stay in prison could be longer if I am not in treatment.
60. My drug use has caused problems with my health.
32. I feel a lot of pressure to be in treatment.
48. I have had legal problems that require me to be in treatment.
68. I am concerned about my legal problems.
92. I have family members who want me to be in treatment.

j. Problem Recognition (PR)

1. My drug use is a problem for me.
11. My drug use is more trouble than it's worth.
19. My drug use is caused problems in the past.
26. My drug use is causing problems in thinking or doing my work.
34. My drug use is causing problems with my family or friends.
46. My drug use has caused problems in finding or keeping a job.
74. My drug use is making my life become worse and worse.
82. My drug use is going to cause my death if I do not quit soon.

k. Desire For Help (DH)

7. I need help in dealing with my drug use.
29. I need immediate help for my drug use.
41. I am tired of the problems caused by drugs.
53. I will give up my friends and hangouts to solve my drug problems.
58. I can quit using drugs without any help.
70. My life has gone out of control.

l. Childhood Problems (CP)

4. I skipped school while growing up.
14. I took things that did not belong to me when I was young.
27. I had good support with my parents while growing up.
35. I had feelings of anger during my childhood.

51. I got involved in arguments and fights while growing up.
57. While a teenager, I got into trouble with school authorities or the police.
66. I felt good about myself while growing up.
89. I was emotionally or physically abused when I was young.
85. I want to get my life straightened out.

Appendix H - Daily Schedule

ARKANSAS DEPARTMENT OF CORRECTION - THERAPEUTIC COMMUNITY
7B EDUCATIONAL GROUP SCHEDULE (AM)

MON		
7:00AM.	SEX AWARENESS	ELDER
8:00AM	DESIGN FOR LIVING: STEP 2	MENTOR
9:00AM	ENCOUNTER/ISSUE GROUP	PROGRAM LEADERS
TUE		
7:00AM	SEX AWARENESS	ELDER
8:00AM	DESIGN FOR LIVING:STEP 2	MENTOR
9:00AM	CHOP SHOP (DISCUSSION GROUP)	PEER COUNSELORS
WED		
7:00AM	SEX AWARENESS	ELDER
8:00AM	DESIGN FOR LIVING: STEP 2	MENTOR
9:00AM	ENCOUNTER/ISSUE GROUP	PROGRAM LEADERS
THU		
7:00AM	SEX AWARENESS	ELDER
8:00AM	DESIGN FOR LIVING:STEP 2	MENTOR
9:00AM	CHOP SHOP(DISCUSSION GROUP)	PEER COUNSELORS
FRI		
7:00AM	GROUP SUMMARY GROUP	CLIENT GENERATED
8:00AM	GROUP SUMMARY GROUP	CLIENT GENERATED
9:00AM	BRADSHAW TAPE	

7B EDUCATIONAL GROUP SCUEDULE (PM)

MON		
1:00PM	SEX AWARENESS	ELDER
2:00PM	ENCOUNTER/ISSUES GROUP	PROGRAM LEADERS
3:00PM	DESIGN FOR LIVING: STEP 2	MENTOR
TUE		
1:00PM	COMMUNITY DEVELOPMENT MEETING PROGRAM LEADERS	
2:00PM	SEX AWARENESS	ELDER
3:00PM	DESIGN FOR LIVING:STEP 2	MENTOR
WED		

1:00PM	SEX AWARENESS	ELDER
2:00PM	ENCOUNTER/ISSUE GROUP	PROGRAM LEADERS
3:00PM	DESIGN FOR LIVING: STEP 2	MENTOR
THU		
1:00PM	SEX AWARENESS	ELDER
2:00PM	DESIGN FOR LIVING: STEP 2	MENTOR
3:00PM	CHOP SHOP (DISCUSSION GROUP)	PEER COUNSELORS
FRI		
1:00PM	GROUP SUMMARY GROUP	CLIENT GENERATED
2:00PM	GROUP SUMMARY GROUP	CLIENT GENERATED
3:00PM .	BRADSHAW TAPE	

NOTE: TRANSITION LIVING GROUP: WED 9:00 AM AND 2:00 PM/THUR @2:00 (7A) CATHCART

7A EDUCATIONAL GROUP SCHEDULE (AM)

MON		
7:00AM	ANGER MANAGEMENT	MENTOR
8:00AM	RET: ANXIETY & GRIEF	ELDER
9:00AM	ENCOUNTER GROUP	PROGRAM LEADERS
TUE		
7:00AM	ANGER MANAGEMENT	MENTOR
8:00AM	RET: ANXIETY & GRIEF	ELDER
9:00AM	ENCOUNTER GROUP	PROGRAM LEADERS
WED		
7:00AM	ANGER MANAGEMENT	MENTOR
8:00AM	RET: ANXIETY & GRIEF	ELDER
9:00AM	CHOP SHOP (DISSCUSSION GROUP)	PEER COUNSELORS
I'HU		
7:00AM	ANGER MANAGEMENT	MENTOR
8:00AM	RET: ANXIETY & GRIEF	ELDER
9:00AM	CHOP SHOP (DISSCUSSION GROUP)	PEER COUNSELORS
FRI		
7:00AM	GROUP SUMMARY GROUP	CLIENT GENERATED
8:00AM	GROUP SUMMARY GROUP	CLIENT GENERATED
9:00AM	BRADSHAW TAPE	

7A EDUCATION GROUP SCHEDULE (PM)

MON		
1:00PM	ANGER MANAGEMENT	ELDER
2:00PM	RET: ANXIETY& GRIEF	PEER COUNSELOR
3:00PM	ENCOUNTER/ISSUE GROUP	PROGRAM LEADERS
TUE		
1:00PM	COMMUNITY DEVELOPMENT MEETING	PROGRAM LEADERS
2:00PM	ENCOUNTER/ISSUE GROUP	PROGRAM LEADERS
3:00PM	RET: ANXIETY& GRIEF	PEER COUNSELOR

WED		
1:00PM	ANGER MANAGEMENT	ELDER
2:00PM	RET: ANXIETY& GRIEF	PEER COUNSELOR
3:00PM	CHOP SHOP (DISCUSSIONS)	PEER COUNSELORS
THU		
1:00PM	ANGER MANAGEMENT	ELDER
2:00PM	RET: ANXIETY& GRIEF	PEER COUNSELOR
3:00PM	CHOP SHOP (DISCUSSIONS)	PEER COUNSELORS
FRI		
1:00AM	GROUP SUMMARY GROUP	C L I E N T GENERATED
2:00AM	GROUP SUMMARY GROUP	C L I E N T GENERATED
3:00AM	BRADSHAW TAPE	

NOTE: TRANSITION LIVING GROUP: WED 9:00 AM AND 2:00 PM/THUR @2:00 (7A) CATHCART

8A EDUCATIONAL GROUP SCHEDULE (AM)

MON.		
7:00AM	DESIGN FOR LIVING: LESSON 3	ELDER
8:00AM	FREE YOUR MIND: LESSON 13	PROGRAM LEADER
9:00AM	DROP THE ROCK (ENCOUNTER/ISSUE GROUP)	PROGRAM LEADERS
TUE		
7:00AM	DESIGN FOR LIVING: LESSON 3	ELDER
8:00AM	FREE YOUR MIND: LESSON 14	PROGRAM LEADERS
9:00AM	DROP THE ROCK (ENCOUNTER/ISSUE GROUP)	PROGRAM LEADERS
WED		
7: 00AM	DESIGN FOR LIVING: STEP 3	ELDER
8:00AM	FREE YOUR MIND: LESSON 15-16	PROGRAM LEADERS
9:00AM	CHOP SHOP(DISCUSSION GROUP)	PEER COUNSELORS
THU		
7:00AM	DESIGN FOR LIVING: STEP 3	ELDER
8:00AM	FREE YOUR MIND: LESSON 17	PROGRAM LEADERS
9:00AM	CHOP SHOP(DISCUSSION GROUP)	PEER COUNSELORS
FRI		
7:00AM	GROUP SUMMARY GROUP	CLIENT GENERATED
8:00AM.	GROUP SUMMARY GROUP	CLIENT GENERATED
9:00AM	BRADSHAW TAPE	

8A EDUCATIONAL. GROUT' SCHEDULE SCHEDULE (PM)

MON		
1:00PM	FREE YOUR MIND: LESSON 13	PROGRAM LEADERS
2:00PM	DROP THE ROCK (ENCOUNTER/ISSUE GROUP)	PROGRAM
LEADERS		
3:00PM	DESIGN FOR. LIVING: LESSON 3	ELDER
TUE		
1:00PM	COMMUNITY DEVELOPMENT MEETING	PROGRAM LEADERS

2:00PM	FREE Y0UR MIND: LESSON 14	PROGRAM LEADERS
3:00PM	DESIGN FOR LIVING: LESSON 3	ELDER
WED		
1:00PM	FREE YOUR MIND: LESSON 15-16	PROGRAM LEADERS
2:00PM	DROP THE ROCK (ENCOUNTER/ISSUE GROUP)	PROGRAM LEADERS
3:OOPM	DESIGN FOR LIVING: STEP 3	ELDER
THU		
1:00PM	FREE YOUR MIND: LESSON: 17	PROGRAM LEADERS
2:00PM	CHOP SHOP(DISCUSSION GROUP)	PEER COUNSELORS
3:00PM	DESIGN FOR LIVING: STEP 3	ELDER
FRI		
1:00PM	GROUP SUMMARY GROUP	C L I E N T GENERATED
2:00AM	GROUP SUMMARY GROUP	C L I E N T GENERATED
3:00AM	BRADSHAW TAPE	

Appendix I - Research Team Members

The Research Team

Maurice Caldwell, M.S.S.W. (Arkansas Department of Correction)

Mr. Caldwell is the Mental Health Administrator for the Department of Correction and is responsible for the Substance Abuse Treatment Program. Also, he is the administrator for the Mental Health Program in the Department. He has been in this position for 9½ years. Mr. Caldwell has a Master's degree in social work administration and has a background in mental health services.

Mr Caldwell's responsibilities as part of this project will include coordination of program managers and administrative staff for interviews and focus group participation. In addition, his experiences and insights will be sought in the inclusion of variables of interest to the ADC.

Roger Cameron, C.A.D.C., C.C.S. (Arkansas Department of Correction)

Mr. Cameron has worked in the substance abuse treatment field for 11 years. For 10 of those years he has worked for H.D.R.S. in Pine Bluff, Arkansas. As Therapeutic Community Coordinator, he manages the 120-bed Therapeutic Community at the Tucker Unit, and he is planning the start-up of a new Therapeutic Community at the Benton Work Release Unit. Other duties include Therapeutic Community staff supervision and development, as well as unit coordination.

Mr Cameron's responsibilities as part of this project will include coordination of program staff and inmates for interviews, session observation, and focus group participation. In addition, his experiences and insights will be sought in the inclusion of variables of interest to the ADC.

Deborah Dwyer, Ph.D. (University of Arkansas at Little Rock)

Dr. Dwyer received her Doctorate in Public Policy and Administration from Virginia Commonwealth in 1995. Her specialization includes criminal investigation, organization and administration, juvenile justice and women's issues. Currently, Dr. Dwyer is an Assistant Professor at the University of Arkansas at Little Rock. She also serves as the deputy editor of the *Journal of Criminal Justice Education*. Prior to receiving her degree, she was a police officer for six years with the Norfolk, Virginia Police Department. Her experience there focused on patrol, crime prevention and undercover vice operations. Her previous research has included identification of chemically dependent property offenders in state prisons, quality of life issues within the correctional institution, rule violation by inmate populations, organization stress within law enforcement and gender issues within criminal justice

curricula. She was also employed as a data entry and research manager for the Crime Control Institute in Washington, D.C.

Dr. Dwyer will be responsible for supervising the data collection and data entry portions of this project. She will direct the data collection by ADC personnel as well as partner the data analysis and reporting phase of the project. Dr. Dwyer's primary responsibilities for this grant will be coordination of research assistants for the purposes of conducting focus groups and interviews. She will also be responsible, in part, for the data analysis and completion of the final report.

Craig Eldridge, C.A.D.C., (Arkansas Department of Correction)

Mr. Eldridge has worked in the substance abuse treatment field both in and out of prison. He has worked for the Arkansas Department of Correction for nine years; serving as a social worker and SATP program leader. As a Certified Alcohol and Drug Counselor (C.A.D.C.), he has managed the Substance Abuse Treatment Program at the Women's Unit and the Maximum Security Unit. The SATP Coordinator since 1993, Mr. Eldridge now coordinates the administrative and clinical services at 15 separate units. These programs vary from outpatient programs to dual diagnosis and therapeutic communities.

Mr. Eldridge will be a key player in the development of the initial screening instrument and its pretest. In addition, Mr. Eldridge will facilitate the gathering of client data.

Jo Ann McLemore (Arkansas Department of Correction)

Mrs. McLemore is the Management Program Analyst for the Arkansas Department of Correction's Substance Abuse Treatment Program. She is responsible for numerous pre-treatment activities such as the collating of inmate file data from numerous sources, initial selection of SATP eligible inmates from the file data, and tracking the SATP client population throughout their treatment experiences both in the institution and the community. Mrs. McLemore's responsibilities also include the selection and comparison of treatment and control groups as well as the compilation of a statistical profile to aid in determining the appropriateness of the SATP program to client needs and successful completion of the program.

Mrs. McLemore will be responsible for inmate data collection concerning inmate screening and suitability for the program in conjunction with Mr. Phillips. Additional duties will include double entry and verification of key variables from inmate files and the transmission of that data to the Department of Criminal Justice.

Max Mobley (Arkansas Department of Correction)

Dr. Mobley earned his Ph.D. in psychology from the University of Arkansas, Fayetteville in 1974. He became a licensed, clinical psychologist in 1976. Since that time, Dr. Mobley has worked for the Center for Study of Crime Delinquency and Correction at Southern Illinois University, been an Assistant Professor of psychology at Northen Kentucky State College, and served as the Director of Research and Evaluation at West Central Arkansas Mental Health Center. Dr. Mobley has also served as Chief Psychologist and later Assistant Director for Health and Correctional Programs for ADC. He currently serves as the Deputy Director for Health and Correctional Programs for ADC.

Dr. Mobley's role in the project will be to serve as the primary facilitator for correctional resources and personnel.

Mary Parker, Ph.D. (University of Arkansas at Little Rock)

Dr. Parker serves as the administrative head of the Department of Criminal justice at the University of Arkansas at Little Rock, which encompasses three degree programs (an Associate of Arts, a Bachelor of Arts, and a Master of Arts), with six full-time faculty and fourteen part-time instructors, serving approximately 300 students. In addition to her administrative duties, she serves as the academic representative to the Board of Correction and Community Punishment, which oversees all adult correctional services in the State of Arkansas. As part of her Board responsibilities she serves as the grant liaison for both the Department of Correction and the Department of Community Punishment, the legislative liaison for both agencies and the Board, and the chief liaison for the Department of Correction. In addition to her service on the Board, she is active in both university and community activities which support efforts on behalf of women in prison and their children, the advancement of literacy and the university community as a whole. She has published in the areas of juvenile law and constitutional rights and is currently working on a project focusing on adult offenders and their constitutional rights. She is an acknowledged expert on corrections in Arkansas, having authored the legislation that supports the current adult correctional configuration, and continues to be a recognized expert by all branches of government.

Her contribution to this project will be limited due to her position on the Board, but will be invaluable nonetheless due to her demonstrated partnership with practitioner agencies and her ability to foster a long term partnership arrangement between this research team and the Department of Correction. She will be in charge of the graduate assistant and research assistants. In addition, she will help with the data analysis and the final report.

Allan L. Patenaude, Ph.D. (University of Arkansas at Little Rock)

Dr. Patenaude received his Doctorate in criminology from Simon Fraser University at Burnaby, British Columbia, Canada in 1997. Dr. Patenaude's primary areas of work are: race/ethnicity and criminal justice, comparative criminology, corrections, criminal justice policy analysis, and criminological theory. Dr. Patenaude has 15 years of professional experience in institutional and community corrections. His career included serving as a correctional officer in two maximum-security penitentiaries, youth and adult probation officer, and coordinating probation services and community justice programs for a territorial (state-level) government. Dr. Patenaude's publications have included articles in *Corrections Management Quarterly*, *Comparative Law Review*, *Journal of Contemporary Criminal Justice*, several chapters in scholarly texts concerned with Native North Americans and the administration of criminal justice, and conference presentations. Dr. Patenaude is a member of the Academy of Criminal Justice Sciences and the American Society of Criminology. He serves as a manuscript reviewer for the *Journal of Criminal Justice Education* (JCJE), *Police Practice and Research: An International Journal*, and Roxbury Publishing Company in the areas of race, ethnicity, and crime.

Dr. Patenaude will be responsible for training interns and research assistants in the qualitative aspects of data collection and assisting in the analysis of interview and focus group results. He will also be responsible, in part, for the completion of the final report.

John Phillips, C.A.D.C., C.C.S., (Arkansas Department of Correction)

Mr. Phillips is assigned to the Arkansas Department of Correction's Diagnostic Unit at Pine Bluff where he has served as both the Early Intervention, Diversion, and Intensive Supervision Project (E.I.D.I.S.P.) Program Leader and Dual Diagnosis Program Leader since 1995. Mr. Phillips has been involved in the substance abuse treatment field for over 11 years. He received his professional designations as Certified Alcohol and Drug Counselor and a Certified Clinical Supervisor from the Arkansas Substance Abuse Certification Board during 1987 and 1996, respectively. Mr. Phillips provides service to the others in the substance abuse treatment field by serving as the current Secretary to the Arkansas Substance Abuse Certification Board, a member of the Bureau of Alcohol and Drug Abuse Program Site Review Team since 1989, and as a former Board Member of the Arkansas Association of Alcoholism and Drug Abuse Counselors. Mr. Phillips was recognized as Counselor of the Year, 1998, by the Arkansas Association of Alcoholism and Drug Abuse Counselors. Mr. Phillips' responsibilities also include the selection and comparison of treatment and control groups as well as the compilation of a statistical profile to aid in determining the appropriateness of the SATP program to client needs and successful completion of the program.

Mr. Phillips will be responsible for inmate data collection concerning inmate screening and suitability for the program in conjunction with Mrs. McLemore. Additional duties will include double entry and verification of key variables from inmate files and the transmission of that data to the Department of Criminal Justice.

Jerry Runyan, L.S.W. (Arkansas Department of Correction)

Mr. Runyan is a Licensed Social Worker and is the Aftercare Coordinator for the Arkansas Department of Correction's Therapeutic Communities located at Tucker Unit and at Benton Work Release Unit. Mr. Runyan has worked with the Arkansas Department of Correction's Therapeutic Communities since April of 1997. Before that he was on the staff at the Department of Community Punishment (Central Arkansas Community Punishment Center), Department of Human Services - Division of Mental Health Services (Act 911, Forensics Program and Behavior Management treatment Unit, Benton Services Center) and the Department of Correction's Mental Health Services Unit at the Tucker Unit during the late 1980's. Mr. Runyan has experience with behavior management techniques and many aspects of chemical dependency issues. He has over 14 years experience in corrections and forensics. As Aftercare Coordinator for the ADC - Therapeutic Community, he prepares - then follows releasees and parolees who have completed the TC program. He is in close contact with the parolee as well as their assigned parole officer to monitor progress and offer assistance as needed. He follows each parolee for approximately 18 months.

Mr. Runyan will be responsible for identifying variables for future research for outcome and impact evaluations.

Appendix J - TC Books and Materials

TC Classroom and Instructional Materials

1. Hamilton, Tim and Pat Samples. 1994. "The Twelve Steps and Dual Disorders." With accompanying workbook.

2. Swanson, Jan and Alan Cooper. 1995. "Relapse and HIV Risk." With accompanying workbook.

3. Perlman, Art. 1992. "Understanding." With accompanying workbook.

4. Perlman, Art. 1996. "Self-Esteem." With accompanying workbook.

5. Perlman, Art. 1996. "Grief." With accompanying workbook.

6. Sheehan, Tim. 1992. "Depression." With accompanying workbook.

7. Sheehan, Tim. 1992. "Shame." With accompanying workbook.

8. Drilling, Eileen. 1992. "Perfectionism." With accompanying workbook.

9. Drilling, Eileen. 1992. "Anxiety & Worry." With accompanying workbook.

10. Hafner, Jack A. 1992. "Anger." With accompanying workbook.

11. Rollo, Ned. 1988. *99 Days & A Get Up: A Pre- and Post-Release Survival Manual For Inmates and Their Loved Ones.*

12. Rollo, Ned. 1993. *Man, I Need a Job: Finding Employment with a Criminal History.*

13. Ingraham, Linda, Steve Bell and Ned Rollo. 1998. *Life Without a Crutch: An Introduction to Recovery from Addiction.*

14. Rollo, Ned and Louis W. Adams. 1993. *A Map Through the Maze: A Guide to Surviving the Criminal Justice System.*

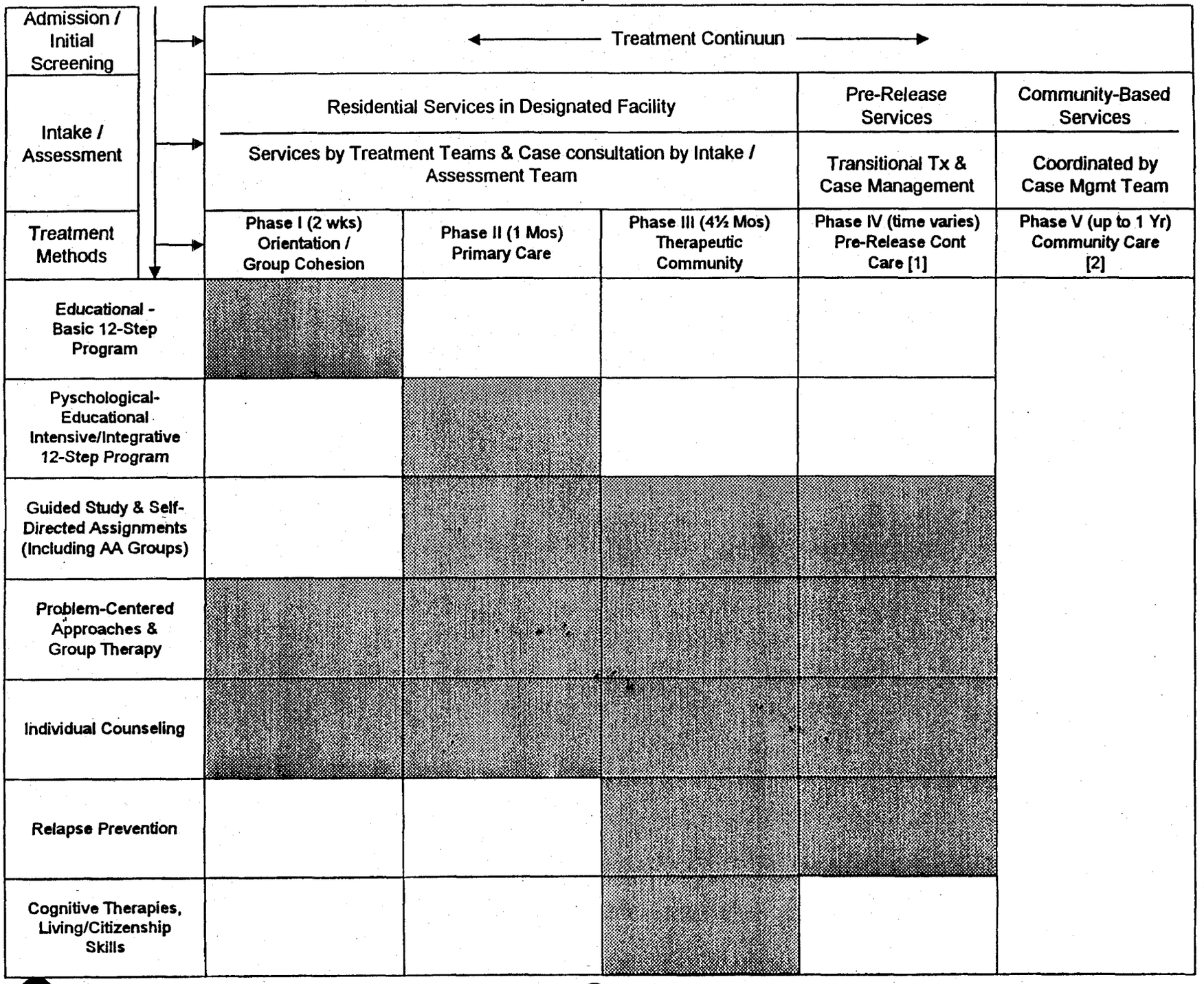
15. Larsen, Robert. 1998. "Medical Aspects of Chemical Dependency." Workbook.

16. Cooper, Jack D. and Michele Julian. 1995. "Free Your Mind." A Workbook for Cognitive Skills, Awareness and Development.

17. Cooper, Jack D. 1993. "The Price of Freedom is Living Free." Relapse, Recidivism and Recovery Workbook.

Appendix K - Phase Schedule

Comprehensive Substance Abuse Treatment Program Design



[1] Persons in Phase IV will be monitored by Social Worker/Case Coordinator and interface with SATP personnel across the 13 existing SATP programs.
[2] - Treatment methods will vary depending on community based needs.