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SUMMARY OF KEY FINDINGS OF A PROCESS EVALUATION OF THE OZARK CORRECTIONAL CENTER DRUG TREATMENT PROGRAM

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Introduction

Therapeutic communities (TC) are emerging as the primary approach used in prisons to treat substance abuse (Wexler, 1995). Through a 24-hour per day learning experience, TC programs seek to make global life-style changes in the residents that include refraining from substance use, engaging in pro-social conduct, obtaining employment, and adopting attitudes and values that support these changes (Pan, Scarpitti, Inciardi, & Lockwood, 1993). Researchers have documented the success of prison-based TC programs in reducing substance abuse and recidivism, particularly when combined with follow-up treatment in the community (Field, 1985; Knight, Simpson, & Hiller, 1999; Martin, Butzin, Saum, & Inciardi, 1999; Wexler, Falkin, & Lipton, 1990; Wexler, Melnick, Lowe, & Peters, 1999).

In October 1993, the Missouri Department of Corrections (DOC) received a 3-year Center for Substance Abuse Treatment (CSAT) grant to create a therapeutic community (TC) substance abuse treatment program for inmates in Ozark Correctional Center (OCC), an all male, 650-bed minimum security prison. Program development and implementation proceeded under this grant, and by April 1995, the first program graduates were released into the community. Between February 1, 1994 and September 30, 1996, the OCC Drug Treatment Program (OCCDTP) admitted 1,268 inmates, of which 693 successfully completed the program.

Most candidates are referred to OCCDTP by the Missouri Board of Probation and Parole. A limited number are sentenced directly to the program by Missouri circuit court judges. DOC staff screens all persons referred to the program. During the study's evaluation period, primary

program criteria included a history of substance abuse, the absence of serious health or mental health problems, and eligibility to participate in the prison's work release program.

OCCDTP consists of four phases. During Phase 1, which typically lasts about 30 days, treatment staff completes assessments and develops treatment plans. Phase 2 involves intensive treatment for a minimum of 30 hours weekly for 6 to 9 months. This treatment includes participation in the TC structure and activities, in substance abuse and life skill psychoeducational activities, in individual and group therapy, and in weekly Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings. In Phase 3, inmates participate in supervised community work release projects for 40 hours weekly for 3 to 6 months. While in the work release program, inmates continue to participate in the TC structure and activities, in relapse prevention activities, and in AA/NA groups. Phase 4 usually takes place during inmates' last 30 days at the prison. During this period, the aftercare plan is completed, including finalization of the inmate's community-based aftercare. The program activities and total length of time in the program, usually 12 to 18 months, are similar to TC programs in other states (Inciardi, 1995; Knight, Simpson, Chatham, & Camacho, 1997).

An initial evaluation of OCCDTP conducted at the end of the 3-year CSAT grant period found that program graduates released into the community experienced fewer rearrests and had lower levels of substance abuse than a matched comparison group of DOC inmates who did not participate in any substance abuse treatment prior to release. In January 1998, the National Institute of Justice (NIJ) awarded a grant (NIJ #97-RT-VXK013) to the Addition Technology Transfer Center, University of Missouri at Kansas City, to conduct a more extensive evaluation of OCCDTP. The grant called for an expansion of the outcome and process studies funded under the initial CSAT grant. The final report of the process evaluation addressed four areas, including

(a) changes in OCCDTP treatment activities; (b) characteristics of OCCDTP participants; (c) utilization of aftercare; and (d) participant ratings of OCCDTP and aftercare (Linhorst, 2000).

This report summaries the key findings from the process evaluation of OCCDTP that was funded by the 1998 NIJ grant (Linhorst, 2000). It focuses on changes in the treatment program that were associated with two events that occurred at OCC during the evaluation period. These included the enactment of a no-smoking policy for inmates and a change in treatment providers contracted to operate the treatment program. This report concludes with recommendations for prisons that are implementing or are considering implementing prison-based TC programs.

Information Sources

Three information sources were used to evaluate the impact of the no-smoking policy and the change in treatment providers on implementation of OCCDTP. First, focus groups were held with key administrative and treatment program staff. To promote openness of discussion, separate focus groups were held with three different groups of staff: (a) the eight OCCDTP counselors who had been employed by both the original treatment provider and the new contract provider; (b) the three OCCDTP counselor supervisors; and (c) four administrative staff, including the OCC Superintendent, the OCC Associate Superintendent, the OCC Chief of Custody, and the site director of OCCDTP.

Second, three sets of documents were reviewed. First were Oversight Committee meetings minutes. Every one to three months, the OCC Superintendent leads a committee referred to as the Oversight Committee. This committee consists of staff from OCC; DOC administrators who work outside of OCC; OCCDTP staff, including the on-site director and regional staff; and the professor from the Center for Social Research at Southwest Missouri State University (SMSU) who was the study's principal investigator. Minutes were reviewed for

seven meetings, spanning September 1996 to October 1997. Second was a DOC report, "Tobacco Free Procedures for Inmates of Institutional Treatment Centers and Community Release Centers: Pilot Project Evaluation Summary Report." Third were program descriptions, including those found in the original grant proposal and the Request for Proposals delineating the program requirements for the new treatment provider.

As a final source of information, a computerized inmate database was created that included demographic, legal, diagnostic, and follow-up data. Relevant to the findings presented in this report were questions added to a 12-month follow-up questionnaire that addressed the impact of the no-smoking policy and the change in treatment providers.

Initiation of No-Smoking Policy

The first major issue impacting implementation of OCCDTP was the initiation of the no-smoking policy for all OCC inmates. State prisons and jails are increasingly banning smoking on prison grounds or limiting it to outdoor areas within prison grounds (Falkin, Strauss, & Lankenau, 1998; Lillis, 1994). Consistent with this trend, a group of Missouri legislators approached DOC about banning smoking in Missouri prisons. The two parties agreed to initiate a smoking ban as a pilot project in selected DOC facilities and to evaluate its impact after one year. On July 1, 1996, DOC instituted a tobacco free pilot project that prohibited use of tobacco by inmates at all DOC Institutional Treatment Centers and Community Release Centers, including OCC. Under this policy, inmates could not smoke anywhere on the facility grounds, although staff were still allowed to smoke outdoors. On April 1, 1998, DOC reversed the policy and inmates were allowed to smoke outdoors.

Participants from all three focus groups believed that the no-smoking policy had a substantial detrimental effect on implementation of the TC program at OCC. Both staff and

inmates indicated that within a short time after enactment of the no-smoking policy, cigarettes became the drug of choice, replacing illegal drugs. Smoking created a subculture of criminal activity, and inmates who previously were not involved in policy violations obtained and used cigarettes illegally, became involved in cigarette trafficking, or committed other violations related to smoking.

These behaviors affected OCCDTP in at least two ways. First, numerous instances were cited by staff in which inmates blatantly smoked in order to obtain violations so they could be discharged from the treatment program and be transferred to a non-treatment prison that permitted smoking. These inmates included some who previously had been actively participating in treatment and had no conduct violations. Hence, the no-smoking policy resulted in an increase in the program dropout rate. Across all DOC Institutional Treatment Centers, the number of negative terminations from treatment increased by 13%, and the number of positive program completions dropped by 15% during the first year of implementation of the no-smoking policy. Consistent with this, 25% of all inmate conduct violations were tobacco-related.

Second, a DOC report that evaluated the impact of the non-smoking policy on all DOC treatment institutions one year after initiation of the policy concluded that the treatment environment had been significantly impaired as a result of the no-smoking policy. Counselors found it increasingly difficult to provide treatment to the large number of inmates who were involved in behaviors associated with violation of the no-smoking policy. Implementation was widely reported to have caused inmates to lose focus on their treatment goals. The effects of the policy interrupted the support that had developed as part of the TC model, particularly since the policy still allowed staff to smoke outdoors. Correctional officers had to assume more of a role of "cop," which negatively affected their ability to support the pro-social behavior of inmates.

Inmates' evaluation of the impact of the no-smoking policy

OCCDTP inmates viewed the no-smoking policy as having had a detrimental effect on the treatment program, which is consistent with perceptions of staff from the focus groups and with the DOC report. Inmates' reactions were measured through two questions added to the 12-month follow-up survey of inmates who had successfully completed the program and who were present when the no-smoking policy began. The vast majority of inmates indicated that the initiation of the no-smoking policy hurt their morale. Even more strongly, almost 80% of the inmates indicated that the policy change significantly hurt the treatment program. Only 6.2% of the inmates responded that the no-smoking policy had no effect or improved the treatment program. Table 1 summarizes their responses to the two questions.

TABLE 1
Inmates' Evaluation of the Impact of the No-Smoking Policy

How did the no-smoking policy affect your morale? Would you say it:	
Significantly improved your morale?	3.4%
Slightly improved your morale?	2.3%
Had no effect on your morale?	34.1%
Slightly hurt your morale?	19.9%
Significantly hurt your morale?	40.3%
Total	*100.0%*
	(N=176)
How did the no-smoking policy affect the treatment program? Would you say it:	
Significantly improved the treatment program?	1.7%
Slightly improved the treatment program?	1.1%
Had no effect on the treatment program?	3.4%
Slightly hurt the treatment program?	14.3%
Significantly hurt the treatment program?	79.4%
Total	*99.9%*
	(N=175)

DOC rescinded the tobacco free policy on April 1, 1998. Although the focus group interviews were held only 21 days after this policy change was made to allow inmates to smoke

outdoors, respondents already observed a substantial improvement in the atmosphere of the prison, with a corresponding positive impact on the treatment environment.

Change in Treatment Providers

The second major issue affecting implementation of OCCDTP was a change in treatment providers. The use of private providers to operate entire prisons or to provide programming within state-run prisons is increasingly common, although the privatization of public services is still controversial (Chalk, 1999; Gormley, 1994; Patterson, 1998; Travis, Latessa, & Vito, 1985; York, 1993). While DOC still operates the state prisons, it contracts with private organizations to provide inmates with medical care and some substance abuse treatment and educational services. OCCDTP is implemented by a private provider under contract with DOC. One treatment provider held the contract throughout the 3-year initial CSAT grant period, which ended on September 30, 1996. At the end of the grant period, DOC assumed funding for the program in its entirety and initiated a competitive process for the treatment contract. On November 1, 1996, DOC issued a Request for Proposals (RFP) for the service contract. DOC selected a different treatment provider, and on May 1, 1997, the conversion to the new provider was completed. Information from both staff and inmates indicated that the change in treatment providers had a negative impact on the program. It affected staffing levels, staff training, and the use of individual treatment of inmates.

Staffing changes

The initial CSAT grant funded 21 counselors and three counselor supervisors. According to the counselor supervisors, on April 18, 1997, the program had 24 counselors and 4 supervisors. On May 1, 1997, the new provider cut the salaries of all treatment staff and reduced the number of counselor positions and counselor supervisor positions to its previous level of 21

and 3, respectively. A number of counselors chose not to accept the pay cut and resigned. Consequently, the number of counselors fell from 24 to 17 almost immediately. New hirings increased the staffing levels to 20 counselors, although it was not until January 1998 that the new treatment provider reached its full staffing of 21 counselors.

Participants in all three focus groups raised concern over the staffing reductions and turnover of staff. Counselors identified the added stress of trying to cover the workload of the counselors who left and believed they no longer had the time to provide needed treatment to all inmates. The counselor supervisors indicated that several of the staff members who left were "key" staff members who had been with the program since its inception. Supervisors believed their absence reduced the overall quality of the program. They also believed that the staffing changes disrupted the sense of trust and community that are integral to TC programs. They strongly indicated that staff retention was vitally important to maintaining the integrity of TC programs.

Participants in the administrator focus group said the staff turnover also negatively affected the relationships between counselors and correctional officers. In a TC system, open communication between the two groups is important, and it is facilitated by strong working relationships that develop over time. The turnover in counselors made the development of such working relationships difficult, particularly during the initial period after the hiring of new counselors occurred.

Counselor training

The issue of counselor training was raised in the counselor and counselor supervisor focus groups. The counselors indicated that while all had prior work experience and education in substance abuse treatment, some had not worked within the TC model, and none had previously

worked within a prison setting. They agreed that it takes counselors about one year to become fully trained and to function as an independent counselor in a prison environment. The counselors indicated that one of the benefits of working during the initial program start-up that was funded through the CSAT grant was the extensive training they received about substance abuse treatment, the TC model, and functioning within a prison setting. Although the counselor training provided by the new treatment provider appeared to meet contract requirements, both counselors and counselor supervisors believed that the training the employees received from the new provider was substantially less than that received under the initial grant and inadequately prepared counselors to implement the TC model within a prison setting.

Services provided

Both counselors and counselor supervisors agreed that the number of group activities offered by counselors remained about the same under both treatment providers. However, the staffing reduction influenced treatment services in two ways. First, both counselors and counselor supervisors indicated that the amount of work with individual inmates greatly diminished because of the staff reductions. Second, counselors indicated the number of inmates participating in each group therapy session greatly increased, which they believed reduced the effectiveness of the treatment. They stated that the optimal group therapy size was 12 inmates with a maximum of 16 inmates, but that group size grew in some instances to 24 inmates or occasionally more. One counselor indicated that this growth began under the first provider as the program reached full implementation. Others stated that the increased number of inmates did not appear to be as great a burden under the first provider because that provider gave staff an opportunity to process the changes and deescalate. They believed that the new provider did not offer this support.

Inmates' evaluation of the change in treatment providers

Inmates' reactions to the change in treatment providers were measured through two questions added to the 12-month follow-up survey of inmates who had successfully completed the program and who had received treatment from both treatment providers. The first question examined the impact of the change in treatment providers on inmates' morale and the second on their treatment. Table 2 includes inmates' responses to both questions.

TABLE 2
Inmates' Evaluation of the Change in Treatment Providers

How did the change to the new treatment provider affect your morale? Would you say it:	
Significantly improved your morale?	0.0%
Slightly improved your morale?	2.7%
Had no effect on your morale?	58.7%
Slightly hurt your morale?	25.3%
Significantly hurt your morale?	13.3%
Total	*100.0%*
	(N=75)
How did the change to the new treatment provider affect your treatment? Would you say it:	
Significantly improved the treatment program?	0.0%
Slightly improved the treatment program?	8.6%
Had no effect on the treatment program?	27.1%
Slightly hurt the treatment program?	28.6%
Significantly hurt the treatment program?	35.7%
Total	*100.0%*
	(N=70)

Inmates' evaluation of the change in treatment providers is consistent with the findings from the focus groups that the change had a negative effect on the treatment program. Morale was largely unaffected for the majority of inmates, although about one-fourth indicated it slightly hurt morale and an additional 13.3% indicated it significantly hurt their morale. The impact on treatment was much greater. Almost two-thirds of the inmates indicated that the change in

treatment providers hurt the program, including 36% who indicated that it significantly hurt treatment. None of the respondents indicated the changed in providers significantly improved the program, and only 9% of the inmates indicated the change slightly improved the program.

Implications for Future TC Prison Programs

OCC's experience with developing and implementing the TC program has implications for prisons that operate or are considering developing TC programs. First, implementation of TC programs requires that administrative, custody, and treatment staff assumes and enacts new roles. Extensive, high quality training is required to provide staff with the knowledge, skills, and attitudes to fulfil those roles. It is important that adequate time and resources be given to carry this out. In the case of OCCDTP, a CSAT grant provided funding for the program start-up, which included a comprehensive training component that was highly rated by staff.

Second, even when TC programs have matured, they still must contend on an ongoing basis with factors beyond their immediate control that can decrease program quality. In the case of OCCDTP, those factors were the enactment of a no-smoking policy and a change in treatment providers. Efforts are needed to anticipate possible unintended consequences of policies, even when not directly related to the operation of the program.

Third, the process of contracting for treatment services and rebidding contracts should take into consideration the importance of a stable workforce trained in the TC model and be mindful of the negative ramifications a change in providers can have on the quality of the program. Therapeutic community treatment contracts may be one instance in which continuity of service takes precedence over marginal short-time financial savings; changing providers ultimately could lead to higher costs and poorer inmate outcomes.

Finally. ongoing administrative support is essential to the implementation of TC programs in prisons. This support is necessary when the program begins to ensure staff is willing and able to assume their new roles within the TC model. This support is also necessary given the large amount of time it takes for TC to mature, which focus group respondents estimated to be between two and three years. Lastly, administrative support is necessary to guide programs through the ongoing changes and challenges they are sure to face.

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