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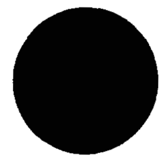

PROCESS EVALUATION OF THE MICHIGAN DEPARTMENT OF CORRECTIONS' RESIDENTIAL SUBSTANCE ABUSE TREATMENT (RSAT) PROGRAM

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at The George Washington University
and
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Submitted to
The United States Department of Justice
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EXECUTIVE SUMMARY

In recent years, the nation's correctional systems have witnessed a significant increase in the number of people incarcerated for drug-related crimes. In 1994, Congress appropriated significant funds to support the treatment and sanctioning of drug-using violent offenders through *The Violent Crime Control and Law Enforcement Act of 1994*. Under this Act, the Correctional Programs Office (CPO) anticipates awarding over $260 million through the year 2000 for intensive residential substance abuse treatment programs (RSAT) within state prisons.

In addition to providing funds to support the operation of RSAT programs, the federal government, through the National Institute of Justice (NIJ), has also provided funds for the assessment of the implementation and impact of the various RSAT models that have been implemented nationwide. In 1998, the NIJ awarded the National Council on Crime and Delinquency (NCCD) a contract to conduct a process evaluation of the Cooper Street RSAT program in Jackson, Michigan. On January 1, 1999, NCCD subcontracted the balance of the original contract to The Institute on Crime, Justice and Corrections at The George Washington University.

Despite significant funds available to support prison-based drug treatment, important questions remain about their implementation and effectiveness. As described in the literature, there is evidence that sound programs can impact both recidivism and substance use (see Lipton (1995), Inciardi (1996), and Wexler et al. (1990)). However, the small number of studies to date, especially studies that employ rigorous experimental designs, prevent conclusive statements about the effectiveness, and sometimes even the content, of correctional substance abuse programming. Tunis et al. (1996) state, "The field could benefit greatly from a thorough description of these programs, including coverage of who participates in them, who completes them, and who goes on to be rearrested and convicted within the following year."

This study was designed to answer the first part of this call for action. The overall goals of this research were to 1) conduct a process evaluation that examined the integrity of program evaluation, and 2) make specific recommendations with regard to program structure and eligibility criteria that could better prepare the program for an impact evaluation. Simultaneous to this project, the Michigan Department of Corrections (MDOC) contracted with the University of Michigan (UM) to conduct an evaluation of the long-term impact of the RSAT program on offender substance abuse and recidivism. This report endeavors to highlight key implementation issues that could create substantial barriers to a rigorous outcome evaluation, and also makes several recommendations for overcoming these barriers.

Research Methodology

The goals of this research were accomplished using a process evaluation framework to examine key components of the program's design, implementation, and operation. The major areas of focus include:

- Program Context, including the way the program was designed, the agencies contributing to its development, program costs, and the operating assumptions regarding criminal behavior and the treatment of addiction;
- Program Goals, including the compatibility of the goals, operating assumptions and

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selection of participants; the goals' clarity and measurability; and the level of buy-in from key stakeholders;

- Selection Criteria, including the stated eligibility criteria and their operation in the selection of participants; the profile of applicants versus the larger pool of eligible inmates; rates of program completion; and the frequency and reason for program drop-outs and terminations;

- Program Intervention, including a comparison between the program's design and its form once operational; the type, intensity and duration of services received and the degree to which treatment standards have been realized; and

- Interagency Linkages, including the level of cooperation and coordination among the agencies actively involved in the delivery of the program, as well as the relationship between the program and the Michigan Parole Board.

These issues were examined using multiple data sources, including a stock population snapshot data file pulled from the MDOC's Correctional Management Information System (CMIS), a data file containing information on the level of satisfaction of each of the eligibility criteria for all applicants to the RSAT program, and a data file built from the manual collection of service tracking data. Further, descriptions of the original program design and eligibility criteria were extracted from written documentation including program manuals, internal memos, and handbooks.

Results

Program Context. All parties who undertook the development of this program agreed on one principle: the time spent in custody by offenders with serious histories of substance abuse represents a unique opportunity to provide treatment that would not be accessed in the community. This, coupled with the reality that drug-using felons are a primary source of parole failures, motivated the essential structure of the MDOC RSAT model–a six-month in-custody component followed by a mandatory 12-month aftercare phase.

The in-custody phase of treatment was guided by a standardized, cognitively-based curriculum created by Ken Wanberg and Harvey Milkman, *Strategies for Self-Improvement and Change*. The main theory behind the curriculum is that education about drugs, their physical, familial, and social effects, coupled with opportunities to learn about recovery and to identify triggers for substance abuse, will help substance-abusing offenders to avoid both drugs use and criminal behaviors once released. The aftercare component is designed to begin during the in-custody phase of treatment and endeavors to involve the offender's family and significant others in a specific plan to support recovery and prosocial behavior upon the offender's release. The aftercare component is also designed to provide on-going guidance and support through linkages with parole officers and community-based treatment programs.

While the Michigan RSAT program was not immune from the conflict inherent in treatment-within-corrections settings, the significant support for the goals and objectives from the facility's Warden was one of the most highly touted assets of the program. In addition to mobilizing the considerable resources of the MDOC to resolve key structural and operational issues, the Warden also contributed significant resources in the form of staff overtime and costs

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associated with drug testing, resources which were required to ensure the compliance with federal RSAT guidelines.

Program Goals. The primary goals of the RSAT program are to reduce recidivism and drug use among substance-abusing, minimum-custody male inmates after their release from prison. The goals were affirmed by all stakeholders, although at times the in-custody and aftercare components did not appear to be equally valued. Part of this imbalance appeared to be associated with the fact that, during the first six-months of operation, none of the RSAT participants had yet progressed to the community-based aftercare phase. However, there was also a lack of coordination and cooperation among the stakeholders that resulted in a significant organizational shift made in the spirit of promoting greater unity among the staff of the two components.

Selection of Participants. The RSAT participants were to be selected from those inmates in the MDOC who were classified as minimum custody, were nearing their release dates, had a documented drug history, and were willing to participate in the RSAT program. In order to select appropriate participants from over 20,000 minimum custody inmates, these basic eligibility criteria were defined:

1. Must be within 12 to 18 months of earliest release date (ERD) at application, and within 6 to 12 months of ERD at admission;
2. Must be non-violent offenders; the non-violent criterion is assessed through an assessment of current offense, institutional behavior and current record;
3. Must have Level I (minimum) classification level;
4. Must meet the DSM-IV diagnosis for substance abuse or dependancy; and
5. Must be free of physical or mental health issues that would prevent full participation.

The program is voluntary, and applicants must agree to follow all rules including drug testing, treatment and participation in the 12-month aftercare component. As of August 30th, 1999 the program had received 834 applications, of which 84 percent were accepted, two percent were denied, and 15 percent were placed in a pending file to await the approach of an appropriate ERD. There were 323 inmates admitted to the RSAT program prior to July 1st, 1999, and only 17 percent of these dropped out or were terminated prior to the completion of treatment. These low attrition rates are promising, but should be interpreted with caution as they include only the program drop-outs from the in-custody phase.

A great deal of ambiguity surrounds the type of offender (violent versus non-violent) who is eligible for admission. The eligibility criteria have been revised several times, yet a gray area still exists regarding the type of violence that would exclude an offender from the program. Approximately 42 percent of the RSAT participants were incarcerated for violent offenses, yet the inclusion of these individuals does not appear to have compromised the safety or security of the unit. Overall rates of misconduct are low, and only three incidents in the first six months of program operations involved physical violence. Therefore, the practice of admitting violent offenders is appropriate. However, the eligibility criteria should be written with greater specificity to ensure their consistent application across offenders.

The issues of greatest concern are the practices of accepting and admitting inmates whose ERDs are beyond the 12 month range, as well as a significant proportion of sex offenders and other violent offenders. These inmates have historically low rates of being granted parole,

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which in turn, compromises the program's goal of having inmates released from the in-custody phase to the aftercare component.

For example, one month after the graduation of the first cohort of offenders (n=128), only 15 percent (or, 20 inmates) had been discharged to the aftercare component within four weeks of completing the in-custody phase of treatment. This is a potentially large source of attrition, and one that needs to be monitored closely. One source of this problem is the large number of inmates who were admitted to the program with over 12 months until their ERDs. While it was prudent to ensure that in-custody beds were filled, it may have sacrificed the integrity of the treatment services as a significant number of offenders may not be able to complete the full program.

The screening process resulted in a moderate rate of overrides. Nearly one in five inmates accepted to the program did not satisfy each of the five eligibility criteria. The documentation of the screening process appears to require further rigor, as the current method resulted in several instances of contradictory data. The reasons for overrides also need to be documented more clearly.

The high rate of applications (averaging 83.4 per month), combined with the limited program capacity (272 beds in the in-custody component), has resulted in a waiting list that is consistently over 150 inmates. The number of applicants accepted to the program suggests that sufficient candidates would be available to conduct an outcome evaluation that employs random assignment, providing that the ERD issue can be resolved.

Intervention. The program, as designed, reflects many of the best practices that have been reported in the relevant research. It included a full six-months of in-custody treatment and a strong aftercare component to support the inmates' continued progress upon release. In practice, however, several modifications were made to the original design that significantly reduced the intensity of treatment (fewer hours of treatment, on fewer days), and that reduced the number of components that created the multi-faceted design. For the most part, these changes were the result of shortages of physical space and inadequate staffing levels.

While the offenders appear to receive consistent services on the modified schedule, there have been significant adjustments in the use of the structured curriculum. The *Strategies for Self-Improvement and Change* curriculum that is the foundation of the program is a phase-based model, under which offenders progress to different phases of treatment based on the passage of time and the completion of specific lessons. Because of the space and staff-shortage issues, the time frames for the phases of treatment did not conform to the prescribed duration. The impact of these adjustments on the effectiveness of treatment is unknown at this time, but is an issue that should be closely monitored.

While the lack of adequate space has improved over time, it still remains marginal in terms of the ability to accommodate multiple group meetings, as well as the considerable number of individual counseling and assessment sessions that are to occur. Early in the program, some important questions arose about the qualifications of the treatment staff and the frequency of supervision. The staff have been recently restructured so that less experienced staff are supervised by more senior counselors. Staff supervision was a challenge due to a lack of unity among the in-custody staff and several volatile situations that, for a time, brought case

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conferences and full staff meetings to an end. The degree to which these issues are resolved should be monitored closely for their influence on the quality of treatment provided.

Interagency Linkage. Originally, Western Michigan University (the agency contracted to provide treatment services) subcontracted with Longford Health Services to provide the in-custody treatment services and with Family Services & Children's Aid to provide the aftercare services. While developed to harness the unique expertise of each agency, these complicated interagency relationships proved to be a significant impediment to the delivery of services. Although Family Services & Children's Aid staff appeared to provide high-levels of treatment and assessment, issues of interagency cooperation and communication resulted in the termination of their contract. The majority of aftercare staff were re-hired by Longford, in order to effect as little disruption as possible in the delivery of treatment services. These changes were made with the hope that unity under one agency umbrella would dissipate some of the animosity that had interfered with the delivery of high-quality services. While the unification under one agency is certainly a symbolic indicator of change, future research should examine the success with which this shift has improved relations between and among the in-custody and aftercare treatment staff.

A critical relationship to the operation of a treatment program within the correctional setting is the program's relationship to the Parole Board. Although reportedly impressed with the services featured by the RSAT program, the Parole Board has withheld any direct connection to the likelihood of parole for graduates until outcome data have demonstrated the program's effectiveness in terms of reduced recidivism.

RECOMMENDATIONS

The recommendations that follow are designed to enhance the integrity of the screening process, improve documentation, and to ensure that the aftercare component is fully utilized.

1. Revise the eligibility criteria to reflect the actual practice of admitting both non-violent and violent offenders, and provide greater specificity of the nuances that would restrict acceptance based on this criteria.

2. Examine the issue of accepting large numbers of offenders who, upon completion of the in-custody treatment phase, are not likely to be discharged from the MDOC in a timely manner. Such offenders would include those with ERDs beyond eight months from the date of admission and offenders with historically low rates of parole (e.g., sex offenders, other violent offenders).

3. Revise the screening form to require an affirmative response for the each of the five criteria, without an additional layer of denial criteria. Denials should be based on the failure to meet one or more of the eligibility criteria, and any overrides should clearly document the reason for the exception.

4. Develop an automated service delivery tracking system that permits the easy retrieval of accurate data pertaining to the dosage and type of intervention received by individual offenders. Issues with data accuracy and the efficiency of current data systems should also be addressed.

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5. Promote greater unity within the treatment components and between the in-custody and aftercare staff. Attend to changes that may arise under the new organizational structure and ensure that the program environment supports adequate supervision of treatment staff.

6. Strengthen the relationship to the Parole Board to ensure a high probability of parole for RSAT graduates.

7. Implement a rigorous experimental design that includes random assignment to treatment and control conditions.

RECENT DEVELOPMENTS

These issues were communicated to the Michigan Department of Corrections which has taken some initial steps in addressing these concerns.

1. The DOC has worked with the Parole Board to develop a revised eligibility screening instrument. This instrument will select offenders for RSAT admission based on their propensity to parole as evident by the nature of their instant offense, prior criminal history and institutional conduct. It is not the intent of the Parole Board to give special consideration to those graduating from the program, hence it is critical that the program admit and graduate only "parole-able" offenders. The impact of this new instrument on the types of offenders admitted and the length of time from graduation to DOC discharge should be a key line of inquiry for future research.

2. Because of the ambiguity surrounding the status and its overlap with the waiting list, the "Pending" admission category has been eliminated. All offenders will be either approved or denied, and organized for admission according to their ERD. The impact of this change should be examined to ascertain the key differences between the groups of offenders who are admitted and denied to the program.

3. The DOC is making a concerted effort to fund and implement an "interim care unit" for RSAT graduates to receive step-down services until release on parole. If funded, this unit would fill an important gap in services for graduated offenders who are awaiting DOC release. Future impact studies should also examine the type, intensity and duration of these "step-down services" and their impact on long-term outcomes.

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1 INTRODUCTION

In recent years, the nation's correctional systems have witnessed a significant increase in the number of people incarcerated for drug-related crime. Between 1990 and 1995, the number of inmates sentenced to state prison for drug-related offenses increased by approximately 8.6 percent.[1] In 1994, Congress appropriated significant funds to support the treatment and sanctioning of drug-using violent offenders through *The Violent Crime Control and Law Enforcement Act of 1994*. Under this Act, the Correctional Programs Office (CPO) anticipates awarding over $260 million through the year 2000 for intensive residential drug treatment programs within state prisons.

One such program, the Michigan Department of Corrections' (MDOC) Residential Substance Abuse Treatment (RSAT) program, is located at the Cooper Street Correctional Facility in Jackson, Michigan. The Jackson Cooper Street facility (JCS) is a secure Level I facility, meaning that it has secure perimeters, a perimeter detection system, and vehicle perimeter patrol. JCS houses offenders who require minimum supervision and who are close to their parole dates. Unlike the regular Level I facilities, a secure Level I facility is permitted to house individuals convicted of sex offenses. The 272-bed RSAT program is designed to treat male, minimum-custody inmates with a history of serious chemical dependency. By design, the program includes a six-month residential phase that features multiple treatment modalities. Following release from custody, a 12-month aftercare component is designed to promote sobriety and stability in the community.

In 1998, the MDOC had a $1.33 billion annual budget, and employed 17,267 staff, which included 8,664 correctional officers. The MDOC operated 39 prisons (two of which were

[1] US Department of Justice, Bureau of Justice Statistics (1997). *Correctional Populations in the United States, 1995*. Washington, DC: Office of Justice Programs.

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for female inmates), 14 camps (one for females), and one boot camp program. The inmate population was approximately 44,000. Since 1992, there has been a significant decrease in the parole approval rate, particularly for assaultive and violent offenders. Of 20,000 cases coming before the Parole Board in 1998, 10,492 were released on parole.[2]

The RSAT program fits into a larger effort within the MDOC to deal effectively with substance use and abuse among its inmates. Since 1980, funding for substance abuse programs has increased more than 500 percent, from $4.2 million to nearly $24.4 million in 1998. In 1998, 67 percent of offenders at intake reported a history of substance abuse. For more than 10 years, the MDOC has utilized a comprehensive institutional drug testing program for inmates and parolees. Drug testing is conducted a) for cause, b) randomly, c) for placement in prison industries and community-release programs, and 4) as a condition of parole. The MDOC has witnessed a significant decrease in the rate of drug use by inmates, as measured by random drug testing results. In 1987, 8.9 percent of inmates tested positive for drug use, compared to only less than one percent in 1998. "The lower positive findings can be attributed, in part, to new penalties withdrawing visiting privileges for inmates with a positive test."[3]

The MDOC currently offers residential and outpatient substance abuse treatment, drug education, treatment readiness, and 12-step programming (both Narcotics Anonymous (NA) and Alcoholics Anonymous (AA)). In 1998, roughly 1,300 inmates participated in either residential or outpatient drug treatment in any given month. Roughly 4,500 inmates completed substance abuse education programs in 1998. Further, the average weekly attendance at AA and NA meetings totaled 1,100 in 1998. At the time of this report, the MDOC was preparing to open

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[2]Michigan Department of Corrections (1998). *Michigan Department of Corrections 1998 Annual Report.* Lansing, MI: Author.

[3]Ibid.

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two additional RSAT programs, one for men and one for women, with an additional bed capacity of 200 (100 per program). As a result of its history of attention to the issue of substance abuse among inmates and parolees, the MDOC was among the first states to be certified by the U.S. Department of Justice as meeting the substance abuse treatment mandate under the Violent Offender Incarceration and Truth-in-Sentencing grant programs.

Not only has the U.S. Department of Justice, through the CPO, provided funding to support the operation of RSAT programs, it has also provided funds for the assessment of the implementation and impact of the various RSAT models that have been implemented nationwide. In 1998, the National Institute of Justice (NIJ) awarded the National Council on Crime and Delinquency (NCCD) a contract to conduct a process evaluation of the Cooper Street RSAT program. On January 1, 1999, NCCD subcontracted the balance of the original contract to The Institute on Crime, Justice and Corrections (The Institute) at The George Washington University.

In addition to this process evaluation being conducted by The Institute, the MDOC also contracted with the University of Michigan (UM) to conduct an evaluation of the long-term impact of the RSAT program on offender substance abuse and recidivism. Given that these two research projects were to be conducted simultaneously, The Institute and UM developed specific parameters and goals for each project to ensure that MDOC and program staff were not overwhelmed by requests for data and access to the RSAT program. When practical, The Institute and UM shared data sets and other program information to prevent duplicate requests. This report examines only the success with which the program was implemented and does not discuss the effectiveness of the treatment model. In light of this process evaluation, the rigorous evaluation of the RSAT program is strongly encouraged. Although RSAT programs have received

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considerable financial and philosophical support, important questions remain about their ability to reduce recidivism compared to other forms of correctional supervision and treatment.

II RESEARCH METHODOLOGY

The overall goals of this research were to 1) conduct a process evaluation that.examined the integrity of program implementation, and 2) make specific recommendations with regard to program structure and eligibility criteria that could better prepare the program for an impact evaluation. These goals will be accomplished using a process evaluation framework to examine the key components of the program's design, implementation, and operation. The major areas of focus include:

A. Program Context. The context surrounding a program includes the way in which the program was designed, the agencies that contributed to its development, and the operating assumptions regarding criminal behavior and the treatment of addiction. The context also includes program costs and funding.

B. Program Goals. The formal goals and objectives of a program should be logically related to the operating assumptions of the program and should, therefore, guide the selection of participants and the delivery of services. Further, in order to conduct a rigorous impact evaluation, the program's goals should be clearly stated and measurable by objective standards. Given that this program operates squarely in the interface of the punishment versus rehabilitation debate, the level of agreement among the different stakeholders as to the goals of the program is also a key point of examination.

C. Selection Criteria. The way in which a program expands or limits admission is inherently related to both cost- and treatment-effectiveness. Therefore, key research questions focus on the eligibility and admission criteria, and their consistency with program goals and objectives. Further, an examination of the total MDOC population permits an estimation of the size of the eligibility pool, as well as changes in that pool that would accompany any shift in eligibility criteria. It is also important to understand the characteristics of the population of RSAT participants that may influence the way in which an impact evaluation is designed. Finally, rates of program completion, and the frequency and reason for program drop-outs and terminations will be examined.

D. Program Intervention. The RSAT model exists in many forms nationwide. Further complicating the task of evaluating the effectiveness of "the RSAT model" are the changes, evolutions, and omissions that occur as a written program description is transformed into a fully operational program. Thus, prior to any assessment of a program's effectiveness, it is important to know what, precisely, constitutes "the

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program." Toward this end, key research questions examine the type, intensity and duration of the treatment services and the degree to which contact and treatment standards are realized. A key aspect of program implementation is the way in which participants move through the various phases and ultimately exit the program. The flow and length-of-stay issues are critical to an assessment of long-term capacity and cost-effectiveness.

E. Interagency Linkage. The correctional environment is inherently complex, and in this case, is further complicated by the fact that treatment services have been subcontracted to a variety of private providers. Western Michigan University received the funds to operate the RSAT program at JCS. Western contracted with Longford Health Sources to provide the in-custody treatment services and with Family Service & Children's Aid to provide aftercare services. After the first cohort of participants completed treatment, the Family Services' contract was terminated. The reasons for and implications of this reorganization is a key point of examination. The degree of cooperation and communication among these stakeholders is critical to the ability of the program to achieve its goals and to the long-term stability of the program.

These issues were examined using multiple data sources. First, The Institute received data from the MDOC's Correctional Management Information System (CMIS) that included demographic, criminal history, programming, and institutional misconduct information for a stock snapshot of the total inmate population. The snapshot date was July 1st, 1999, and included information on all inmates in the custody of the MDOC on that date. These data were cleaned, audited, and analyzed to form the basis of the comparisons between RSAT applicants and the total inmate populations. These data were also used to estimate the total eligibility pool and to project the number of eligible inmates given slight adjustments to admission criteria.

The Institute also received a data file from the UM researchers containing information on all applicants to the RSAT program. Key variables included: the inmates' identification numbers, race, age, date of screening, ERD, satisfaction of each of five acceptance criteria, and the relevance of any of five denial criteria. While the inmate's drug of choice was included, these data were discarded because of questions about their validity. The drug of choice was not ascertained through any standardized nor objective means; rather, written documentation in the

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offender's file was scanned for mention of relevant drugs. These data were collected using a screening form for each application, and were initially generated and entered into an electronic format by RSAT program staff. UM researchers cleaned and audited the data for consistency and completeness. These data were used to assess the extent to which the screening committee adhered to the established admission criteria, and to detect any differences between inmates who were offered versus denied admission to the program. During the course of this research, other variables were added to the data set, including the inmates' admission status and the date of admission (if applicable) as well as the inmate's parole action and projected date of parole (if applicable). It is important to note that there were several errors and inconsistencies found in these data during the course of this project and significant time was required to verify their accuracy. Given that these data are a primary source of program information for administrators and program managers, improved record keeping procedures are critical to ensure that accurate data are available to UM researchers for their outcome analyses.

In addition to these quantitative data, project researchers made a total of four site visits to the RSAT program to participate in program planning meetings, to develop the parameters for The Institute's and UM's separate projects, and to observe program operations, interview staff and to collect service tracking data. Much of the discussion of the original program description and the evolution of the program is based on written documentation including program manuals, internal memos, and handbooks.

III PROCESS EVALUATION

A. PROGRAM CONTEXT

All parties that undertook the development of this program agreed on one principle: the time spent in custody by offenders with serious histories of substance abuse represents a unique

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opportunity to provide treatment that would not be accessed in the community. Research has shown that drug-using felons are a primary source of parole failures, with as many as 60 to 75 percent of untreated parolees with a history of substance abuse returning to drug abuse and criminal activity within three months of release.[4] This reality motivated one of the unique components of the Michigan RSAT program–a mandatory 12-month aftercare component for RSAT graduates. Unlike many other programs, participation in aftercare services is not voluntary. In order to be eligible for program entry, the RSAT applicant must express his commitment to participate in the 12-month case management program upon release from prison.

This focus on the post-release adjustment of the offenders is a hallmark of the program which is grounded in the philosophy that substance abuse is a "whole-person" disorder that requires attention to the individual's behavior, values and attitudes as well as to his support network and post-release environment. The conceptual underpinnings of the program rest on a standardized curriculum that guides the individual-based work throughout the phases of treatment, *Strategies for Self-Improvement and Change*[5]. This curriculum was originally developed as a state and federally-funded research endeavor by Ken Wanberg and Harvey Milkman. Upon completing an exhaustive review of existing literature on cognitive treatment in correctional settings, Wanberg and Milkman integrated various approaches into a 50-session curriculum that is based on motivational intervention. The curriculum has been implemented in several states, nationwide, but Michigan is currently the largest state using it in a correctional environment. The main theory of change behind the curriculum is that education about drugs, their physical, familial, and social effects, coupled with opportunities to learn about recovery and

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[4]Wexler, H., D. Lipton, and B. Johnson (1988). *A Criminal Justice Strategy for Treating Cocaine-Heroin Abusing Offenders in Custody*. Issues and Practices in Criminal Justice. Washington, DC: National Institute of Justice.

[5]Wanberg, K. and H. Milkman (1998) *Criminal Conduct and Substance Abuse Treatment: Strategies for Self Improvement and Change*. Thousand Oaks: Sage Publications.

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identify triggers for substance use, will help substance-abusing offenders to avoid both substance abuse and criminal behaviors once released into the community. Numerous staff and inmates identified the content and structure of the *Strategies* curriculum as the program's major strength.

The Program Manual developed specifically for the Michigan RSAT program incorporates the *Strategies* curriculum with other program components to provide multi-faceted treatment using individual, group and family-based approaches. Treatment focuses on the lifestyle of addiction, rather than drug use *per se*, an approach which has support throughout the relevant research.[6] The model was developed by Jim Kendrick, of Western Michigan University, and Jeff Kessler, of Longford Health Services. Though not providing direct services, Western Michigan University continues to be highly involved in the program's operation and evolution.

Researchers have often noted the significant challenges inherent in implementing a treatment-based program in a correctional setting. The problems are usually more practical than philosophical, as demands for bed space and procedures for inmate transfers can impede the smooth delivery of treatment services. Indeed, the overall goals of treatment staff and correctional personnel are often the same: to reduce recidivism and substance abuse.[7] Lipton (1995) holds, "In the field of corrections, the [public] health goals and criminal justice goals are compatible, but not frequently implemented coherently. This often gives rise to tension, though as an unintended consequence."[8]

One of the most highly touted assets of the Michigan RSAT program is the high level of practical and philosophical support offered by the facility's Warden. When faced with myriad

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[6] Most notably, Lipton, D (1995). *The Effectiveness of Treatment for Drug Abusers Under Criminal Justice Supervision*. Washington, DC: National Institute of Justice; and Inciardi, J. (1996). *A Corrections-Based Continuum of Effective Drug Abuse Treatment*. Washington, DC: National Institute of Justice.

[7] Lipton, D. (1995). *The Effectiveness of Treatment for Drug Users Under Criminal Justice Supervision*. Washington, DC: National Institute of Justice.

[8] Ibid.

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issues that have challenged the implementation of the program (space limitations, disruptions to the continuity of care, staffing issues) the Warden's response focused primarily on the goals and operational necessities of the program. She mobilized the considerable resources of the JCS facility and the MDOC. For example, the Warden authorized considerable expenditures to cove staff overtime and drug test costs. These expenditures were underbudgeted in the original proposal, and the Warden's contribution from the facility's budgets preserved the operation of the program. Her expectation of cooperation and support for the program from the facility's custody staff not only served to attract highly qualified officers to the RSAT units, but also promoted the flexibility necessary to operate a program that falls in the interface of the fields of corrections and treatment.

Program Costs and Funding

The cost of the treatment services provided by the RSAT program is $1,312,203 per year. These funds are used for staffing (both in-custody and aftercare administrative, treatment, and clerical staff), associated costs (i.e., fringe benefits), equipment, supplies, and MDOC/Treatment staff cross training. The costs associated with the applicant screening process are also included. This figure does not include costs associated with drug testing, program space rental, or MDOC staff costs. The cost per bed, per day, is $19.44[9], which is in addition to the costs associated with the normal operation and services provided by the MDOC. System-wide, the average cost per bed per day in 1997 was $85.32.[10] Providing that the RSAT program is able to deliver low rates of recidivism among its participants, the long-term cost-effectiveness of this program could be substantial. This question will be examined in detail by the UM's outcome study.

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[9] By comparison the MDOC's two newest RSAT units operate at a cost of $16.55 per bed per day and $22.00 per bed per day.

[10] Camp, C. and G. Camp (1998). *The Corrections Yearbook 1998*. New York: Criminal Justice Institute, Inc. The $85.32 figure includes $2.56 for food, and $12.95 for basic medical care.

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B. PROGRAM GOALS

The formal goals of the RSAT program are to reduce recidivism and drug use among substance-abusing, minimum-custody male inmates. These goals are to be addressed through the provision of:

- A six-month residential treatment component that targets the links between substance abuse, criminal thinking, and behavior, and that provides a solid foundation for the steps of recovery; and
- A 12-month aftercare component that facilitates community reintegration, promotes continued treatment services, and assists in the creation of other forms of stability such as family support, continued education or training, and employment.

The goals of the program were affirmed by all stakeholders, including the treatment staff, custody staff, facility administrators, and MDOC administrators. It is important for programs with two separate components to ensure that equal value is placed on both components, as evidenced by resources, attention, and participation in key decisions. During the first phase of residential treatment, a focus on the in-custody component of the program appeared to dominate the process of implementation, and, at times, challenged the creativity and resources of the aftercare staff. This imbalance appeared to be associated with the fact that none of the RSAT participants had yet progressed to the aftercare phase of programming, but may also be associated with a lack of coordination and communication among the stakeholders. When graduation approached and inmates began to flow into the final phase of treatment, the coordination among the in-custody and aftercare components became more at issue and significant program changes were made in the spirit of promoting greater compatibility across the treatment modalities. Though the umbrella agency has changed and new policies have been developed, the majority of staff have remained the same. Future research should examine the extent to which this top-level change resolved staff-level conflict.

Given the theoretical approach to addiction and criminal behavior as a "whole-person"

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disorder, program goals that include a focus on thoughts, feelings, and behavior make intuitive sense. Further, the recognition that substance-abusing offenders need significant support to maintain a positive lifestyle once released is compatible with treatment goals that have an equal focus on post-release services. Thus, the program goals are compatible with the theoretical underpinnings of the program model. In terms of clarity and measurability, several procedures were created at the outset of the program to ensure that quality data would be available to assess the effectiveness of the program as it relates to the treatment goals. The clerical staff at Family Services and Children's Aid included a data manager to track program applicants, admissions, and discharges. Further, the Aftercare Treatment Monitors (ATMs) were charged with the administration of a comprehensive assessment tool for each inmate to identify the severity of addiction and surrounding behaviors. These data were audited and maintained electronically for future analysis by the UM researchers.

Throughout the operation of the program, situations arose that required the development of new procedures for tracking the participants' flow and movement and their progress toward program goals. For example, a monthly statistical report was developed to track the number of applicants, the disposition of each application, the number of admissions, discharges, misconducts, and parole actions. Further, new structures were developed to ensure that the Orientation activities were properly documented.

A key issue that has yet to be resolved is the compilation of dependable, automated service tracking data. Although manual daily attendance records are maintained, they are not transferred to a format that permits an assessment of the extent to which treatment standards are being attained (i.e., the type and "dosage" of services). Such procedures are critical to any evaluation effort that seeks to measure the success with which program goals are achieved.

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C. SELECTION OF PARTICIPANTS

One of the key goals of a process evaluation is understanding the way in which inmates were selected for the program. In this case, the analysis of the selection of inmates clustered around three key areas: 1) a profile of the characteristics of the MDOC population as a whole, all Level I inmates, RSAT applicants, and participants in order to note any key differences among the groups; 2) the level of satisfaction of each of the program eligibility criteria; and 3) the way in which the flow of inmates in and out of the program affected operations.

Eligibility Criteria

In order to select appropriate candidates from over 20,000 Level I inmates, the following eligibility criteria for the RSAT program were defined:[11]

- Must be within 12 to 18 months of earliest release date (ERD) at application and within 6 months of ERD at admission. Preference given to those closest to ERD, in order to facilitate the transition to aftercare phase while on parole or in residential placement in a correctional setting[12].
- Must be a non-violent offender. In assessment of non-violent criterion, review is made of current offense, as well as institutional behavior and current record. Offenders incarcerated for driving while intoxicated are targeted as potential candidates[13].
- Must meet the criteria for placement at JCS, meaning that the inmate must have a Level I external classification.

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[11] Michigan Department of Corrections, *RSAT Admission Criteria For Prisoners Admitted to Prison-Based Substance Abuse Treatment*, revised January 7, 1999.

[12] Closer examination of the data revealed that, for those offenders who had not yet appeared before the Parole Board, the ERD recorded WAS the offender's ERD. However, for offenders who had been previously denied parole, the ERD recorded was actually the date of the offender's next Parole Board appearance. For the purposes of this research, this distinction is not important, and "ERD" is used to refer to both situations.

[13] This criterion has been the subject of much debate. It is possible that, as worded here, the criterion can be interpreted in a way that permits the admission of offenders convicted of violent offenses, if, upon reviewing of the circumstances surrounding the offense and the inmate's institutional behavior he is determined to be "non-violent" in his current behavior. It is strongly recommended that this criterion be further specified to eliminate any confusion and ambiguity.

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- Must meet the criteria for a diagnosis of substance abuse or dependency, according to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV). Priority is given to inmates with substance dependance, as opposed to substance abuse.

- Must agree to the philosophy, goals, and rules of RSAT program and subsequent aftercare services including drug testing, treatment, and participation in Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) (evidenced by letter from inmate and signature on Consent for Treatment).

- Must have no current or history of serious mental illness or thought disorder that would mitigate against successful substance abuse treatment or ability to participate in group counseling, which is the primary treatment modality.

- Must have functional intelligence sufficient to participate in the RSAT educational and treatment components.

In addition to the formal criteria, the following indicators were suggested to identify potential candidates for program referral:

- Positive drug test while in prison or in the community while under MDOC supervision;

- Prior parole failure associated with alcohol or drug use;

- History of driving while intoxicated offenses;

- Commission of property and other offenses consistent with addictive behavior;

- Crimes committed under the influence of alcohol or other drugs;

- Recommendation for residential substance abuse treatment in the Pre-Sentence Investigation report;

- Court-mandated substance abuse treatment, especially for residential treatment;

- High score on the SASSI (*Substance Abuse Subtle Screening Inventory*) given at the reception center or at a correctional facility. If space is available at the RSAT, a medium score will be considered;

- Request for substance abuse treatment by inmate or person on behalf of inmate; and/or

- No prior substance abuse treatment, or previous failure due to unsuccessful participation.

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The satisfaction of each of the eligibility criteria was tracked by the Screening Committee using the RSAT Program Applicant Review Form, which summarizes the information contained in each inmate's application package. An inmate was considered for admission to the RSAT program upon receipt of the following materials from the inmate's current facility: basic offender information forms; pre-sentence investigation reports; MDOC records showing institutional misconduct, involvement in treatment, and in-custody drug test results; the *Substance Abuse Subtle Screening Inventory* (SASSI); the inmate's handwritten Letter of Interest; a transfer order; and health care clearance. From this information, the Screening Committee decided whether to offer or deny admission to the RSAT program, or to place the application in a pending file. Most often, inmates were placed in pending status if they had not yet reached the specified time frame for the Earliest Release Date (ERD). Although an inmate may have been accepted to the RSAT program, he was not admitted immediately due to the limited capacity of the program. Instead, he was added to the waiting list. During the first stages of program operations, inmates were moved off the waiting list and admitted to the program on a first-come-first-served basis. This procedure made sense given the effort toward fairness and the relatively short wait required for program admission.

However, once the program began to operate at capacity, few inmates could move off the waiting list and significant periods of time were apt to pass before a vacancy would allow a new admission. Therefore, the screening committee reorganized the waiting list according to ERD for the second cohort of participants. This way, the program would not lose the ability to serve inmates because, as they waited for a vacancy, many became "too short" and did not have enough custody time left to complete the six-month residential component.

At the outset of the program, the Resident Unit Manager (representing the custody staff) and the Clinical Supervisor of the aftercare staff (representing the treatment staff) screened all

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incoming applications and made a recommendation to the Warden regarding the inmates' eligibility for admission. Prior to the commencement of services, the screening committee recommended that a number of inmates should be denied admission, based on their failure to meet one or more of the objective criteria. Upon review, the Warden over-ruled a number of these recommendations, resulting in very high levels of acceptance that went on to characterize the future screening process. Approximately midway through the first cohort of participants, the screening committee composition changed to include the RSAT Assistant Deputy Warden and the Program Director (and later, the Clinical Supervisor) of the in-custody treatment component. Again, this team was tasked with making admission recommendations to the Warden who had the authority to make the final decision.

The following section compares three groups of offenders (total MDOC population, Level I inmates, and RSAT applicants) along key demographic, legal status, and classification dimensions. These data are interpreted through the filter of the eligibility criteria to determine the integrity of the selection process. Further, any important distinctions between groups are discussed.

Profile of MDOC Inmates and RSAT Applicants

The following tables present demographic, classification, and offense profiles for three groups of inmates housed in the MDOC: the total population, the Level I Confinement population, and inmates who applied for admission to the RSAT program. The profiles illustrate the extent to which the RSAT program has attracted the full pool of eligible inmates and specific groups of offenders who were encouraged to apply. As shown in Table 1, there were no significant differences between the three groups in terms of neither race/ethnicity nor age.

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However, the RSAT applicants had a significantly greater number of prior felony convictions than their Level I counterparts.[14]

Classification data for the three groups are shown in Table 2. The MDOC classification system consists of two forms—an initial and review scoring form. The initial instrument is applied to inmates at the time of admission to the MDOC, while the review instrument is completed after the inmate has been in custody for a specified period of time, within at least one year of the initial classification.

Table 1.
Demographic Characteristics of MDOC Inmates, 1999.

CHARACTERISTIC	TOTAL MDOC POPULATION N=44,061	LEVEL I POPULATION N=20,305	RSAT APPLICANTS N=807
	100%	100%	100%
Race/Ethnicity			
White/Caucasian	41.0	44.2	45.5
Black/African American	55.6	52.9	51.4
Hispanic	2.5	2.1	2.6
Asian	0.1	0.1	0.1
Other	0.8	0.7	0.4
Mean Age, in years	35.0	34.7	36.1
Mean Number of Prior Felony Convictions	1.70	1.76	2.80

Note: Because the time frames of the two data files are not completely parallel, the CMIS data includes only 807 of the total 834 applications received.
Source: Michigan Department of Corrections' Correctional Management Information System (CMIS); stock population snapshot on July 1st, 1999. RSAT inmates identified using the RSAT applicant file.

The forms, themselves, are separated into two major sections. The "Confinement Level" section consists of 11 items that are used to place an inmate in one of four custody levels (I, II, IV and V). In standard classification terminology, these items reflect non-discretionary overrides in that classification staff have no discretion to ignore or alter the implications of these scores as

[14] A t-test was performed on the mean number of prior felony convictions for the Level I offenders and RSAT applicants: $t=10.415$, $df = 19118$, $p = .0001$.

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they would impact a custody designation. These factors are imposed on an inmate's classification assessment regardless of the risk assessment.

The second major section consists of what are referred to as "Management Level" items. These factors were found to be associated with inmate misconduct and are used to assess the inmate's classification level with respect to risk to staff and inmates. There are ten Management Level items which are tallied and converted into a scale which reflects five custody levels (I-V).

The review instrument is very similar to the initial instrument. The 11 Confinement Level items are identical to the ones contained on the initial instrument. However, the Management Level items are very different on the review instrument in that they reflect the inmate's misconduct since the last classification scoring process was completed. The initial and review instruments use the same scale. The review instrument is used to adjust the inmate's prior classification designation in relation to his/her demonstrated institutional behavior. Points can be accrued for both negative and positive prison behavior.

An inmate's classification level is determined by comparing the Confinement Level to the Management Level. Whichever is higher determines the inmate's "True" classification level. If the classification staff disagrees with the "True" classification level, it can be overridden (i.e., a discretionary override) with justification. The resulting classification is the offender's Final Classification Level. As shown in Table 2 below, the RSAT applicants, as expected, were housed in the least restrictive MDOC facilities and posed a low-risk to the safety and security of the institution.

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Table 2.
Classification Levels of MDOC Inmates, 1999.

CHARACTERISTIC	TOTAL MDOC POPULATION N=44,061	LEVEL I POPULATION N=20,305	RSAT APPLICANTS N=807
	100%	100%	100%
Confinement Level			
Level I	46.1	100.0	97.8
Level II	38.5	0.0	2.2
Level IV	12.7	0.0	0.0
Level V	1.7	0.0	0.0
Level VI and up	1.0	0.0	0.0
Management Level			
Level I	75.0	80.3	98.3
Level II	6.2	4.5	1.6
Level III	3.9	2.9	0.1
Level IV	5.0	3.9	0.0
Level V	8.9	8.4	0.0
Level VI and up	1.0	0.0	0.0
Final Classification Level			
Level I	36.3	77.2	95.5
Level II	35.2	7.0	4.2
Level III	4.2	3.0	0.2
Level IV	14.5	5.7	0.2
Level V	8.0	6.4	0.0
Level VI and up	1.8	0.7	0.0

Note: Because the time frames of the two data files are not completely parallel, the CMIS data includes only 807 of the total 834 applications received.
Source: Michigan Department of Corrections' Correctional Management Information System (CMIS); stock population snapshot on July 1st, 1999. RSAT inmates identified using the RSAT applicant file.

To obtain a broad estimate of the size of the total eligibility pool, the assumptions of the major eligibility criteria must be imposed. First, from the full MDOC population, only Level I inmates were permitted to apply (n=20,305). Second, these inmates must have an ERD that conforms to the six to 18 month range (n=3,185), and must be male (n=3,185 x 96 percent = 3,058). In addition, these inmates must have a substance abuse history severe enough to score in the highest ranges on the SASSI. A modest estimate of the size of this group can be obtained

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by applying the DOC-wide rate of substance abuse history reported at admission (n=3,058 x 67 percent = 2,049). Finally, approximately 50 percent of Level I inmates meet the non-violent offender criteria, leaving a total of 1,024 eligible inmates. As discussed earlier, this number may be conservative, as there are several current interpretations of the "non-violent" offender criterion. If both non-violent and violent offenders are considered to be eligible, the total pool of eligible offenders on any given day is approximately 2,049. The following analyses examine the extent to which modifications to the eligibility criteria were made, along with the resulting impact on the pool of eligible candidates.

As shown in Table 3, approximately 42 percent of RSAT applicants were incarcerated for a violent offense. While slightly lower than the overall Level I population (51 percent violent offenders), the high numbers of violent offenders are of concern for two reasons. First, the original eligibility criteria appears to exclude offenders convicted of violent crimes, although several individuals indicated that this was not the intention. In operation, these criteria seem to be broadly interpreted, thus new operational definitions need to be developed to reflect the actual practice of accepting both non-violent and violent offenders. While revising the eligibility criteria to include both violent and non-violent offenders would dramatically increase the size of the total eligibility pool (from 1,024 to 2,049 inmates), this may create other problems down the line. In Michigan, sex offenders and offenders convicted of other assaultive crimes have parole rates that are significantly lower than those of property and drug offenders. In 1998, offenders convicted of drug-related crimes had a parole rate of 74 percent, while other non-assaultive offenders had a parole rate of 63 percent. This is in stark contrast to offenders convicted of sex-related crimes who had a parole rate of 15 percent and other assaultive offenders with a parole rate of 45 percent. These lower parole rates limit the ability of violent offenders to participate fully in the RSAT program. If, upon graduation from the in-custody phase of RSAT, an inmate is

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denied parole, he cannot participate in the aftercare component and is therefore excluded from all outcome research. This means that if the 272-bed program was filled with equal numbers of drug and other non-assaultive offenders, all with ERD's six to eight months from the date of admission, 187 of these offenders would progress to the aftercare component. On the other hand, if the 272-bed program was filled with equal number of sex and other assaultive offenders, only 81 offenders would progress to the aftercare component. While it is too soon to be conclusive, the current offense type of the participants may be a source of significant subject attrition that could compromise the validity of the impact evaluation. These issues will be discussed in greater detail throughout the report.

As shown in Table 3, 17 percent of RSAT applicants were incarcerated for drug-related offenses. While it is expected that substance abuse underlies the behavior of many offenders, the proportion of OUIL offenders (i.e., driving under the influence) is of particular interest because the program specifically targets these offenders as ideal candidates for the RSAT program. Of the 365 Level I offenders currently incarcerated for OUIL (1.8 percent of 20,305 offenders), only 25 applied for RSAT admission. Further efforts should be expended to determine the reasons behind the low levels of interest among these offenders, and to encourage their application for future admission to RSAT.

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Table 3.
Offenses and Sentence Type of MDOC Inmates, 1999.

CHARACTERISTIC	TOTAL MDOC POPULATION N=44,061	LEVEL I POPULATION N=20,305	RSAT APPLICANTS N=807
	%	%	%
Offense Type			
Homicide	10.9	1.3	2.9
Robbery	14.3	13.7	14.1
Criminal Sexual Conduct	16.9	21.8	13.5
Assault	9.7	11.0	7.7
Arson	0.7	0.8	0.5
Other Sex Offense	0.6	0.8	0.4
Other Assaultive Offense	1.1	1.5	2.6
Burglary	10.4	10.5	14.9
Larceny	9.3	9.5	14.3
Fraud	1.4	1.6	2.0
Forgery/Embezzlement	2.1	2.2	3.2
Motor Vehicle Theft	2.7	2.3	2.2
Malicious Destruction	0.6	0.8	1.4
Weapons	5.2	4.2	2.7
Drug-Related Offense	11.2	12.0	13.5
OUIL 3rd Offense	1.2	1.8	3.1
Other Non-Assaultive	1.4	1.2	1.0
Missing	0.3	3.0	0.0
Sentence Status			
Concurrent	17.2	17.4	19.6
First Ordered	69.4	75.0	68.8
Life	2.0	0.1	0.1
Murder, Ist Degree	3.3	0.1	0.1
Parole Violator, New Sentence	0.1	0.1	0.0
Repeat Offender	0.5	0.4	0.7
Other	7.5	6.9	10.7
Gun Law Violator	9.8	7.0	4.2

Note: Because the time frames of the two data files are not completely parallel, the CMIS data includes only 807 of the total 834 applications received.

Source: Michigan Department of Corrections' Correctional Management Information System (CMIS); stock population snapshot on July 1st, 1999. RSAT inmates identified using the RSAT applicant file.

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Table 4. Sentence Length and Time to be Served Among MDOC Inmates, 1999.			
SENTENCE (in months)	TOTAL MDOC POPULATION N=44,061	LEVEL I POPULATION N=20,305	RSAT APPLICANTS N=807
Average Sentence Length	216.6	127.6	90.6
Average Time Served, to date	47.0	40.9	27.5
Average Time to Earliest Release Date	70.4	25.9	8.4
Average Time to Expiration Date	169.6	86.7	63.1

Note: Because the time frames of the two data files are not completely parallel, the CMIS data includes only 807 of the total 834 applications received.
Source: Michigan Department of Corrections' Correctional Management Information System (CMIS); stock population snapshot on July 1st, 1999. RSAT inmates identified using the RSAT applicant file.

Table 4 presents a number of key sentence-related variables that have a significant impact on the operation of the RSAT program. As shown, the average RSAT applicant had a shorter sentence than his Level I counterparts, and had also served significantly less time in prison, to date. The final row of data shows the potential length of stay for the three groups of inmates, i.e., the maximum time in custody, as determined by the offenders' crime and criminal history. Of particular concern is the RSAT applicants' average expiration date of 63.1 months, meaning that, as of July 1st, 1999, the average RSAT applicant had over five years to serve until the expiration of his sentence. While inmates rarely serve their maximum sentence, the expiration date provides a global indicator of a potential obstacle to a speedy discharge from the MDOC upon completion of in-custody treatment. A major assumption of this type of program is that treatment of this nature will be most effective when inmates are between six to nine months of release at the time of admission. The success with which this was achieved, and the various influencing factors, will be discussed throughout this report.

As shown in Table 5, as of August 31st, 1999, 834 MDOC inmates had applied for admission to the RSAT program. Eighty-four percent of the 834 inmates were accepted, two

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percent were denied, and 15 percent were placed in a pending status. Demographic and criminal history profiles of these groups are presented in the following tables.

Table 5.
Demographic characteristics of RSAT applicants, 1999.

CHARACTERISTIC	ACCEPTED N=696	DENIED N=13	PENDING N=125	TOTAL N=834
	100%	100%	100%	100%
Gender				
Male	100.0	100.0	100.0	100.0
Female	0.0	0.0	0.0	0.0
Race/Ethnicity				
White/Caucasian	48.0	53.8	28.8	45.2
Black/African American	47.1	46.2	60.0	49.0
Hispanic	1.9	0.0	4.0	2.2
Asian	0.1	0.0	0.0	0.1
Other	0.3	0.0	0.8	0.4
Missing	2.6	0.0	6.4	3.1
Mean Age, in years	36.0	38.1	35.7	36.1

Source: RSAT Applicant file.

The RSAT applicant pool was 45 percent white, 49 percent Black, 2 percent Hispanic and less than one percent Asian or "Other." Similar proportions are evident among those offered and denied admission to the program. Among those accepted, 48 percent were white and 52 percent were Black, Hispanic, Asian, or "Other." Among those denied admission to the program, 54 percent were white and 46 percent were Black, Hispanic, Asian or "Other." In contrast, among those placed in the Pending category, approximately 30 percent were white and 70 percent were Black, Hispanic, Asian, or "Other," a pattern which indicates a statistically significant racial bias.[15] Although the application process is quite structured and objective, there appears to be a bias in favor of white applicants when discretion does exist. The race variable

[15]Chi-square analyses were performed on a cross-tabulation of case disposition and applicant race, as recorded in the RSAT Applicant file.(X^2 = 13.986, df = 2, p=.001).

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was not statistically related to any of the acceptance criteria, yet it is possible that another variable is driving the apparent bias. Future research should continue to examine the influence of race in the screening process. In terms of age, approximately half of the applicants were age 35 or younger, and very few inmates were over age 55, a pattern which is consistent throughout the accepted, pending, and denied categories.

Tables 6 and 7 present criminal history and classification data for the pool of applicants versus the pool of participants. In terms of their criminal history and custody classification, the inmates who were actually admitted into the program are comparable to the population of inmates who applied for admission. There were no significant differences in offense category, sentence type, proportion of gun law violators, number of prior felony convictions, or current classification levels between the two groups. Because the progression from "acceptance" (i.e. the waiting list) to "admission" was based on the chronological order in which the applications were received, it is not surprising that the participant sample is fully representative of the larger population. In future cohorts, inmates will be moved from "acceptance" to "admission" based on the proximity of their ERD, a procedure which should also be free from bias and which should result in significant improvements in the proportion of RSAT participants who move to the aftercare phase of treatment. This is discussed in greater depth at the end of this section.

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Table 6.
Offenses and Sentence Type of RSAT Applicants and Participants, 1999.

CHARACTERISTIC	RSAT APPLICANTS N=807	RSAT PARTICIPANTS N=286
	%	%
Offense Type		
Homicide	2.9	2.1
Robbery	14.1	15.7
Criminal Sexual Conduct	13.5	15.7
Assault	7.7	5.2
Arson	0.5	0.7
Other Sex Offense	0.4	0.0
Other Assaultive Offense	2.6	3.8
Burglary	14.9	11.9
Larceny	14.3	15.4
Fraud	2.0	2.8
Forgery/Embezzlement	3.2	3.8
Motor Vehicle Theft	2.2	2.1
Malicious Destruction	1.4	1.0
Weapons	2.7	2.1
Drug-Related Offense	13.5	12.6
OUIL 3rd Offense	3.1	4.5
Other Non-Assaultive	1.0	0.3
Sentence Status		
Concurrent	19.6	25.2
First Ordered	68.8	62.9
Life	0.1	0.0
Murder, Ist Degree	0.1	0.0
Parole Violator, New Sentence	0.0	0.0
Repeat Offender	0.7	0.3
Other	10.7	11.5
Gun Law Violator	4.2	3.8
Mean Number of Prior Felony Offenses	2.83	2.82

Note: Because the time frames of the two data files are not completely parallel, the CMIS data includes only 807 of the total 834 applications received, and 287 of the 323 inmates admitted to the program.
Source: Michigan Department of Corrections' Correctional Management Information System (CMIS); stock population snapshot on July 1st, 1999. RSAT inmates identified using the RSAT applicant file.

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Table 7.
Classification Levels of RSAT Applicants and Participants, 1999.

CHARACTERISTIC	RSAT APPLICANTS N=807	RSAT PARTICIPANTS N=286
	100%	100%
Confinement Level		
Level I	97.8	99.0
Level II	2.2	1.0
Level IV	0.0	0.0
Level V	0.0	0.0
Level VI and up	0.0	0.0
Management Level		
Level I	98.3	98.6
Level II	1.6	1.0
Level III	0.1	0.3
Level IV	0.0	0.0
Level V	0.0	0.0
Level VI and up	0.0	0.0
Final Classification Level		
Level I	95.5	97.9
Level II	4.2	1.7
Level III	0.2	0.3
Level IV	0.2	0.0
Level V	0.0	0.0
Level VI and up	0.0	0.0

Note: Because the time frames of the two data files are not completely parallel, the CMIS data includes only 807 of the total 834 applications received.
Source: Michigan Department of Corrections' Correctional Management Information System (CMIS); stock population snapshot on March 15th, 1999. RSAT inmates identified using the RSAT applicant file.

Moving beyond the analyses which focus on the differences between groups of offenders, the following section examines the integrity of the screening process and its impact on program operations and future outcome evaluations.

RSAT Screening Process

In addition to indicating their interest and willingness to participate in all stages of the program, RSAT applicants were expected to meet each of the five eligibility criteria: 1) ERD within

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six to 18 months at application; 2) non-violent offender; 3) documented substance abuse; 4) no serious mental health or health issues; and 5) appropriate MDOC Classification Level. Breaking the applicants into three groups, those accepted, denied, and pending, Table 8 illustrates the proportion of offenders in each group who satisfied each of the five criteria.[16]

Table 8.
Rates of Satisfaction of Individual Acceptance Criteria by RSAT applicants, 1999.

ACCEPTANCE CRITERIA	ACCEPTED N=696	DENIED N=13	PENDING N=125	TOTAL N=834
	%	%	%	%
ERD within 6 to 18 months	96.0	38.5	15.2	83.0
Non-violent offender	89.4	46.2	58.4	84.1
Substance abuse history	98.1	30.8	83.2	94.8
No mental health issues	95.8	15.4	63.2	89.7
Appropriate MDOC security level	94.3	61.5	74.4	90.8

Note: Columns do not add to 100% because the categories are not exclusive.
Source: RSAT Applicants 11/01/98 through 08/31/99

Overall, the patterns of satisfaction make intuitive sense across the accepted, denied, and pending categories. For example, the low rate of satisfaction of the first criteria, ERD within six to 18 months at application, for the pending group is commensurate with staff reports that if the ERD criteria was not met, an application was put aside for another review within the appropriate time frame. In general, the group of offenders denied admission to the RSAT program had low rates of satisfaction of each of the admission criteria. The lower rates of documented substance abuse histories among the applicants denied admission suggest that this

[16]The satisfaction of each of the five criteria, as analyzed here, reflects the way in which the offender's screening form was completed, and was not verified using CMIS or other secondary data sets.

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item was a useful screening tool for filtering out those inmates who were attracted to the program for reasons other than its primary intent. These five admission criteria appear to be used in a consistent manner so that the three groups of offenders are internally similar, yet distinct from the other two groups. However, more in-depth analysis of the ERD item suggested that the criteria may not have been scored entirely accurately (e.g., inmates for whom this item was checked in the affirmative actually did not have an ERD that was within range).

The eligibility criteria specify that, *at application*, the ERD must be between six and 18 months, and *at admission*, the ERD must be between six and 12 months. However, the applicant file identified 100 inmates who were accepted to the program in spite of the fact that their ERDs were over 12 months away. It is important to recognize that these offenders will remain in prison long past their completion of the in-custody treatment phase. Not only will they be challenged to maintain any positive changes without on-going support, they will also be excluded from the evaluation of the program's effectiveness. It is important to remedy this, and similar issues, to ensure the integrity of the outcome evaluation.

By design, an inmate's substance abuse history was to be assessed based on the inmate's score on the SASSI. However, at the outset of the program, the inmates' SASSI scores were generally not available because the MDOC reception center began to administer the assessment after the first cohort of applicants had already been though the process. For the first cohort, determination of a substance dependance was made through a review of the inmate's institutional records. In subsequent cohorts, the inmate's SASSI score will be available at the time of application and will be considered for admission. Shortly after admission of the first cohort or RSAT residents, the SASSI was administered to all of the participants. These data have been analyzed by the UM, with preliminary results showing very high levels of substance abuse and dependence among those admitted to RSAT. Out of a possible four levels (IV being the highest),

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42 percent of the inmates scored as Level IV, 55 percent scored as Level III, less than one percent scored as Level II and Level I (2 percent were discarded for random response patterns)[17]. Level IV and III offenders were considered to be appropriate candidates for the RSAT program.

Table 9 shows the percentage of offenders in each group who met each level of satisfaction of the eligibility criteria. Of the inmates who were accepted to the RSAT program (n=696), 82 percent satisfied all five of the admission criteria. This translates into an 18 percent rate of overrides (i.e., situations in which the Screening Committee makes an admission decision that does not correspond to the satisfaction of all five eligibility criteria). While the current rate of overrides is not exorbitant, it does indicate that the eligibility criteria and the screening process need to be further refined. More specifically, the Screening Committee needs to further specify its position on an inmate's history of violence, and as discussed earlier, needs to make a more precise estimate of the targeted ERD given what is known about the rate of program admissions. Forty-four percent of those admitted without satisfying all five eligibility criteria were white, while 51 percent were Black and two percent were Hispanic. Race does not appear to influence override decisions.

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[17] Personal communication with Amy Young, Ph.D., University of Michigan, September 21, 1999.

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Table 9.
Percentage of Inmates Meeting Acceptance Criteria, 1999.

ACCEPTANCE CRITERIA	ACCEPTED N=696	DENIED N=13	PENDING N=125	TOTAL N=834
	%	%	%	%
Met none of five criteria	<1	30.8	11.2	2.5
Met one of five criteria	<1	7.7	13.6	2.6
Met two of five criteria	1.0	23.1	7.2	2.2
Met three of five criteria	2.7	15.4	11.2	4.2
Met four of five criteria	13.9	23.1	51.2	19.7
Met all five criteria	81.5	0.0	5.6	68.8

Note: Columns may not add to 100% due to rounding.
Source: RSAT Applicants 11/01/98 through 08/31/99

Participant Flow and RSAT Operations

As shown in Table 10, applications for admission to the RSAT program have flowed in at a steady rate, with an average of 83.4 applications per month. The program administrators did considerable outreach to the state's Level I facilities to encourage qualified offenders to apply. In late 1998, the level of interest in the program had not met the staff and administrators' expectations. The RSAT administrators suspected that, while information on the RSAT program was sent to all facilities, it may not have filtered down to the housing unit supervisors nor the inmates. This situation was corrected with several on-site presentations of the RSAT program to staff and inmates to stimulate interest and to clarify the eligibility criteria. The RSAT program received top-level organizational support from the Deputy Director of the Correctional Facilities Administration, who required that each Level I facility Warden must indicate in their monthly reports to the Director the number of RSAT applications generated. Historically, the program has received few applications from the DOC's nine camp programs.

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Table 10. Number of RSAT Applications Received, 1999										
	Nov/Dec	Jan	Feb	March	April	May	June	July	August	TOTAL
Received	196	60	1	140	102	79	107	98	51	834
Accepted	190	52	0	126	92	53	73	64	46	696
Pending	3	8	1	12	10	22	32	32	5	125
Denied	3	0	0	2	0	4	2	2	0	13
Source:: RSAT Applicant Data file, 1999										

As shown in Table 10, the vast majority of offenders who apply are accepted to the RSAT program. Approximately 83 percent of applicants were accepted, 15 percent were placed in pending status to await the approach of an appropriate ERD, and only two percent were denied admission. Beginning in January, 1999, large numbers of inmates were transferred to the Cooper Street facility to begin the RSAT program. The RSAT program occupies two housing units: B-unit with a capacity of 152 offenders, and the eastern section of C-unit with a capacity of 120 offenders, for a total of 272 program slots. B-unit was opened first, and 152 offenders were transferred to the unit within days of each other. While there were significant fiscal and practical reasons for this transfer *en masse*, it later proved to be a significant obstacle to the delivery of program services. The necessary treatment staffing levels had not been attained, and issues of space for service delivery remained unresolved. As a result, many inmates who had given up well-paying jobs at other institutions to join the RSAT program were forced to wait between four and six weeks for program services to begin. This created significant resentment and frustration that subsequently became significant obstacles to developing clinical rapport and the motivation for recovery that characterized many inmates' initial entry to the program. Unfortunately, these issues were not recognized in time to prevent a similar problem when the 120 beds in C-unit began to be filled. However, treatment staff were able to provide bi-weekly group sessions in an

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effort to maintain enthusiasm and prevent the volatility that often accompanies boredom. In addition, some of the physical transfers to the unit were delayed so that the treatment start dates across inmates were more staggered.

The problems associated with the transfer *en masse* re-surfaced later, at the conclusion of the program, when the 152 B-unit program participants prepared to graduate from the RSAT residential component at approximately the same time. Fortunately, some of the departures were staggered, and some were not transferred off the unit immediately, which helped to create a system of rolling admissions that will characterize the subsequent RSAT cohorts. Further, such high numbers of new RSAT clients entering the aftercare component has the potential to place a heavy burden on the ATMs who would be faced with sharply increasing caseloads. A system of rolling admissions will also enhance the clinical integrity of the program. If treatment groups began at several points throughout the six-month period, new admissions could join a group at the beginning of the curriculum, rather than having to jump in at the middle if they missed the "start date" of the program. Further, with groups at multiple stages, the ability to "hold-over" inmates who are progressing more slowly through the treatment phases would ensure that treatment is more individualized.

Table 11 illustrates the flow of inmates into and through the program. Once the program initially reached capacity, there were very few program admissions during the first six months of program operation. Essentially, inmates were transferred into the program only when a bed became available as the result of an unexpected discharge. These inmates were required to join a group in progress, without an opportunity to move through the earlier sessions in a thoughtful and structured way, which may have compromised the efficacy of the treatment process for these inmates. Further, the addition of new members to an existing group can be a challenge to the clinical rapport that develops over time.

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Table 11.
RSAT Program Capacity, 1999

	Jan	Feb	March	April	May	June	July	August	TOTAL
Residents	170	199	272	272	270	265	257	272	–
Admissions	170	39	86	7	10	11	82	73	564
Discharges									
Completed Tx	0	0	0	0	0	0	76	48	
Parole	1	2	4	1	1	7	4	3	
Quit	1	2	8	3	1	0	6	5	
Terminated	1	3	1	3	8	7	2	3	
Other	0	0	0	0	2	0	0	0	
TOTAL	3	7	13	7	12	14	88	59	203
Waitlist	56*	17*	58*	155	188	242	244	265	–

Note: Other reasons for discharge include Out on Writ and Death; Wait list includes inmates who have been accepted to the RSAT program, but who have not been admitted due to space limitations.** Waitlist figures for January-March are estimated, calculated using the number of applications received, number admitted, and number on waitlist from previous months.
Source: JCS RSAT Program Quarterly Report, 1999

Reasons for discharge included parole, voluntary resignations, and terminations for misconduct and changes in security level. Overall, there was relatively low attrition among the first cohort of offenders in the residential phase of the program, i.e. offenders removed from the program prior to the completion of treatment. Only 17 percent of the first cohort of 323 participants admitted prior to July 1st fell into this category.[18] At first glance, these statistics are very promising considering drop-out rates of between 30 and 60 percent have been cited in similar studies.[19] However, it is important to remember that this represents the dropout rate for *only the residential component*. It is likely that the level of attrition will increase significantly as the offenders await MDOC discharge, and again as they move into the community-based aftercare

[18]The July 1st cut-off date is used as an end-point for first cohort RSAT participants. In July, 1999, second cohort RSAT participants began to be transferred in to the program.

[19]Austin, James (1998). The Limits of Drug Treatment. *Corrections Management Quarterly, v.2 (4)*, p. 66-74; and Tunis, S., J. Austin, M. Morris, P. Hardyman, and M. Bolyard (1996). *Evaluation of Drug Treatment in Local Corrections*. Washington, DC: National Institute of Justice.

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component. Further, despite reports from treatment staff to the contrary, a significant source of attrition has been due to the parole of inmates prior to the completion of treatment. Twenty-three inmates fell into this category, which automatically excludes them from participating in the outcome evaluation. Future studies should re-examine this issue to assess the proportion of participants who are maintained throughout the residential and aftercare components.

The issue of attrition is fundamental to any impact evaluation that endeavors to compare the outcomes of a treatment group (i.e., inmates who participate in the RSAT program) with the outcomes of a control group (i.e., inmates who do not participate in RSAT). Several researchers have developed formulas to estimate the number of participants necessary to account for attrition rates while maintaining a rigorous research design.[20] There are two issues involved: sample sizes and statistical power. In general, an evaluation involving random assignment needs to have a pool of eligible candidates that permits a control group of at least 100 cases. For this RSAT program, with a capacity of 272 and drop out rate of approximately 17 percent, this translates into approximately 420 inmates on the waiting list. If random assignment is not employed, questions of statistical power become especially important, (i.e., the minimum number of subjects required to demonstrate the presence of statistically significant differences among outcome variables). Using a standard formula,[21] an outcome evaluation of the RSAT program would need at least 217 subjects for sufficient statistical power.

The issues presented in this process evaluation not only speak to the integrity of the implementation process, but also highlight key issues to be considered in a future outcome

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[20] Austin, J., P. Hardyman, and S. Tunis. (1993). *Evaluation Proposal for the Fresh Start Program: Post-Incarceration Services for Substance Abusing Ex-Offenders*. San Francisco: National Council on Crime and Delinquency.

[21] Austin, et al. (1993) recommend the following formula: $N= (1.96/.05)^2 \times (\text{dropout rate})(\text{dropout rate}-1)$ or $N=(1536.64) \times (.17)(.17-1)$ or $N=(1536.64) \times (.1411)$ or $N=217$.

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evaluation. The current program capacity, coupled with high numbers of applicants, has created a waiting list that has continued to increase in size. With a constant influx of new applications, pending applications that have since become eligible, and very few program drop-outs, a strategy of random selection is feasible. For the past five months, the waiting list has averaged 219 offenders. When added to the cases admitted to the program (n=272), the total applicant pool is 491, which is well above the minimum required. A specific strategy for random assignment is outlined at the end of this report.

However, the success of this strategy depends on the rate at which the RSAT participants are paroled after completing the in-custody component. Using the first cohort's offense types and MDOC parole rates, Table 12 projects the total number of inmates who are likely to be discharged from the MDOC at their ERD. According to these calculations, only about half of the offenders were likely to be paroled. There are two caveats to this finding: 1) there may still be a significant lapse between in-custody graduation and ERD, so even if paroled, an offender may spend a significant period of time in MDOC custody post-graduation; and 2) these parole rates indicate the likelihood of parole at the *first* Parole Board appearance. Many of the RSAT participants have already had one or more parole failure, so this count may underestimate the number of offenders who would be paroled.

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Table 12. ***Projected Number of RSAT Participants Who May Be Paroled and Placed in Aftercare Component***				
OFFENSE	PERCENT OF TOTAL PARTICIPANTS (N=286)	NUMBER	PAROLE RATE	TOTAL
Sex Offenses	15.7	46	15.2	7
Other Assaultive	27.5	79	44.5	35
Drug-Related	17.1	49	73.8	36
Other Non-Assaultive	39.4	113	63.3	71
			TOTAL TO AFTERCARE	149
Source: RSAT participants identified by July 1st, 1999 snapshot data from CMIS; Parole rates obtained from Michigan DOC Research Section, personal communication on 10/28/99.				

The extent to which residential substance abuse treatment programs contribute to safer and more secure institutional settings has been an enduring question throughout process and impact evaluations of drug treatment in correctional settings. Not only do safer programs lead to lower levels of stress and increased job satisfaction among treatment and custody staff; but also, researchers and practitioners posit, safer environments are critical to advancing the treatment mission for the program participants. Table 13 presents the mean number of misconduct reports per month from January, 1999 through June, 1999. In Michigan, inmates receive "tickets" for incidents of misconduct that may include several citations. Counting each of the citations would result in an inflated misconduct rate, so the misconduct analyses were performed using the number of "tickets" issued, with the most serious citation defining the level of severity. The types of misconduct have been divided into three categories: major, drug-related, and minor. The RSAT unit does not differ significantly from other Level I facilities in terms of the rate of minor

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misconduct. However, RSAT participants have significantly lower rates of major and drug-related misconduct than their Level I counterparts.[22]

Table 13.
Rates of Institutional Misconduct among MDOC Inmates, 1999.

MEAN NUMBER OF MISCONDUCTS PER MONTH	TOTAL MDOC POPULATION N=44,061	LEVEL I POPULATION N=20,305	RSAT APPLICANTS N=807	RSAT PARTICIPANTS N=286
Mean Major Misconducts	0.250	0.244	0.171	0.135
Mean Minor Misconduct	0.0071	0.0068	0.0011	0.0077
Mean Drug-Related Misconduct	0.0068	0.0064	0.0013	0.0019

Note: Because the time frames of the two data files are not completely parallel, the CMIS data includes only 807 of the total 834 applications received; these data represent the number of "tickets" received, which may contain multiple citations.
Source: Michigan Department of Corrections' Correctional Management Information System (CMIS); stock population snapshot on July 1st, 1999. RSAT inmates identified using the RSAT applicant file.

Looking at the RSAT unit as a whole, low levels of misconduct are evident. As shown in Figure 1, there have been a total of 40 major misconduct incidents over the eight-month period, for an average of five per month. The most recent three months have witnessed a slight increase in the number of major misconducts per month. Future research should examine this trend and, if continued, the possible explanations for it. Table 14 presents the distribution of these misconduct violations across major categories. Non-bondable offenses result in placement in a higher custody level until the misconduct hearing. If found guilty, the inmate's custody level increases and he is removed from the RSAT program. Bondable offenses do not result in an escalation of custody level, nor removal from the program, unless several infractions have been committed over time with sufficient frequency and severity to score a higher level once

[22] T-tests were completed for on the mean number of misconducts of the two groups: Major (t=2.514, df=9964, p =.012); Minor (t=-.310, df = 9964, p = .756); Drug-related (t=-2.896, df = 9964, p = .004).

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reclassified. The RSAT program terminates participants for any bondable offense that is substance-abuse related.

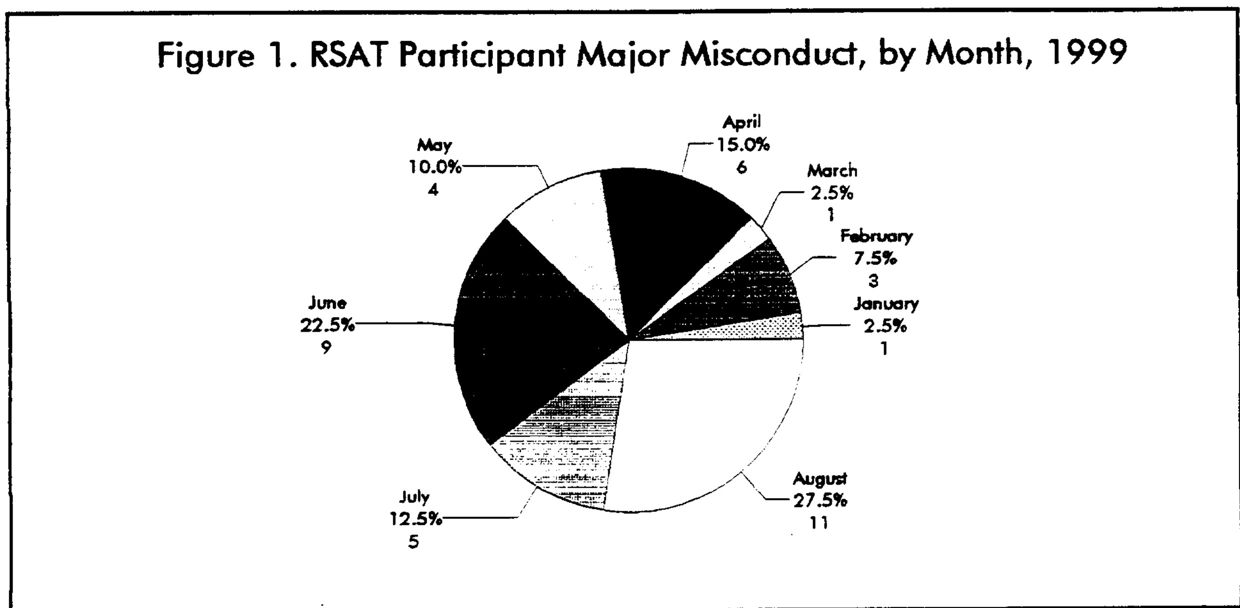

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Table 14. Type of In-Program Misconduct for RSAT Participants, 1999.		
TYPE OF MISCONDUCT	N	%
First Cohort Total Misconducts	40	100
Non-Bondable Offenses		
Fighting	1	2.5
Assault and Battery (inmate victim)	2	5.0
Possession of Dangerous Contraband	2	5.0
Substance Abuse**	2	5.0
Bondable Offenses		
Creating a Disturbance	1	2.5
Out of Place	11	27.5
Insolence	4	10.0
Disobeying a Direct Order	8	20.0
Unauthorized Occupancy of a Cell/Room	1	2.5
Possession of Forged Document/Forgery	1	2.5
Theft	2	5.0
Not Specified	5	12.5

Note:**In the MDOC, Substance Abuse is a bondable offense, but the RSAT program terminates participants who received a drug-abuse related misconduct report.
Source: RSAT Quarterly Data Reports, 1999.

As shown, only 17 percent of the infractions (n=7) involved non-bondable offenses resulting in immediate removal from the program, and only three of these involved physical violence. While there was a slightly larger number of inmates removed overall (n=28; see Table 11), these inmates were most likely removed for a compilation of misconducts that increased their external classification level above Level I. The vast majority of institutional misconduct involved non-violent offenses. These findings indicate that the safety and security of the facility were not compromised, despite high number of offenders incarcerated for violent offenses.

As shown in Table 15, the MDOC performs a large number of drug tests (both urinalysis and "patch" tests) each month. The MDOC conducted an average of 548 drug tests per month in the RSAT unit. On average, each inmate is drug tested twice per month (as required by the

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CPO), which is very high according to industry standards. These drug tests, conducted randomly and for cause, appear to be a significant deterrent to drug use, as only five inmates tested positive in the past eight months (less than one percent of all tests). These rates mirror the success achieved department-wide, and should be considered very promising considering a substance-dependant population.

Table 15.
RSAT Resident Drug Testing, 1999

	Jan	Feb	March	April	May	June	July	August
Drug Tests								
Administered	N/A	N/A	N/A	552	540	538	552	557
Positive	0	3	1	0	0	1	0	0
Refused	0	3	0	0	0	0	0	0

Source: JCS RSAT Program Quarterly Report, 1999

The rates of parole for the RSAT participants is a key issue that has relevance not only to the smooth operation of the program, but also to the composition of future samples for an outcome evaluation. While a significant number of inmates were granted parole while participating in the RSAT program, the effective parole date was most often after the completion date of the treatment program. During the first few months of program implementation, the Parole Board granted a few inmates parole with effective dates months prior to their completion of the program. Although given the option to complete the program before discharge from the MDOC, none of the inmates decided to continue treatment, and therefore they were removed from the potential pool of candidates for the UM's outcome study. A total of 23 inmates fell into this category from the first cohort, indicating that the issue should continue to be monitored closely and further discussions with the Parole Board should work toward limiting this situation.

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Table 16 below presents the number of RSAT participants who had a Parole Board hearing as of August 30th, 1999, and the outcome of that hearing. A total of 153 inmates went before the Board, two-thirds of whom were paroled. In Michigan, an inmate is first seen by the Parole Board two to three months before his ERD. If the Board votes to parole the inmate, he is given a "projected release date," which may be on or just after his ERD (within 1 or 2 months). An inmate may also be given a "fixed date parole," which sets the date of discharge even further into the future to permit the completion of programming. Generally, these fixed dates are three to six months beyond the ERD. Only about half of MDOC inmates are granted a parole at their first parole hearing. If parole is not granted, it is continued, meaning that the offender will be seen again by the Board one year from his ERD (or last Parole Board appearance). If the Parole Board needs additional information in order to make a vote, the parole action is deferred.

Table 16.
Parole Board Actions for RSAT residents, 1999

	Jan	Feb	March	April	May	June	July	August	Total
Parole	N/A	N/A	N/A	25	14	9	30	26	104
Deferred	N/A	N/A	N/A	1	0	0	1	2	4
Continued	N/A	N/A	N/A	6	13	10	7	9	45

Note: Parole Board Action data are not available for the first three months of program operations; manual audit revealed that five inmates had been counted twice by RSAT monthly reports; actual monthly totals have been adjusted. The Applicant Data file did not contain information on four inmates listed on monthly reports (three parole, 1 denied).
Source: JCS RSAT Program Quarterly Report, 1999

While the number of RSAT participants who were granted parole is certainly a positive indicator, the actual date of discharge from the ERD is the more relevant issue. An inmate may be granted parole, but may still remain in the custody of the DOC for several months. The following analyses examine the Parole Board actions for the first cohort of in-custody graduates.

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The RSAT program held a graduation for 128 inmates from the first cohort in late July, 1999. These inmates were among the first to begin to receive services; an additional 24 inmates remained in B-unit, in an effort to stagger program vacancies and admissions as discussed earlier. The graduation ceremony was a full production, complete with visitors from the MDOC headquarters, facility administrators, and inmate speakers. Members of the inmates' families were also permitted to attend. Several staff reported that the ceremony provided a meaningful sense of closure that was only possible because of the high degree of cooperation among the facility, treatment, and MDOC staff. While future graduations are expected to be less grand, they will continue to be an important marker of progress for the RSAT graduates.

The following figure illustrates the parole board actions for the first cohort of graduates. As shown, 38 percent (n=48) of the graduates had not seen the parole board at the time of graduation, most likely due to an ERD that was too far out. Sixty-three percent (n=80) of the graduates had seen the parole board by the end of August with varying outcomes. Only 15 percent (n=20) of the graduating cohort were actually discharged to the community within four weeks of completing the in-custody treatment program. A significant number of offenders will remain in MDOC custody for at least six months (those whose parole was continued, and those whose parole date was not for six to 12 months).

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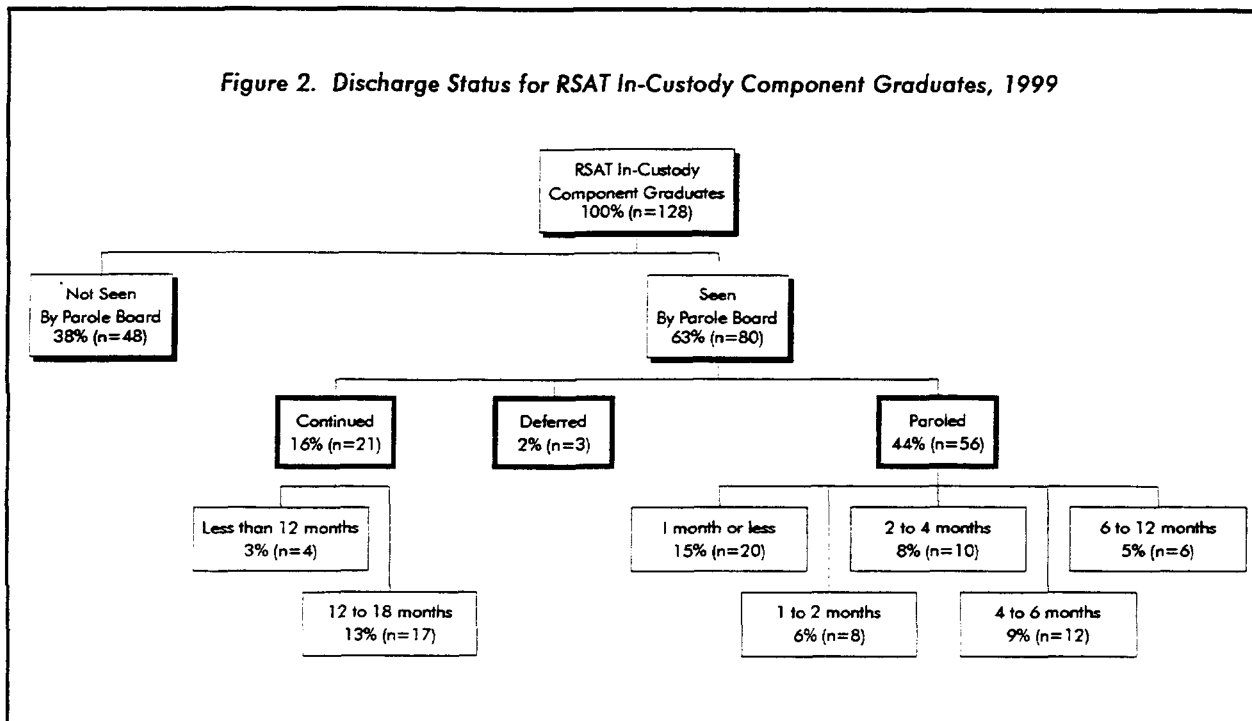

Figure 2. Discharge Status for RSAT In-Custody Component Graduates, 1999

Because 85 percent of the RSAT graduates remained in the custody of the MDOC, questions about their physical location, continuity of care, and ability to participate in the outcome evaluation surfaced. First, if the inmate is to remain in custody, the ideal scenario is one in which RSAT post-release preparation continues both individually and in groups. However, when inmates are transferred to facilities around the state, such continuity is not practical. Second, while an inmate's transfer order requests that he be given access to the new facility's substance abuse services, admission is not guaranteed. The disruption of services is a severe threat to the integrity of the treatment process. Finally, the ultimate test of the program's effectiveness rests on the offender's functioning once released to the community. While the number of inmates who are discharged from the MDOC will increase over time, there are significant numbers of inmates who will not even come before the parole board for 12 to 18 months. This issue will be discussed in greater depth in the next section, but it is clear that a 15

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percent discharge rate for graduates of the in-custody phase will challenge the sampling strategy for a future outcome evaluation because too few inmates will progress to the aftercare phase of the program.

Implications

The operation of the screening process has had mixed results, to date. On one hand, the screening process functioned well to admit inmates with high levels of substance abuse, and who did not have medical or mental health issues that would prevent their full participation. Further, the inmates admitted to the program had low rates of misconduct and very low rates of positive drug tests while in the program. These results are indicative of an in-custody environment that was safe, secure, and relatively free from illicit drug use. The low rate of program drop-outs during the in-custody phase also testifies to the overall positive and appealing environment created on the unit.

However, there are two issues that are of concern: 1) the selection of inmates whose ERDs and offense types may prevent their quick entry into the aftercare component, and 2) the level of discretionary overrides used to change the acceptance decision that should be dictated by the stated criteria. First, a critical issue in the smooth operation of the full two-component program is the use of the ERD as both a screening tool and a method for determining admission. At first, it was important to cast a wide net to attract enough applicants to fill the 272-bed program. Given that the waiting list has remained consistently over 150 inmates, filling the program slots is no longer a primary concern. Instead, it is important to shift to a long-term perspective by developing admission criteria that will result in the largest number of inmates progressing to the aftercare component. The following calculations reveal the challenges experienced with this issue to date. On the date of admission:

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- 23 percent of inmates had less than six months until their ERD;
- 21 percent had between six and eight months until their ERD (ideal);
- 30 percent had eight to 12 months until their ERD; and
- 23 percent had over 12 months until their ERD.

Only 22 percent had what would be considered *ideal* ERDs at the time of admission, i.e., between six and eight months to complete the full in-custody program and a relatively short lag time to potential MDOC discharge/In contrast, a number of inmates could be paroled prior to the completion of treatment since their ERDs were within six months (which was the case for 23 offenders in the first cohort).

It is important to remember that the ERD does not guarantee discharge, but instead is heavily influenced by the type of offense for which the offender is incarcerated (refer to Table 12). Because sex offenders often have ERDs that have passed (due to multiple failures), large numbers of sex-offenders and other low-parole groups have high rates of eligibility for RSAT admission. Given these realities, if current screening and admission processes continue, it will be difficult for a large number of inmates to complete both the in-custody and aftercare components of the program.

From a cost-benefit standpoint, consideration of the likelihood for parole is critical for documenting the cost-effectiveness of the program. An applicant's likelihood of parole is part of the revised eligibility criteria; however, the way in which this standard has been operationalized is unknown. Similarly, there has been a lack of clarity in the eligibility criteria pertaining to violent offenders.

Forty-two percent of those admitted to the RSAT program were incarcerated for a violent offense; viewed in light of the extremely low rates of violent institutional misconduct on the unit, this does not appear to be problematic, the likelihood of parole notwithstanding. Discussions

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with screening committee members confirmed the flexibility of this criterion, as inmates with violent current offenses, prior offenses, and institutional misconduct have been regularly admitted to the program, apparently without incident. The issue here is not to change the practice, but rather to document it. Given the questions that remain about possible racial bias, it is extremely important for the screening process to be as objective as possible. Errors and anomalies in the applicant database illustrate the fact that the current documentation of the screening process is problematic. Operational definitions and a formal system of documenting and reviewing discretionary overrides should be established. Recommendations toward this end are presented at the end of the report.

It is vitally important that the two components be unified and that screening decisions are made that benefit the two components equally. Filling the in-custody beds, only to sacrifice the ability of the aftercare component to reach capacity, threatens the integrity of service delivery as well as the potential for rigorous evaluation. While ERD, current offense, and lag time to parole issues, individually, are manageable, their combined impact could seriously jeopardize the ability to conduct an outcome evaluation as a result of insufficient sample sizes. It is expected that tightening the screening process and reorganizing the waiting list by proximity of the ERD will radically improve this situation. The next section discusses the specifics of the intervention itself, with specific attention to the required interplay between the aftercare and in-custody components.

D. INTERVENTION

In addition to understanding the way in which applicants are accepted to and flow through the program, the value of a process evaluation lies in its ability to articulate any differences between the way the program is designed and the form it takes upon

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implementation. Further, future outcome evaluations need to be attached to the specific components that were fully operational rather than to a concept of what the program was supposed to look like. The integrity of implementation, in terms of the extent to which treatment standards were realized, is critical to understanding the impact of the program on the criminal and substance abuse behavior exhibited by the inmates after program completion.

Original Design

Though promoted as a "modified therapeutic community (TC)," the RSAT program can be more accurately described as a curriculum-driven program that operates in a residential setting and incorporates a structured aftercare component. Unlike typical TCs, the RSAT program does not feature daily intensive services nor are treatment staff on-site 24-hours a day. Instead, program services are delivered several days a week in housing units that are separate from the rest of the prison facility, and that are complemented by regular MDOC services such as education, employment, and recreation. While an RSAT community certainly does exist at the JCS program, it is less intensive, less exclusive, and less focused on the traditional resident hierarchy that one would expect from a TC model. These caveats are important, as they will prevent a misinterpretation of the program's intent and design as the effectiveness question comes more into play. The next section of this report presents the original design of the RSAT program, as it is described in printed program materials, memos, and handouts.

The Michigan RSAT model includes four phases after a short orientation period. The orientation period was designed to include a standardized assessment (*The Addiction Severity Assessment Protocol, ASAP*) and to ensure the presence of a significant substance abuse problem (using the *DSM-IV Checklist for Substance Dependence*). Further, the orientation period was designed to provide an opportunity for participants to develop a clear understanding of program rules and their various responsibilities. This understanding was to come about through daily,

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organized interaction with RSAT counselors. In addition to 15-minute opening and closing meetings, the orientation period was structured to include one or two group sessions per day.

Upon completion of the orientation, participants begin Phase I of the program. This phase model of treatment relies on *time* as the major criteria for progression. While each participant has certain assignments and lessons within each phase, progression from one phase to another is based more on the structure of the curriculum and less on motivation or progress. While this structure permits a tighter control over the duration of treatment, it makes it more difficult to ascertain the commitment and accomplishments of the program participants. Further, it does not account for individual differences in terms of time needed to process certain issues, or difficulties in reading or writing that would suggest a slower progression through the curriculum.

Phase I was designed to last approximately six weeks and to assist participants in adapting to the treatment process and to the daily program structure. The design also includes the development of an *individualized* treatment plan, meaning that each resident's particular issues and challenges would be approached with strategies that met that resident's life situation.

A large part of the programming is focused on a structured curriculum entitled *Strategies for Self-Improvement and Change* which is comprised of 50 sessions that help participants to confront errors in thinking, triggers for substance use, and to identify the motivation to change both substance abuse patterns and criminal behavior. The curriculum includes a manual for the group facilitator as well as a workbook for the participants. The curriculum is structured as a three-stage behavioral treatment model that includes therapeutic support, motivation, confrontation, and reinforcement. The theory behind the curriculum includes the need for participants to develop new thinking skills to reorganize their drug-related beliefs, which will enable changes in their criminal behavior. During Phase I, the first 12 sessions (two hours per session, two sessions per week) are completed. Residents are educated about expectations, the

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use of the workbook, how change occurs, and their responsibility in the process. In addition, Phase I focuses on developing trust and cooperation among the group members and the counseling staff.

Phase II is designed to last 12 weeks with the majority of "in-depth" treatment taking place during this phase. In addition to working through 24 two-hour sessions (two per week), the program design includes initial contact with family and community support systems as the inmate prepares for release to the community.

Phase III, lasting six weeks, includes the development of a comprehensive and realistic community aftercare plan that includes on-going community substance abuse treatment, self-help or other support groups, a vocational plan and/or educational programming. During this phase, the program design requires that contact be made with the proposed community program to verify acceptance. In addition, the participant is to complete an additional 12 sessions of the *Strategies for Self-Improvement and Change* curriculum. During this phase, the program design includes the role of the participant as a mentor for new RSAT participants entering the program.

Phase IV is the aftercare component, coordinated by the Aftercare Treatment Monitor (ATM), that begins once the participant is released from the RSAT residential program. Ideally, release from the program would coincide with release from the MDOC; however, some participants may remain in custody but would have access to weekly aftercare sessions. Once in the community, ATMs assist parolees in accessing treatment services, monitor their participation in treatment and other community resources, and offer other assistance as needed. The RSAT program manual[23] states, "Case management is viewed as the critical component of the

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[23] *Cooper Street Correctional Facility, Residential Substance Abuse Treatment Program.* Program Materials. p.3.

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treatment process. It is necessary to develop a clear system, across agency boundaries, in an effort to assist offenders in making a successful transition from a highly-structured prison environment to the 'freedom' of the community." Local parole offices play a key role in assisting the RSAT case managers in both planning for release and in monitoring behavior and compliance once paroled.

It is important to note that the design of the RSAT program requires that the residents move through the phases of the program in a rather planned and structured way. While this is typical of correctional programming and of cognitive-behavioral techniques, it is somewhat at odds with addictions research which holds that "recovery does not happen on a schedule." Finding the balance between these two paradigms is critical to the operation of the program. In addition to working through the *Strategies for Self-Improvement and Change* curriculum, the program design included the following activities:

> Daily Opening/Closing Meetings. The Opening Meetings are designed to initiate daily treatment activities through devotional readings, reviewing plans, and discussions of daily and weekly goals. Closing Meetings function to organize the group for the next day and to clarify expectations and responsibilities.
>
> Psychoactive Substance Educational Groups. The purpose of the PSE groups is to assist the resident in understanding how substance abuse has affected his life, including its impact on social, familial, psychological, scholastic and vocational functioning; legal status; criminal thinking; and physical health. Group activities include lectures, videos and discussions on topics related to substance abuse, criminal thinking, social skills, and independent living.
>
> Thinking Skills Group. These groups follow the *Strategies for Self-Improvement and Change* curriculum and include lectures and workbook activities.
>
> Interactive Therapy Groups. A group format guides focused, interactive therapy in which personal treatment goals are addressed in greater detail. Each resident is expected to complete both a paper and a project for each phase of treatment, which are presented during these group sessions.
>
> Relaxation Sessions. Sessions include a variety of techniques to combat stress including audio and video relaxation tapes, meditation techniques, muscular relaxation response instructions and self-hypnosis.

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Homework Assignments. Both group and individual counseling sessions assign homework to be completed by each resident.

Individual Sessions. Residents meet individually with counselors to review progress made toward reaching treatment goals and to provide time to discuss confidential issues. The original design included twice-monthly individual sessions, with more frequent individual attention available as necessary.

AA and NA Meetings. Following the standard 12-step materials, group activities include Big Book/Basic Text readings, 12-step meetings, and speaker meetings. Each resident is expected to attend three meetings per week.

Recreation. All residents are expected to participate in recreational activities including basketball, volleyball, pool, weight lifting, etc.

Family Counseling and Visitation. The purpose of family counseling is to offer families the opportunity to participate in counseling in order to establish a support system upon release. These sessions are coordinated by the case managers, and occur toward the end of treatment.

Special Sessions, Community Meetings. Supplemental meetings are held to resolve issues pertaining to the entire RSAT community. These sessions are facilitated by a senior resident and must have staff approval.

The original schedule included a minimum of four hours of organized, structured treatment activity six days per week. These four hours included the Opening/Closing Meetings (15 minutes each); one Thinking Skills Group OR Psychoactive Substance group (1.5 hours each); and one Interactive Group (2 hours) per day. In addition to these groups, the program design also called for a variety of other program activities such as Family Counseling, Relaxation, AA and NA groups to occur throughout the week. Clearly, the RSAT model was designed to include a high "dosage" of in-custody treatment on a daily basis.

Once an inmate graduates from the in-custody component, he is transferred to the aftercare component which was designed to begin preparation for release from the beginning of the in-custody programming.[24] Although a specific ATM is assigned to each resident, the

[24] Cooper Street Correctional Facility, Residential Substance Abuse Treatment Program, *Aftercare Treatment Monitoring Program*, developed by Family Services & Children's Aid.

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aftercare system was designed so that the ATMs operate as a team to ensure that their combined skills and backgrounds are utilized when planning for individual participant's needs. The ATMs work 40 hours per week, with flexible schedules to permit weekend direct service at JCS. ATM assignments are based on in-custody counselors and the region of the state to which the inmate is paroled. The aftercare component involves several activities designed to commence while the inmate is in custody:

> Assessment: The ATM completes the *Criminal Justice Assessment of Substance Abuse Problems* (CJ-ASAP) for each resident to establish a baseline severity of substance dependence and recovery issues. Six months after release from prison, the ATM completes a follow-up assessment to detect changes in the level of dependence, frequency of substance use, and involvement in criminal behavior.
>
> Monthly Contact: The ATM conducts monthly group sessions with all offenders on his/her caseload, and also meets with each resident individually to complete Monthly Contact forms. These forms review the progress the resident has made in preparing for release and highlights any concerns or problems the participant is experiencing.
>
> Support Persons Network: The ATM obtains consent from the offenders to contact their family and/or significant others to encourage their assistance in preparing for the offender's return to the community. With consent, each offender's support network is mailed a "Concerned Person Questionnaire" that is used to further develop the aftercare plan. The ATM is also responsible for conducting monthly support groups with the offenders' families and significant others.
>
> Coordinate Post-Release Treatment Resources: Early in the in-custody phase, the ATM is responsible for designating a DOC-approved treatment provider and for educating the providers about their responsibilities when treating RSAT participants. Toward the end of treatment, the ATM assists the offender in preparing for release by contacting parole agents, and scheduling appointments with treatment providers.
>
> Monitoring Continued Care: The community-based treatment providers are required to submit monthly reports to the ATM that describe the offenders' compliance and progress in their continued substance abuse treatment. The ATM will also coordinate with parole agents to monitor the offenders' community behavior.

These two components were meant to function as an integrated whole, with the activities of the in-custody phases augmenting the efforts of the pre-release planning. Similarly, as the offender adjusts to the community, he is expected to draw on the skills and tools learned in the

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in-custody component to successfully complete his aftercare phase. It is vital that unity be established so that the full impact of both components can be realized.

Implementation Issues

The following section discusses the extent to which treatment standards were realized and any modifications that were made to the original program design. Staffing patterns and qualifications are also discussed.

Treatment Standards

While on the surface, the program appears to have run "on schedule" (meaning that for the most part, RSAT residents spent approximately six months on the unit), a closer examination reveals several inconsistencies in the structure, format, and flow of treatment from what was originally intended by the program design described above.

In order to determine the type, intensity, and duration of services provided, a random sample of files was selected and manually coded.[25] Targeted data included the date of physical transfer onto the RSAT unit, the date on which services began, the date of advancement to the subsequent phases, and the occurrence and duration of the six different program services on a weekly basis (while the original design included twelve core components, only six separate program services had been implemented). Normally, random selection would create a sample that is statistically similar to the larger population from which it is drawn. However, analyses revealed that while the sample was comparable in terms of the reason for incarceration, the

[25] A 30 percent sample was taken (n=85) from both B-unit and C-unit inmates. Cases were selected based on prisoner identification numbers, e.g. all cases that ended in 0,1,2, or 5. None of these inmates had yet advanced to the community aftercare component of the program.

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number of acceptance criteria met, and the ERD, there were differences in both age and race.[26] Therefore, the results of these analyses should be interpreted with caution.

First, as discussed previously, the Michigan RSAT model is a highly-structured, curriculum-based program that has prescriptive lengths of treatment for each of the three in-custody phases. Overall, the program is expected to require 24 weeks (6 months) to complete. Indeed, just over half of the RSAT participants completed the program within the anticipated time frame, and 15 percent completed the program in 20 weeks (5 months) and 30 percent completed the program in 28 weeks (7 months). The mean time in the program was 23.6 weeks.

Deeper analyses revealed that the time spent in each of the phases was quite different than that prescribed by the program's design. The dates of entry and completion of each phase were pulled directly from case files to determine the length of stay (LOS) in each phase. It is believed that these data were incomplete, as there were a number of inmates whose files indicated that they were in Phase I, but because of the level of treatment received, it is likely that they were actually in Phase II or III. Regular and accurate documentation of the inmates' progression through treatment has been an on-going challenge for in-custody treatment staff. Such cases were included in the analyses of Phase I, but were excluded from Phase II and III analyses due to missing data.

Phase I was designed to last 6 weeks, yet the mean LOS was 10.4 weeks. The LOS for Phase II, designed as a 12-week phase, was 7.7 weeks. Phase III, designed to last 6 weeks, had a mean LOS of 4.1 weeks. Table 17, below, shows the proportion of inmates with verified completion dates, who completed the phases according to the time frame specified by the

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[26] Chi-square analyses were performed with the following results: reason for incarceration ($X^2 = 1.277$, df = 2, $p > .01$); number of acceptance criteria ($X^2 = 2.272$, df = 2, $p > .01$); ERD ($X^2 = .727$, df = 2, $p > .01$). The age analysis was statistically significant ($X^2 = 164.034$, df = 5, $p=.0000$). The race analysis indicated a statistically significant difference at the .05 probability level, but not at the .01 level ($X^2 = 4.701$, df = 1, $p=.030$).

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Strategies curriculum. Again, because of issues with missing data and sample representativeness, these data should be interpreted with caution[27]

Table 17. *Length of Stay in Each Phase of Treatment, RSAT Participants, 1999*	
TREATMENT PHASE AND LENGTH OF STAY	PROPORTION
PHASE I, 6 WEEKS	n=76
Finished in 4 to 8 weeks	25%
Finished in 8 to 10 weeks	51%
Finished in 10 to14 weeks	23%
PHASE II, 12 WEEKS	n=37
Finished in 6 to 7 weeks	54%
Finished in 7 to 8 weeks	35%
Finished in 8 to 9 weeks	11%
PHASE III, 6 WEEKS	n=32
Finished within 3 weeks	47%
Finished in 3 to 4 weeks	38%
Finished in 4 to 7 weeks	16%

Source: Manual data collection from random selection of B-unit and C-unit files, May and July, 1999. At the time of coding, from a total sample of 85 inmates (31% of total RSAT participants), 76 inmates had completed Phase I; 37 inmates had completed Phase II; and 32 inmates had completed Phase III. These categories are not exclusive, so inmates in Phase III are also included in Phase II and Phase I calculations.

As shown above, the suggested duration for each of the three phases of in-custody treatment did not progress as planned. In general, inmates spent a much longer time in the first phase of treatment, and a shorter than expected time in Phases II and III. At least 74 percent of offenders spent longer than the prescribed six weeks in Phase I. None of the offenders spent the full 12 weeks in Phase II, and at least 85 percent of offenders spent less than six weeks in Phase III. Short of an audit of the exact sessions that were covered in each meeting, it is unclear how the curriculum was reorganized within these time frames. It is of critical importance that a

[27] In spite of the methodological challenges accompanying these data, the findings have been replicated elsewhere. The RSAT monthly reports include a quarterly summary of the phase completion of the participants. These data are currently hand-collected and are not available for audit. However, the reported findings are similar: LOS for Phase I was 11.5 weeks, for Phase II was 8.2 weeks, and 4.5 weeks for Phase III.

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mechanism is developed to permit the on-going monitoring and evaluation of the duration of treatment in each phase. These data should be maintained in an automated format that is available to the UM researchers for the outcome evaluation. Without these data, modeling the flow of inmates into and through the RSAT program will be extremely labor intensive.

Given that the program manual describes Phase II as the phase during which the most intensive, introspective work is to be done, it is possible that the relatively short length of stay in this phase may have compromised the ability to delve deeply into the issues surrounding each inmate's addiction, recovery, and criminal thinking. One explanation for the lengthy time spent in Phase I is the presence of significant organizational issues that hindered the smooth operation of the program at the outset. While not included in the calculations presented above, it is important to note that almost one-quarter (22 percent) of all RSAT residents spent five weeks on the unit prior to the commencement of treatment services. Approximately half of the residents spent between four and five weeks on the unit, while roughly 30 percent waited three weeks for program services to begin. It is likely that the staffing and space issues which hindered the commencement of services also prevented a quick progression through the Phase I materials, a situation that is expected to be resolved in future cohorts.

An examination of the intensity and duration of services actually provided lends some insight to pattern of service delivery. As mentioned earlier, service tracking data were collected for a sample of inmates to determine which services were received each week and the duration of those services. The treatment standard set forth in the program manual included a minimum of four hours of structured, organized services per day, six days per week, for a total of 576 hours across the 24 week program. Space and staffing limitations, to be discussed in greater detail in the next section, resulted in most inmates participating in an average of three hours of structured, organized treatment three days per week, for an operative total of 216 hours across

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the 24 week program. Clearly, the "dosage" of in-custody services put into operation differed substantially from the program model.

Controlling for the length of time in the program, three percent of the sample received less than five hours per week of structured services; 26 percent received between six and seven hours per week; 62 percent received between seven and eight hours per week; and 10 percent received between eight and 10 hours per week. The mean number of hours of treatment per week for the sample was 7.2 hours.

Table 18 shows the total mean number of sessions and hours for six different treatment services delivered under the RSAT program. These six services are the core components of the program that were offered regularly and documented in the treatment files through July 30th, 1999. They include: Case Conference, Psychoactive Substance Education (PSE), Thinking Skills (TS), Interactive Group, Individual Counseling, and Aftercare Case Management. Refer to the preceding section, Program Design, for a description of these components. In order to represent full-program dosage, only those sampled inmates who had either graduated or been in the program for at least 24 weeks (n=38) were included in the analysis.

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Table 18.
RSAT Program Service Intensity, 1999

COMPONENT	TOTAL HOURS		TOTAL NUMBER OF SESSIONS	
	Mean	Range	Mean	Range
Case Conference	.91	.5 to 1.5	3.7	2 to 6
Psychoactive Substance Education	24.3	16 to 28	24.9	16 to 28
Thinking Skills	46.1	40 to 54	46.1	40 to 54
Interactive Group	91.1	63 to 105	60.7	42 to 70
Individual Counseling	2.1	.75 to 5	4.1	2 to 9
Aftercare Case Management	7.6	5.5 to 11	7.2	5 to 9

Source: Manual review of random sample of 85 RSAT cases as of July 30, 1999. Includes only those inmates who either graduated from the program or who had been in the program for at least 24 weeks (n=38).

Recognizing that the treatment standards could not be met due to space limitations, the following standards were expected for inmates in RSAT's first cohort:

- Case Conference: once a month, for a total of 6 sessions
- Psychoactive Substance Education: once a week, for a total of 24 sessions
- Thinking Skills: twice a week, for a total of 48 sessions
- Interactive Group: for the first 11 weeks, twice a week; for the remaining 13 weeks, three times a week, for a total of 51 sessions
- Individual Counseling: once a month, for a total of 6 sessions
- Aftercare Case Management: once a month, for a total of 6 sessions.[28]

For the most part, the revised service expectations were met, even exceeded by some components (Thinking Skills, Interactive Group, Aftercare). However, these revised expectations are still well below those outlined in the original program design. While the core components appeared to be delivered consistently, cases were not brought to case conference as often as

[28] As communicated by the RSAT in-custody Program Director and Clinical Supervisor. Personal communication, April, 1999 and July, 1999.

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expected, nor were participants seen individually as often as recommended by the Program Director and Clinical Supervisor.

As evident in the list above, there were a number of components that are part of the original design that were not implemented by the current model. For the most part, these omissions were a consequence of space limitations; however, other components were not implemented due to difficulty in locating a group facilitator (e.g., the AA and NA groups). Completely absent were the Relaxation Sessions, and AA and NA meetings, which are often seen as cornerstones to TC-type interventions that rely on the development of a community of recovery. Other components functioned on a modified schedule. For example, the Opening and Closing Meetings were intended to be a daily occurrence, but were implemented on a weekly schedule instead. As mentioned earlier, the educational groups and interactive groups functioned on an abbreviated schedule of three days per week, rather than six days per week as designed. The program manuals recommended individual sessions at least twice monthly, and more often as needed. In reading the files, it appeared that the average duration of the monthly individual sessions was about 15 or 20 minutes. The manual review of case files did note that there were several inmates who were referred for individual counseling and seen weekly for about one month. The proportion of inmates receiving this intensity of service appeared to be very small (only five of the 85 cases (6 percent) were seen more than once a month).

The aftercare component implemented Family Support Groups for the families of the inmates. As a result of scheduling issues, and the long distance that many families would have to travel, this component was implemented with only limited success. Only three or four families attended regularly. Finally, the in-custody component did assign homework, projects and papers that corresponded to the didactic group lectures. However, the time required to complete these assignments and the content of the papers and projects were not available for review. In-custody

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treatment staff also reported that a Tutoring Group had been established for inmates having difficulty completing their assignments due to literacy issues; however, the attendance, frequency, and duration of these groups were not recorded, so analysis of their implementation is not possible.

These differences are not offered as criticism, but instead to highlight the actual type and intensity of services delivered. Although relevant research highlights the need for "high dosage" programs, few studies specify "how much is enough" or prescribe global treatment standards. However, any deficits in service delivery need to be understood for their potential impact in future outcome evaluations. Further, as the RSAT program evolves and space and staffing issues are resolved, future research will need to specify the exact type, intensity, and duration of services received by participants included in the outcome study.

Physical Space

As discussed earlier, the RSAT program began its operation in B-Unit, which provided housing for 152 inmates, and had a large day room and two offices for counseling staff. From the very beginning, the lack of physical space that was appropriate for group processes limited the availability of services. Because there was only one large room within the unit, additional space in the school building had to be used. While useful in terms of expanding the number of groups that could begin to receive services, using an out-of-unit location added yet another layer of complexity to inmate movement (e.g., inmates had to be "called out" from their housing unit to go to the school building located on another part of the facility grounds). In addition to having insufficient space to operate groups containing approximately 20 inmates, there was a serious lack of office space for counselors to meet with inmates privately (resulting in few inmates receiving the optimal number of individual counseling sessions), to complete the significant paperwork required to maintain the files, and to conduct in-depth interviews that include

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sensitive and confidential information. During one site visit, a counselor was observed administering the standardized assessment while hunched over an ironing board. Another counselor was stationed in the laundry room while she met individually with her residents.

During the first six months, some improvements were made, but the space remains inadequate for the delivery of a high-intensity program to a large number of inmates. The large day room in B-unit was divided, doubling the group space available. Modular office furniture was installed in both B- and C-units to provide space for the counselors to complete paperwork, store files, and to permit more informal interaction among professionals. The MDOC has also authorized the installation of a mobile trailer that will provide additional group and office space. While these efforts are laudable, it remains extremely difficult to deliver the program as designed.

Staffing

Western Michigan University's proposal to the MDOC promised highly qualified and skilled staff. While there were several veteran treatment counselors involved with the program, the overall level of staff experience in both substance abuse and correctional settings was an issue during the implementation of the program. The residential component experienced difficulty enticing highly qualified staff to join the program, as many of the promising applicants were deterred by the prison setting.

Table 19 presents the staffing levels, qualifications, and level of experience for the in-custody and aftercare treatment staff. While there were several highly-credentialed staff associated with the program, there were a number of inexperienced staff members who had significant responsibilities for the treatment of large groups of offenders. As the in-custody Program Manager stated, "Everyone has to start somewhere." Given proper supervision, a small number of inexperienced staff should not compromise the integrity of the treatment services

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provided. Both contract agencies (Longford and Family Services) conducted several in-service training sessions throughout the first eight months of operation. The content of these training sessions included policies and procedures for working in a correctional environment, as well as a number of clinical topics. Industry standards include both individual and group supervision with clinical supervisors, as well as opportunities for less experienced staff to co-facilitate groups in order to observe more experienced counselors in their role and to provide an opportunity for firsthand feedback to refine the newer counselor's skills. Throughout the beginning stages of the in-custody phases, such supervision was rarely available to the counselors (primarily due to space issues and staffing levels), and when it was offered, a lack of procedures guiding staff-staff interactions resulted in a somewhat volatile staff environment. However, at the end of July, the in-custody treatment staff were restructured, with more experienced counselors identified as "Senior Counselors" and given the responsibility to directly supervise three or four counselors with lower levels of experience. Further, a consultant was hired to provide weekly professional development seminars to increase the expertise of the staff. Regular supervision by senior staff, opportunities for professional development, and the creation of a more collegial environment should greatly enhance the quality of services delivered to the RSAT participants.

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Table 19.
Staffing Levels and Qualifications, In-Custody and Aftercare Components

QUALIFICATION	IN-CUSTODY COMPONENT	AFTERCARE COMPONENT
Total Number of Staff		
Program Directors	1	1
Clinical Supervisors	4	1
Counselors	13	4
Average Counselor Caseload		
Residential component	17 to 22	68
Released on Aftercare status	n/a	11
Academic Degree		
High School Diploma	2	1
Bachelor's Degree	6	3
Master's Degree	10	1
Doctoral Degree	0	0
Relevant Certification/License*		
No relevant certifications	3	2
Registered Social Worker	5	1
Licensed Social Worker	2	0
Licensed Professional Counselor	2	1
Certified Addictions Counselor	6	2
Assessment and Referral Management Specialist	0	2
Years of Experience in Substance Abuse		
No experience with Substance Abuse treatment	0	0
1 or 2 years	6	1
2 to 5 years	2	2
5 to 10 years	5	0
Over 10 years	5	2
Years of Experience in Correctional Setting		
No experience in Correctional setting	7	4
1 or 2 years	2	0
2 to 5 years	5	1
5 to 10 years	1	0
Over 10 years	3	0

Note: Individuals may hold more than one Certification or License, so columns will not add total number of staff.
Source: Personal communication with Program Managers, 1999.

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While the aftercare staff also had a range of experience, it was not challenged by the same space limitations or under-staffing issues that prevented the in-custody staff from accessing proper supervision. The Clinical Supervisor (a Registered Social Worker and Certified Addictions Counselor) held weekly individual sessions with each of the four ATMs. Further, the group met formally at least weekly, but given such a small staff and close quarters, interacted informally as a group much more often.

E. INTERAGENCY LINKAGES

As noted in previous sections, multiple agencies were involved in the implementation of the RSAT program. Figure 3 below illustrates the structure of the program during the first stages of operation. Western Michigan University was the primary contractor charged with the development and operation of the RSAT program. Western subcontracted the in-custody treatment services to Longford Health Sources, which employed the Program Director, Clinical Coordinator and facility-based Counselors. The aftercare treatment services were originally subcontracted to Family Service and Children's Aid, which employed the Aftercare Coordinator, four Aftercare Treatment Monitors (case managers), and Clerical Staff. While developed to harness the unique expertise of each agency, this complicated interagency relationship proved to be a significant impediment to the delivery of services. Not only were there philosophical differences of opinion about the way in which the program should operate, but individual animosities also impeded the delivery of an integrated treatment package. At times, these differences were obvious even to the inmates, who attempted to use the tension to their benefit (e.g., "My ATM told me I didn't have to do what you [the in-custody counselor] said"). Not only

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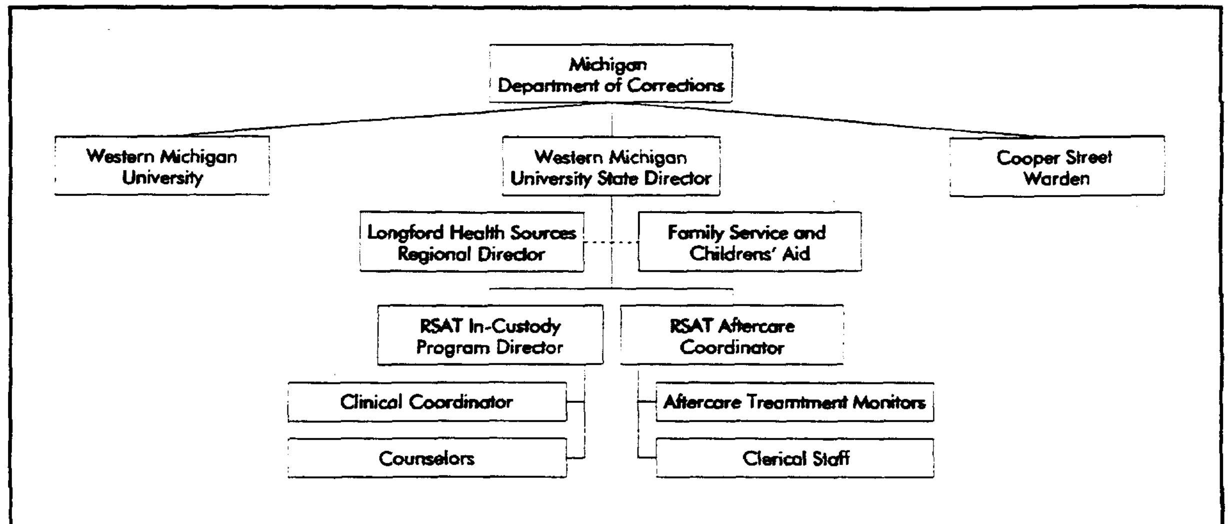
FIGURE 3. MICHIGAN RSAT ORGANIZATIONAL CHART



were these schisms visible between agencies, but also among the in-custody program staff. The tensions between counselors escalated to the point that group supervision and large staff meetings had to be discontinued for a time. The source of these tensions is difficult to identify, yet were evident on both individual levels (e.g,. staff-staff interaction) and in the way in which issues of interagency cooperation were addressed in staff meetings.

In an effort to resolve these difficulties, in August, 1999, Western Michigan University decided to terminate Family Services' contract for the aftercare component. The four ATMs and clerical staff were offered positions with Longford Health Sources, in an effort to effect as little disruption as possible in the delivery of services. These changes were made with the hope that unity under one agency umbrella would dissipate the "us-versus-them" attitude that had developed. Future evaluations should examine the extent to which cohesion among the staff and treatment components has been achieved, as it is a critical underpinning to the delivery of high-quality services.

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Prior to the termination of the contract, the ATMs reported a challenge in working with the parole officers once the individuals on their caseloads were released to the community. In large part, this challenge appears to be the result of a lack of interagency communication between the correctional and the parole administrators. Oftentimes, during an initial contact with the parole officer, the ATM would be required to launch into a lengthy discussion of what the RSAT program was, the ATMs' role, and the anticipated relationship between the two entities charged with the offender's supervision. The lack of top-down information about this issue gave the ATMs little leverage in encouraging cooperation or gaining access to information about the offender's behavior on parole.

An unresolved question is the relationship of the RSAT program, and an inmate's participation in it, to the Parole Board. As mentioned earlier, the first few months of program operations were marked by instances in which an offender would be paroled out from the program, preventing both continued treatment and the ability to retain him as a candidate for the impact evaluation. Again, these challenges were thought to be the result of a lack of interagency communication and appeared to have been resolved toward the middle of the program's first treatment period. In March, 1999, the Parole Board was invited to tour the RSAT program in order to learn more about the services offered and its anticipated effects on recidivism and post-release drug use. While extremely supportive of the program, the Parole Board has refrained from making a commitment to the effect of RSAT participation on the likelihood of parole until empirical research has demonstrated its effectiveness with regard to community behavior.

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IV RECOMMENDATIONS FOR FUTURE RESEARCH

What follows are several recommendations for strengthening the admissions process and enhancing the delivery of high-quality treatment services.

A. PROGRAMMATIC ISSUES

The preceding report and analyses illustrate the operation of a program that has considerable strength in terms of its implementation, as evidenced by low drop-out rates, low rates of institutional misconduct, a high monthly rate of applications received, and high-level support and cooperation from the Warden and other MDOC administrators. These strengths form the foundation of an RSAT model that requires only a few adjustments to prepare for an outcome evaluation to test its effectiveness.

Screening Process

The basic eligibility criterion, that inmates must have a final Classification Level of I, is both clear and objective. However, several of the other eligibility criteria suffer from a lack of specificity. First, the stakeholders need to develop a sound and specific operational definition of the violent/non-violent offender criteria that reflects the actual practice of admitting non-violent and violent offenders (including sex offenders). This could be accomplished by screening only for serious, violent institutional misconduct in the prior six months, a factor that would serve the purpose of ensuring the safety and security of the RSAT unit. Further, the screening committee should develop a dependable mechanism for calculating the ERD to ensure that inmates with significant custody time are not admitted to the program. The current screening criteria specify that an inmate must have between six and 18 months until his ERD at the time of application, and six to 12 months at the time of admission. It appears that a more rigorous standard of six to eight months until ERD at admission would ensure that the majority of participants are discharged to the aftercare component. Similarly, the stakeholders should examine and commit

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to admitting only a small proportion of offenders with historically low-parole rates (e.g., sex offenders) so that the program's attrition rate does not increase as a result of too few inmates being discharged from the MDOC.

In addition to greater specificity in the eligibility criteria, the program could also benefit from screening and over-ride procedures that feature greater specificity. First, as before, applicants should be expected to meet *all five admission criteria*. The screening form should construct this measurement as an affirmative response entry for each criteria (as shown below):

ELIGIBILITY CRITERIA

- ☐ Level I MDOC Classification
- ☐ ERD within 6 to 12 months at application, and between 6 and 8 months at admission
- ☐ No serious violent institutional infractions in last 6 months
- ☐ Offense category with greater than 50% parole rate
- ☐ No mental health or medical issues that would prevent full participation
- ☐ Level IV or III on SASSI

The current screening form has a list of "acceptance criteria" and "reasons for denial." There were a number of instances in which items checked on each list contradicted each other. Using a single checklist, like that shown above, will ensure that the reasons for admission/denial are clear and consistent. If an inmate does not meet one of the criteria, yet the screening committee believes him to be an ideal candidate for the program, a recommendation should be made that justifies, in writing, the reason for the over-ride. For example, an inmate with a sex offense will not meet the fourth criterion listed above (greater than 50 percent parole rate). However, a case could be made for his acceptance based on the number of prior continuances that would

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improve current chances for parole. If approved, the Warden should clearly indicate that the candidate was accepted or denied and the reason for over-ride. The proportion of overrides should be monitored closely throughout the program's operation.

Continued efforts to encourage eligible inmates to apply will ensure that sufficient numbers of candidates are available to both fill the program slots and to conduct rigorous outcome research. For example, targeting OUIL offenders (i.e., three-time driving under the influence offenders) to encourage application would increase the rate at which these offenders are admitted to the program.

Documentation of Service Delivery

As the program focus shifts from implementation to questions of effectiveness, it will be very important to have quick access to the type, intensity, and duration of treatment services that are provided. Further, the lengths of stay on the unit and within each of the three in-custody phases are important indicators of the rate at which inmates can be expected to flow into and out of the program. These data are currently only available through a manual audit of case files. Given that the in-custody program staff have access to computers, a service tracking database should be developed that tracks daily attendance, which can be converted to total hours of service received in each program component. These data will be required by UM researchers in conducting their outcome research, but should also be monitored on a monthly basis to ensure the consistency of treatment delivery across counselors.

Component Unity

A new organizational structure was created to improve the level of cooperation and coordination between the in-custody and aftercare staff. While changing the "umbrella" under which the program operates is a clear symbolic shift, it is critical that the importance of communication, respect, and teamwork be transmitted throughout all levels of staff. The

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successful unification of staff may also be aided by greater infrastructure in terms of clinical supervision, staff meetings, and case conferences. Developing these opportunities for problem-solving and learning can enhance the skill of staff with lower levels of clinical experience and may also promote greater teamwork within the components.

B. PAROLE BOARD

Because the data for this report were gathered in such close proximity to the end of the first cycle of in-custody treatment, the information available to discuss thoroughly the influence of Parole Board decisions on program operations is limited. Future research should examine the rate at which RSAT participants are paroled compared to other Level I offenders, and should examine the time lag from program completion to MDOC discharge. The disaggregation of these variables across offense type would be especially relevant to further refinement of the eligibility criteria.

Cooperation with the Parole Board, to date, has been positive. The Board members were reportedly impressed by the type and level of services delivered to the RSAT participants, and the program staff were optimistic about the resolution of the issue of MDOC discharge prior to program completion. The Parole Board has expressed a reservation to fully back the program, pending the availability of solid outcome research that demonstrates decreased recidivism rates among RSAT graduates. If the UM's outcome evaluation includes such findings, it would be useful to strengthen the ties to the Parole Board. More specifically, Parole Board involvement in the screening process could ensure that inmates who complete the in-custody component would have a high probability of being paroled.

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C. OUTCOME EVALUATION

As discussed, many questions remain about the efficacy of prison-based drug treatment programs. Not only is the treatment environment often difficult to create in a correctional setting, but the effectiveness of treatment programs in terms of appreciable decreases in rates of post-release substance abuse and recidivism has not been demonstrated decisively. Further, a number of states have tried to implemented program plans that were too ambitious and have since warned against programs that are "popular, but ineffective and costly interventions."[29] The State of Texas proposed to fund 12,000 correctional treatment beds, a number that was reduced by 57 percent (to 5,200) as the State experienced significant difficulty in delivering quality treatment to such a large population. Critical implementation issues included:

- Programs did not have sufficient numbers of trained and experienced treatment staff;
- The screening, assessment, and selection processes for admitting offenders were not sufficiently standardized; and
- The post-release programs were not fully developed.[30]

Once implemented properly, though, the research does support the effectiveness of some in-custody treatment. Lipton's (1995) review of TC model programs recommended that inmates should be within a year of their release dates and that a nine to 12 month in-custody component should be followed by a strong aftercare component. The summary of this research found that inmates who have participated in the model programs *and who completed all phases of*

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[29] Fabelo, T. (1995). "Why it is prudent not to expand the correctional substance abuse treatment initiative." *Bulletin from the Executive Director, No. 16*. Texas: Criminal Justice Policy Council.

[30] Ibid.

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treatment had low rates of recidivism or continued substance use.[31] These findings highlight the importance of making the necessary organizational and structural modifications to resolve the issues presented in this report, prior to the initiation of the outcome evaluation.

While existing research is useful to highlight implementation issues and to identify promising approaches for working with substance-abusing inmates, questions will continue to be raised about programs that do not have demonstrable measures of success. The best research methodology to achieve this level of certainty is an experimental design that employs random assignment. By randomly assigning inmates determined to be eligible for the RSAT program to either the RSAT program (i.e., the treatment condition) or regular MDOC programming (i.e., the control condition), sources of confounding and error are effectively controlled. Such rigor is especially advisable for states that are considering replication of a particular treatment model. Further, such an approach would be an important contribution to the field, given the plethora of softer research that, to date, has been unable to provide definitive answers.

Given the many procedures that are already in place, and with the recommended refinement in the admission criteria and override procedures, random assignment could be accomplished under the expertise of the UM research team. The recommended procedure is outlined below:

- The screening committee, which includes a member of the security staff, the in-custody treatment staff, and the aftercare staff, uses the objective screening criteria to make an admission recommendation. Careful attention should be paid to the calculation of the ERD, and to the likelihood of parole (however operationalized).

- Once basic eligibility is established, the list of potential candidates should be submitted to the Warden for final approval. The Warden should document all discretionary overrides, and should confirm the reasons for any denials.

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[31] Lipton, D. (1995). *The Effectiveness of Treatment for Drug Abusers Under Criminal Justice Supervision*. Washington, DC: U.S. Department of Justice; as discussed by Austin, J. (1998). The Limits of Drug Treatment. *Corrections Management Quarterly, v.2 (4)*, p. 66-74.

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- The list of applicants and their final admission decisions should be submitted to the UM researchers for data entry, and as a final check that all data are complete and accurate. From the list of inmates who were accepted (ordered by proximity of ERD), UM can randomly select those inmates to be assigned to RSAT versus the control group. It is always recommended that the individual making the group assignment be a third-party entity that is not involved in the delivery or operation of the program.

- The UM will inform the Warden of the inmates assigned to the treatment condition in order to initiate the notification and transfer of inmates.

This basic procedure, which can be fully designed and employed by the UM research team, relies on the generation of sound, accurate data during the screening process. The quality of these data depend on the thoroughness of the operational definitions of the eligibility criteria and on the use of forms that are free from ambiguity and easy to complete.

RECENT DEVELOPMENTS

These issues were communicated to the Michigan Department of Corrections which has taken some initial steps in addressing these concerns.

1. The DOC has worked with the Parole Board to develop a revised eligibility screening instrument. This instrument will select offenders for RSAT admission based on their propensity to parole as evident by the nature of their instant offense, prior criminal history and institutional conduct. It is not the intent of the Parole Board to give special consideration to those graduating from the program, hence it is critical that the program admit and graduate only "parole-able" offenders. The impact of this new instrument on the types of offenders admitted and the length of time from graduation to DOC discharge should be a key line of inquiry for future research.

2. Because of the ambiguity surrounding the status and its overlap with the waiting list, the "Pending" admission category has been eliminated. All offenders will be either approved or denied, and organized for admission according to their ERD. The impact of this change should be examined to ascertain the key differences between the groups of offenders who are admitted and denied to the program.

3. The DOC is making a concerted effort to fund and implement an "interim care unit" for RSAT graduates to receive step-down services until release on parole. If funded, this unit would fill an important gap in services for graduated offenders who are awaiting DOC release. Future impact studies should also examine the type, intensity and duration of these "step-down services" and their impact on long-term outcomes.

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