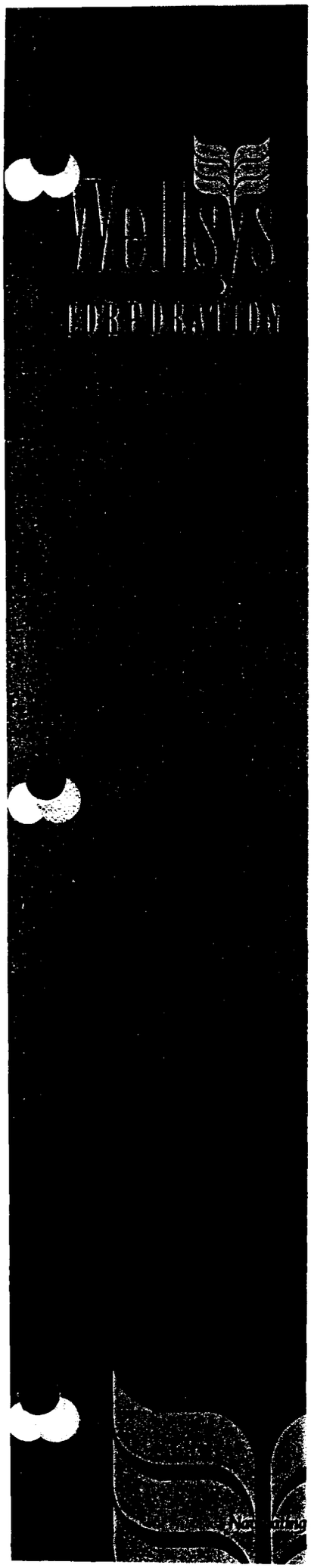

Process Analysis of GDC RSAT Program

Draft Final Report

Presented to:

Programs Development Unit
Georgia Department of Corrections
July, 2000

Presented by:

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Executive Summary

This document reports the findings of a process evaluation of the Residential Substance Abuse Treatment (RSAT) program operating within the Georgia Department of Corrections (GDC). The process evaluation was conducted by Wellsys Corporation, under contract to the GDC. The RSAT program is provided by Spectrum Health Services/CiviGenics (SHS), an independent vendor of health services operating in the GDC since 1994.

There are seven RSAT programs operating at four prisons in the GDC system: Scott, Macon, Calhoun, and Pulaski State Prisons. A total of 310 beds are available for program participants.

The report focuses on and is organized according to four aspects of the RSAT program:

- Proposal and development of the RSAT program
- Referral and selection processes of the RSAT program
- RSAT program implementation
- Aftercare and discharge planning

A variety of methods and data sources were utilized in the writing of this report, including interviews with GDC and SHS staff, examination of computerized databases, observation at service delivery sites, and examination of a variety of written materials and research.

Findings suggest that the RSAT program is operating in a way that is reflective of its design and the intent of its designers. There appears to be a significant degree of fidelity between the actual and proposed programs regarding the structure, setting, and content of the programs. Further, both on-site SHS staff and correctional administrative staff express satisfaction with the RSAT program itself. Benefits of the program cited by those interviewed included lower rates of institutional misconduct and significant attitudinal and behavioral change as participants progress through the program. Weakness cited by both RSAT staff and correctional administrators focused on the selection and referral processes and the lack of sufficient aftercare services once graduates are released from prison. Specific factors cited included a lack of communication between various entities within the GDC and a lack of knowledge concerning the RSAT program among diagnostic and classification staff.

Specific recommendations for the RSAT program are provided, and include the following:

1. Address deficiencies with the MIS system to allow more complete and comprehensive data collection, retrieval, and reporting functions
2. Implement a standardized system of identifying inmates' degree of substance use and involvement, so as to aid in referral and decision making concerning treatment need
3. Refine and simplify the referral process
4. Address and resolve issues between various GDC units and the parole authorities
5. Substantially increase the opportunities available for aftercare upon release

Section I - Summary of Project

This report documents the process evaluation of the Georgia Department of Correction's (GDC) Residential Substance Abuse Treatment (RSAT) Program conducted by Wellsys Corporation. Wellsys Corporation is an Atlanta-based consultancy group with particular experience in program evaluation of not-for-profit organizations and governmental agencies. Wellsys Corporation, together with the Program Development Unit of the GDC applied for and received Federal funding to perform the process evaluation.

Summary of Proposal

A proposal for a local evaluation of Georgia Department of Correction's (GDC) Residential Substance Abuse Treatment (RSAT) Program was submitted for the September 15, 1998 cycle in response to the National Institute of Justice Solicitation of February, 1998. At that time no other local process evaluation of the GDC RSAT program was being conducted, and the GDC was not at the time of the proposal receiving NIJ funds to conduct a local process evaluation.

The overall goal of the process evaluation was to examine the RSAT program in sufficient detail that the GDC has the information necessary to assess the program's quality, efficiency, and effectiveness and to provide the needed contextual framework for an outcome evaluation of the program. Specific goals of the process evaluation were:

1. To describe the programs being implemented and the extent to which they are complete, consistent, and as intended, based on the program design.
2. To identify program deficits and opportunities for improvement.
3. To determine what characteristics comprise a quality program, i.e., what are the best practices.
4. To identify important components for program replication.

Framework of the RSAT process evaluation

The framework and structure of the RSAT process evaluation directly follows the logic model of the RSAT program, presented in Figure 1 below.

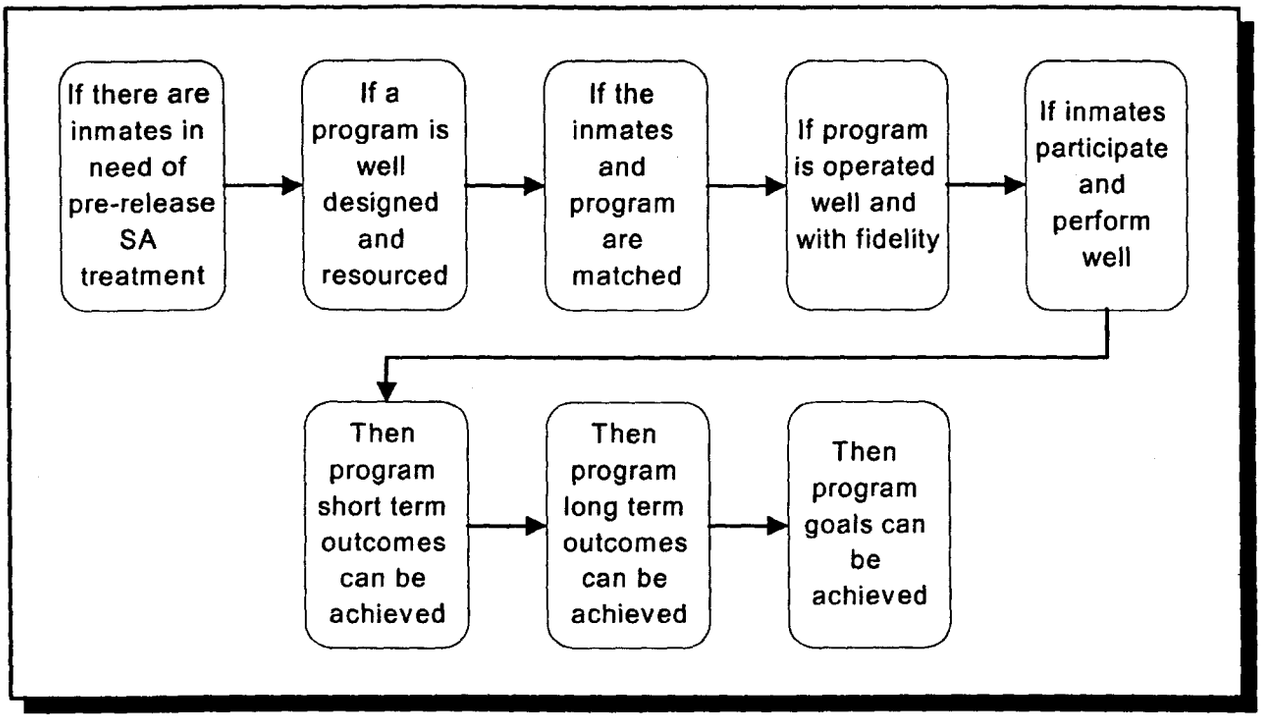

Figure 1 RSAT program logic model.

The first five boxes of this model — the conditions — are the focus of this process evaluation, and the remaining three boxes — the results — will be the focus of a proposed outcome evaluation. The conditions represent those elements that must be in place for the desired program results to be realized. In this model, the "conditions" for the RSAT program are:

- needs driving the program - pre-release substance abuse treatment,
- what is planned to address these needs - program design and resources,
- proper matching of inmates to program - selection process,
- how the program is implemented and operated - program quality and performance, and
- how inmates function in the program - inmate participation and performance

These conditions determine the program's short-term outcomes, long-term outcomes, and goals. A general description of the process evaluation elements follow.

- Pre-Release Inmates Needs — This area of the evaluation documents the need for programmatic services in the context of understanding what role inmate characteristics and other factors, including substance abuse, play in offender recidivism, and what is needed to address these factors. The substance abuse-related factors are the focus of what the RSAT program design was intended to address.
- Program Design and Resources — This area of the evaluation documents how the program was designed and planned to address the identified needs in a way that is expected to achieve the desired results. This establishes the baseline

(what is intended) for comparing the actual program implementation and operation. The primary methods for collecting this information included reviewing program documentation including the program proposal and logic model. Understanding how the program resources were determined and intended to be applied is important in understanding the inputs that go into establishing and operating the program.

- Inmate Selection — Documenting general inmate pre-release needs is important but does not, in itself, identify which inmates would be considered best candidates for participation in the program. Therefore, it is important to examine the selection process to understand which inmates are or are not chosen for the program and why or why not.
- Program Quality and Performance — The intent of this area of the process evaluation is to clearly describe and document the program as it has been implemented and being operated at each of the sites. While the previous three areas provide a context and a baseline, this and the following area are the heart of the process evaluation. Fully understanding the program implementation and performance at each site individually and comparing sites to each other and with the comparison site will provide the basis for understanding a) how well the programs conform to the program design, b) where there are deficits that may require design or implementation changes, c) what needs to be considered for program replication, d) the nature of staff performance, and e) what are the programmatic contributors to inmate outcomes.
- Inmate Participation and Performance — This is the second major area of the process evaluation that will describe and document how the inmates, individually and collectively, are participating in the various program elements and their progress in preparing for release. Both the level and quality of inmate participation needs to be understood in the context of each programmatic element. This will form the basis of understanding the inmates' preparation for release, and ultimately, the outcomes they realize.

Scope of work, involved parties

Program Sites

Currently, a total of 310 beds are provided for the program through seven RSAT programs located at four specified state prison inmate dorms reserved for the RSAT program. The programs all began operation during the first two weeks of January, 1998. Six of the programs serve male inmates and one program serves female inmates. The process evaluation was implemented at each of the four program sites.

Table 1 RSAT prison locations, number of beds, and type of facility.

State Prison	No. of Beds	Male Facility	Female Facility
Calhoun	96	✓	
Macon	96	✓	
Pulaski	48		✓

The RSAT programs are housed in state prison facilities in middle and south Georgia, as displayed in the map below.

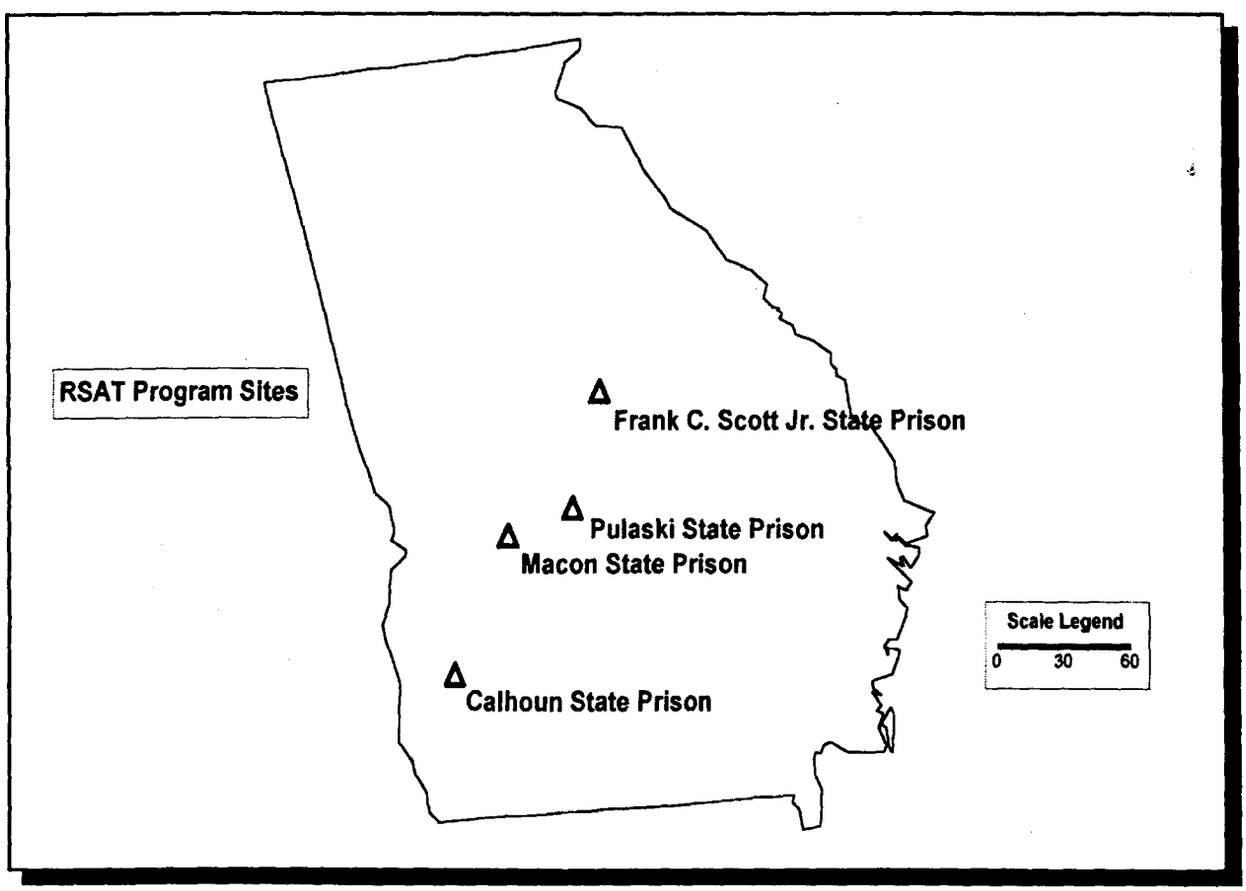

Figure 2 Locations of RSAT programs.

The process evaluation design, planning, and implementation represent a collaboration among three entities who will comprise the process evaluation team. These entities are:

- GDC Program Development Unit,
- CiviGenics/Spectrum Health Systems, Inc. (SHS), and
- Wellsys Corporation

The GDC Program Development Unit is responsible for the RSAT program and its implementation and for the inmates participating in the program. Responsibility for the program participants shifts to the State Board of Pardons and Parole when the inmates are released. CiviGenics/Spectrum Health Systems, Inc. (hereafter referred to as SHS) is currently providing the programmatic services for GDC's RSAT programs. Wellsys Corporation had primary responsibility for the implementation of the process evaluation.

Methodology of the Process Evaluation

The process evaluation of the RSAT programs was accomplished using a variety of data collection methods. These fall into five basic areas: Interviews; review of written records and documentation; administration of a survey instrument; site visits and observation; and examination of computerized databases. Each of these are discussed briefly in turn, with particular issues addressed in the report as needed.

Interviews

A semi-structured interview format was developed by Wellsys Corporation in an attempt to provide structure and consistency in the interview process (a copy of the interview can be found in Appendix 1). The interview format was used in discussions with GDC administrative personnel, RSAT program directors, assistant directors, and assorted RSAT counselors. The interview focused on five domains related to the interviewee: Involvement with the RSAT Program; prior experience, duties within the RSAT Program; process of implementation; and general impressions.

In addition to the use of this interview, many less formal interviews and discussions occurred with individuals who, in one way or another, are involved in the RSAT programs.

Review of written records and documentation

Written materials were requested and obtained from SHS, GDC, and a host of other sources. These materials included, but were not limited to: Program manuals and curricula; grant-related documents; staffing materials; training materials; documents related to organizational

structure; reporting and oversight materials; and program evaluation documents. In addition, a review of current and retired clinical charts at each of the four RSAT sites was conducted. Literature searches were performed to access relevant academic and governmental publications. Information was also obtained through use of various Internet sites, most notably via the Sourcebook of Criminal Justice Statistics and the Bureau of Justice Statistics.

Administration of a survey instrument

Wellsys developed the Counselor Rating Form (CRF) survey as a means of assessing the progress of individual participants in the RSAT Program. The CRF consisted of 20 questions, grouped into four general areas: motivation; degree of participation; performance; and predicted outcomes concerning crime and drug use. The CRF utilized a Likert-type response format, ranging from a 1 (Very Low) to a 5 (Very High). The instrument, which can be found in Appendix 2, was completed by the RSAT counselors at each of the four sites, with the counselors completing one CRF for each of the participants on their caseload. A total of 244 completed CRFs was received, providing a "snapshot" of an entire population of current RSAT participants at a given point in time.

Site visits and observation

Each of the four RSAT sites was visited on at least three occasions by members of the evaluation team. These visits provided opportunities to observe group sessions, meet with RSAT Program participants, interview RSAT staff members, review documentation, and meet with GDC correctional administrators. In addition, a member of the evaluation team attended part of the SHS Georgia Annual Training event and also attended an RSAT Program graduation ceremony.

Examination of computerized databases

Three sources of computerized databases were identified. The degree of success in gaining access to the data differed greatly depending upon the source of the data.

The first source was SHS, which provided their screening and tracking databases. These databases are used respectively to record the referrals and track participants for the programs that administered by SHS within the GDC. These databases, though flawed by significant amounts of missing data, were relatively simple and easy to obtain and access.

The second source of data was the Mainframe Support Unit of the GDC. We approached this unit in an effort to obtain data using the Offender Tracking Information System (OTIS) database. OTIS is the online system used within the GDC to keep track of almost every piece of information related to offenders in the GDC system. Periodically the information is uploaded to tape-based media for archival purposes. Due to problems with this uploading procedure, the most recent dataset available for our review was uploaded in September of 1997.

The third and final source for computer-based data was OTIS summary information concerning inmate participation in various GDC programs, including substance abuse treatment programs. Due to limitations with the report generator, this procedure could produce reports covering only a 3-month window. The data also was somewhat redundant with that provided in the annual and semi-annual reports provided by SHS and GDC.

Section II - Substance Abuse and Criminality

Substance Abuse Issues - Prevalence and Incidence

Widespread abuse of drugs and alcohol is considered to be a public health issue of primary importance in the United States. Whereas substance abuse is considered alarmingly high in the general population, statistics indicate that it has reached epidemic proportions among jailed and incarcerated individuals. In 1997 there were approximately 11.5 million arrests for alcohol-related offenses in the United States, representing 23% of all arrests. Over 180,000 of these arrests occurred in Georgia, fully 21% of in-state arrests. The 1997 Survey of Inmates in State and Federal Correctional Facilities found that 51% of respondents reported the use of alcohol or drugs at the time of their offense (*Bureau of Justice Statistics Special Report, January, 1999*). Fully 67% of adult arrestees in Atlanta (Georgia) tested positive for illicit drugs at the time of arrest (*Sourcebook of Criminal Justice Statistics, 1998*, p. 367; p. 370). Close to 70% of all State Prisoners in 1997 reported having ever used illicit drugs regularly, with 56% reporting illicit drug use in the month prior to their arrest, compared to 62% and 50% respectively in 1991 *(Bureau of Justice Statistics Special Report, January, 1999).* Approximately 60% of the federal prison population is composed of individuals convicted of drug offenses. Thirty-seven percent and 33 percent of state prisoners report using alcohol and drugs respectively at the time of offense.

Examining the amount of crime linked directly to alcohol and/or drugs provides a conservative estimate of drug-involved criminal activity. Taken together, drug trafficking, drug possession, and DUI account for about 18% of the total incarcerations within Georgia Prisons (counting the most serious instant offense; *GDC Monthly Prisons Report for May, 2000*). This statistic does not take into consideration the vast amount of criminal activity peripherally related to the manufacture, distribution, procurement, and consumption of drugs. "Among State Prisoners, the incidence of alcohol or drug use at the time of offense showed little variation by offense type, ranging from 52% of violent offenders to 56% of public-order offenders. Among specific offense types, only weapons (42%), fraud (43%) and sexual assault (45%) offenders had a minority reporting the influence of alcohol or drugs at the time of their offense" (*Bureau of Justice Statistics Special Report, January, 1999,* p. 2). In fact, the specific offenses most closely related to alcohol use at the time of the offense were assault, murder, manslaughter, and sexual assault (*Bureau of Justice Statistics Special Report, January, 1999).* Taken together, these statistics indicate that fully 75% of all prisoners can be characterized as alcohol or drug-involved offenders *(Bureau of Justice Statistics Special Report, January, 1999),* making clear that the majority of criminal activity is related the abuse of either drugs or alcohol.

Substance Abuse Issues - Treatment

The link between substance abuse and criminality is well established, although not completely understood. As shown above, statistics indicate that a high proportion of offenses in general, and violent offenses in particular, are committed while persons are under the influence. A significant proportion of criminal activity is also involved in the acts of buying, selling, making, trafficking, and procuring drugs. Whatever the exact nature of the relationship between criminal activity and substance abuse, it could be argued that successfully addressing the substance abuse issues of incarcerated felons would likely result in an overall decrease in drug-related criminal activity. And since most criminal activity is in fact drug-related, these efforts would also result in an overall decrease in criminal behavior.

It can also be argued that simply putting criminals in prison is not an effective means of reducing recidivism. A recent meta-analysis of fifty studies with an overall sample size of 336,052 inmates found that "prisons produced slight increases in recidivism" compared to community sanctions. Further, there was some evidence that lower-risk offenders were more negatively affected by the experience of imprisonment (*The effects of prison sentences on recidivism: User report 1999-24*, Solicitor General of Canada).

One means of addressing substance abuse among inmates is to provide substance abuse-specific education and/or treatment directed at those inmates who are identified, either by themselves or by custodial staff, as having substance abuse problems. In 1997 approximately 35% of state inmates reported having participated in some form of substance abuse treatment (including residential treatment, professional counseling, detoxification, and/or participation in a maintenance program) in the past. Twenty-six percent of State prisoners reported receiving treatment while under correctional supervision - 20% while in prison and 15% while under community supervision. About 6% of State and Federal inmates in 1997 had participated in residential substance abuse treatment, with about 20% of both inmate groups participating in other programs such as self-help groups or education. It appears that the percentage of inmates in drug treatment programs has decreased since 1991, while participation in other drug programs (such as self-help and education) has increased. Regarding demographic differences among State Prisoners, whites and women are more likely than minorities and men to receive substance abuse treatment (*Bureau of Justice Statistics Special Report, January, 1999).*

Substance Abuse Issues - Recidivism

While by no means an established fact, it appears that at least some of these programs have the potential to reduce recidivism. Three recent studies of a combined 1461 inmates in California, Texas, and Delaware found that the combination of prison-based treatment and

substance abuse-specific aftercare significantly reduced the recidivism rates of inmates who completed both the prison-based and community aftercare programs. For instance, The Texas study found that 26% of inmates who completed both phases of treatment had returned to prison within three years, compared to 66% of those who dropped out of aftercare and 52% of those who received no treatment. Even more striking were the results of the Delaware study, which found a 31% recidivism rate after three years for those who completed both phases of treatment, compared to recidivism rates of 95% for inmates receiving no treatment, 83% for inmates who dropped out of treatment while in prison, and 73% of inmates who completed prison-based treatment but received no aftercare. The Delaware study in particular suggests the presence of a dosage effect and emphasizes the importance of substance abuse-specific aftercare (*HealthSCOUT: January 15, 2000:* Robert Preidt).

As noted, incarceration alone does not appear to be an effective deterrent to the commission of criminal acts. The encouraging, yet preliminary, findings concerning the effects of comprehensive substance abuse treatment suggest that treatment, most notably that which includes an aftercare component, may have a significant effect in reducing recidivism. Taken together, it appears that offering a well-designed, comprehensive substance abuse treatment program within the prisons and including aftercare would likely reduce recidivism among those inmates who complete the program.

Section III - Proposal and Development of the RSAT Program

The Criminal Justice Coordinating Council (CJCC: a division of Georgia State Government) in the Fall of 1996 issued a request for proposals for the institution of an intensive, prison-based substance abuse treatment program. Derek Allen, Manager of the Programs Development Unit within the Georgia Department of Corrections (GDC), supervised the writing of the grant in response to the request for proposals. Near the completion of the proposal he assigned the management of the project to Audrey Moffitt, Director of Substance Abuse Services. The GDC issued an RFP (RFP# 0467-027-953117) in July of 1997 for respondents to describe a residential substance abuse treatment program that could be implemented in the state's prison system. The proposal was sent to over 30 vendors, with three or four vendors responding with proposals. Spectrum Health Systems/CiviGenics (hereafter referred to as SHS) responded to the RFP with a proposal detailing their *Correctional Recovery Community (CRC): An intensive residential substance abuse treatment program for inmates*. The SHS proposal and bid was accepted, and on November 12, 1997 SHS was subsequently awarded the contract to provide the residential substance abuse programs described in response to the GDC proposal. Full services were first offered to inmates through at the four RSAT sites on January 12, 1998.

Spectrum Health Services/CiviGenics Inc. (SHS)

Background of company

Spectrum Health Systems is a 501 (c) (3) corporation that regards itself as both a major healthcare provider (accredited by the Joint Commission on Accreditation for Healthcare Organizations) and as a research organization. Both aspects of their mission revolve around issues related to substance abuse. CiviGenics was formed in 1994 by the senior executives of SHS in order to assume the management functions of SHS, and is not bound by the restrictions placed upon 501 (c) (3) organizations.

Spectrum began offering substance abuse treatment in the 1960's in Massachusetts via the Spectrum House, an application of the treatment model known as the Therapeutic Community, or TC. This eventually grew to become the most extensive substance abuse treatment network in New England, providing both residential and out-patient clinical services to a variety of substance abusing and court-involved clients. Their entry into prison-based substance abuse treatment began in 1991, with the development of the Correctional Recovery Academy (CRA), an institution-wide application of a therapeutic community modality. SHS first began operating CRAs in Georgia in 1994. These therapeutic communities were instituted at Lee Arrendale, Homerville, Forrest Hays (later merged with Homerville), and Pulaski State Prisons.

Programs offered by SHS in the GDC

Spectrum Health Systems/CiviGenics offers a range of substance abuse treatment programs within the GDC. In addition to the RSAT program, these programs include the Prison Substance Abuse Programs (PSAP), the Substance Abuse Intervention (SIP) programs, and the Correctional Recovery Academy (CRA) at Homerville State Prison.

Wellsys Corporation is under contract to provide process evaluations of all three of these programs as well as the Substance Abuse 101 program. This report however will focus exclusively on the RSAT program, with the evaluation of the other programs being reported on in a separate document.

Overview of proposed RSAT program offerings

The Residential Substance Abuse Treatment (RSAT) program was planned as a comprehensive substance abuse treatment program targeted to selected inmates within six to eighteen months of their release. The RSAT program, based upon the Correctional Recovery Community (CRC) model, is designed, in general terms, to treat substance abuse, prepare substance abusing offenders for parole, and to improve post-parole outcomes. RSAT provides an intensive six-month program involving four phases of treatment: (I) Assessment and Orientation, (II) Intensive Activity Focused Drug Treatment, (III) Pre-exit Planning, and (IV) Exiting. Please refer to Appendix 3 for a comprehensive schedule of one of the RSAT programs.

The RSAT program is, along with the other SHS substance abuse programs, referred to by SHS as a recidivism reduction program. As such, the goal is to reduce chronic recidivism related to substance abuse. The CRC utilizes a specialized expert curriculum supported by the principles of social learning. The design provides inmates a genuine opportunity to acquire the knowledge, skills, and attitudes necessary to successfully integrate back into the social mainstream of society. The structure, content and methods of the Community are informed by empirically proven methods of effective programming and continuous evaluation of program effectiveness.

SHS provides a detailed list of RSAT program characteristics, described as follows:

- Emphasis on safety and security
- Consistent applications of rules, regulations, and standards
- Strong support for abstinence
- Practical, respectful perspectives
- Repeated coaching in primary skills
- Promotion of pro-social rather than criminal norms
- Productive use of time

- Therapeutic behavioral controls
- Continuing feedback on personal behavior and thinking
- Association with viable role models
- Respect for the learning abilities and potential of offenders
- Responsivity to individual needs

These values are communicated through a variety of tools of the therapeutic community, described as follows:

- Social Learning perspective
- Therapeutic community atmosphere
- Peer support and the use of peers as role models
- Use of staff members as rational authorities
- Regarding work as both educational and therapeutic
- Employment of both corrective and disciplinary interventions
- Specific graduation ceremonies
- Detailed list of specific inmate rights

Goals of the RSAT program

The Goals of the RSAT Program are described by SHS in the RSAT Technical Proposal entitled *"The Correctional Recovery Community: An intensive Residential Substance Abuse Treatment Program for Inmates"*(p. 95 ff). The stated goals are as follows:

1. To increase participants' level of knowledge of chemical dependence and reduce anti-social thinking, reduce criminal thinking patterns and corresponding criminal behaviors and reduce the negative effects of chemical dependency.

2. To maintain a 98% level of offenders who have developed an effective individualized recovery plan by the end of phase 2 of the program.

3. To maintain a 98% level of offenders who have developed an individualized community-based aftercare plan by the end of the last phase of the program.

4. To decrease the number and seriousness of Disciplinary Reports over the course of the program.

5. To decrease the number and frequency of positive drug screens while under Parole supervision, after graduation from the RSAT Correctional Recovery Community. (A copy of the Relapse Prevention Activity Checklist (RePAC) will be sent to each graduate's Parole Officer.) Results of all drug screens administered subsequent to graduation will

be tracked and reported in aggregate form to the Department by the RSAT-CRC program staff.

6. To decrease the proportion of offenders who violate parole. The proportion of offenders who violate parole will be tracked by program staff and reported to the Department by accessing the OTIS database.

7. To increase the proportion of offenders employed or in approved education programs within 30 days of release. Program staff will document and report to GDC on inmate post-graduation employment through access to the Parole OTIS database.

The design of the program is such that these goals are achieved through a combination of key elements, curricula, treatment modalities, program phases, structure, and activities on personal recovery. It is proposed that through a combination of these program elements, participants will experience significant and lasting change in the areas of thinking patterns, attitudes, and behaviors. Specific goals for participants are as follows:

1. To develop pro-social values and positive attitudes.

2. To learn anger management and violence reduction techniques.

3. To develop relapse prevention skills.

4. To learn how to identify and cope with urges and cravings for criminal behavior and drug use.

5. To learn how to effectively utilize peer support.

6. To explore new sources of personal satisfaction, including healthy sources of recreation.

7. To experience a sense of belonging in a safe, structured, and orderly community characterized by peer support, mutual respect, and common goals and values.

Means of achieving goals

The RSAT program provides a highly structured setting that includes a schedule of daily activities and meetings, a Therapeutic Community milieu, and a set of rules and standards with

clear consequences for noncompliance spelled out. Participants are considered to be engaging in treatment only if they truly belong to and are committed to the community. Evidence of this belonging is construed as participants learning to develop both individual responsibility and responsibility to the community. The community is thought of as the primary therapeutic agent, and effects change through mutual help, enhancement of community belonging, and provision of privileges and sanctions.

The RSAT program is delivered in four distinct phases of treatment, reflecting a process-oriented approach that emphasizes the incremental nature of change. The phases are as follows:

1. Phase I - Assessment and orientation

2. Phase II - Intensive activity focused drug treatment

3. Phase III - Pre-exit planning

4. Phase IV - Exit plan

Process through each stage is dependent upon completion of a specific set of phase change criteria. Both responsibilities and privileges increase with each successive phase of treatment.

Specific service elements of the RSAT program are described as follows:

1. The CORE SKILLS (Cognitive Behavioral building blocks)

2. Correctional Recovery Training Units (CRTs)

3. Learn to Work Groups (LTWs)

4. Twelve Step Self help Programs

5. Relapse Prevention Training

Program participants are expected to progress through the four phases of treatment, with each phase bringing an increase in knowledge, skills, responsibility, and privileges. Those who do not progress to the satisfaction of program staff are referred to as program failures or "wash-outs". Program failure occurs when:

- A participant repeatedly fails to comply with program rules and regulations;

- an inmate refuses to attend program or other scheduled groups or activities (including work details, educational groups, wellness walking, etc.);
- an inmate does not meet the criteria for movement to the next phase or to graduation after repeated opportunities to do so;
- medical or psychiatric conditions prohibit or interfere with continued participation in the program.

Program failure is addressed through a combination of incrementally applied sanctions and corrective measures and treatment team staffing.

Section III - Participant referral and selection process for the RSAT Program

Eligibility criteria for participation in the RSAT Program

Inmates to be considered for entry into the RSAT program must have a demonstrated history of serious substance abuse indicators. These indicators are as follows, with potential participants displaying at least one:

- Positive drug screen while in prison
- Prior parole failure associated with substance abuse
- Property and other crimes consistent with substance abuse problems
- Crimes committed while under the influence
- Medium or high score on the substance abuse section of the GDC needs assessment program/plan
- Medium or high score on the substance abuse section of the GDC offender profile
- Parole Board or Court mandated substance abuse treatment
- GDC counselor recommendation
- Inmate self-referral, provided inmate meets at least one of the above criteria

Literacy is not a requirement, and decisions are made without regard to race, religion, sex, sexual preference, ethnicity, age, or disability. The GDC however maintains discretion for final placement into the program.

Given the above criteria and the statistics indicating the degree of drug involvement of the typical State prisoner, it seems unlikely that significant numbers of prisoners would fail to meet at least one of the characteristics above. As a result, and given the intensive nature of the program, it is necessary to have in place certain exclusionary criteria as defined below.

Inmates will not be admitted into the program if they display any of the following conditions:

- Medical or psychiatric conditions which would interfere with their safe and productive participation in the program
- A personality disorder which would precipitate violent and/or threatening behavior
- Insufficient cognitive ability to grasp the program's principles

Other factors that may be involved in decisions to admit particular inmates into the RSAT program include, but are not limited to:

- Criminal history

- Personal characteristics, such as:
  - Educational history and achievement
  - Mental Health history and current status
  - Behavioral history and current status
  - Institutional history and current status

As is apparent from these statements, the exclusionary criteria are somewhat vague, in that they are not measurable or clearly defined. For example, there is no particular set of diagnoses that would be considered exclusionary, nor is there an IQ score cut-off that would define "insufficient cognitive ability". This allows for a considerable amount of discretion upon the part of those referring inmates and those who ultimately select inmates for participation in the program.

Proposed referral process of selected inmates

Substance abuse issues are designed to be addressed within the GDC through a comprehensive, multi-stage method based on an assessment of the degree of need for each inmate. Whereas "all inmates determined to be in need of substance abuse treatment" (*GDC: Substance Abuse Programs*, February 2000) receive drug abuse education in the form of Substance Abuse 101 (SA101), a funnel mechanism is designed to direct those inmates with increasingly serious substance abuse issues into increasingly more intensive treatment options. The flow diagram below depicts the substance abuse treatment offerings within the GDC.

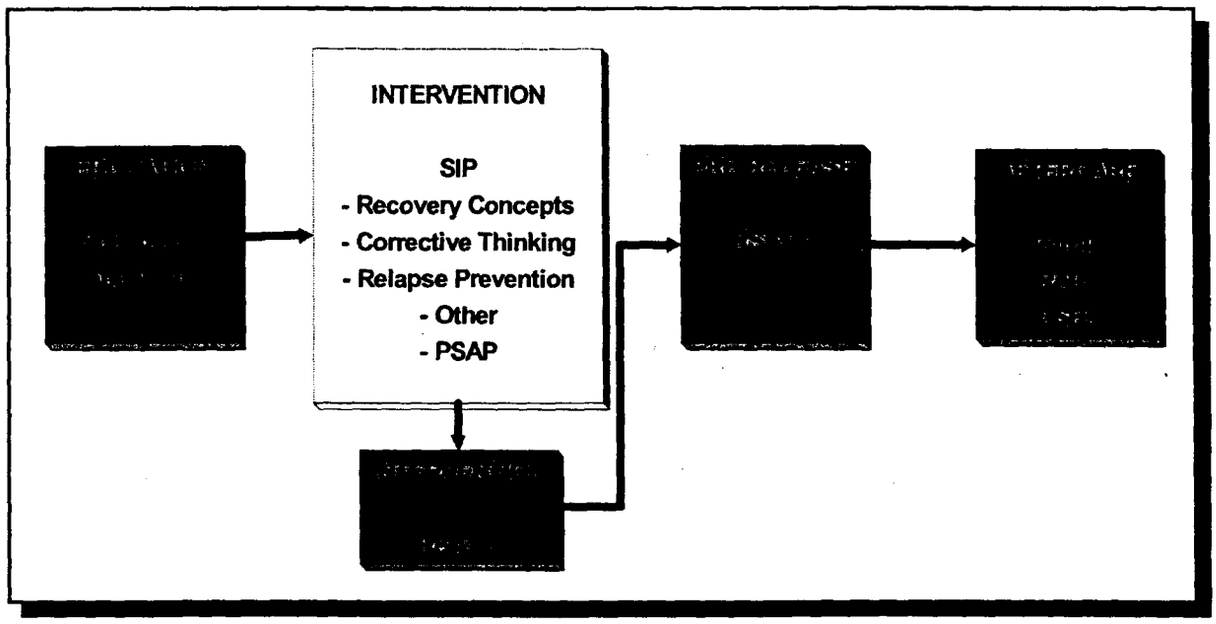

Figure 3 Substance abuse intervention programs within the GDC.

The progression of each inmate through the various service elements is to be determined by an ongoing assessment process, optimally resulting in a match between the severity of the problem and the amount and intensity of the intervention. The following diagram depicts this process:

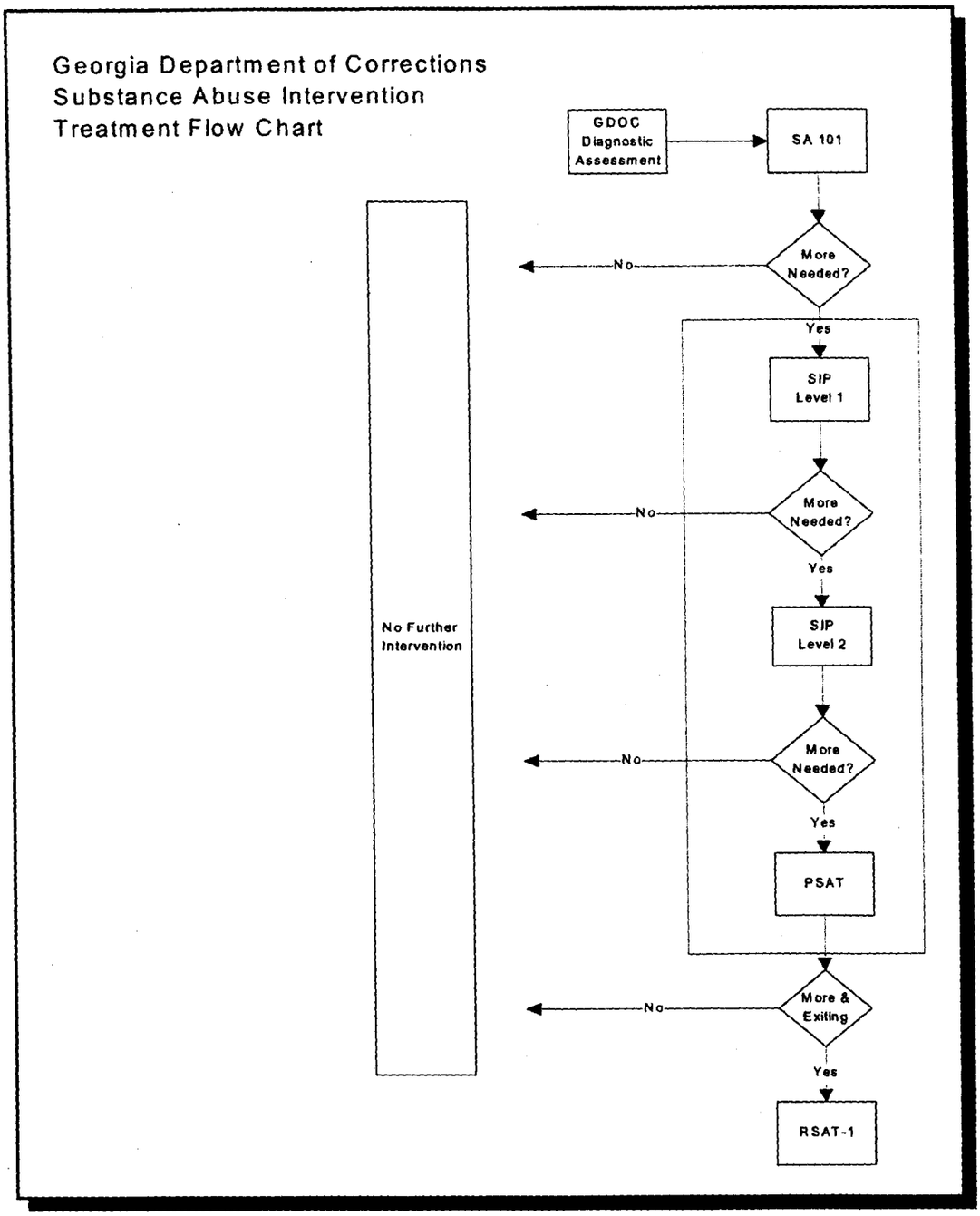

Figure 4 GDC substance abuse intervention programs flow chart.

The processes above, if they are to work according to plan, require a great deal of coordination of efforts within various GDC departments and divisions and between GDC and SHS. Various GDC components include the Programs Development Unit, diagnostic and classification services, unit counseling staff, and parole authorities. SHS components include unit staff and both regional and state administrative staff. Due to the progressive nature of the treatment process, it is imperative not only that correct decisions be made as to need for treatment, but the timing has to be such that inmates will be available to complete the prescribed course of treatment before they are scheduled for release to the community.

Problems identified with the RSAT Program referral process

Due to the focus of this report, only referrals to the RSAT programs will be addressed. Nonetheless, it appears that there are more than enough problems with this rather small piece of the overall assessment and referral picture. Figure 5 depicts a flow diagram of the RSAT referral process as it was originally designed to function.

This diagram depicts the referral process for the three programs for male offenders. The referral process for female offenders is much simpler, and involves direct communication between SHS and GDC Programs Development and Diagnostics and Classification personnel. According to GDC Programs Unit and Diagnostics and Classification personnel, the referral process for the women's program at Pulaski is working very well, with few if any difficulties. Unfortunately the same is not the case with the referral process for the three remaining RSAT sites.

Interviews with RSAT unit staff at the various RSAT sites suggest that there are significant problems in the area of inmate referral. These issues were also raised by correctional administrators at the sites, GDC staff in various departments, and SHS administrative staff. The problems are in a number of areas, and seem to compound one another. In fact, the referral process as depicted above was later modified somewhat in an effort to streamline procedures, resulting in the elimination of three steps in the referral process.

Tentative Parole Month Issues

One significant issue that was raised by almost every interviewee is an issue of timing, and involves Tentative Parole Month (TPM) dates of RSAT referrals. Not infrequently, inmates arrive for the RSAT program with a TPM date that, if left unchanged, would result in their being released from prison sometime before the completion of the six-month program. Alternately, inmates also arrive with TPM dates far exceeding the graduation date of the RSAT program, making discharge planning difficult at best. Early TPM dates require that RSAT unit staff contact

parole authorities to inquire as to a change in the TPM date for the inmate concerned. Late TPM dates leave the inmate with months or even years to serve following graduation, affecting release planning and options for aftercare and the maintenance of treatment gains.

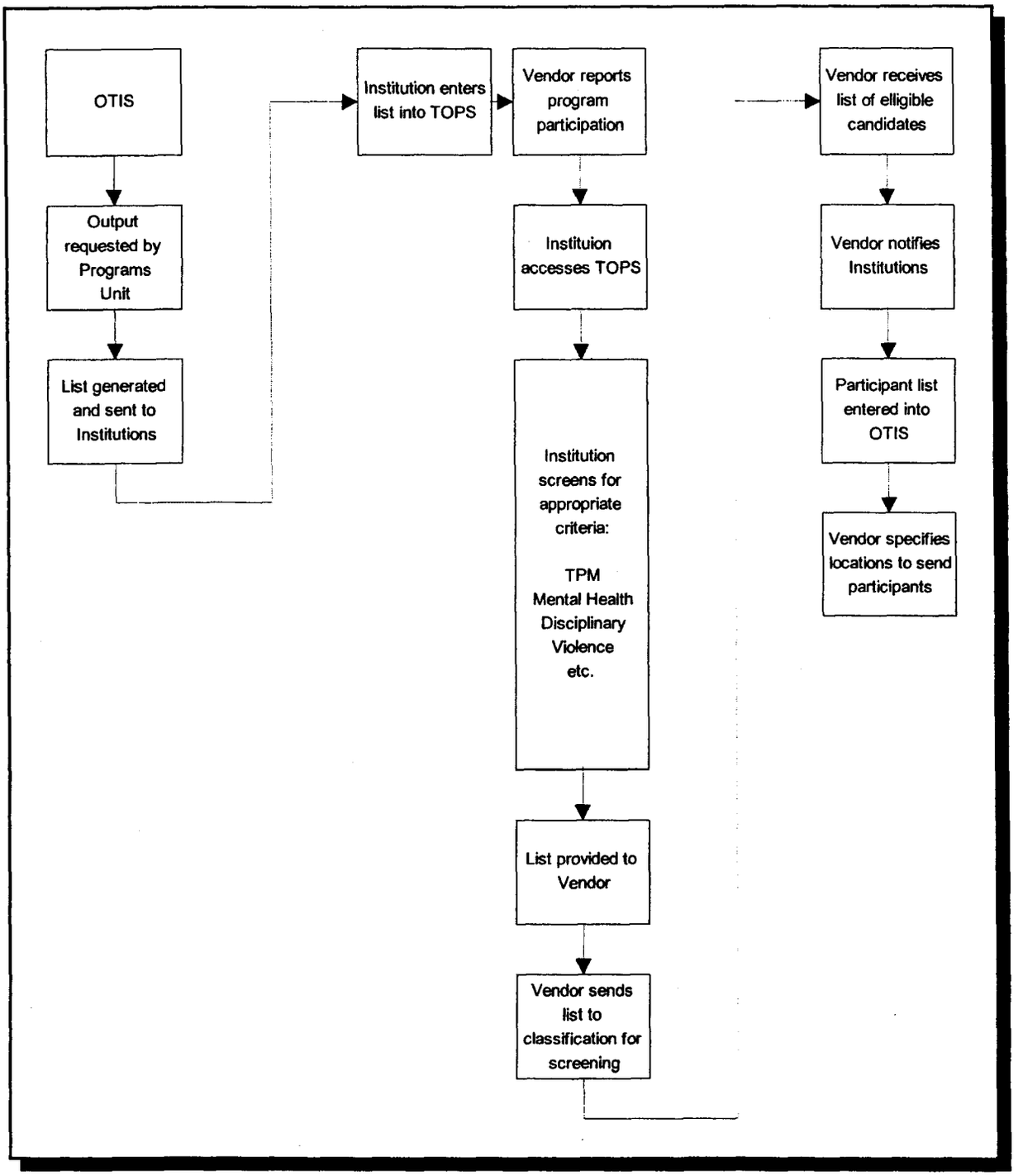

Figure 5 Flow diagram of initial RSAT referral process.

RSAT program staff were the most vocal concerning the issue of inappropriate TPM dates. One program director stated that inappropriate TPM dates were a problem up until late 1999. Things changed because they "started listening to RSAT staff complaints. The current group [March 2000] is the first one with really appropriate TPMs, as opposed to getting a significant number of participants with excessively short TPMs. This puts the program director in the role of "keeper of the keys", in that the director of the treatment program now has control over when the participants are released from prison. This can create some unfortunate dynamics between treatment staff and participants." A counselor at one of the other RSAT sites stated that they still receive too many participants with early TPMs. It has gotten better not because they are getting participants with appropriate TPMs, but because they now have leverage with parole authorities and are able to keep participants until they finish the program. It was in fact suggested by another counselor that "parole authorities align the TPM dates with the completion of the RSAT Program". One program was, as of April 2000, still experiencing significant difficulties with TPM dates that fall during the course of the program. A counselor at another site mentioned the issue of Performance Incentive Credits (PICs - similar to credit for good behavior that results in time taken off a sentence) coming up. While admittedly problematic, these do not occur at the same rate of frequency as do issues with inappropriate TPM dates.

The issue of TPMs and PICs was addressed early on in a memorandum signed by the Director of Parole and the Assistant Commissioner of the GDC and dated February 15, 1988. This document (a copy of which can be found in Appendix 4) details an agreement of procedures between the GDC and the State Board of Pardons and Paroles ("The Board") regarding how the two departments will work together regarding the RSAT program. Among other things, this document states that the GDC agrees to "admit only inmates who have a PIC date or a TPM date that is 6 to 9 months from date of admission to the RSAT program" and "not to place violent inmates (based on current offenses or history of violence), due to possible reconsideration of release by the Board". The Board agrees to "Release the above mentioned inmates upon completion of the RSAT program, assuming all other pre-conditions of the Board have been met" and to "Cancel or delay the release of an inmate once placed in the RSAT program until completion of the program".

Data collected during this evaluation indicate that these agreements have not been adhered to by either party. Inmates with inappropriate TPMs continue to be referred, and RSAT participation seems to have little or no effect on the administration of TPM dates by parole authorities. In fact, a reviewed letter received by an inmate from his attorney, whose consultation with a member of the Parole Board indicated that the Parole Board would provide no sanction if the participant wished to leave the RSAT Program early due to his TPM date.

The issue of TPM dates was again addressed in a joint meeting of GDC and Board authorities in May, 2000. Parole authorities agreed to delay TPM and PIC dates until after RSAT participants

complete the program. They expressed concern that they have not been receiving lists of RSAT participants, and thus were unaware of inmates' RSAT participation when making decisions about release. The GDC agreed in the February 15th, 1998 memo to submit lists of RSAT participants to the Board's Senior Hearing Examiner upon admission and again 30 days before release. According to GDC Program Development personnel, these lists had been sent on a regular basis by the SHS office on admission to the RSAT program and at the beginning of phase IV, six weeks prior to graduation. (This was confirmed by SHS, who have record of continuous faxes of these lists). It seems that perhaps the lists are not being directed to the appropriate person at the Board, and that this issue needs to be addressed as soon as possible. One approach may include tracking the data at every juncture and instituting a systems of redundancy checks to allow for errors in the data communication process.

Other inappropriate referrals

Another issue concerning the referral process is the general appropriateness of referrals. Whereas specific inclusionary and exclusionary criteria exist (described above), RSAT staff have noted that inappropriate referrals continue to be made. Examples include, but are not limited to: Non-English speaking inmates; inmates with significant mental health and/or behavioral problems; criminal history inclusive of significant violence; issues relating to custody level; and inmates with significant histories of institutional misconduct. According to one program director, "the typical referral is changing, in that there are more pressing and more serious needs. We are getting more referrals with low IQ, low reading levels, serious mental health issues such as psychosis - the mental health needs are pressing". Conversely, a program director at another site noted that during the implementation of the RSAT program a number of inappropriate referrals, specifically inmates with behavior problems and/or violent crimes, made it into the program. This problem was later eliminated, as SHS made these exclusionary criteria in the referral process. Another program director reported getting large numbers of parole revocators, "...and they come straight from county jails. They have made up the majority of the last two groups." This is no doubt because there is no specific program for this population, as there is for male inmates at another facility.

Another referral issue commonly cited by RSAT staff concerned inmates with little or no reading skills. These participants have difficulty finishing tests, understanding the program materials, and also are not able to participate in the Georgia State Academic and Medical System (GSAMS), the vocational training component available to RSAT participants. RSAT participants not eligible for participation in GSAMS are often assigned various jobs around the institution, ostensibly in order to provide some basic job skills training. During one site visit, RSAT participants were observed spray-painting metal grates. It was recommended by staff at one of the sites that an 8th grade reading level be required for admission to the RSAT program. Other RSAT staff suggest that these inmates be provided literacy training and/or GED work in

order to "get them to where the rest of the class already is" upon admission. A seeming move in the right direction involved the recent hiring at one of the institutions of a person to work with the lower-functioning inmates, including RSAT participants. The success of this approach remains to be seen.

Referral process in general

When asked what they identified as the problem in the referral process, staff usually identified the diagnostic and classification system as the culprit. A Deputy Warden of Care and Treatment (the correctional administrator assigned to oversee specific programs at the institutional level) at one institution stated that "It is a classification issue [the program would be improved] with early identification and proper training". In a similar vein, another Deputy Warden of Care and Treatment stated that "Classification with the GDC is the problem. People don't understand who should be in [the program]. The GDC bureaucracy needs to assist, not complicate the situation". When asked to elaborate, the warden replied that "The substance abuse people don't talk with the vocational people, and there is poor communication with parole authorities and every other department and agency. It effects outcomes". Finally, it has been stated that there is little flexibility in how the Diagnostics and Classification Unit makes the final decisions as to who will and who will not be transferred to the RSAT programs.

On a micro level, the process of identifying inmates for potential participation in the RSAT program was also seen as problematic. One RSAT staff member stated that GDC counselors who do the screening do not do so with the proper intent, stating that "for them it is just another task". Another opined that GDC counselors don't know enough about the RSAT program to send the appropriate inmates. One staff member stated that in general, "There is a problem with screening - it is poor". A GDC chief counselor noted that the process of referring inmates through the comprehensive system of interventions is simply not working as designed.

One possible reason for these comments could be the schedule of referrals. There are eight referral cycles for the RSAT program each year, four for the SIP programs, and 16 for the PSAP programs. During four of these nine RSAT cycles referrals are required for the SIP and PSAP programs as well. This schedule would require that those involved in the diagnostic and classification aspect of the referral process would be actively engaged in the referral process for a significant portion of their work hours. Given the many other demands upon their time, it is reasonable to imagine that counselors may not place referrals to the RSAT program at the top of their list of priorities. One way to address this would be to streamline the referral process so as to limit as much as possible the repetitive tasks associated with a process that occurs so frequently. Another possible solution would be to provide counselors with specific training. A Deputy Warden of Care and Treatment recommended that the RSAT staff conduct annual training for the diagnostic and classification counselors on issues related to RSAT participants.

In particular, counselors could be educated concerning the program itself, the issue related to TPM dates, and provided specific information concerning inclusionary and exclusionary criteria. According to RSAT documentation, this training is already taking place for the chief counselors and operations analysts. Given the likely high degree of turnover among counselors and the importance of making appropriate referrals, the training of all counselors should be seriously considered.

How counselors refer inmates to the RSAT program

The procedures whereby counselors refer inmates to the RSAT program are not at all clear-cut. Interviews conducted with GDC Programs Development staff, GDC Diagnostics and Classification staff, GDC Office of Planning and Analysis staff and SHS staff all suggest that the determination of which inmates have drug and/or alcohol problems happens in different ways. What is clear is that all male inmates are interviewed during their initial processing at one of three institutions: Coastal, Jackson, or Bostic State Prisons. Female prisoners are all processed at Metro State Prison. During the interview process a series of determinations are made as to the extent of the inmate's alcohol and drug involvement and his or her desire to participate in treatment. Until June 30, 1999, inmates completed a structured instrument known as the Jemelka (after its designer, Dr. Ronald Jemelka). This instrument was designed in part to assess the seriousness of alcohol and drug use through the administration of the Minnesota Alcohol Screening Test (the MAST) and the Drug Abuse Screening Test (the DAST), two well-known assessments of substance abuse. The data was entered into OTIS, and, along with a host of other information, was included in a document known as the GDC Diagnostic and Classification Packet. As of July 1, 1999, this procedure ceased to occur. Another structured assessment was suggested, but according to Diagnostic and Classification personnel, was, at approximately $6.50 per inmate, too expensive to implement.

Data concerning drug and alcohol use seemingly continues to be collected however, and is actually available via the official GDC website (www.dcor.state.ga.us). This website, among other data, provides a downloadable document known as the *Prisons Monthly Report*, produced by the GDC Office of Planning and Analysis. This document contains a host of statistics concerning GDC inmates. Among this information is a table referred to as the "Inmate Diagnostic Behavior Problem by current age and sex". The table from the May monthly report can be viewed in Appendix 5. This table presents raw frequencies and percentages for a number of behavior problems ranging from substance abuse to suicidal ideation. The first five categories of behavior problems are as follows: Alcoholic; alcohol abuse; drug experience; drug abuse; and narcotic addict. Frequencies and accompanying percentages are given for both males and females across four age ranges, as well as grand totals. A staff member at the GDC Office of Planning and Analysis, the office responsible for compiling the statistics in question, stated that the data are current and come directly from OTIS. Personnel in both the

Programs Development unit and the Diagnostics and Classification unit insisted that this must be "old data", that is, data collected prior to the discontinuation of the Jemelka instrument in July of 1999. Diagnostics and Classification staff indicated that a structured interview currently under revision is being used at the diagnostic centers, but that the results do not go into OTIS at the present time. The section of the interview (referred to as "the final interview") related to substance abuse appears in Appendix 6. This section of the final interview requires the counselor administering the interview to assign the interviewee into either low, moderate, or high categories of substance involvement based on inmate self-report data. The assignment then dictates the degree of substance abuse treatment subsequently recommended by the counselor.

Clearly, there is some disagreement about how the initial information concerning inmate substance abuse is collected, stored, aggregated, and reported. This is problematic in that this data is of critical importance in making initial determinations as to which inmates would likely most benefit from substance abuse-specific treatment. Given the issues with the timing of the referral process, it is imperative that those inmates most in need of substance abuse treatment be directed towards completing the comprehensive system of interventions put in place to address this specific need. Another reason why the uncertainty regarding these statistics is troubling is that this information is being widely disseminated to the public via the website, as well as likely provided to the U.S. Department of Justice for inclusion in their statistical reports.

A related concern is with the methods used to obtain substance abuse data during the diagnostic process. The method in which the data is collected is likely to have an impact on the accuracy of the data. An examination of the statistics provided in the aforementioned table reveals that 14% and 19% of inmates report a history of alcohol and drug abuse, respectively. These numbers, when compared to data cited earlier, suggest a certain degree of under-reporting. Also troubling is the behavior problem labeled "alcoholic". Alcoholic is a diagnostic label, and certain criteria must be met in order to be labeled an alcoholic. It is not clear who is making this determination. Are GDC counselors applying this diagnosis, or is the data obtained via self-report (e.g., are you an alcoholic)? Clearly, the process of obtaining information concerning the substance abuse histories of inmates during the diagnostic process is in dire need of revision and clarification.

Specific details concerning referrals were explored using data found in the screening database provided by SHS. The screening database is used by SHS to keep track of referrals to the various programs and the results of said referrals. The database provided to Wellsys in November of 1999 contained a total of 2176 records of referrals, of which 1611 were made to the RSAT program. It is not clear how far back the recorded referrals extended, as referral dates were missing for a number of records. Sixty-three of the RSAT referrals were not coded as to their eligibility and were removed from consideration. Of the remaining 1548 referrals, 331 were coded as eligible for entry into the RSAT program. Another dichotomous variable

within the same database indicates that a total of 394 referrals were found to be eligible. This discrepancy is most likely due to missing data on variables noting the reasons for ineligibility variable. Table 2 displays the reasons provided for ineligibility.

Table 2 Reasons RSAT referrals were found to be ineligible.

Ineligible reason	Frequency	Percent	Valid Percent
Physical health	25	2.0	2.0
Mental health	91	7.1	7.5
Disciplinary	145	11.3	11.9
Additional time	69	5.4	5.7
No SA 101	192	15.0	15.8
No longer at the prison	114	8.9	9.4
Refuses	8	0.6	0.7
Critical detail	42	3.3	3.4
Violent offender	416	32.5	34.2
Other	115	9.0	9.4
Missing	63	4.9	----
Total	1280	100.0	100.0

The above figures were very close to those provided in the *RSAT Report for Fiscal Years 1998-1999*, provided by SHS, and referring to the first six months of 1999. Referring back to the admission criteria for the RSAT Program, we find that the above categories include the majority of reasons provided for program ineligibility, with the exception of the critical element of time left to serve (the TPM issue). What is immediately apparent from the above table is the small proportion of referrals that are found to be eligible for participation in the RSAT Program. Approximately four out of five referrals (78.6%) are coded as ineligible, leaving only 21.4% of referrals eligible to participate in RSAT. As noted earlier, the referral process fails to screen out inmates with eligibility problems, leaving the number of truly eligible inmates even lower than these figures suggest.

Reasons for ineligibility

Further examination of the above table indicates that 15% of the ineligible referrals were found thus because they had not participated in SA 101, an essential prerequisite for admission to the RSAT Program. Given the intensity of the RSAT program, it may not in fact be necessary that

inmates participate in SA 101 prior to attending RSAT. Over a third (34.2%) of ineligible referrals were coded as being violent offenders, another group ostensibly excluded from participation in RSAT programming. It is interesting to note that less than 1% of referrals found to be ineligible were found thus as a result of their refusing to participate in the program. While likely not a representative sample of the entire inmate population, this indicates that of those referred, very few refused to participate. This suggests that, at least among referrals, there is widespread support for the RSAT Program.

As a whole, these findings suggest that the majority of referrals are inappropriate, and given the investment of time involved in the referral process, likely represents a significant unnecessary expenditure of resources. This finding is likely due to a combination of factors. There likely exists a certain amount of pressure to refer inmates to the RSAT Program, and this pressure is communicated to classification and diagnostics personnel responsible for initiating the referrals. It is also likely that, due to factors such as turnover and poor communication and/or training, GDC counselors involved in referring inmates to the RSAT Program are unaware of or do not fully understand the admission criteria. Another factor likely to influence the low eligibility rate is the lack of consistent and complete information (as noted above) available regarding the substance abuse history (and other historical factors) of potential referrals. A lack of reliable data could result in the over-reliance on self-report data, and inmates are generally not regarded as the best historians. Finally, time pressures exerted by referral deadlines and significant caseloads requiring attention may contribute to a more or less random assignment approach to referring inmates to RSAT.

Possible sources of the difficulties observed in the referral process relate to the rather significant degree of coordination required among and between the many systems described above. In particular, RSAT unit staff and correctional administrative staff cited a lack of communication between the GDC Diagnostics and Classification Unit and the other systems involved in the referral process. Another area of communication found lacking was that between RSAT program staff and parole authorities, generally around issues relating to TPM dates. An additional issue was the lack of communication and cooperation cited between the Diagnostics and Classification Unit and the Programs Development Unit within the GDC administrative structure.

Another source of difficulty likely involves the availability of reliable data upon which to base decisions regarding eligibility. As noted, there are significant issues related to the manner in which data concerning inmate substance abuse histories are gathered, stored, and communicated. Standardizing and systematizing these procedures would likely go a long way toward providing a degree of reliability of data, and the use of a respected, standardized data collection instrument would lend some validity to the data. The cost of such an instrument may seem prohibitive if viewed in isolation. However, the cost may appear more reasonable however when seen as a way to reduce the number of man-hours spent on inappropriate

referrals. Systems of data storage and communication can be addressed by instituting a system-wide database and reporting mechanism, possibly through OTIS.

Source of referrals

One aspect of the referral process seems to be going quite well, that being the variety of sources referring inmates to the RSAT program. Thirty-eight institutions were represented among the 1333 cases for which this data was available (of 1611 total RSAT referrals). The only State Prison not to send referrals to the RSAT Program was Homerville State Prison, which is itself a Correctional Recovery Community much like RSAT. Hays and Rogers State Prisons, the two largest referral sources, together contributed one of every five referrals. Excepting these institutions, referrals were fairly well distributed across the various institutions.

Results of the problems with the selection and referral process

According to interviews with RSAT unit staff, Inappropriate referrals to the RSAT program result in:

- Non-completion of the program for some inappropriate referrals;
- Inmates having significant time to serve following RSAT completion;
- Staff time not optimized due to time spent addressing problems related to inappropriate referrals.

Combined with the finding that four of five referrals to the RSAT program are found to be inappropriate prior to transfer, the degree of time and energy spent on inappropriate referrals that enter the RSAT program is out of proportion to their actual numbers.

Section IV - Implementation of the RSAT Program

Selecting program locations

As previously noted, SHS was awarded the contract to provide the RSAT programs on November 12, 1997. The programs began on January 12, 1998 at the four sites. The four sites, three male institutions and a female institution, were selected among 38 State Prisons for a variety of reasons. An overriding concern was that the staff and administration at each of the facilities be supportive of treatment and rehabilitative efforts. An additional concern was that the units selected had to possess an infrastructure and physical plant that could accommodate a therapeutic community that would, in some respects, operate somewhat separately from the rest of the institution.

Pulaski State Prison was chosen due to its status as a female institution with an established vocational program. Scott State Prison was chosen due to its level four (medium) security status and its reputation as a training and treatment center. Macon State Prison was chosen due to its level five (close) security status and the relatively high rate of idleness (lack of job and/or training assignments) among the inmates housed there. Calhoun State Prison was chosen due to its impending transition from a level four to a level five facility and for the fact that the warden was formerly warden at Homerville State Prison, site of the SHS Correctional Recovery Academy.

Facilities at the Four RSAT Sites

Given the nature of most state prison systems, it is expected that there will be a significant degree of variation in prison facilities in terms of age of the facility, size, architecture, and mission of the facility. This variation is certainly apparent in regard to the four RSAT sites.

The Scott State Prison is a medium security institution housed in what was once a state psychiatric facility. The grounds are sprawling, and the RSAT Program itself is housed in a former living and treatment facility. The sleeping areas and day rooms are long, narrow rooms. The day rooms have room air conditioner units, while the dorms themselves are not air conditioned. The day rooms house the televisions and telephones. Three of eight phones were in working order during one observation. The main classroom, a former laundry room, was approximately 15 x 15, had painted white brick walls, and an exposed, approximately 10-ft high ceiling. There were two filing cabinets, 25 student desk/chair combinations, 2 portable white boards on easels, and a small table with a TV/VCR combination device.

Calhoun State Prison is a close security (level 5) facility, with modern, low-slug brown buildings. Movement is semi-controlled, and the grounds were impressively landscaped. The RSAT dorm is an open-bay design, with two wings. There is a large, open day-room area, with phones and televisions. The televisions come on after 4pm on weekdays. There were a number of bunks in the common area, suggesting a number of residents over census. There were bulletin boards with RSAT programming information, one for each of the two bays. The RSAT facilities consisted of three group rooms, one computer lab, and a vocational GSAMS classroom. The rooms were all large and well lit. The computer lab had ten personal computers, many with printers, each about a year old. The classrooms were spotless, and nicer than many college classrooms. A class observed was held in one of the group rooms, and had a large blackboard and bulletin board at the front of the room. There were 14 study carrels and a desk for the counselor. There were doors and windows leading both outside to the yard and inside to the rest of the classrooms.

Macon State Prison, a close security institution, is similar to the Calhoun facility in that it is a modern, well-equipped, and neatly manicured facility. The RSAT offices, dorms, and classrooms are all in separate locations, dissimilar from the other sites. An observation was made of a class taking place in one half of a large, well-lit vocational studies room. The other side of the room was set up to accommodate a woodworking shop, with various woodworking tools and supplies and a massive steel overhead door at one end of the room. The participants, of which there were 11, sat at 2 long rows of tables, with the counselor at front leaning on a desk.

The Pulaski RSAT Site is housed in a close security, modern and sprawling campus of single story buildings. Some of the buildings are a pale pink, and the overall look and feel is that of a community college. The RSAT Program is housed in a open dorm, and consists of two small offices. The director and one counselor share one office, while the secretary and the other counselor share the second office. Both offices were crowded with books, videos, and program materials. During one visit a class was observed being held in the hallway of a dormitory wing.

Whereas the Macon and Calhoun program facilities have ample space for classes and other RSAT activities, the same cannot be said for either the Pulaski or Scott programs. Both are in need of space, particularly the program at Scott State Prison. The RSAT director at Scott bemoaned the lack of available space for his program, stating that they have to use counselors' offices and day rooms (location of telephones, TVs, adjacent to bathrooms and sleeping areas) as classrooms, in addition to the former laundry room recently converted to a classroom. Multiple use rooms means that classes have to be canceled and/or postponed (this happened during one visit). Space, rather than programmatic issues, dictates the schedule. Usually there are four classes and a twelve-step program occurring simultaneously. The lack of space also contributes to a lack of privacy, and an inability for counselors to meet one-on-one with

participants during class times. Echoing the director's concerns, both the warden and the deputy warden at the Scott facility expressed a strong desire and had preliminary plans to expand the space available to the RSAT program there. Regarding space needs at Pulaski, the fact that a class at Pulaski was being held in a dormitory hallway speaks for itself.

Initial Program Implementation

The period between November 12, 1997 and January 12, 1998 encompassed approximately 45 working days in which to get the four RSAT sites up and running. While the RSAT program had for the most part been designed and instituted elsewhere, the issues of modifying the program for this particular application needed to be addressed. A seventh program (the original contract was for six) was also added in January, although to a site that was already set to host one program. Just as pressing were staffing needs, in that four directors, three assistant directors, 14 counselors and three secretaries would be needed to fully staff the four sites. Once hired, staff would need to be trained and oriented not only to the RSAT Program, but also to the prisons in which they would be working.

In speaking with RSAT staff, some expressed feeling unprepared to begin delivering the program so quickly after being hired. Two of the program directors had been hired within two weeks of the start date, after having responded to advertisements in their local newspapers. They each reported having received approximately three days of training from SHS prior to the first groups of participants arriving. Another of the directors had been working at another substance abuse treatment program at the same site, and reported that the transition to RSAT was fairly straightforward. The fourth program director assumed that position when the then current director left, six months after the program began operating.

Given that the RSAT curriculum was already established at the time it was implemented, there were few issues raised regarding the actual delivery of the material. There were issues, however, in obtaining necessary materials and supplies. One director noted that "It took a considerable amount of time to get certain supplies - six months for the table and chairs, and things still arriving after 18 months. For a start-up though, it went OK.". The same director noted that perhaps the most difficult aspect of implementing the program was building and developing a sense of trust among both correctional staff and inmates. There has traditionally been a degree of mistrust among correctional systems employees concerning treatment programs. Treatment is considered "soft", and those providing treatment are sometimes seen as being easy on inmates. Those RSAT program staff members with prior experience in corrections seemed to expect these attitudes at first, while those without correctional experience may have experienced some initial difficulty dealing with this aspect of their jobs.

Despite the lack of preparation time, RSAT staff involved in the initial implementation agreed that the process went very well. Program directors noted the significant degree of assistance they received from SHS, as well as the assistance and cooperation received from the host institutions. At least one of the programs began by only bringing in nine participants during the first few cycles, as opposed to the 20 to 24 that constitute a full class. Another decided to cut down on some class time due to a temporary shortage of counselors. Program directors noted that other than those few variations, there was a good degree of fidelity between the design and initial implementation of the RSAT program.

Budget and operating issues

Budget figures were obtained from two sources, both summary reports of the RSAT program. The first of these documents is the *Residential Substance Abuse Treatment for State Prisoners: Report of the State Agency Administering the RSAT Program(s)* report, produced by the National Evaluation of Residential Substance Abuse Treatment (NERSAT). This document reports that the operating budget for the RSAT programs for the 1996 RSAT Period (11/1/96-6/30/98) was a total of $1,002,355. Of this amount, $751,766 was from the federal RSAT grant administered by the Criminal Justice Coordinating Council. The remaining $250,589 was provided by state matching funds. These numbers increased to $815,727 from federal funds and $271,909 in state matching funds for the 1997 RSAT Period (7/1/98-6/30/99), for a total of $1,087,636. This amounts to an approximate 8.5% increase from RSAT Period 1 to RSAT Period 2. The RSAT Programs began service delivery in January of 1998, with the time until that period being used for preparation of the proposals and request for proposals and other start up issues.

The second source of information concerning budgetary issues was the *RSAT Annual Project-Level Evaluation Report*, prepared for the CJCC by the GDC Programs Unit. This document was dated 4/12/2000, and provides summary information for fiscal year 1999 and for the entire length of the RSAT project. This report states that as of 9/30/99, the average cost per offender to complete the RSAT program was $370.21. With a then total of 586 inmates having completed the program, this amounts to a total of $216.943.06. These figures represent the cost of program delivery over and above the costs associated with incarceration itself, which likely explains the significant discrepancy with the budgetary figures provided in the NERSAT report.

Overview of staffing structure

The staffing structure of the RSAT programs includes a number of positions at a variety of work locations. The director of Recidivism Reduction Programs is housed at the SHS/CiviGenics headquarters in Massachusetts. A regional director is responsible for the oversight of all programs in the Southeast. The state director of substance abuse programs works out of the metropolitan Atlanta office, along with the associate state director for the northern region. The

state director for the southern region works out of an office in Florida. The programs at the three institutions for male offenders (Scott, Macon, and Calhoun State Prisons) each have an RSAT program director, an RSAT program assistant director, four counselors, and a full-time secretary. The program at Pulaski State Prison, a female institution, has one RSAT program director, two counselors, and a secretary.

SHS organizational structure

The organizational chart for SHS appears below in Figure 6.

Selection and training of staff

As previously noted, at least two of the program directors were recruited by and responded to newspaper ads. A number of counselors were recruited from the GDC counselor or correctional officer positions, while others came shortly after finishing their schooling or retiring from the military. Still others came from private industry, such as the insurance business. Clearly, SHS has drawn fro a wide variety of backgrounds and experience levels to fill its RSAT positions.

Staff selection criteria, requirements

According to SHS RSAT program descriptions, all staff must meet the following criteria:

- Be able to work in partnership with GDC personnel in understanding and supporting institutional priorities and protocols
- be certified addictions counselors, licensed or certified mental health professionals, or working toward certification or licensure
- support the goals and objectives of the program
- Be able to use both cognitive-behavioral and social learning methods comfortably
- Be mature and committed to their own growth
- Serve as positive role models for inmates in the program

SHS expects that all RSAT program staff will combine academic and experiential backgrounds in the fields of substance abuse and correction. Further, staff guidelines indicate that priority consideration is given to "qualified applicants who are themselves recovering from addiction and/or criminal backgrounds and who have been continuously abstinent and have maintained wholesome lifestyles for at least three years".

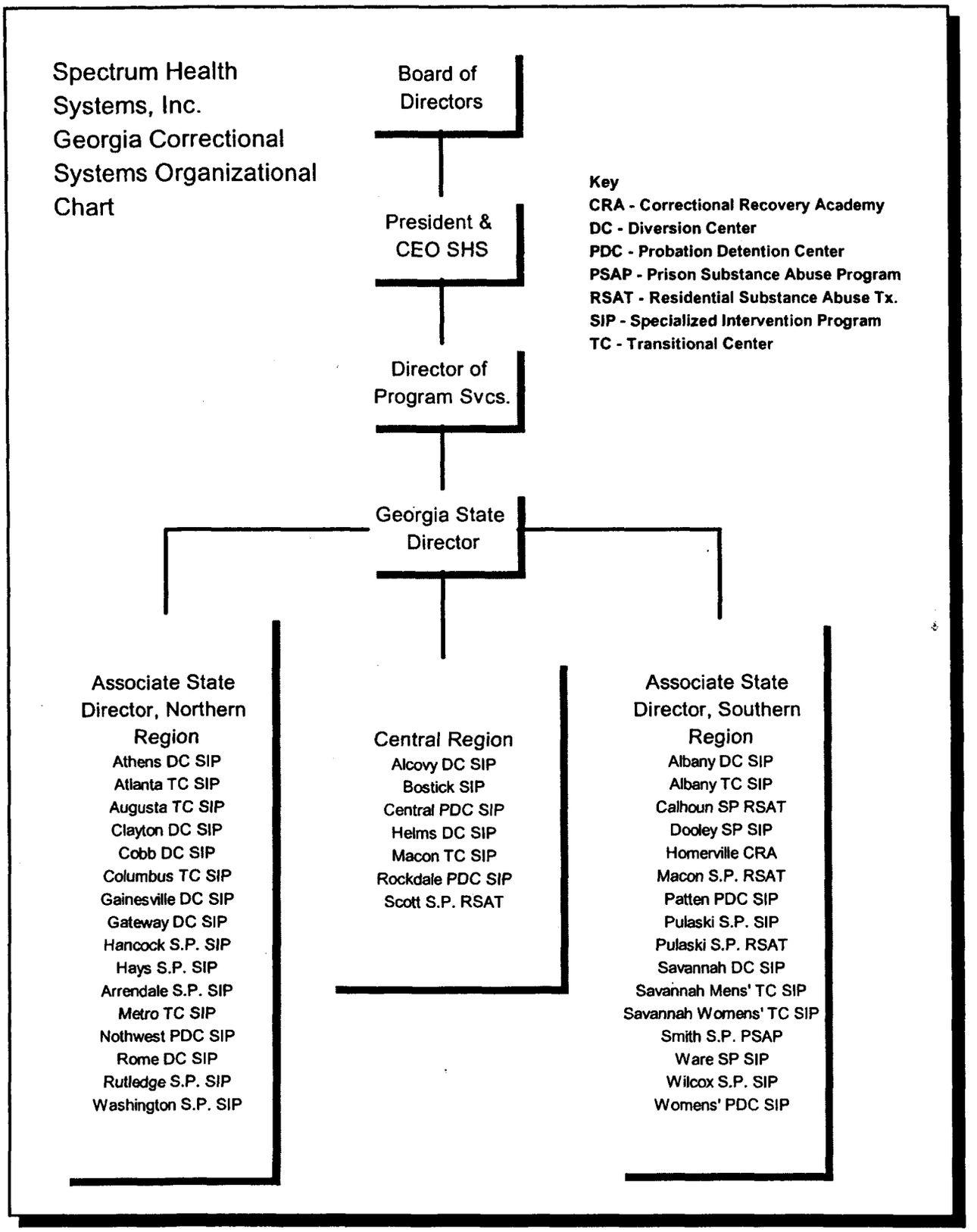

Figure 6 SHS organizational chart.

As would be expected, the program directors brought the most relevant experience to their positions. One of the directors worked for 23 years as a probation and parole officer in another state. His substance abuse experience was as a probation officer with a specialized drug and alcohol caseload and with a mentally-impaired chemical abuser caseload. He also had significant experience as a training officer within both probation and parole. Another of the program directors was employed by SHS at the unit since 1995, working as a counselor in a SIP Program prior to the RSAT program being assigned to the unit. The third program director had no mental health, correctional or substance abuse-specific experience prior to his beginning at the RSAT program in January of 1998 as an assistant director. He brought to the position significant military history as an operations manager, and became the program director when, after six months, the then current director left for another correctional system. The fourth director brings the most extensive and relevant experience to the position. She was directing a Community Mental Health Clinic in Rural Georgia immediately before coming to the RSAT Program. This director has over 20 years of experience in mental health and substance abuse treatment in four different states, having worked in community mental health and both public and private hospitals and clinics. She has obtained Master Addiction Counselor (MAC) and Licensed Professional Counselor certification nationally, and is a Certified Marriage and Family Therapist and Certified Addictions Counselor in Texas. The three other directors are all in the process of obtaining Certified Addictions Counselor (CAC) credentials.

Regarding the three assistant directors, one graduated from college in 1997, and began with SHS as a counselor on the first day of the RSAT program. She was promoted to the assistant director position on 1/12/99, her first year anniversary with the RSAT program. She is in the process of obtaining CAC credentials. Another of the assistant directors received his MAC through his experience in the military. Georgia does not recognize this particular certification, so he is working on the MAC certification recognized by the state. He possesses a Masters degree in human relations. The third assistant director brings a significant degree of experience in the field of adult education to his position. He also is seeking certification as a Certified Addictions Counselor.

The counselors, as would be expected, bring the least amount of substance abuse-related experience to their positions. Former positions represented among the ranks of the counselors include: correctional officer; physical education teacher; detention officer at county jail; house parent at a state facility for troubled adolescents; activity therapist for community mental health center; and a psychiatric nurse, with some experience with substance abuse detoxification and mental health issues. Educational backgrounds include, but are not limited to Bachelors degrees in psychology, criminal justice, political science, and special education. Whereas most counselors have their Bachelors degrees, a significant minority are currently in the process of earning them. Further, none of the 14 counselors have CAC credentials. All but one counselor (on the job less than one month at the time of the interview) are in various stages of the process, typically accumulating classroom hours and setting up supervisory hours. Clearly,

the substance abuse treatment experience of the counselors has in large measure been a matter of on-the-job training.

Given the job requirements as stated above, it is clear that while the staff as a whole meet these requirements, many do so only minimally in the area of certification. That only two out of 21 staff members working full-time in substance abuse treatment possess credentials in the substance abuse treatment field is somewhat surprising. This is all the more notable considering that the program has been in place for over two years. While the credentialing process takes time (and for CAC level I certification requires two years of full-time work in the field), it is expected that more staff would be further along the process than they are at this point.

SHS seems to be aware of this deficiency, and held a seminar at their 2nd annual training in April on the certification process. The one director who had obtained certification stated that, if possible, she would "hire only counselors with substance abuse certification or experience working with dually-diagnosed clients. We seem to have applicants with no substance abuse-specific experience. It is difficult to hire qualified staff, probably due to our rural location". It is assumed that she speaks for SHS in that hiring certified staff would be preferable, but is likely not practical. At the same time, the additional costs associated with the hiring of credentialed, experienced counselors must be taken into account.

A number of counselors mentioned the low salaries that they were being paid, and expressed disappointment that their starting pay was actually lower than that of correctional officers. A discussion during a meeting at the annual training between counselors and one of the state assistant directors was focused on issues of salary and compensation for the engaging in the process of CAC certification. In sum, the assistant state director stated that SHS will provide release time, but not fiscal reimbursement, for their counselors to pursue certification. If they were dissatisfied with their compensation, they could note that on the feedback forms provided for their use.

The contract for services with GDC originally specified hiring only certified personnel, but they were unable to fill the positions. This was relaxed in order to allow employees who were actively pursuing certification. The sense seems to be that once counselors obtain certification, they will leave their relatively low-paying jobs to seek other employment, as SHS only offers a one-time 4% salary increase for obtaining certification. This type of atmosphere may result in the programs becoming akin to training sites, as opposed to treatment programs.

In interviews with counselors following the training, a few stated that they felt "put-off" by SHS administrative staff regarding their questions about compensation. An assistant program director put it plainly, stating that "Employees want to feel valued. It helps to feel valued, to help with retention and lower turnover. People also want to be heard. If employees are not

valued, they will leave. It is demoralizing to see [correctional] officers paid more for starting." The program director at that site replied by noting the demands placed upon the counselors, and the increased responsibilities as a result of changes in the RSAT program. It was stated that "In the beginning, RSAT was viewed as psycho-educational. As of September 1999 with CARF [accreditation], it was re-conceptualized as a treatment program. The focus changed, resulting in much more demands placed upon staff. This is especially relevant for the one-on-one sessions required for crisis management and treatment planning. It makes it hard to walk the walk, as counselors say what is valuable but don't have the time to spend with inmates. Nonetheless, [we] are getting things done, working as a team. It is tough to keep staff motivated."

When asked what they would change about the RSAT program, a number of counselors indicated that they would like more financial compensation. While this request is likely an almost universal part of the human condition, the RSAT counselors do seem to be especially dissatisfied with their pay. At the same time, the status of SHS as a not-for-profit entity, the RSAT program being a result of a competitive bidding process, and the lack of credentials possessed by the counseling staff are all factors that must be taken into account.

Training required, provided by GDC and/or SHS

All staff are to receive 40 hours of orientation provided by SHS during a one-week intensive orientation program. The orientation is designed to cover such topics as:

- Specific duties assigned to the employee
- Procedures for handling incidents and emergencies
- Familiarization with existing staff backup and support systems
- Developmental recovery from addiction and criminality
- Principles of cognitive-behavioral programming
- Structure and approach of Correctional Recovery Training
- Social therapy and social learning in a correctional environment
- Role-modeling, norm-setting, and criminogenic awareness
- Assessment skills and case management

Additional training was to have been provided during the first few months of program implementation (January through March of 1998). While it appears clear that this training was not provided to all employees before they began working with RSAT participants (SHS Orientation for one RSAT program occurred in March of 1998), a significant amount of ongoing training has been and continues to be provided to RSAT personnel.

Staff are also required to attend 40 hours of orientation provided by the GDC, and to obtain 40 hours of continual education yearly through attendance at in-services, workshops, and other

training opportunities. All training opportunities are documented in a training log by the program directors at each RSAT program location. Review of the training logs indicates a variety of training opportunities made available to and attended by RSAT personnel. Training opportunities were made available almost every month, and were presented by SHS personnel, GDC personnel, and a variety of outside trainers.

Staff-to-inmate ratios at the RSAT sites

The staff-to-inmate ratio varies depending upon the RSAT program site, as there are differences in the number of beds available for the programs depending on the site. The program at Pulaski State Prison has 48 beds and three full-time service staff, for a ratio of 1 clinical staff member per 16 inmates. The programs at Calhoun and Macon State Prisons each have 96 beds and six clinical staff members, also producing a ratio of one clinical staff member per 16 inmates. The program at Scott State Prison has 70 beds and 6 clinical staff members, for a ratio of one clinical staff member per 12 inmates.

Timelines of RSAT Program

As previously noted, there are eight RSAT admission cycles each calendar year. New participants (cohorts) arrive every six weeks; 24 at a time for the Calhoun and Macon programs, 22 at a time for the Scott program, and 16 at a time for the Pulaski program. Each of the four phases is six weeks in length, for a total of 24 weeks, or approximately 6 months of treatment. Graduation exercises also occur every 6 weeks, which are followed by discharge of the recently graduated cohort.

A typical scenario detailing entry to the RSAT program begins with a transport officer picking up RSAT participants at the Georgia Diagnostic and Classification Prison on Tuesdays and Thursdays the week prior to the beginning of phase I. New referrals arrive at the unit, are assigned to the RSAT dorm, and are assigned a roommate (if applicable). They spend the first few days getting acclimated, and participate in a unit orientation. Groups start on Monday mornings, and the new participants arrive after the first daily count, between 7:30 and 8:30 am. They go over the RSAT handbook, sign various forms (including the treatment agreement), and begin the orientation to the RSAT Program. Then participants complete the pre-treatment assessment battery composed of the Criminal Sentiments Scale, the Coping Behaviors Inventory, and the Buss-Durkee Hostility Inventory (Descriptions of these inventories can be found in Appendix 7). Participants spend time becoming familiar with the RSAT schedule, and are then assigned a primary counselor.

Phase I of the RSAT program is concerned with orientation and the learning of basic recovery skills (RSAT curricula and schedules can be found in Appendix 3). Phase II focuses on identifying Criminal Addictive Thinking and Relapse Prevention skills, and is accompanied by the beginning of vocational training through the GSAMS program. Phase III begins an intensive focus on preparation for release, with Phase IV continuing the focus on release and relapse prevention while adding real-world skills such as relationship building and parenting. Entry into each successive phase is accomplished only by completing all the assignments of the previous phase, including achieving a passing grade (70% correct) on the end-of-phase examination. If participants miss more than a week, they are required to start the phase over.

In addition to the extensive RSAT curriculum, most participants also receive vocational training through the vocational Georgia State Academic and Medical System (GSAMS). The GSAMS programs are operational at all four RSAT sites, and form an integral part of the treatment program by providing computer and job skills to participants as an additional relapse prevention tool. The initial GSAMS contract was fulfilled by Thomas Technical Institute, but was changed to Middle Georgia Technical College due to increased costs and a sense that the initial vendor was not delivering a fair product relative to those costs. The switch from Thomas Technical Institute to Middle Georgia Technical College was initiated by the GDC Programs Development Unit, not SHS. The transition was smooth, and according to interview data, the new vendor seems more receptive than the former. Interview data with RSAT staff and GDC correctional administrators indicate that there is a high level of satisfaction with the GSAMS programs as operated.

One issue with the GSAMS program is that a significant number of RSAT participants is excluded from participation due to low academic performance. While figures vary according to the particular characteristics of referred cohorts, data from the Counselor Rating Survey indicate that approximately 20% of RSAT participants as of April 2000 are ineligible for participation in GSAMS. Given the expected role played by vocational skills in the reduction of recidivism, it is postulated that those inmates not receiving GSAMS training will have less favorable outcomes that inmates who participate in GSAMS classes.

Participants' attendance in RSAT classes is tracked in various ways, depending upon the particular site. One program records individual attendance for each class, and submits the data to GDC personnel on site. Another keeps individual attendance data on forms, but disposes of the forms without recording the data for later use. The other two programs indicated that they had no formal procedures for collecting individual attendance data, but that the sanctions built-in to the RSAT program made it such that any problems with attendance were addressed immediately through the use of a system of increasingly serious sanctions. While chart reviews indicated that sanctions are clearly given for failure to attend sessions, a central repository of complete attendance data would allow for the measurement of a potential dosage effect of treatment.

Statistics of RSAT Program Participants

Three datasets were obtained from three separate sources in order to provide descriptive statistics regarding the following areas:

- Number and characteristics of inmates identified as potential participants
- Number and characteristics of inmates referred
- Number and characteristics of inmates selected
- Number and characteristics of inmates who began the RSAT program
- Number and characteristics of inmates who completed the RSAT program

A variety of sources of electronic data were explored in an effort to provide this information.

SHS tracking database

Table 3 Instant offense of RSAT participants.

Instant Offense	Frequency	Percent	Valid Percent
Assault	23	2.8	5.9
Fraud	10	1.2	2.6
Murder/Manslaughter	14	1.7	3.6
Robbery	31	3.7	7.9
Sexual Offender	4	.5	1.0
Weapons	3	.4	0.8
Drug Trafficking	57	6.8	14.5
Drug Possession	99	11.9	25.3
Property Offense	86	10.3	21.9
Domestic Violence	1	.1	.2
DUI	19	2.3	4.8
Other/NOS	45	5.4	11.5
Missing data	443	53.1	-----
Total	835	100.0	100.0

In addition to the screening database discussed earlier, SHS also maintains a participant tracking database. This database was designed for the purpose of tracking participants in the SIP, PSAP, Homerville CRA, and RSAT programs. It contains records of 835 participants in the RSAT programs, covering a longer time span than the screening database. Similar to the screening database, the tracking database contains significant gaps due to the large amount of missing data. Information obtained from this database included instant offense, drug of choice, age, and race data.

Instant Offense

The type of crime responsible for the current incarceration was coded, and appears in Table 3. Taken together, drug trafficking, drug possession, and DUI account for about 45% of current RSAT incarcerations. System-wide data concerning most serious instant offense indicate that

these three crimes together account for about 18% of the total. The *GDC Monthly Prisons Report for May, 2000* indicates that 19% of active inmates reported drug abuse histories and 14% reported alcohol abuse histories. These are self-report data collected during diagnostic screening, and are likely underestimates of the true incidence of these problems. Nationwide, 23% of all arrests were alcohol-related, compared to 21% of arrests in Georgia. Fully 67% of adult arrestees in Atlanta tested positive for illicit drugs at the time of arrest (*Sourcebook of Criminal Justice Statistics, 1998*, p. 367; p. 370). Taken together, these figures suggests that RSAT participants are much more likely to have current drug or alcohol-related offense than the typical general population inmate. Given state and national data concerning the significant degree of drug involvement in general criminological behavior, it is clear that the RSAT population came to prison heavily involved in substance abuse.

Another interesting aspect of this data is that it indicates that a sizable proportion of RSAT participants had been convicted of a violent crime. About 10% of this sample had been convicted of either assault, murder/manslaughter, or a sexual offense.

Table 4 Drug of choice for RSAT participants.

Drug of choice	Frequency	Percent	Valid Percent
Alcohol	109	13.1	27.9
Cocaine	162	19.4	41.4
Opiates	11	1.3	2.8
Amphetamines	17	2.0	4.4
Marijuana	83	9.9	21.2
Other	5	.6	1.3
None reported	4	.5	1.0
Missing	444	53.2	----
Total	835	100.0	100.0

Drug of choice

The tracking data included information concerning drug of choice for 431 RSAT participants, and the results can be found in Table 4.

As indicated by Table 4, cocaine is far and away the most commonly reported drug of choice. It is unfortunate that the data did not distinguish between powder and crack cocaine, as that would have provided further insight into usage patterns of RSAT participants. Nonetheless, this finding suggests that cocaine abuse is a significant issue for this sample of RSAT participants. Alcohol at about 28% and marijuana at 21% are second and third, respectively. Together, these three account for about 90% of the cited drugs of choice. What this data does not represent is the totality of usage - given what is known regarding substance abuse, there is likely a great deal of polysubstance abuse not indicated by this data.

Race of participants

Of 916 total RSAT admissions, 63% were coded as Black, 36% as White, and 1% as Hispanic (RSAT Report for Fiscal Years 1998-1999). This corresponds fairly closely with GDC system-wide data indicating that 67% of inmates are "non-white" (GDC; 1999 Annual Report). No information was available concerning ethnicity.

Age of participants

The tracking database contained one variable indicating the age of participants. There were data for 391 of 835 records, for a 47% rate of return. The average age of RSAT participants was 35.2 years of age, with a standard deviation of 8.56 years. The age range was from 19 to 64 years, with a median of 34 years. Ten percent of participants were aged 25 or younger, and 10 percent were aged 47 or older. RSAT participants are close in age to the average of 33.83 years of age for the entire GDC inmate population (GDC; 1999 Annual Report).

Combination of Screening and Tracking databases

Table 5 Admissions to the RSAT Programs

Status	Calhoun	Macon	Scott	Pulaski	Total
Admitted	250	279	228	159	916*
Discharged	166	203	160	105	634
Graduated	95	116	84	44	339
Graduation Rate	57%	57%	52%	42%	53%
Completion Rate**	80%	70%	72%	67%	73%

*As of June 30, 1999 there were 235 active RSAT participants

*Completion rate is "adjusted for those offenders who were unable to complete the program due to premature release or other factors outside of program control" (*RSAT Report for Fiscal Years 1998-1999*).

The two SHS databases were combined to provide information concerning the relationship between the screening dates, the dates of entry into the RSAT Program, and the TPM dates. The screening date was subtracted from the date of entry into the RSAT Program to provide the number of calendar days between those two dates. The data appeared somewhat unreliable, as a number of records were such that the date of entry into the RSAT Program preceded the screening date. These values appeared as negative numbers, and were excluded from analysis. A total of 436 (of 835 RSAT referrals) complete date records resulted. The average number of days between screening and entry into the program was 42.4, with the range of values extending from a low of 0 to a high of 276 days. While this figure fits with the timing of

the referral process, external verification is necessary due to the previously mentioned problem of negative values.

A similar procedure was followed in order to compute the number of days between the screening date and the TPM date. The average number of calendar days between the screening date and the TPM date was 318.2 (SD = 98.8), with a low value of -44 days and a maximum value of 493 days. The negative value (of which there were 4) for the low is likely accurate, as a number of sources (interviews, collateral paperwork, etc.) indicated that it was not uncommon for inmates to be referred with little if any time between the start date of the program and their TPM date. Given the length of the program (6 months) and the average length of time between referral and entry into the program, a TPM date that is at least 7 months (approximately 213 days) after the date of screening is advisable. Only 10% of the TPM dates were less than 226 days beyond the screening date, so it appears from this data that in general the TPM dates are adequate. This finding does not square with the vast number of complaints received from practically all sources concerning inappropriate TPM dates. It may be that this data is flawed, as the dataset does have a significant amount of missing data. It is also possible that while perhaps only 10% of referrals have inappropriate TPM dates, the difficulties caused by this problem creates a disproportionate degree of distress.

Admissions to RSAT

Of the 1611 total RSAT referrals, 394 were coded as having been transferred to various RSAT sites. This number represents 24.5% of RSAT referrals for which we have data. The database did not report to which RSAT site the referrals were transferred. The incompleteness of this data becomes apparent when compared to project totals provided in the *RSAT Report for Fiscal Years 1998-1999*. This document provides monthly, year-end, and total summary statistics concerning admissions and discharges to the RSAT Program, covering the period between January 1998 and June 30, 1999. Table 5 above provides summary statistics concerning RSAT admissions.

Table 6 Discharge dispositions of RSAT participants

Disposition	Frequency	Percent	Percent of non-graduates
Graduation	339	53.5	----
Voluntary withdrawal	10	1.6	3.4
Disciplinary Sanction	106	16.7	35.9
ETOH/Drug Use	10	1.6	3.4
Paroled	100	15.8	33.9
Transferred	55	8.7	18.6
Medical/Mental Health	12	1.9	4.1
Cognitive deficit	2	.3	.7
Language barriers	0	.0	.0
Administrative/Other	0	.0	.0
Total	634	100.0	100.0

As is apparent from the above data, there is a considerable difference between the completion rate as computed by SHS and the graduation rate. The completion rate is "adjusted for those offenders who were unable to complete the program due to premature release or other factors outside of program control" (*RSAT Report for Fiscal Years 1998-1999*). While an adjustment of this type makes sense, a more complete explanation of its computation is warranted. It is quite possible that due to the lack of clarity concerning its origin, the completion rate is somewhat misleading. It is helpful in one sense however in that when compared to the graduation rate, it makes clear the impact of early withdrawal due to factors such as early parole and transferring to another prison.

Completion Status

Discharge code, or completion status, was available for 656 of the 835 RSAT participants in the database. Due to the amount of missing data, the following information was taken from the *RSAT Report for Fiscal Years 1998-1999* rather than from the screening database. Please see Table 6 for a depiction of the various discharge dispositions.

According to the data, approximately 53 percent of RSAT participants completed the program. Of interest is that of those who did not complete the program, fully one-third failed to graduate due to their having been paroled during the course of the program. Given the existence of an agreement between GDC and Parole authorities to not parole active RSAT participants, it appears as though this represents a deviation from that policy and may indicate a problem in communication between the two agencies. Assuming that approximately 60% of these participants would have otherwise completed the program, another 50 participants would be RSAT graduates. This data provides a counterpoint to the calculations involving TPM dates

above, and provides empirical support for the numerous anecdotal reports of issues with inappropriate TPM dates.

Another finding apparent from this data is that over a third of participants who do not complete RSAT fail to do so as a result of a disciplinary sanction. As previously noted, the RSAT program has a graduated system of sanctions that can ultimately result in removal from the program. That 12% of all participants and a third of all non-completions are due to disciplinary measures indicates that, if nothing else, the system of sanctions is being employed. A review of participant files indicates a variety of reasons for disciplinary measures being imposed, and is not unreasonable given the population served by the program.

What is both interesting and encouraging to note is that so few participants (1.4% of RSAT participants; 3.6% of program failures) were removed for use of drugs or alcohol. This is in spite of both regular and random urine screens at each of the institutions. One of the RSAT programs has a perfect record, in that since the inception of the program not a single participant has produced a positive urinalysis result. Other disciplinary problems are few, in comparison to those of the general population. The *RSAT Report for Fiscal Years 1998-1999* indicates that the rate of both disciplinary reports (DR) and positive drug screens (+UDS) for RSAT participants during the first six months of 1999 are significantly lower at each of the four sites. Overall, 9% of RSAT participants during this period received a DR, compared to 67% of the general population. During this same period less than 1% of RSAT participants provided a positive urinalysis result, compared to 4% of the general population. These findings were given anecdotal support by the senior administrative staff at each of the sites, all of whom indicated the lack of disciplinary problems with the RSAT participants.

Counselor Rating Form

Wellsys developed the Counselor Rating Form (CRF) survey as a means of assessing the progress of individual participants in the RSAT Program. The CRF consisted of 20 questions, grouped into four general areas: motivation; degree of participation; performance; and predicted outcomes concerning crime and drug use. The CRF utilized a Likert-type response format, ranging from a 1 (Very Low) to a 5 (Very High). The instrument, which can be found in Appendix 2, was completed by the RSAT counselors at each of the four sites, with the counselors completing one CRF for each of the participants on their caseload. A total of 244 completed CRFs was received, providing a "snapshot" of an entire population of current RSAT participants at a given point in time.

Counselor Rating Form Findings

Fourteen counselors provided ratings - four counselors each from the Calhoun, Macon, and Scott State Prison programs, and two from the Pulaski program for women. The average number of CRFs completed by each counselor was 17.4, with a standard deviation of 5.0. The smallest number of CRFs from one counselor was 5, with the most completed by a single counselor being 25. Thirty-nine completed CRFs were received from Pulaski, 52 from Calhoun, 68 from Scott, and 85 from Macon. Summary statistics for each of the twenty items appear in Table 7 below.

As is apparent from Table 7, scores tended to cluster around the value of 3, the midpoint of the scale. An examination of the frequencies for each of the items revealed the same pattern, in that each frequency distribution formed a bell-shaped curve. The only exceptions appeared to be the items concerning performance in both RSAT and GSAMS classes and assignments.

Table 7 Summary statistics for the Counselor Rating Form.

Variable	Mean	Std Dev.	N
Motivation to come to RSAT	3.08	.93	244
Motivation to participate in RSAT	3.41	.83	244
Motivation to change criminal thinking	3.44	.84	243
Motivation to change criminal behaviors	3.48	.84	244
Motivation to get off drugs/alcohol	3.58	.87	241
Motivation to achieve lasting change	3.60	.85	244
Motivation - overall	3.50	.77	244
Participation in the community	3.28	.78	244
Participation in RSAT classes	3.51	.82	244
Participation in GSAMS classes	3.38	.89	197*
Participation in 12-step groups	3.32	.94	244
Participation - overall	3.43	.77	243
Performance in the community	3.36	.78	244
Performance in RSAT classes	3.56	.84	244
Performance on RSAT assignments	3.58	.88	244
Performance in GSAMS classes	3.44	.90	199*
Performance on GSAMS assignments	3.44	.90	198*
Performance - overall	3.54	.78	242
Chances of staying drug free	3.31	.78	242
Chances of staying crime free	3.33	.81	243

*Not all participants are eligible for participation in GSAMS

These distributions displayed positive skew, in that the number of fours approached or exceeded the number of threes overall.

Group Differences

The next step in the analysis of the CRFs was to explore the possibility of differences among the four sites. A series of one-way Analysis of Variance tests (ANOVAs) was performed in an effort to reveal any group differences. Of the 20 mean comparisons, group effects were found to be significant at the .01 level on 19 items, with the 20th being significant at the .05 level. Post-hoc analyses indicated that the ratings of the participants in the Calhoun program were consistently higher than those in the other three programs. A significant, though less prevalent finding was that the ratings of the participants in the Pulaski program were often lower than those in the other programs. It was thought that these differences may in part be the result of one or two raters at each site rating participants either consistently high or low. An additional series of ANOVAs was performed in an effort to examine within-program variation in ratings. Results indicated that there was one rater in each group that consistently rated higher or lower than the other group members.

There are a number of possible explanations for these findings. As all raters were trained together in the administration of the instrument, it is unlikely that differences in training contributed to the significant within-and between group variance. It is possible that the within-group differences are reflective of the different phases of treatment, but this pattern was not found. It could be simply a matter of differences in perspective, training, and experience among the counselors. Two of the sites had one counselor each who consistently rated their participants higher than the others, while two sites had counselors who provided ratings consistently lower than their peers.

The within-group differences notwithstanding, the between-group differences remained significant, despite the significant within-group variance. The counselors at Calhoun consistently rated their participants higher than the other programs, and to a lesser degree, those at Pulaski were more likely on a number of items to rate their participants significantly lower than the other programs. This finding could be explained as a difference in training, skill, experience, or perspective of the counselors. Alternatively, it could be seen as indicating that the participants at Calhoun are actually doing better, and those at Pulaski are doing worse, than their peers at the other programs. The Calhoun program is directed by a clinician with many years of experience in the treatment of substance abuse and psychiatric disorders. She has directed the program since its inception, and possesses advanced credentials in substance abuse treatment (Master Addiction Counselor). Her credentials and experience in the field are significantly stronger than those of the other program directors. It is possible that her direction of the program has resulted in a higher degree of service delivery.

The Pulaski program, being the only RSAT program for female offenders, may be impacted by some of the factors unique to that distinction. The Pulaski program has recently been pressured to take a significant number of parole revocators, inmates who have no choice but to complete the program if they wish to regain their freedom in the most timely fashion. There is a RSAT-like program for males specifically for this segment of the male population, the Correctional Recovery Academy (CRA) at Homerville State Prison. It is possible that parole revocators, due to their special status, may not be as motivated and/or interested in fully participating in treatment. Unfortunately, this evaluation did not encompass the program at Homerville, so this hypothesis cannot be tested. Further, Pulaski participants were not coded so as to indicate whether or not they were revocators.

In summary, results of these analyses indicate that overall, counselors rated participants as having a moderate degree of motivation, participation and performance. Further, participants were, on the average, rated by their counselors as having moderate chances of staying both drug and crime free upon release from prison. There were differences between programs, with participants at the Calhoun program receiving the highest ratings and those at the Pulaski program receiving the lowest.

Interviews with RSAT staff were completed in part to further elucidate details about participant attitudes toward recovery. Specifically, staff were asked to estimate the percentage of participants who took the program seriously and the percentage who were genuinely interested in change. The consensus was that approximately 40% of inmates took the program seriously, with an equal percentage genuinely interested in change. An equal proportion was attempting to "fake it to make it", with the remainder failing to complete the program.

Regardless of the degree to which participants genuinely buy into the program, interview and empirical data indicate that RSAT participants get in significantly less trouble than non-RSAT participants. This was especially evident in interviews with correctional administrators, each of whom indicated that the program drastically reduces disciplinary sanctions. A warden at one of the RSAT sites noted that "The RSAT participants are the easiest group in the entire prison to manage and supervise. I feel like I don't have to worry about that building. They are orderly, clean, and respect each other. They seem more caring, more concerned about each other. All of this will likely translate to life on the street". RSAT staff have noted that there are very few behavior problems among the participants, and statistics complied by SHS (and cited above) attest to these reports. From a correctional management perspective, hosting an RSAT program is an asset as it reduces significantly the amount of disciplinary incidents among a portion of the inmate population. It is no surprise then, that the majority of correctional administrators interviewed expressed a desire to both increase and expand the RSAT program and similar programs.

Classroom observation

Classes were observed at all four RSAT sites, with a member of the evaluation team sitting in on classes spread throughout the four phases of treatment.

At the Macon RSAT program a class was observed taking place in one half of a large, well-lit vocational studies room. The other side of the room was set up to accommodate a woodworking shop, with various woodworking tools and supplies and a massive steel overhead door at one end of the room. The participants, of which there were 11, sat at 2 long rows of tables, with the counselor at front leaning on a desk. The warden of the institution had been sitting in on the class, and he reportedly sits in on a class at least once a week. The phase IV class was a lively discussion-oriented affair, with most participants adding to the discussion.

During one visit to the Pulaski RSAT program a class was observed being held in the hallway of a dormitory wing. While it was the RSAT wing, it did not appear to be an environment optimally conducive to learning and discussion.

At the Scott site one class was observed with 18 participants and one counselor present. The class was for phase IV participants, and the focus was on the availability and utilization of community services. It was a discussion format, with all but three or four participants joining the discussion. Both the warden and the deputy warden for care and treatment came by during the count procedure. The deputy warden remained and observed the class for approximately 30 minutes. A participant and the counselor present for the class said that it was not unusual for the deputy warden to observe classes. Other than the administration staff, one inmate left the class early for an undisclosed reason.

A class observed at the Calhoun RSAT program was with phase I participants, and the focus was on appropriate communication skills. The class was didactic in format, with a modicum of discussion at times. One inmate came in 40 minutes after the class had begun, and another arrived 15 minutes later (both were at the canteen). An inmate was called out of the room at 20 minutes by the assistant director, and a correctional officer removed another inmate at 55 minutes into the class. There was an officer posted outside the classroom door during the entire class, with his radio squawking loudly. The class ended after some participants engaged in role plays to demonstrate effective and appropriate communication.

All of the classes observed were marked by respect and what seemed to be honest attempts to learn the material being presented. While this can be explained in part by the fact that they were being observed, interview and survey data indicate that good behavior is class is by far the norm rather than the exception. It is imagined that this degree of consistently good behavior is due to a combination of internal motivation to learn and the fear of external sanctions imposed by the RSAT staff.

Graduation

A graduation ceremony at the Macon RSAT Program was observed on April 7, 2000. The ceremony was a joint graduation of the GED and RSAT programs, and was very well attended. The ceremony was attended by a number of visitors, including politicians, GDC and GSAMS officials, and members of the press. There was an inmate vocal group, awards and certificates were distributed, and the keynote speaker was a state senator. The statewide director of GSAMS noted that the facility would be getting six more personal computers, allowing each student to work on a single computer during classes. It was also announced that beginning one week hence, five of the GSAMS classes would provide credit hours directly transferable to any of the junior colleges in the state.

Chart reviews

A review of current and retired RSAT charts was conducted as a means of assessing the documentation concerning individual RSAT participants. Both current and retired charts were reviewed at each of the four RSAT sites. The charts were chosen at random, by the evaluator, from the chart repositories. While not a formal audit of charting procedures, the charts were checked for completeness, consistency, and formatting. As previously noted, the RSAT program underwent a considerable review process for CARF accreditation in late 1999. A significant part of this process was the assessment of RSAT charting procedures. It is reasonable to assume that this impacted, in a positive way, the state of the charts during my review of them in early 2000.

Clinical Chart Storage and Retrieval

Procedures to keep clinical charts varied from one location to the next, with levels of chart security varying as well. Procedures for accessing and storing charts are described below.

At the Pulaski RSAT program there are two filing cabinets in the director's office, one containing active and retired charts, the other program materials and paperwork. The cabinet containing the charts did not lock, while the other cabinet did. Most of the retired charts have been transferred to the Atlanta office.

Personnel at the Scott RSAT program keep retired charts in the office shared by the director, the assistant director, and the secretary. They are kept in a closet that cannot be locked. The file cabinet is not kept locked, though the office door is locked when no one is in the office. When visited, this closet was being reorganized due to a lack of space for files and supplies. Current participant charts are kept in an office shared by two of the four counselors. They are kept in a filing cabinet that is locked during off-hours. The counselors' office is locked when unoccupied.

Table 8 Average number of chart audits for the RSAT sites.

Site	Average	SD	Range
Scott	3.5	2.3	1-8
Calhoun	6.0	1.3	4-9
Macon	1.3	.7	0-2
Pulaski	.8	.7	0-2

At the Calhoun RSAT program, files from 1998 are kept in a large cardboard banker's box in a locked storage closet located in another building. Files from 1999 are kept in a cardboard box in the director's office. Active participant files are kept in a locked filing cabinet, also in the director's office.

Procedures at the Macon RSAT Program are such that retired charts are kept in file boxes in a storage closet located in the administration complex. The director and the deputy warden for care and treatment have keys to that closet and thus have access to the files. Current charts are kept in a locked filing cabinet in the secretary's office, which is in the RSAT complex.

The RSAT charts reviewed evidenced a good deal of consistency in terms of chart order and content across sites. A copy of the form used to review the charts can be found in Appendix 8. Each chart typically had as its front piece a chart order form, listing the correct order for the contents of the chart. This was consistent across sites, and helps explain the consistency observed.

As noted earlier, SHS requires chart audits to occur on a regular basis. Each chart contained documentation of this requirement in the form of an audit trail. There were significant differences among sites as to the frequency of audits. Using retired charts, the number of audits for each of the charts reviewed was tallied. An average was computed, with the results appearing in Table 8.

The differing rate of chart auditing suggests there exists a difference across sites in the degree to which documentation is being reviewed. While charts were found to be consistent across sites in terms of content, the differing rates of review could, for those charts receiving few audits, result in the perpetuation of errant procedures and incomplete documentation.

Whereas the charts reviewed displayed a good degree of consistency regarding ordering and content, the documentation was not without its problems. Early charts (chiefly those from 1998 and early 1999) were marked by a lack of specificity concerning treatment goals and plans for release. The RePACs of this period were often characterized by a lack of detail in the areas of avoiding risk factors, financial and living arrangements, and general aftercare. Release Preparation Activity Checklists (RePACs) tended to contain unrealistic statements concerning future plans, such as the following: One participant anticipated returning to his job as a "waterboy", hosing down machinery at a mill. He expected to make $230 per week, and his plans were to "buy a nice big house" within three months and to buy a car within a year. Others contained vague plans to avoid relapse, such as the following question and response item within a crisis plan: "Q: How do you plan on dealing with thoughts and/or feelings about drinking, drugging, or doing crimes? A: To stay out of the neighborhood". Ironically, elsewhere in the RePAC it was indicated that he would be moving into his former place of residence upon release from prison. The RePACs become more specific and more realistic over time, likely reflecting an increased degree of understanding and experience among staff members reviewing the RePACs. Some changes were also made in the RePAC format itself, in that more specificity was required regarding finances and aftercare plans.

Narrative reports in the charts evidenced some inconsistencies in reporting, such as age discrepancies, varying accounts of "drug of choice", and plainly contradictory statements. For instance, a Latino inmate's primary language was listed as French. Another instance included a summary narrative with one paragraph containing two mutually exclusive phrases regarding drug treatment history ("He also has had outpatient treatment for substance abuse" and "He reports never having received treatment for alcohol or drug abuse"). Some charts indicated very poor writing skills on the part of counselors, and some narrative handwritten sections were illegible.

The accreditation review resulted in a change in some of the paperwork used to track participants (please see appendix 9 for an example of the new RSAT participant chart and charting procedures). These changes were instituted in early January of 1999. The new forms allow for increased and more direct linking between the treatment plan and progress towards goals. The new paperwork also helps in specifying treatment goals and writing disciplinary reports, assists in supervision and oversight of staff. In general, the staff thought that the new paperwork made the documentation more clear and was more able to specifically document change (or the lack thereof). The new RePAC format provides for more attainable goals, allows for more detain concerning crisis plans, and requires more specificity in the budgeting sections. At the same time, the new forms increase the time required to do effective treatment planning. The accreditation review has imposed specific requirements regarding the need for increased specificity in the development of treatment plans.

In general, the more recent the chart, the better the documentation. This is likely due in part to the institution of the aforementioned new reporting procedures established in January of 2000, as a result of suggestions made during the accreditation process. It is also likely due to the staff becoming more familiar with the RSAT Program, the documentation standards, and the field of substance abuse treatment. Nonetheless, the charts, and especially the treatment goals and RePACs, suggest a fairly low baseline level of substance abuse-specific expertise among the counselors in general. I expect that these elements of the documentation will improve as counselors continue to accrue knowledge and experience in substance abuse treatment as a function of their pursuing CAC credentials.

Aftercare planning

Consistent with outcome research in the area of substance abuse treatment, significant emphasis in SHS program descriptions is placed upon aftercare and the maintenance of change behaviors. Recent research findings underscore the significant part that aftercare plays in the maintenance of behavior change. Inmates receiving both prison-based substance abuse treatment and community-based aftercare have significantly lower rates of recidivism than those inmates who receive no treatment or only prison-based treatment.

Aftercare planning in the RSAT begins in Phase III of the program, when participants begin working on their Relapse Preparation Activity Checklist (RePAC). The RePAC is a document created by the participant and program staff and provided to the participant's parole officer to be used as an adjunct to the community monitoring process. It is designed to ensure comprehensive preparation for release by covering such areas as work and housing plans, finances, principles of recovery, and social relationships, among others. This document also serves as a point of contact between program staff and parole officers, as RSAT staff are to contact parole officers at one week, three months, six months, and one year following discharge for each program graduate.

Another aspect of preparation for release concerns the preparation, by SHS staff, of a state-wide resource manual of substance abuse treatment services. This manual is to be continually updated by program and administrative staff, and forms the basis of the referral network used in discharge planning. One aspect of this is a list of available twelve-step programs, provided to each graduate. The utilization of community resources, together with close adherence to the RePAC and ongoing supervision via parole authorities, constitutes the aftercare component of the RSAT program.

Discussions with RSAT and GDC staff suggest that aftercare planning is a relative weak point in the delivery of RSAT program services. More specifically, staff cite the lack of community substance abuse intervention resources, especially in rural communities. Oftentimes the only resource available to recent graduates in their community of origin is a twelve-step program. Quoting one counselor, "aftercare is where the program fails however. A copy of the RePAC is sent to the probation/parole officer, and that is it. Aftercare is part of true treatment". These sentiments were echoed by many, with some expressing considerable doubts about the ability of RSAT graduates to remain out of prison without having access to significantly more aftercare resources. The *RSAT Annual Project-Level Evaluation Report for FY '99* indicates that while 586 inmates had successfully completed the RSAT program as of September 30, 1999, only 36, or 6%, had completed the aftercare program. That so few of the participants have completed the aftercare portion of treatment is troubling at the very least, given the importance of aftercare in maintaining gains made during the residential part of treatment.

Particular suggestions for improving aftercare options included partnering with community resources to provide sponsoring and mentoring relationships, to build more transition centers, and to establish a tracking or coaching system to aid in the transition to a drug-free life on the streets. Ultimately, the success of the RSAT program is likely limited by the dearth of aftercare resources.

Gaps in Resources

Gaps in resources were identified by a number of those interviewed, with the RSAT staff providing the most consistent responses. In general, RSAT staff expressed a strong desire to have one more counselor at each of the sites. Counselors feel overburdened with the demands of their work, a situation likely compounded by the degree of on-the-job training necessary for them to perform competently. In particular, counselors reported that the amount of documentation and general paperwork requires a substantial portion of their time. This results in a lack of time available to spend doing the one-on-one counseling needed to provide proper treatment planning. It also limits the time counselors can spend working with the curriculum and on their methods of delivering the curriculum to the participants. These concerns were echoed by both assistant program directors and program directors themselves. One counselor put it thus: "We are here to rehabilitate inmates, but we can't do it for all the paperwork we have. Approximately 60% of my time is spent doing paperwork, the other 40% in class. There is no time available for review and enhancement of the curriculum...what is most lacking is consistent interactions with the participants regarding their treatment plans. As a result the program can get somewhat generic." As noted earlier, many counselors report feeling overwhelmed and underappreciated, which could ultimately result in high turnover among RSAT program staff and the attendant difficulties.

Other gaps in resources were identified by staff in the GDC Programs Development Unit, and included limited funds to expand the program, a potential conflict with Homerville (and thus Parole) for inmates, the need to end reliance on "soft" money from the CJCC, and the need to implement a comprehensive performance measurement system. Another need that has already begun to be addressed is the need for a greater degree of regular, ongoing communication between SHS and GDC.

Interviewees were also asked what they would like to see happen in terms of the RSAT program, in effect, to make a "wish list". Again the responses were quite consistent, and echoed some of the difficulties already noted. In particular, counselors requested less paperwork, another counselor to join them, more time to spend with the participants, and better screening and referral procedures. The directors at Scott and Pulaski (and correctional administrators at Scott) expressed a strong desire for more and better space. RSAT staff also wished for meaningful alternatives for participants who do not qualify for the GSAMS component. One counselor stated that "For those participants not eligible for RSAT, they should get GED or remedial work, as GSAMS criteria intensified after the accreditation process. It will help them significantly more than doing work detail [during one visit, a number of RSAT participants were spray painting metal grates]". Some RSAT staff also requested additions to the curriculum, expressing a desire to see more focus on anger management and relationship issues. Finally, every correctional administrator interviewed noted that they would like to see more RSAT and RSAT-type programs made available. Quoting one administrator, "From a

management perspective, [the RSAT Program] is a way of getting the cream of the crop. From a programs perspective, The GDC needs more of these programs".

One warden requested more integration of the RSAT program into the functioning of the prison itself, similar to the Correctional Recovery Academy at Homerville. "The staff, administration, and the inmates all need to buy into the program, resulting in more accountability and responsibility". Taken as a whole, it seems that those involved with the RSAT program want a few specific issues addressed, but as a whole would like for the program to continue, and in fact for it to be expanded.

Section VI - Summary and Conclusions

In summarizing the results of this process evaluation, it makes sense to look back at the logic model that serves as the organizing theme behind the evaluation. This model appears below in figure 7.

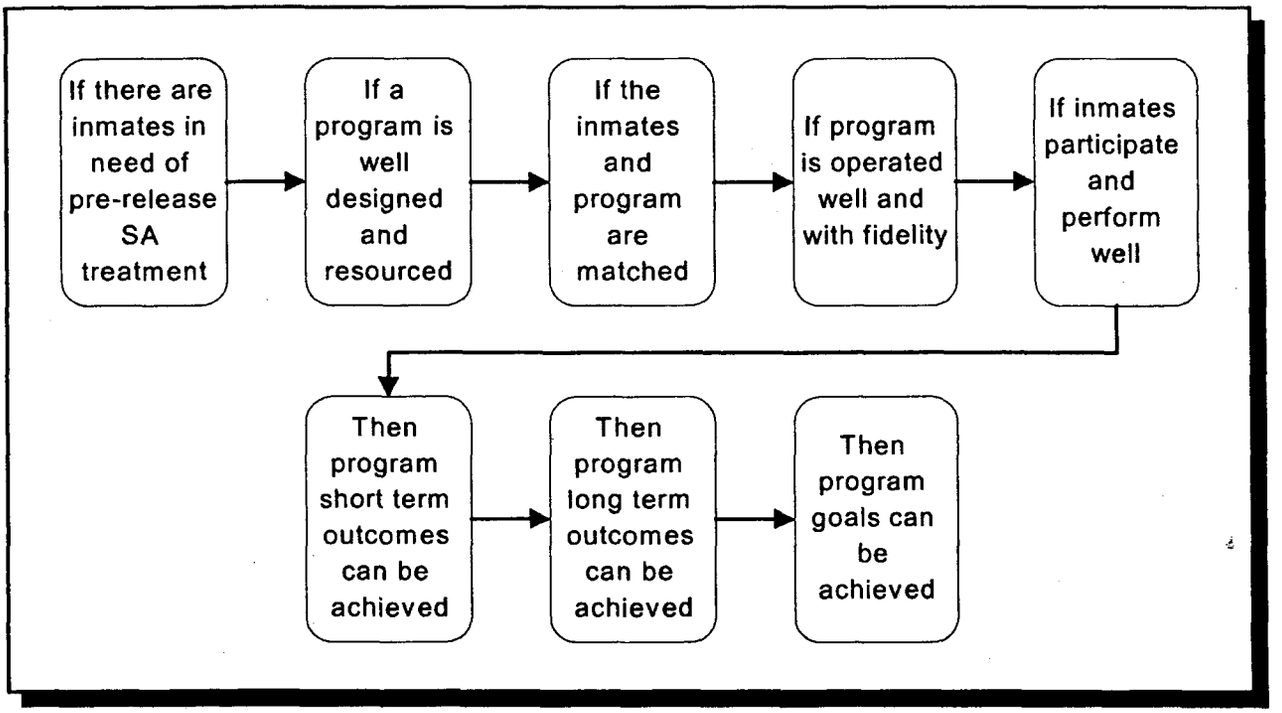

Figure 7 RSAT program logic model.

Need for pre-release substance abuse treatment

Step I is a conditional statement and a presupposition, as, given what is known about inmates in general, a need exists for pre-release substance abuse treatment. Due however to various issues within the GDC, assessing the degree of need and identifying those inmates most in need of these services is far from straightforward.

Concerning the degree of need, the degree of drug-involvement of current GDC inmates is unclear. We can fairly easily ascertain the proportion of crimes that are directly drug-related, simply by tallying felonies such as drug possession, drug trafficking, and DUI arrests. As is apparent from the literature however, this would provide only the most conservative estimate as to the proportion of inmates who are drug-involved. Federal estimates are such that a substantial majority of inmates are drug-involved, and it is likely that this holds true in Georgia. At the present time there is no way of knowing, as there is no standardized method of capturing this data. A series of questions concerning substance abuse history is reportedly asked during initial diagnostic screening, but are asked in such a way that the answers are very

likely unreliable and therefore invalid. Furthermore, the results of this inquiry are not communicated, other than to place the query in the inmate's chart. The previous use of a standardized instrument, while not perfect, resulted in a standardized process of collecting, storing, and communicating data. This is sorely lacking in the current system, as evidenced by GDC upper-level management disagreeing as to the source and date of published information regarding substance use and abuse among Georgia prison inmates.

Given the difficulties assessing the degree of substance abuse, it is not at all surprising that there exists as well a difficulty in identifying those inmates most in need of substance abuse treatment. Relying on individuals to be totally forthcoming and honest regarding their failings is imprudent. Relying upon prison inmates to be completely open as to their substance abuse histories and needs is all that much more so. This population presents significant assessment challenges even when using the most sophisticated instruments and surveys.

The lack of a sound assessment strategy notwithstanding, another significant difficulty concerns the process whereby inmates are referred to the various substance abuse treatment offerings within the GDC. The referral process as it stands at the time of this report is needlessly complex, with far too many steps to be practical given the characteristics of the system. These issues will be more fully addressed in a subsequent section, but an issue relevant to this section concerns the vendor's lack of access to the OTIS system. If the vendor is to be involved in the referral process, specifically in selecting inmates based upon their particular characteristics, they need access to the OTIS system. Without this access, they either have to go without certain information of rely upon others with access to provide the information to them. This results in uninformed decisions or added complexity and inefficiency, respectively. If the vendor is not going to be involved in the referral process (a cleaner design), then the lack of access to OTIS is immaterial.

The above noted issues are at core, issues of information gathering. If information gathering is to be successful and useful, it must take place within the context of a reliable and inclusive method of information management. This MIS system should be comprehensive in scope, accessible to all who need it, and flexible enough to allow modification as needs and conditions change. Given the degree of difficulty experienced in obtaining summary information from the OTIS system, as well as the current lack of OTIS-based information regarding substance abuse among inmates, the current system is not supporting sound decision making regarding substance abuse treatment issues.

Program design and resources

The RSAT program itself appears to be a well designed and well thought-out program. It relies upon proven principles such as relapse prevention, cognitive restructuring, and behavioral management through a system of reward and punishment. The program is delivered within a

therapeutic community setting, allowing for an intensive, immersion-type atmosphere that is conducive to change. The curriculum and materials are structured, allow for a straightforward presentation of the material, and have been modified and updated through their use in similar settings for a considerable period of time. Finally, the system of administrative oversight within SHS appears to provide the necessary structure, technical assistance, supervision, and encouragement to allow the program staff to deliver the program with a good degree of fidelity to the initial design.

While the RSAT program is well designed, there are significant issues with how the program is resourced. Probably the resource issue with the most apparent impact is the need for more space at two of the four RSAT sites, Scott and Pulaski State Prisons. The situation at Scott is particularly pressing, and is likely having an impact on the quality of programming offered there. Specifically, the lack of classroom space is such that the counselor offices are used for classrooms, limiting the work counselors can do while classes are is session. Given the increased demands for individualized treatment plans and thus the need for one-on-one work, this is a critical need. Both the staff program staff and the correctional administrative staff are well-aware of these needs, and are working to resolve them.

The space needs at Pulaski were not as prominent, and were not mentioned as significant issues by Pulaski staff. The facility is much more modern than the facility at Scot t State Prison, and gives the impression of sufficient resources. The office space and the holding of class in a dormitory hallway speak to the need for more space.

It appears that the RSAT program sites have material resources sufficient to provide the program as designed. One program director mentioned some initial difficulty in obtaining materials, but interviews with other staff indicate that program-related materials are not lacking. Likewise, site visits and observations confirm these findings.

It also appears that RSAT staff have sufficient access to technical resources to deliver the programs effectively. Staff appear to have ample access to supervision, both from their program director and from the state director and associate directors. There are varying methods of providing supervision, with program directors providing regularly scheduled supervision and also holding an "open-door" policy. Additionally, the state director and assistant directors spend approximately two days per month at each of the sites, providing on-site supervision and training. Program directors also reported receiving supervision from their supervisors within the GDC, and on the whole reported that they felt comfortable approaching their SHS and GDC supervisors.

It also appears that RSAT staff have ready access to training opportunities. Both SHS and GDC provide regularly-scheduled, ongoing training opportunities. An examination of the training log at one of the sites indicates training opportunities occurring approximately once per month.

SHS-sponsored training typically focuses on issues related to substance abuse and the treatment of substance abuse, while the GDC training typically focused on issues related to corrections and correctional management. In addition to these offerings, SHS provides a yearly training event that occurs over a two-day period. The most recent annual training covered a panoply of topics, from record keeping and proper charting procedures to 12 step groups. Finally, and as noted earlier, the majority of staff are engaged in the process of obtaining CAC credentials. Whereas neither the training nor the supervision necessary for this are provided by either SHS or GDC, SHS does offer release time for those pursuing credentials.

An area of resources that seems to be somewhat lacking concerns the human resources available to the RSAT program. There appear to be significant issues concerning the staffing of the RSAT program. When contracted, it was stipulated that SHS hire counselors who have obtained certification in the area of substance abuse treatment. It proved impossible to meet this requirement, likely due to factors such as the accelerated start-up schedule and the rather remote locations of the RSAT sites. As a result, staff without substance abuse credentials or experience were hired, and two-and-a-half years after the start date there are still no counselors who have obtained credentials. While the curriculum is detailed and straightforward, the need for individualized treatment planning and other tasks would certainly benefit from input form experienced, well-trained counselors. This situation may also impact the concerns of a number of counselors that they are understaffed. Were counselors more expert in their capacity, they may not feel so overwhelmed and underpaid in attempting to fulfill their duties.

Inmates and program matching

Step III depends, in large measure, on the proper identification and referral of inmates in need of pre-release substance abuse treatment (Step I). Due to the significant issues with theses processes, the matching of inmates and programs is inevitably compromised. At this point, it is a challenge to identify which inmates are most in need of substance abuse treatment. Further, even if properly identified, it is difficult to see how these inmates will proceed in order through the substance abuse treatment programs offered by the GDC, ultimately ending up as RSAT graduates. The referral process is convoluted and the cycling of the process is complex. The system would benefit from increased efficiency and prioritizing of tasks. Finally, regular training should be provided for all counselors involved in the process of referring inmates to the various substance abuse programs within the GDC.

Program Operation and fidelity of implementation

As noted earlier, the RSAT program is well designed, but seems to suffer from some issues related to resources. Physical plant issues, particularly at Scott and Pulaski, are pressing. Another resource issue paramount to the operation of the program is the quality and

experience of the front-line staff, the RSAT counselors. Due to relaxed hiring standards, the counselors are likely somewhat less experienced and trained than would be preferred. At the same time, recent changes undertaken to comply with recommendations provided by an accrediting body have resulted in increased demands places upon these very counselors. These duties, in addition to their performing some GDC counselor duties, seems to have resulted in counselors feeling overburdened and underappreciated. This attitude, while not universal, appears widespread enough to warrant concern about factors such as burnout and turnover.

In spite of these resource issues, the program is operating with a good degree of fidelity to its design. Furthermore, there is widespread support for the program, and both quantitative and qualitative data suggest that the program is operating in such as a way that preliminary outcomes are positive. It is likely that addressing these resource issues would allow the early positive results to continue, rather than allow the success of the RSAT program to be compromised by poor resourcing.

Another factor that limits the efficiency of the program is the often-cited lack of communication and cooperation among and between the various GDC units and the parole authorities. These issues were addressed most openly by administrators within the GDC. While correctional administrators were quite complimentary of the RSAT program as delivered, as a group they expressed disappointment and frustration with the bureaucratic elements of the GDC in the areas of referral and aftercare/discharge planning. Echoing the comments of RSAT staff, administrators noted the difficult managerial issues related to inappropriate referrals being sent to the various RSAT programs.

In summary, it appears that the problems identified as most pressing concern getting inmates into the RSAT program and providing sufficient resources after their graduation.

Inmate participation and performance

RSAT participants do indeed seem to be both participating and performing well. Available data indicate that they have fewer disciplinary problems, treat others with respect, and seem to be interested in working towards changing for the better. This confluence of data indicates that RSAT inmates do well in a very real sense. The performance of RSAT participants reduces the management burden on correctional administrators, and may over time effect a reduction in stress and burnout levels among both general population inmates and the correctional staff. It is no wonder that correctional administrators wished for an expansion of these programs within the GDC.

While acceptable, one area of RSAT performance that could stand improvement is the graduation rate. This would likely be improved by addressing the problems with the referral process and as a result achieving a better match between participants and the RSAT program.

Recommendations

Based on the process evaluation of the RSAT program, recommendations for the program are as follows:

1. Employ a reliable and inclusive MIS system that is broad, flexible, and accessible.
    a. All information needed for proper diagnostic/classification functions must be available to all persons making decisions in the classification and referral process.

2. Employ a reliable and valid tool for the evaluation, classification, and referral of substance involved inmates.

3. Revise and clarify the diagnostic and referral processes.
    a. If SHS is to be involved, they need access to the MIS system (OTIS).
    b. The referral system needs to become more efficient , with clear priorities and conflicts made explicit.
    c. Reduce the complexity of the referral cycles for all of the substance abuse treatment offerings.
    d. Provide regular, ongoing training for all personnel involved in the referral process.

4. Address the physical plant and space issues, most notably at the Pulaski and Scott RSAT sites.

5. Address issues related to staffing and remuneration of RSAT program staff.
    a. Address the difficulties encountered in hiring qualified, credentialed personnel.
    b. Examine the work load and capacity of RSAT counselors.

6. Examine the processes involved in the administrative oversight of the RSAT program, with an eye towards what additional administrative support could assist with.

7. Address and improve the inadequate aftercare resources available to RSAT graduates.
    a. The lack of aftercare resources will likely severely restrict the effectiveness of the RSAT program in achieving its stated outcome goals.

Appendices

Appendix 1 - RSAT Evaluation Interview Protocol.

RSAT Evaluation Interview Protocol

I. *Involvement with the RSAT program*

How did you come to be involved with the RSAT program?

What factors influenced your becoming involved?

When did your involvement begin?

What role did you have in the program when you first became involved?

Has your role changed, and if so, how has it changed?

What portion of your time is devoted to the RSAT program? Are you pleased with that?

Who else do you work with in your work on the RSAT program?

Prior experience

Have you worked in a treatment setting before coming to the RSAT program?

Have you had specific experience in mental health or drug and alcohol treatment?

What specific strengths or skills do you bring to your work with the RSAT program?

What sorts of training have been helpful to you in your work with the RSAT program?

III. *Duties within the RSAT program*

What is your current title?

What responsibilities do you have in the RSAT program?

Could you describe for me what you do in the RSAT program in a typical week?

Could you rate the degree of contact that you have with the following personnel?

Inmate RSAT participants

Inmates in the general population

Probationers/Parolees

GDOC custodial staff

GDOC custodial administrative staff (wardens, associate wardens, etc.)

GDOC administration

Vendor staff (RSAT)

Vendor staff (non-RSAT)

Did you have any role in designing and/or modifying the RSAT program?

Did you have any role in deciding which sites would house the RSAT programs?

Did you have any role in staffing the RSAT program?

What sorts of decisions are you responsible for making within the RSAT program?

Do you have any involvement in the referral process for the RSAT program?

If so, what is your involvement?

Do you have any involvement in deciding which inmates come to the RSAT program?

If so, what is your involvement?

Are you involved with the RSAT program at more than one site?

IV. ***Process of implementation***

How involved were you in setting up the RSAT program at your site(s)?

If involved, how do you think the process of implementation went?

What sorts of problems did you encounter in implementing the program?

How did the program implemented compare to the intended program?

Do you have any involvement in budgeting for the RSAT program?

If so, what is your degree of involvement?

Do you have any involvement in the process of scheduling the RSAT program?

If so, what is your degree of involvement?

What impressions do you have about how the program is being delivered?

What problems or weaknesses have you identified with the way the program operates?

What strengths have you identified with the way the program operates?

What aspects of the program do you think need to be changed or modified?

Design of the RSAT program

Staffing patterns/processes

Inmate selection

Inmate referral process

Inmate transfer process

Schedule of the RSAT program

Length of the RSAT program

Inmates' preparation for discharge

Aftercare elements of the RSAT program

Administrative oversight of the RSAT program

What are your impressions of the inmates who participate in the RSAT program?

Do you think the participants generally take the program seriously?

Do you think the participants have a genuine interest in changing?

Do you think the participants are adequately prepared for release?

V. ***General impressions***

What are your general impressions of the RSAT program as it is delivered?

What are your impressions of your involvement with the RSAT program?

Do you think the RSAT program makes a difference for those who complete it?

Do you think that anything would make a difference?

What do you think would improve the program?

What do you think would harm the program?

If you could do any one thing to improve the RSAT program, what would it be?

Appendix 2 - Counselor Rating Form (CRF).

RSAT Program Process Evaluation
Counselor Rating Form

Inmate initials: _____ Inmate number: _____ Date: _____
Counselor: _____ RSAT site: _____

We are interested in assessing the motivation, participation, and performance of inmates in the RSAT program. Your ratings of these dimensions will aid us in understanding the relationship between these factors and other aspects of the RSAT program. Please rate each of the inmates on your caseload, and return the ratings to the RSAT Program Director. Thank you very much.

	Very Low				Very High
How motivated was this inmate to come to the RSAT program?	1	2	3	4	5
How motivated is this inmate to actively participate in RSAT?	1	2	3	4	5
How motivated is this inmate to change his criminal thinking?	1	2	3	4	5
How motivated is this inmate to change his criminal behaviors?	1	2	3	4	5
How motivated is this inmate to get off drugs and/or alcohol?	1	2	3	4	5
How motivated is this inmate to achieve lasting change?	1	2	3	4	5
How would you rate this inmate's overall degree of motivation?	1	2	3	4	5
To what degree does this inmate participate in the community?	1	2	3	4	5
To what degree does this inmate participate in RSAT classes?	1	2	3	4	5
To what degree does this inmate participate in GSAMS classes?	1	2	3	4	5
To what degree does this inmate participate in 12 step groups?	1	2	3	4	5
How would you rate this inmate's overall degree of participation?	1	2	3	4	5
How is this inmate performing in the community?	1	2	3	4	5
How is this inmate performing in RSAT classes?	1	2	3	4	5
How is this inmate performing on his RSAT assignments?	1	2	3	4	5
How is this inmate performing in GSAMS classes?	1	2	3	4	5
How is this inmate performing on his GSAMS assignments?	1	2	3	4	5
How would you rate this inmate's overall level of performance?	1	2	3	4	5
How would you rate this inmate's chances of staying drug free?	1	2	3	4	5
How would you rate this inmate's chances of staying crime free?	1	2	3	4	5

Additional comments about inmate: _____
_____
_____.

Thank you very much for your time, effort, and input.

Appendix 3 - RSAT schedule.

Curriculum

Phase I

Orientation Group	Core Skill Group	Principal of Recovery	Learning about 12 Steps Fellowships
Introduction	Affirming	Don't Feed Your Monsters	Getting to Know 12 Step Fellowships
Addiction & Recovery	Asserting	Avoid Your Triggers	Guide to Twelve Step Groups 1
Key Terms & Concepts	Brain-Storming	Stick to Your Structure	Guide to Twelve Step Groups 2
Learn to Learn	Calming	Think it Through	Guide to Twelve Step Groups 3
Giving & Receiving Feedback	Danger-Spotting	Trust the Truth	Guide to Twelve Step Groups 4
Inner Self vs Habit Self	Focusing	Learn by Practice	What is an AA/NA Group
Criminal Addictive Thinking I	Forecasting	Step Slow & Steady	The Twelve Traditions
Criminal Addictive Thinking II	Humanizing	Reach Out & Open Up	What an AA/NA Meeting is Like
HIV Education	View Switching	Be a Member	Getting Into A Home Group
Too Proud Too Learn	Prioritizing	Make the Moment Count	All About Sponsors
Life Is Not Fair	Resourcing	Remember the Past	More About Sponsors
Authority & Freedom	Self Listening	Nourish Your Spirit	Step 1
	Tension Sensing	Respect Life	
		Put Recovery First	

In addition to the groups above, phase I inmates will participate in Morning meetings, Skills Practice group, Phase meeting, Twelve Step meetings, and Community meeting.

Phase II

Criminal Addictive Thinking–CRTs	Relapse Prevention Groups
Wising Up the Negative Mind	Understanding Relapse
Why It's Called Getting Wasted	Here's Looking at Urges & Cravings
Getting Over	Breaking the Behavior Chain
Challenges, Excitement & Danger	Handling More Urges & Cravings
Warning Signs & Protectors	Identifying High Risk Situations
Fighting For Pride & Get Even Get Ahead	Coping with High Risk Situations I
	Coping with High Risk Situations II
	Coping with High Risk Situations III
	Pain & Prescription Drugs
	Roadblocks & Body Language
	Problem Solving I
	Problem Solving II

In addition to the groups above, Phase II inmates will participate in Morning meetings, Skill Practice group, Phase meeting, Twelve Step meetings and Community meeting. Daytime hours will Vocational Training or OJT.

Phase III

Correctional Recovery Training	Relapse Prevention Groups	Release Preparation
Anger Triggers & Violence Traps	Interpersonal Skill Training I	Rejoyment
Hear it Right	Interpersonal Skill Training II	Taking Root in A Self Help Community
Say It Right	Interpersonal Skill Training III	New Groups/Review RePAC
Wounding Love	Building a Support System	Recovery Partners/Review RePAC
Reaching Agreement	Life Balance	Using Help/Review RePAC
Source of Strength	RP History I	Review RePAC
	RP History II	
	RP History III	
	Preventing a Lapse	
	Getting Out of a Lapse	
	Relapse Prevention Planning	
	Booster	

In addition to the groups above, Phase III inmates will participate in Morning meetings, Skill Practice group, Phase meeting, Twelve Step meetings and Community meeting. Daytime hours will be devoted to Vocational Training or OJT.

Phase IV

Correctional Recovery Training	Life Skills	Relational Issues Women	Parenting Men
Self Assessment	Stages of Change	Boundaries & Assertiveness	Being a Parent
Self Presentation	A Working Life	Achieving Dignity	Effective Limit Setting
Keeping On	Honesty at Work	Roots, Roles, & Relationships	Active Communication
Letting It Go	Job Safety	Violence in the Home	Developing Responsibility
Fatherhood/Motherhood in Recovery I	Job Search	Child Abuse Effective Parenting	Parenting Teens
Fatherhood/Motherhood in Recovery II	Resume Writing	Healthy Relationships	Effective Discipline
Sexual Respect/Respecting Your Body	Interviewing I		
Old Friends	Handling the Green Drug		
New Friends	Budgeting		
Family Ties	Family Trap I		
Preparing for Home Life	Family Trap II		
Your First Days Out	Resourcing the System		

In addition to the groups above, Phase IV inmates will participate in Morning meetings, Practice Skill, Phase meeting, Twelve Step meetings and Community meeting.

Service Elements - RSAT

Service Elements	*Orientation – Phase I*	*OJT – Phase II*	*Intensive-Phase III*	*Exit Planning – Phase IV*
Intake Assessment	Prior to Admission			
Pre/Post Testing	Within 48 hours			1 week prior to graduation
Needs Assessment	Within 10 days			
Treatment Plan	Within 15 days			
Periodic Review	Every 60 days	---------->	---------->	---------->
Progress Notes	Weekly	---------->	---------->	---------->
Discharge Summary				10 days post discharge
Orientation Groups	(2) 2 hour groups per week Week 1 – 4			
Core Skill Groups	(3) 1 hour groups per week			
Principles of Recovery	(3) 1 hour groups per week			
Morning Meeting	Daily – 30 minutes Monday – Friday	30 minute group 3 times per week	30 minute group 3 times per week	Daily – 30 minutes Monday – Friday
Skills Practice	Daily – 30 minutes Monday – Friday	30 minute group 3 times per week	30 minute group 3 times per week	Daily – 30 minutes Monday - Friday
Learning About 12 Step Groups	(1) 2 hour group per week			
CRT Groups		(1) 2 hour groups per week	(1) 2 hour groups per week	(2) 2 hour groups per week
Phase Meeting	Weekly - 2 hour Group	Weekly – 2 hour group	Weekly – 2 hour Group	Weekly – 2 hour Group
Relapse Prevention		(2) 2 hour groups per week	(2) 2 hour groups per week	
Life Skills				(2) 2 hour groups per week
Parenting (Males) Relational Issues (Females)				(1) 2 hour group per week
Seminar	Weekly – 1 hour			Weekly – 1 hour
RePAC			(1) 2 hour group per week	
Community Meeting	Weekly 60 minutes	---------->	---------->	---------->
Twelve Step Fellowship Group	Daily – 1 hour Monday – Friday	Daily – 1 hour Monday – Friday	(2) 1 hour groups per week	Daily – 1 hour Monday – Friday

Description of Program Service Elements

Though drawn from various disciplines of rehabilitation therapy and education, the RSAT's elements are integrated into a consistent whole. Each element reinforces the others. Each structural component on its own targets inter-related issues. The following describes the program's content and curriculum. All program components are described in detail in our RSAT program manuals.

Morning Meeting and Skills Practice Group

Morning Meeting is a structured daily 30 minute meeting attended by all RSAT inmates. The purpose of Morning Meeting is to assist the inmates in beginning their day on a positive note with specific goals for the day.

The Skills Practice group is a format for review and reinforcement of the skills being taught in other groups throughout the program. This group allows the more "upper" phase members to preview the skills that the

"lower" phases have not yet learned. Also, the inmates in Phases III and IV can provide strong feedback and suggestions to the inmates in Phases I and II.

Orientation Groups
During phase 1 in the RSAT, inmates will attend twelve orientation groups. Titles include: Addiction & Recovery, Inner Self vs. Habit Self and Criminal Addictive Thinking. These sessions are focused on the specific rules, regulations, expectations, values, norms, and procedures of the RSAT as well as the basic concepts that form our definition of recovery and what it takes to achieve a balanced life of recovery. During the sessions, the admission agreements, resident handbook and grievance procedures are reviewed.

Orientation: Interpersonal Skill Training - Core Skill Groups
During phase I, inmates will attend a series of Core Skill groups. These groups are intended to provide fundamental interpersonal skills training to inmates. Core Skills are our building blocks of cognitive-behavioral competencies. Inmates will learn how to apply these skills in their everyday activities while incarcerated and upon release. Repeatedly used and reinforced throughout the other service elements of the RSAT, Core Skills compose the elements of a pro-social repertoire.

Orientation: Principles of Recovery
During phase I, inmates will attend a series of Principles of Recovery groups. These groups are intended to provide inmates with a set concepts for right living and universal truths about social behavior and what it takes to succeed – titles include "Avoid Your Triggers", "Trust the Truth".

Correctional Recovery Training Sessions (CRTs)
CRTs groups are topic-specific training modules. They follow a written lesson plan that is interactive requiring participants to take an action role in the group process. Each lesson plan contains a cognitive and behavioral element. Group participants are required to role-play and demonstrate competency in the skill being taught.

Each CRT unit focuses on one topic chosen for its relevance and importance in reducing recidivism from crime and relapse from alcohol and other drugs. Examples of CRT topic areas are: criminal addictive thinking and thinking errors, anger management, relapse prevention, problem solving, life skills, victim awareness, spirituality, etc.

The content of the curriculum has been well received by group members of all cultural and ethnic groups. We recognize that the racial and cultural appropriateness of program materials is crucial to the success of the RSAT.

Learning about 12 Step Fellowships
The goal of this group is to give the inmates a basic understanding about the concepts of Twelve Step Fellowships (AA, NA). How they work. What are the guiding principles. How they can assist the resident in their daily recovery efforts.

Seminars
Seminars are forums where inmates present to their peers and counselor what they have accomplished in working on their assignments. As part of their individual treatment plan, inmates are required to present at least one assignment presentation per phase I and II. Open criticism and discussion stimulates social learning, making the assignment a useful exercise for more than just the "assignee. " Seminars are assigned and monitored by RSAT Staff.

Community Meeting
Community Meetings are open to inmates and all unit staff. With standard procedures that impose orderliness and rationality, the meetings serve as vehicles for establishing common understanding and instilling norms. By allowing responsible questions, suggestions, and in some cases resident-staff consultation, the meetings give legitimacy to the RSAT and confer dignity to resident. Individual achievements of inmates are recognized

during this weekly meeting including educational advancement and phase advancements. Special attention and time is devoted for the persons graduating from the RSAT.

Twelve Step Fellowships (TSF)

Many CRT units lay the groundwork for TSF participation. All CRT materials are compatible with, and many explicitly reinforce, Twelve Step perspectives. Together with the Release Preparation Activity Checklist (RePAC), TSF perspectives demand planning for sustaining recovery through peer support in the community. Twelve Step Fellowships are unequaled as social learning environments for awakening and sustaining the commitment to abstinence. As transition cultures in local neighborhoods they are clearly "the best for the most." But just as a school has a role that is distinct from that of a spiritual congregation, the RSAT strives to focus on skills and issues that the Steps and Traditions of TSFs necessarily leave to others. The RSAT pursues its agenda with full respect for the self-help, spiritual, and highly intimate nature of the Twelve Step recovery experience.

Relapse Prevention Groups

These groups are a cognitive-behavioral approach encompassing a wide range of strategies designed to prevent relapse to substance use/abuse/dependence and recidivism to crime. A key assumption underlying the relapse prevention approach is that destructive habit patterns and thoughts can be changed through the application of self-management and self-control procedures. Self-control in this context encompasses strategies and techniques in three main areas:

-acquiring adaptive coping skills as alternatives to addictive behaviors and crime.
-fostering new cognitions i.e. attitudes, attributions, and expectancies.
-developing a daily lifestyle that includes pro-social behaviors, activities, and non-destructive ways of achieving personal satisfaction and gratification.

The Phase System/Phase Meeting

The RSAT is divided into three phases. Each phase has clear, specific, and measurable expectations the inmates must complete to progress to the next phase. Inmates participate in weekly Phase Meetings. The purpose of the Phase Meeting is for inmates' peers to provide each other: a) supportive feedback, b) reinforcement for positive behaviors, and c) encourage and make suggestions for changing negative behaviors and attitudes. As peers, inmates are responsible to hold each other accountable and maintain RSAT values. The Unit Team consisting of RSAT and Institutional Staff with a recommendation from the receiving phase will determine if the resident has met all of the requirements to progress.

Appendix 4 - Agreement of procedures between GDC and the Board of Pardons and Paroles.

STATE BOARD OF PARDONS AND PAROLES

2 Martin Luther King, Jr., Drive. S.E.
Balcony Level. East Tower
Atlanta, Georgia 30334-4909
(404) 656-5651
www.pap.state.ga.us

Walter S. Ray
Chairman

Jim Wetherington
Vice-Chairman
Bobby K. Whitworth
Member
Garfield Hammonds, Jr.
Member
Dr. Betty Ann Cook
Member

February 15, 1998

To Whom it May Concern:

This letter acknowledges an agreement of procedures between The Department of Corrections (DOC) and The State Board of Pardons and Paroles (Board) regarding the Department of Corrections Residential Substance Abuse Treatment (RSAT) initiative. Specifically, this agreement will insure that appropriate inmates are placed in the (RSAT) program who will be eligible for release upon completion of program and that inmates who are placed in the program will not be released before the completion of the program. The existing community-based aftercare network will continue with improvements already set in place in certain districts and progress in the others. Homerville State Prison and Whitworth Detention Center will continue to be utilized if necessary, if a parolee is noncompliant with treatment or supervision.

The Department of Corrections agrees to:

1. Admit only inmates who have a PIC date or a TPM that is 6 to 9 months from date of admission to the RSAT program.

2. Not to place violent inmates (based on current offenses or history of violence), due to possible reconsideration of release by the Board.

3. Provide the Board's Senior Hearing Examiner a list of inmates in the RSAT programs upon admission and again 30 days before release.

4. Provide a packet with a complete discharge summary to the parole office before completion to insure appropriate aftercare upon release.

The State Board of Pardons and Paroles agrees to:

1. Release the above mentioned inmates upon completion of the RSAT program, assuming all other pre-conditions of the Board have been met.

2. Cancel or delay the release of an inmate once placed in the RSAT program until completion of the program. See procedure for cancellation or delay of release. Inmates will not be referred to work-release until completion of RSAT.

3. Continue to provide immediate supervision and aftercare as is, with the aid of the discharge summary/aftercare plan and packet. The Community Based Service Division with the Board, along with the Field Services Division of the Board, will be responsible for the continuation of these services.

Procedure for cancellation or delay of inmate.

The Program Development Consultant in the Programming section of DOC will notify the Senior Hearing Officer with the Board. The Senior Hearing Officer with the Board will be responsible for cancelling the release.

Both the Department of Corrections and State Board of Pardons and Parole commit to achieving the above stated goals. However, each agency reserves the right to deviate from these goals where circumstances may cause a conflict with their respective missions.

_____ Date 2-17-99
Charles J. Topetzes
Director of Parole

_____ Date___
Paul Melvin
Assistant Commissioner
The Department of Corrections

Appendix 5 - Inmate diagnostic behavior problem table.

Georgia Department of Corrections
Office of Planning and Analysis

Inmate statistical profile

Sample: ACTIVE PRISONERS EXCLUDING JAIL
Active inmates 05/15/2000

Requestor: Statistics

Inmate Diagnostic Behavior Problem * by current age & sex

	MEN										WOMEN									
Diagnostic Problem	Age 00-21	%	Age 22-39	%	Age 40-54	%	Age 55-99	%	Men Total	%	Age 00-21	%	Age 22-39	%	Age 40-54	%	Age 55-99	%	Women Total	%	Grand Total	%
ALCOHOLIC	29	0	1062	2	898	5	156	7	2145	3	5	2	198	6	91	7	6	6	300	6	2445	3
ALCOH ABSE	638	10	6042	14	2871	16	356	17	9907	14	19	7	370	11	142	11	15	15	546	11	10453	14
DRUG EXP	1379	22	8256	19	2927	16	172	8	12734	18	30	11	245	7	94	7	5	5	374	8	13108	17
DRUG ABSE	1172	18	8380	19	3376	19	149	7	13077	18	55	20	909	28	326	26	12	12	1302	26	14379	19
NARC ADDCT	28	0	619	1	395	2	22	1	1064	2	1	0	43	1	34	3	2	2	80	2	1144	2
EPILEPTIC	29	0	280	1	178	1	28	1	515	1	5	2	69	2	31	2	4	4	109	2	624	1
MANIPULTVE	668	11	3444	8	954	5	110	5	5176	7	4	1	74	2	40	3	4	4	122	2	5298	7
ASSAULTIVE	1495	24	9013	20	3449	19	506	24	14463	20	61	22	571	17	196	16	16	16	844	17	15307	20
ESCPE TEND	85	1	1040	2	632	4	83	4	1840	3	6	2	106	3	34	3	0	0	146	3	1986	3
SUICIDAL	130	2	1071	2	402	2	38	2	1641	2	14	5	163	5	58	5	4	4	239	5	1880	2
WITHDRAWN	10	0	160	0	68	0	15	1	253	0	13	5	70	2	26	2	1	1	110	2	363	0
PR RLTY CT	23	0	362	1	219	1	21	1	625	1	8	3	81	2	34	3	2	2	125	3	750	1
HOMOSEXUAL	12	0	138	0	64	0	15	1	229	0	8	3	122	4	18	1	0	0	148	3	377	0
NONE	62	1	1148	3	584	3	168	8	1962	3	3	1	34	1	28	2	12	12	77	2	2039	3
OTHER	53	1	527	1	296	2	72	3	948	1	2	1	28	1	15	1	5	5	50	1	998	1
NOT RPTD	470	7	2480	6	679	4	179	9	3808	5	44	16	210	6	87	7	11	11	352	7	4160	5
Total reported	6356	100	44254	100	18009	100	2097	100	70716	100	278	100	3293	100	1255	100	99	100	4925	100	75641	100
Percent reported	98.1		99.1		99.8		99.5		99.2		100.0		100.0		99.9		100.0		100.0		99.2	
UNKNOWN	73		232		17		7		329		0		0		1		0		1		330	
Total	3897		25265		10039		1440		40641		178		1731		671		66		2646		43287	

* NOTE: SINCE THERE CAN BE UP TO FIVE BEHAVIOR CODES PER INMATE, THE NUMBER OF CASES REPORTED IN THE DETAIL LINES AND THE TOTAL REPORTED LINE MAY EXCEED THE TOTAL NUMBER OF CASES. IN SHORT, THIS TABLE COUNTS THE NUMBER OF BEHAVIOR PROBLEMS, NOT INMATES.

Appendix 6 - Substance involvement section from inmate diagnostic interview.

Comments: _____

_____

_____

8. ALCOHOL / DRUGS - POTENTIAL FOR SUBSTANCE ABUSE: (Base on MH Profile, PHS, MAST/DAST, & self-report)
Write the letter for the statement that best describes the inmate's potential for substance abuse in thebox to the left of the appropriate level. For example, if the inmate reports use of alcohol or drugs, write d next to HIGH.

MAST/DAST RESULTS

Drugs Reported Used	Reported Regular Use	Rptd Use 2 Mo. Before Lockup
Marijuana		not at all
Alcohol		not at all

Inmate reported alcohol or drug use caused the following problems in the year prior to being locked up:
None acknowledged

Inmate reported having received treatment for alcohol or drug abuse once.

Inmate rated desire for drug treatment as not at all.

Inmate rated desire for alcohol treatment as not at all.

[ ] LOW = Program Recommendation SA 101 only

a. The inmate denies frequent or excessive use of alcohol or non-prescribed substances and there is no indications of a substance abuse history.

[ ] MODERATE = Program Recommendation SI 1, 2, 3

a. The inmate denies frequent or excessive use of alcohol or drugs, though admits to occasional use of alcohol and/or drugs.
b. The inmate has a history of alcohol / drug related offenses (1-3), although inmate denies any problem.
c. The inmate has a history of alcohol/drug related offenses (1-3) and admits to having some problems.

[ ] HIGH = Program Recommendation SI, 1, 2, 3, RSAT - *Justification Required*

a. The inmate reveals a history of: (*Check Appropriate Statement*)
___ Inpatient detox for alcohol and/or drug dependence.
___ Outpatient TX for alcohol and/or drug dependence.
___ Both inpatient and outpatient TX for alcohol and/or drug dependence.
b. The inmate has a history of multiple admissions for alcohol/drug Detox and Interventions.
c. The inmate has multiple alcohol/drug related offenses (greater than 3).
d. Inmate self reports excessive use of alcohol / drugs.

Justification: _____

_____

_____

Appendix 7 - Testing materials used in the RSAT program.

Criminal Sentiments Scale (CSS): a 41-item questionnaire providing measures of opinions about the law, courts and the police and assessing tolerance of law violators. The CSS also assesses the degree to which respondents identify with criminals.

2. **Coping Behaviors Inventory (CBI)**: A 36-item inventory that assesses the substance abuser's use of coping strategies in response to urges to abuse substances.

3. **Buss-Durkee Hostility Inventory (BDHI)**: A 64-item measure evaluating hostility that provides scores on the following aspects of hostility - assault, indirect hostility, irritability, negativism, resentment, suspicion, verbal hostility, and guilt.

4. End-of-phase assessments are given, and must be passed (a score of 70% correct is considered passing) in order to move on to the next phase. These exams are constructed at each program, and vary considerably from program to program.

Appendix 8 - SHS chart review form.

Spectrum Health Systems, Inc.

RSAT
Clinical Chart Review Sheet

Inmate Name:	EF #:	Date of Admission:
Primary Counselor:	Reviewed By:	Date:

	Acceptable?		Define Deficiencies (Be Specific)
Chart Order	Y	N	
Audit Trail	Y	N	
Treatment Summary	Y	N	
Admission Agreement (completed within 1 business day)	Y	N	
Assessment Information (completed within 10 business days)	Y	N	
Initial Intake & Summary Narrative (completed within 10 business days)	Y	N	
Needs Assessment (completed within 10 business days)	Y	N	
Individual Treatment Plan (opened within 10 business days)	Y	N	
Progress Review (most recent on top, completed every 60 days)	Y	N	
Progress Notes (most recent on top, completed every week)	Y	N	
Learning Experience Form – If used (place in progress note section chronologically)	Y	N	
Termination Warning – If used	Y	N	
Termination Notice – If used	Y	N	
Release Plan (RePAC) (copy of completed plan before discharge)	Y	N	
Discharge Summary (completed within 10 business days of discharge)	Y	N	
Parole Consent to Disclosure (every inmate must have one on file)	Y	N	
General Consent to Disclosure	Y	N	
Misc.	Y	N	

Spectrum Health Systems, Inc.

INSTITUTIONAL FILE REVIEW

(Circle One)	
Active	**Inactive**

SUPERVISORY REVIEW SECTION

****Any noted deficiencies are to be corrected no later than seven (7) days from above date ****

Chart was in:

Full Compliance _____
Partial Compliance _____
Minimal Compliance _____

Date reviewed this RSAT (CRC) Inmate Record with Primary Counselor:

_____

_____ _____
Reviewer Signature Primary Counselor Signature

This form is then to be given to Program Director.

_____ _____
Program Director Signature Date

Additional Comments:

Appendix 9 - Current RSAT charting policies, procedures, and forms.

Spectrum Health Systems, Inc.

Record Keeping Standards

1. Materials must be developed within the stated time frames.

2. All clinical forms must contain the individual's name and number.

3. All entries must be in black ink and legible.

4. All entries must be **signed** indicating **degree, certification or licensure, title** and **date.**

5. All forms are placed in the order outlined on the Chart Order. If a form is not listed on the Chart Order, it should be placed in the miscellaneous section. Most recent on top.

6. Do not use 'white-out' (correcting fluid) in the clinical record. If a mistake has been made, draw a line through the word(s), write 'error' and initial.

7. Any clinical record is potentially a public record and great care should be taken to accurately enter information into the file. All descriptions must be stated in measurable and behavioral terms.

8. Any form completed in any way other than in the prescribed manner should contain a note detailing the reason for the deviation, the signature of the appropriate staff member and the date.

Spectrum Health Systems, Inc.

Consent to Disclose

Name:_____ #:_____ DOB:___/___/_____

I, the undersigned, hereby authorize _____
to release the specified information stated below for the purpose of coordinating my treatment.

SPECIFIC INFORMATION to be DISCLOSED:_____

_____

_____

INFORMATION to be DISCLOSED TO: _____

_____

_____

_____

_____

I understand my record is protected under Federal regulations governing Confidentiality of Alcohol/Drug Abuse records, 42 CFR Part 2, and cannot be disclosed without my written permission except in the case of: 1) threat to self or others: 2) child abuse or neglect: 3) escape plans: 4) any alcohol or drug usage: and 5) any action that threatens the security of the Institution. I understand this consent is subject to revocation at any time except to the extent action has been taken in reliance on it, and will automatically expire 10 days following my discharge from the Program: unless an earlier date, event or condition is specified. Any other use/re-disclosure is forbidden by law.

_____
Date/Event/Condition

_____ _____
Resident/Detainee Signature Date

_____ _____
Witness Date

Consent to Disclose
Revised 02/25/00

Spectrum Health Systems, Inc.

RESIDENTIAL SUBSTANCE ABUSE TREATMENT

PAROLE CONSENT TO DISCLOSE

Inmate Name: _____ **#:** _____ **DOB:** _____

I, the undersigned, hereby authorize the staff of the **Residential Substance Abuse Treatment** program to release the specified information stated below to the **Georgia Board of Pardons and Parole:**

1. Release Preparation Activity Checklist
2. Discharge Summary
3. Admission and Discharge Dates
4. Verbal communication as necessary for the purpose of planning aftercare services

I understand my record id protected under Federal regulations governing Confidentiality of Alcohol/Drug Abuse records, 42 DFR Part 2, and cannot be disclosed without my written permission except in the case of: 1) threat to self or others; 2) child abuse or neglect; 3) escape plans; 4) any alcohol or drug usage; and 5) any action that threatens the security of the Institution. I understand this consent is subject to revocation at any time except to the extent action has been taken in reliance on it, and will automatically expire sixty (60) days following my discharge from the Program unless an earlier date, event or condition is specified. Any other use/re-disclosure is forbidden by law.

_____

Date/Event/Condition

_____ _____

Inmate Signature **Date**

_____ _____

Witness Signature **Date**

SPECTRUM HEALTH SYSTEMS, INC.

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT INFORMATION

Spectrum Health Systems, Inc. its employees and volunteers who provide services for its programs, strictly adheres to all Federal regulations governing the confidentiality of information about persons receiving alcohol and drug abuse prevention, assessment and treatment services. The legal citation for these laws and regulations is 42 U.S.C. 290 dd-2 and 42 C.F.R. Part 2.

These laws state that no information may be released to any person or entity which discloses that a client has sought, or is involved in, substance abuse treatment. Substance Abuse Treatment is defined as beginning at the time of the first appointment or application to the program. These laws also apply to persons mandated for treatment.

Spectrum Health systems provides continuing training for all staff, and specific orientation for all new personnel in the principles of confidentiality and privacy.

Program participants are notified of their right to confidentiality and will also be instructed to protect the confidentiality of their fellow residents in the program.

Consent for Release of Information

Information, verbal or written, may only be released through a signed release, or through a court order. (Exceptions to this law are delineated below.) Consent for release of information must be in writing and must include:

-name of program disclosing information
-name of recipient of information
-name of program participant
-purpose/use of information
-how much and what kind of information will be disclosed
-a statement allowing revocation of consent at any time
-date, condition, or event of expiration
-participant signature and date

Criminal Justice System Release

When treatment is an official condition of probation, sentence, dismissal of charges, release from detention, or other disposition, a Criminal Justice System release is utilized. This release permits communication between the criminal justice system and the treatment program, and is identical to the traditional release except that it contains a statement stating that the resident cannot revoke

this release prior to the expiration date or event. In the case of these releases, the expiration date or event is usually determined by the duration of the treatment, type of criminal proceeding, need for treatment information, or when the final disposition will occur. This information can be used only with this particular criminal proceeding. This release should be signed before referral to the program, or at a minimum of first appointment. **If no consent is given, the program cannot communicate with the referring criminal justice agency.**

Disclosure of Information to Prison Personnel

Information can be disclosed within a program to an entity having direct administrative control over the program. Those who are determined to have direct administrative control are considered to be part of the program and are governed by the same confidentiality laws and legal responsibility as the program.

Re-disclosure of Information

Any information disclosed whether internally to other program staff members or to any persons or organizations authorized to receive such information, through valid consent or by court order, may not be re-disclosed to third parties. When information is released, it must be sent with a notice forbidding re-disclosure of this information, due to protection under federal law (42 C.F.R. Part 2).

Exceptions

1. Crimes on program premises or against program personnel. When an offender commits or threatens to commit a crime on program premises or against program personnel, regulations permit the program to report the crime to a law enforcement agency. An escape is a crime and may be reported.

2. Disclosure or information about suspected child abuse or neglect as required by Georgia law.

3. Disclosure of a threat to seriously harm a specific, identifiable victim.

4. Disclosure of program participant's own records to participant or a consented in consented in writing by the client.

5. Disclosure of information to medical personnel if necessary in a medical emergency.

6. Report of aggregate information about the program that does not contain resident identifying data.

confidentiality
02/25/00

7. Disclosure of information as authorized by an appropriate court order upon showing a good cause, after appropriate procedure and notice, and with appropriate safeguards against unauthorized disclosure contained in the order, as set forth in 42 C.F.R. 2 61-67, (1987).

8. Disclosure of information to qualified personnel for the purpose of conducting scientific research, as set forth in 42 C.F. R. 2. 52, (1987).

9. Communications of information between or among personnel having a need for the information in connection with their duties either within the program or between the program and an entity having direct administrative control over the program.

10. Disclosure of information to qualified personnel who are authorized by law or who provide financial assistance for the purpose of conducting audit or financial or management audits and other similar activities, as set forth in 42 C. F. R. 2.53, (1987).

11. Any other disclosure not precluded by the regulations and statutes cited above, nor by any other applicable law, provided that any and all of the above disclosure is consistent with regulations and laws cited above, and is made only to the extent permitted, for the purposes permitted, and the program adheres to required safeguards.

Maintenance of Records

Spectrum Health Services shall maintain files, records and information in accordance with the laws and rules cited above. Files shall be maintained in a locked file cabinet or filed in a secured room. In cases where client data is stored electronically, security measures will be provided to prevent inadvertent or unauthorized access to such data.

Records which are to be disposed of shall be deleted for electronic systems, or shredded if in hard copy to assure confidentiality of client information.

Except as authorized by an appropriate court order granted pursuant to the regulations and statute cited above, no record referred to by said laws shall be used to initiate or substantiate any charges against a client or to conduct an investigation of a client.

Prohibitions against disclosure or re-disclosure apply to records of an individual client regardless of whether or not he/she ceases to be a client.

RSAT Chart Order

Chart Order	
Audit Trail	
Treatment Summary	
Admission Agreement (completed within 1 business day)	
Assessment Information (completed within 10 business days)	
Initial Intake & Summary Narrative (completed within 10 business days)	
Needs Assessment (completed within 10 business days)	
Individual Treatment Plan (opened within 10 business days)	
Progress Review (most recent on top, completed every 60 days)	
Progress Notes (most recent on top, completed every week)	
Learning Experience Form – If used (place in progress note section chronologically)	
Termination Warning – If used	
Termination Notice – If used	
Release Plan (RePAC) (copy of completed plan before discharge)	
Discharge Summary (completed within 10 business days of discharge)	
Parole Consent to Disclosure (every inmate must have one on file)	
General Consent to Disclose, if used	
Misc.	

Spectrum Health Systems, Inc.

Audit Trail

Name: _____ **#:** _____

Date	Reviewer	Comments

Spectrum Health Systems, Inc.

Treatment Summary Sheet

Name:_____ #:_____ DOB: _____

Date of Admission:_____ Date of Discharge:_____

New Admission: _____ Re-Admission: _____

Primary Counselor:_____

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Date Entered Phase Two: _____ Test Score: _____

Date Entered Phase Three: _____ Test Score: _____

Date Entered Phase Four: _____ Test Score: _____

Date of Graduation: _____ Test Score: _____

==========

Reason for Discharge:

Program Completion _____

Program Withdrawal _____

Program Termination _____ (please specify) _____

_____

Spectrum Health Systems, Inc.

Admission Agreement

I,_____#_____understand the program is performance based and will require a minimum of 6 months of my participation.

a. I understand if I violate any of the following **Cardinal Rules**, I will be discharged from the program:
- -Acts of physical violence – possession of weapons – gang representation – escape plans
- -Use and/or possession of any illicit drugs and/or alcohol
- -Any act which puts at risk the program, program inmates, staff, or the Institution

b. I understand the program staff will immediately report to the appropriate Institution staff knowledge of any of the following conditions:
- -threats to self or others
- -current alcohol or drug use
- -escape plans
- -any action that threatens security of the Institution
- -child abuse or neglect

c. I understand the program will support and follow all Institutional rules and regulations outlined in my handbook. I agree to follow all Institutional and program rules and procedures.

d. I understand the program staff will follow all rules regarding confidentiality and will not disclose any information about me to any agency and/or person outside the Department of Corrections and Parole/Probation, without my written permission.

e. I agree to attend and fully participate in all program and Institution activities as directed.

f. I agree to uphold the values of the therapeutic community and help my fellow participants.

g. I agree to follow all directions and complete all assignments presented to me.

h. I understand I may be discharged for lack of progress toward program goals and/or consistent violation of rules and procedures.

I. I understand that I may be subject to random urine drug screens.

Additional requirements:_____

The above information has been explained to me and I have received a copy of the program rules.

_____ _____ _____

Inmate signature Date Program Staff signature

RSAT Admission Agreement
Revised 01/04/00

Assessment Information

Name: _____ **#:** _____

Please answer all questions accurately and honestly. This information will be used to identify your individual needs and develop an individual treatment plan. ***As always, all information is confidential.*** *If you have any questions or need any assistance, feel free to ask your counselor. Please return the completed form to your counselor. Thank you for your participation.*

Category I

1. Did it take more alcohol to get you drunk than it used to? O yes O no

2. Check any of the following you have experienced due to stopping or cutting down on the amount of alcohol you used:

___Headache ___Disturbed Sleep ___Fatigue ___Diarrhea

___Nausea ___Night Sweats ___Increased Dreaming ___Fever

___Vomiting ___Tremors/Shakes ___Irritability

___Sleeplessness ___Increased Heart Rate ___Changes in Appetite

Did you check any of the above? O yes O no

3. Have you ever used alcohol to relieve a hangover? O yes O no

4. Have you ever used more alcohol than you planned (binged)? O yes O no

5. Have you ever tried to quit or cut down, unsuccessfully, on your alcohol use? O yes O no

6. Did you spend a lot of time in activities in order to get alcohol? O yes O no

7. Did you give up social, occupational, educational or recreational activities in order to use alcohol? O yes O no

8. Did you continue to drink even though you had a medical problem that was caused by your drinking? O yes O no

9. Has continued alcohol use caused you problems at work, school, or home(e.g., repeated absences or poor work performance related to alcohol use; alcohol related absences, suspensions, or expulsions from work or school; neglect of children or household)? O yes O no

10. Have you used alcohol in situations in which it is physically hazardous (for example: driving an automobile or operating a machine when drinking alcohol)? O yes O no

11. Has your alcohol use caused you legal problems (for example: arrests for minor in possession, public intoxication, DUI/DWI #____, disorderly conduct)? O yes O no

12. Have you continued to use alcohol despite having constant relationship problems caused or made worse by the effects of alcohol (e.g., arguments or fights with spouse/girlfriend/boyfriend/parents/family/friends about the consequences of alcohol use/abuse)? O yes O no

13. Has anyone in you family ever used alcohol? If yes, who: _____

_____ O yes O no

14. Has anyone in your family been in treatment due to alcohol use/abuse? If yes, who:_____ O yes O no

15. Do you drink to relieve stress? O yes O no

16. Have you ever gotten into fights when drinking? O yes O no

17. Do you think you have an alcohol problem? O yes O no

18. Did it take more drugs to get you high than it use to? O yes O no

19. Check any of the following you have experienced due to stopping or cutting down on the amount of drugs you used:

___Headache ___Disturbed Sleep ___Fatigue ___Diarrhea

___Nausea ___Night Sweats ___Increased Dreaming ___Fever

___Vomiting ___Tremors/Shakes ___Irritability

___Sleeplessness ___Increased Heart Rate ___Changes in Appetite

Did you check any of the above? O yes O no

20. Have you ever used drugs to relieve a hangover? O yes O no

21. Have you ever used more drugs than you planned (binged)?

O yes O no

22. Have you ever tried to quit or cut down, unsuccessfully, on your drug use?

O yes O no

23. Did you spend a lot of time in activities in order to get drugs?

O yes O no

24. Did you give up social, occupational, educational or recreational activities in order to use drugs? O yes O no

25. Did you continue to use drugs even though you had a medical problem that was caused by your drugging? O yes O no

26. Has continued drug use caused you problems at work, school, or home(e.g., repeated absences or poor work performance related to drug use; drug related absences, suspensions, or expulsions from work or school; neglect of children or household)? O yes O no

27. Have you used drugs in situations in which it is physically hazardous (for example: driving an automobile or operating a machine when using drugs)? O yes O no

28. Have you experienced legal problems due to drugs (for example, arrests for possession, selling, trafficking, positive drugs screens, etc.)? O yes O no

29. Have you continued to use drugs despite having constant relationship problems caused or made worse by the effects of drugs (e.g., arguments with spouse/girlfriend/boyfriend/parents/family/friends about the consequences of drug use/abuse)? O yes O no

30. Has anyone in you family ever used drugs? If yes, who: _____ _____ O yes O no

31. Has anyone in your family been in treatment due to drug use/abuse? If yes, who:_____ O yes O no

32. Do you use drugs to relieve stress? O yes O no

33. Have you ever gotten into fights when high? O yes O no

34. Have you committed crimes to buy or obtain drugs? O yes O no

35. Have you ever shared needles? O yes O no

36. Do you think you have a drug problem? O yes O no

37. Have you ever completed a drug or alcohol program? O yes O no

==========

Category II

1. Do you believe the end justifies the means? O yes O no

2. Is this a dog eat dog world? O yes O no

3. Do you have direction and purpose in your life? O yes O no

4. Is having close friends and/or family important to you? O yes O no

5. Do you think men and women have equal roles in society? O yes O no

6. Do you think employment is valuable? O yes O no

7. Do you consider the feelings of others before you act? O yes O no

8. Do you worry about things not worth worrying about? O yes O no

9. Do you believe in a higher power and/or spiritual being? O yes O no

10. Do you do anything specific everyday to keep your values positive or to strengthen them? O yes O no

If yes, specify _____

11. Do you enjoy high-risk thrills and excitement? O yes O no

12. Do you get enjoyment from activities that often lead to trouble? O yes O no

13. Do you engage in activities that are dangerous to yourself and/or others? O yes O no

14. Do you often try to use clever ways to get what you want? O yes O no

15. Do you often think about the victims of your crime/substance abuse? O yes O no

16. Are you bothered by the crimes you have committed? O yes O no

17. Do you need to change your lifestyle in order to be a responsible parent? O yes O no

18. Have you made attempts to quit using alcohol/drugs? O yes O no

19. On a scale of 1 to 4, how important is treatment for your substance abuse? 4 being the highest. _____

20. On a scale of 1 to 4, how important is treatment for your criminal activity? 4 being the highest. _____

21. Are you willing to work hard, make sacrifices, and changes in your lifestyle to maintain a crime/drug free life? O yes O no

==========

Category III

1. Is it hard for you to define and recognize problems? O yes O no

2. Is it hard for you to solve problems? O yes O no

3. Do you usually come up with more than one way to solve a problem? O yes O no

4. Do you usually think carefully about the consequences before you act? O yes O no

5. Do you consider the feelings of others before you act? O yes O no

6. Is it hard for you to solve problems without hurting anyone? O yes O no

7. Do you consider yourself an impulsive person, like when you feel like doing something you do it right away? O yes O no

8. Have you gotten into trouble because you did not understand how people felt? O yes O no

9. Do you think a lot about yourself and your behavior? O yes O no

10. Do you think most of your problems come mainly from things that have been done to you? O yes O no

11. Can you identify at least three aspects of your personality that makes

it hard for you to change? O yes O no

12. Can you identify three habits you have that frequently lead to trouble?

O yes O no

If yes, specify _____

13. Is it usually better to plan in advance rather than act on instinct?

O yes O no

14. Is it better to trust your own opinion instead of getting others?

O yes O no

15. Do you think you have direction and plans in your life? O yes O no

16. Most of time, have you been good at reaching your goals?

O yes O no

17. Do you often explore new ideas/ways to handle yourself and situations?

O yes O no

18. Do you feel you basically don't have much control over your own life?

O yes O no

19. If you were released today, could you deal successfully with most of the situations you would face? O yes O no

==========

Category IV

1. Is coping with stress difficult for you? O yes O no

2. Do you get frustrated or upset easily? O yes O no

3. Do you have problems settling conflicts with others? O yes O no

4. Do you have firm opinions about things? O yes O no

5. If someone disrespects you, is it okay to show them respect? O yes O no

6. If someone disrespects you, is it OK to demand respect from the person? O yes O no

7. Are you able to let most insults "wash off" you without getting angry? O yes O no

8. Is it important to even the score with anyone who insults/disrespects you? O yes O no

9. When people around you are angry/fighting, do you take sides? O yes O no

10. Is it okay once in a while to be violent depending on your purpose? O yes O no

11. Do you think it is okay for a person to hit another person? O yes O no

12. Do you think that sometimes threats or violence are useful options? O yes O no

13. In the past, have you needed to use threats/violence in situations? O yes O no

14. Have you verbally abused or hit your partner? O yes O no

15. Have you experienced abuse from your partner? O yes O no

==========

Category V

1. Highest grade completed? _____

2. Can you read? O yes O no Can you write? O yes O no

3. Do you find learning difficult? O yes O no

4. Is it hard to pay attention or remember things you're trying to learn? O yes O no

5. Do find it difficult to follow directions? O yes O no

6. Do you have a skill, trade, or profession? O yes O no

   If yes, specify _____

7. Are you satisfied with your skill, trade, or profession? O yes O no

8. How many people depend on you for the most of their food, shelter, etc? _____

9. Were you unemployed at the time of your arrest? O yes O no

10. During the year prior to your incarceration, were you employed 50% of the time? O yes O no

11. What is your job history? O Consistent O Seasonal O Irregular

12. In the year before this incarceration, did you quit a job? O yes O no

13. In the year before incarceration, were you fired or laid off from work? O yes O no

14. Have you had difficulty with teachers in school? O yes O no

15. In the past, have you had trouble with co-workers? O yes O no

16. In the past, have you had trouble with supervisors? O yes O no

17. Is it difficult for you to stay focussed or complete tasks on time? O yes O no

18. Do you think people in authority want people under them to succeed? O yes O no

19. Does a person do better when they don't have authority over them? O yes O no

20. Have you been criticized a lot for not knowing or being good at things? O yes O no

21. Do you tend to hurry to complete tasks? O yes O no

22. If you had a lot of money and didn't have to work, would it be easier to stay out of trouble? O yes O no

23. Do you believe the safest place for your money is in your pocket? O yes O no

24. Have you had enough experiences to know your real potential/abilities? O yes O no

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Category VI

1. Marital Status O Married O Separated O Divorced O Never Married

2. Are you satisfied with this situation? O yes O no

3. During the year before incarceration, with whom did you live?

_____

4. Are you satisfied with this situation? O yes O no

5. Do you have any children? O yes O no

If yes, specify # : _____

6. Do you have parenting responsibilities? O yes O no

7. Do you know how to handle parenting responsibilities? O yes O no

8. How would you describe your relationship with your mother?

O Good O Fair O Poor

9. How would you describe your relationship with your father?

O Good O Fair O Poor

10. How would you describe your relationship with your brothers/sisters?

O Good O Fair O Poor

11. Did one of your parents abuse the other during your childhood? O yes O no

12. Were you abused as a child? O yes O no

13. During the year before incarceration, did you live with someone who used drugs, alcohol or commit crimes? O yes O no

14. During the year before incarceration, did you live in a high crime neighborhood? O yes O no

15. When you are released from prison, do you have a stable living situation to go to? O yes O no

If yes, specify: _____

16. Do you have a least three close friends who often tell you when you are heading for trouble? O yes O no

17. Is a friend someone who mainly helps you out of a jam? O yes O no

18. With whom do you spend most of your free time?

O Family O Friends O Alone

19. Do you consider yourself a loner? O yes O no

20. Is there anyone in your family that uses drugs or abuses alcohol or commits crimes? O yes O no

21. Do most of your friends commit crimes or use drugs or abuse alcohol? O yes O no

22. Have you ever belonged to a gang? O yes O no

23. Are you easily influenced or victimized by others? O yes O no

24. Do you avoid joining formal groups of organizations because you don't think you will fit in? O yes O no

25. Do you have bad credit? O yes O no

26. Do you own a car, house or have $500.00 in the bank? O yes O no

27. During the year before incarceration, did you receive any kind of public assistance? O yes O no

28. Do you engage in any hobbies? O yes O no

29. During the year before incarceration, did you spend most of your free time seeking drugs? O yes O no

30. When you need help who do you turn to? _____

31. Are you involved in any community help programs? O yes O no

32. Does it seem to you that most people in self-help recovery groups are fanatics or dishonest? O yes O no

33. Could you ever build a close friendship with people whom never had the kind of life you have had? O yes O no

34. Do you feel you have a good support system? O yes O no

==========

Category VII

1. Are you concerned about what others think of you? O yes O no
2. Do you think about the people you have committed crimes against? O yes O no
3. Do you ever think about the impact of your drug abuse on the people who care about you? O yes O no
4. Do you think you should make amends to the people you committed crimes against i.e. pay restitution, etc.? O yes O no
5. At times is it necessary to lie/manipulate to achieve your goals? O yes O no
6. If a person disagrees with you are they disrespecting you? O yes O no
7. Can a person be responsible for causing harm to another even if they didn't mean it? O yes O no

Inmate Signature: _____ Date _____

Primary Counselor's Signature: _____

(Signing indicates you have carefully reviewed assessment)

Name: _____ EF Number: _____

Date: _____

Instructions: Please answer all questions accurately and honestly. This information will be used to identify your individual treatment plan. As always, all information is confidential. If you have any questions or need any assistance, feel free to ask your counselor. Thank you for your participation.

	Age 1st used	Frequency of use	Amount Used	Date last used
Alcohol				
Marijuana				
Inhalants, glue, gas				
Hallucinogens LSD, PCP, etc.				
Pills, downers, sedatives, tranquilizers				
Amphetamines, Ice, crystals				
Opiates				
Cocaine,				
Crack, freebase				
Heroin				

If you could have only one drug what would be your:
First Choice: _____

Second Choice: _____

Third Choice: _____

Assessment Score Key

To Determine Diagnostic Impression of Inmate

Did the inmate answer Yes:

_____ to 3 or more of questions 1 through 8, indicates Alcohol Dependence
_____ to 1 or more of questions 9 through 12, indicates Alcohol Abuse

_____ to 3 or more of questions 19 through 26, indicates Substance Dependence
_____ to 1 or more of questions 27 through 30, indicates Substance Abuse

The Drug History form will help you determine drug of choice and the exact drugs used, abused and experimented with by the inmate.

Spectrum Health Systems, Inc.

[redacted]

Date of Interview: _____

Name: _____ # : _____ DOB _____

Referred by:_____ New Admission _____ Re-Admit _____

Legal Status

Current

Reason for incarceration:_____

Length of sentence:_____

Date committed:_____ Parole eligibility date: _____

Prior Two Incarcerations:

_____

_____

Substance Abuse History

	Type	Age First Use	Last Use
Primary			
Secondary			
Tertiary			

Medical & Psychiatric

1. Do you have any chronic medical problems? Yes _____ No _____

   If yes, specify: _____

2. **Allergies:** Yes ____ No ____ If yes, specify: _____

3. Do you have any psychiatric problems? Yes ____ No ____

   If yes, specify _____

4. Past suicide attempts: Yes _____ No _____ If yes, specify: _____

5. Past and/or current suicidal ideation: Yes ____ No _____

   If yes, specify: _____

Inmate's desired treatment outcome: _____

_____

Staff signature _____ Date _____
(signature and title)

RSAT Intake
Revised 01/04/00

Spectrum Health Systems, Inc.

RESIDENTIAL SUBSTANCE ABUSE TREATMENT

Summary Narrative

.nate Name:_____ #: _____

Diagnostic Impression:

_____ _____

.ounselor's Signature Date

RESIDENTIAL SUBSTANCE ABUSE TREATMENT

Summary Narrative

Continued

Inmate Name:________________________ **#:** ____________________

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Counselor's Signature Date

RSAT Narrative Summary
Created on 01/17/00

NEEDS ASSESSMENT

The Needs Assessment is a tool for generating an offender's Individual Treatment Plan. That is, it helps identify each individual's personal set of goals and achievements as part of the standard program.

The offender's counselor should conduct a Needs Assessment within two weeks of the person's admission to the program. In so doing the counselor should consult:

- All the offender's relevant records, program assessment information and other available documentation;
- All other available staff who have knowledge of the offender;
- The offender him or herself in individual sessions.

From whatever source data can be collected, special attention should be given to the offender's drug abuse and drug treatment history, past behaviors during incarceration, nature of offenses, breaches of trust (escapes, defaults, etc.), parole/probation reports, employment history, family and psycho-social reports.

Further, the Needs Assessment must be conducted in consultation with other members of the treatment team if possible. The needs assessment must be approved by the site supervisor.

The Needs Assessment is mainly a tool for treatment planning. After its application early in the program the Needs Assessment would normally give way to regular Progress Reviews as described below. However, at any point after its application staff should revise the Needs Assessment and hence the ITP in light of any significant new data about the offender that would suggest a change in the rating. In such cases a formal re-assessment would not be necessary, but appropriate notation on the original Assessment record and corresponding changes in the ITP should be made.

The Needs Assessment addresses the following Needs Categories:

Specific Addiction Factors
Lengthy addiction and early first use; key role of drug use and intoxication in criminal acts; very frequent use/intoxication; central role of drugs in lifestyle.

Motivations & Values
Strong drives for quick and selfish satisfactions; few skill-based forms of enjoyment; attraction to thrills and especially to activities dangerous to self or others; no evident interest in a positive value system, pro-social activities, or spiritual practice.

Critical Thinking & Planning
Lack of clarity and insight; limited recognition of options and consequences or own powers of choice; little general thoughtfulness and deliberateness or interest in new or difficult ideas.

Anger & Violence
Strong history of violence or abuse toward others; tendency to express anger and hostility; approval of threats or violence as a useful option.

Work & Discipline
Limited employment, education, or personal accomplishment; frequent conflicts with authority figures and resistance to most forms of external authority; inability to delay gratification or to remain focused on task; general lack of impulse control.

Social Support & Resources
Few friends, relatives, or contacts who would support recovery; serious conflicts or ruptures with family; alienation from mainstream society; little access to or knowledge of helpful groups or services; general lack of material or human resources for change.

Social Sensitivity
Lack of concern or empathy for others; little remorse for one's own wrongs; little concern for how one is seen by others; limited sense of responsibility or accountability to others for one's own actions; frequent lying and manipulation.

SCORING THE NEEDS CATEGORIES

Each Needs Category is to be scored by the offender's counselor, with appropriate input from other personnel, according to the following 3-point scale:

1 = "**minor**": the category represents no evident or serious problem for the offender; the issues do not appear to cause the person difficulties in the institution and would likely not be problems in the community either.

2 = "**moderate**": the category represents a clear and perhaps recurrent problem, and the severity may be roughly typical of the institutional population; the issues would likely cause the offender significant difficulties in the community.

3 = "**major**": the category represents a severe problem that may exceed the norms of the institutional population; the issues cause the offender serious difficulties (even if denied) and unless significantly reduced would probably make successful community re-integration impossible.

Spectrum Health Systems, Inc.

NEEDS ASSESSMENT

Inmate Name _____ **Number** _____ **Date Performed** _____

Primary Counselor _____ **Supervisor's Signature** _____

Other Participating Staff _____ _____ _____ _____

NEEDS CATEGORIES	Rating (circle one)
Specific Addiction Factors Lengthy addiction and early first use; key role of drug use and intoxication in criminal acts; very frequent use/intoxication; central role of drugs in lifestyle	1 2 3
Motivations & Values Strong drives for quick and selfish satisfactions; few skill-based forms of enjoyment; attraction to thrills and especially to activities dangerous to self or others; no interest in a positive value system, pro-social activities, spiritual or treatment services.	1 2 3
Critical Thinking & Planning Lack of clarity and insight; limited recognition of options and consequences; general thoughtfulness and deliberateness; interest in new or difficult ideas; recognition of own powers of choice	1 2 3
Anger & Violence History of violence or abuse toward others; tendency to express anger and hostility; approval of threats or violence as a useful option	1 2 3
Work & Discipline Limited employment, education, or personal accomplishment; frequent conflicts with authority figures and resistance to most forms of external authority; inability to delay gratification or to remain focused on task; general lack of impulse control	1 2 3
Social Support & Resources Few friends, relatives, or contacts who would support recovery; alienation from mainstream society; little access to or knowledge of helpful groups or services; general lack of resources for change.	1 2 3
Social Sensitivity Lack of concern or empathy for others; little remorse for one's own wrongs; little concern for how one is seen by others; limited sense of responsibility or accountability to others for one's own actions	1 2 3

Diagnostic Impression: _____

Inmate's stated preferences for program: _____

_____

Inmate's strengths and abilities: _____

_____

Needs Assessment
Revised on 01/04/00

Guidelines for Developing an Individual Treatment Plan

The needs assessment, initial intake and weekly (or Homerville bi-weekly) ITP reviews provide the foundation for the initial and ongoing development of individual treatment planning. **In conjunction with their primary counselor, the inmate must be actively involved in the individual treatment planning process and participate in the development of their individual treatment plan.**

Each inmate's treatment must be:

1. Specific as to the problems and objectives
2. Individualized to meet the particular inmate's needs and goals
3. Measurable in terms of setting milestones that can be used to chart the inmate's progress and assess treatment outcome

There are many benefits to an Individual Treatment Plan:

- A treatment plan provides a road map for the inmate to follow while in the program. This road map will help point the way and keep the inmate focused on the concepts of the Program.
- The ITP serves to structure the focus of treatment.
- Remember that issues can and will change as the inmate progresses through each week, and the treatment plan must be updated/modified to reflect any changes or additions of problems, goals, and objectives.
- ITP's benefit both the inmate and the counselor, as the ITP forces each to think in terms of treatment outcomes. When clear behavioral objectives are used, they allow the inmate to focus on specific changes that lead to long-term problem resolution.
- ITP's help the counselor to think in analytical and critical terms about which objectives are best suited for each individual inmate to reach set treatment goals.
- ITP's can also aid in treatment team meetings when addressing inmate's strengths/weaknesses and progress level. ITP's increase the quality and continuity of the documentation in clinical charts.
- ITP's allow counselors to use more precise measurable objectives to evaluate success of treatment and in collection of data to measure whether inmate met treatment expectations that were established.

HOW TO DEVELOP A INDIVIDUAL TREATMENT PLAN

- Developing an ITP is a process of several logical steps that build on each other
- The foundation for any ITP is the information gathered from the inmate's GDC file, needs assessment, initial intake and through the counselor's observations during groups
- Counselor must pay close attention to the information disclosed by the inmate. Such things could be: family issues, stressors, emotional status, social issues, health, coping skills, interpersonal relationships, self-esteem, finances, legal issues, just to name a few.
- The ITP objectives should be tied to the treatment goal and to each specific program phase the inmate is in

Step One – Problem Solving Selection:

- Counselor must review all information gathered from the above mentioned sources and then with the inmate prioritize the most significant issues
- Most inmates will have a primary problem (usually Substance Abuse/Dependence related problems), secondary problem (usually criminal addictive thinking), tertiary problem, etc. Other problems will be evident, however they may need to be set aside until either the primary/secondary, etc., has been resolved or progress has been made toward the most urgent problems.
- The counselor and the inmate must identify the problems that are or have been the most disruptive to the inmates functioning in society and those that are most important to the inmate.
- It has been noted that the inmate's motivation to participate and cooperate in completing ITP depends on the degree to which the ITP addresses the inmate's needs.

Step Two – Problem Definition: (see examples)

- Each inmate reveals how their problems occurred behaviorally in their lives. Therefore, each problem selected for the ITP must be defined in its relation to the individual inmate.
- Must be individualized to fit the inmate's needs

Step Three – Goal Development

- Set broad goals aimed at replacing the dysfunctional behaviors that were stated in the Problem with more adaptive ones.
- Goals are, basically, the Problem stated in positive statements
- Goals should focus on long-term outcomes of treatment
- Arnold Goldman suggested using the "see Johnny test":
  - If you can see Johnny do something (make a list of triggers), it is a objective
  - If you can't see Johnny do it (improve self-esteem), it is a goal
- Goals must be individualized to address the need of the inmate

Step Four – Objective Construction:

- Objectives must be stated in behavioral terms that are measurable (results must be measurable)
- Each objective must be individualized
- Each objective should be steps to obtaining the goal
- Use as many objectives as necessary
- Update/add new objectives as the inmate progresses through each week and phase of treatment, as necessary
- The completion of all objectives for the Problem/Goal should indicate resolution of the inmate's stated problem and the attainment of the stated goal

Step Five - Time Frame:

- Each objective is assigned a date that it will be completed

Step Six - Revised Time Frame:

- Used when the counselor has agreed to change the due date of a objective

Step Seven - Date Completed:

- Indicates the date the objective was completed to the counselor's satisfaction

Step Eight– Staff Signature:

- Indicates the counselor has developed the ITP using all information/data collected and in conjunction with the individual inmate

Step Nine – Inmate Signature:

- Indicates agreement and participation in the formulation of the of the ITP by the inmate.

Step Ten – Inmate Initial:

- Inmate must initial (**I/M Init**) each time a new objective is assigned

INDIVIDUAL TREATMENT PLAN EXAMPLES

This is only to be used as a guide. Use these as suggestions, put into your own words, individualize them to the inmate's specific problem, goals and Objectives and where they are in the program (in regards to phase). As a part of the assignment you can have the inmate share their assignment in a group(s) and/or meetings. You can take the concepts of core skills/CRT's/Principle of Recovery/Orientation, etc. and make them into Objectives. On any of the suggested Objectives, where it says list ___#, put the number of things they need to list appropriate for the inmate and the assignment. (All information taken from The Chemical Dependence Treatment Planner by Robert R. Perkinson and Arthur E. Jongsma, Jr.)

Substance Abuse/Dependence:

Problems:

- Maladaptive pattern of substance abuse due to increased tolerance
- Inability to stop or cut down use of drugs/alcohol despite the stated desire and the negative consequences of continued use
- Physical problems caused/due to heavy drug/alcohol use
- Denial that drug/alcohol use/abuse/dependence is a problem despite feedback from others that the use is negatively affecting them
- Continued use despite physical, legal, financial, vocational, social, or relationship problems that are caused by the drug/alcohol use
- Arrests for drug/alcohol related offenses – (DUI, minor in possession, assault, possession/delivery/sale of controlled substance, shoplifting, etc.)
- Use of drugs/alcohol lead to stopping important social, recreational or occupational activities
- Great deal of time spent in activities to obtain, use or recover from effects of drugs/alcohol

Goals:

- Accept powerlessness and unmanageability over drugs/alcohol and participate in a recovery based program
- Admit to having a drug/alcohol use/abuse/dependence and begin active participation in a recovery program
- Establish a sustained recovery, free from the use of all drugs/alcohol use
- Increase knowledge of the disease and recovery process
- Learn skills necessary to maintain long-term sobriety from all drugs/alcohol and live a life free of drugs/alcohol
- Learn how being free from all drugs/alcohol will improve quality of life

Objectives

- Attend groups and read assigned material to increase knowledge of addiction and recovery process
- Attend group sessions to share thoughts and feelings related to, give and receive feedback related to, reason for, consequences of, feelings about, alternative, etc. to drug/alcohol use/abuse/dependence
- List ten negative consequences resulting from or exacerbated by drug/alcohol use/abuse/dependence
- During _____ group/meeting admit to your powerlessness over drugs/alcohol use/abuse/dependence
- State your understanding of the problems caused by the use of drugs/alcohol and the need to stay in recovery
- Admit that drugs/alcohol were used as the primary coping mechanism to escape from stress or pain and resulted in negative consequences
- List the negative emotions that were caused or worsened by the use of drugs/alcohol
- List the social, emotional, and family factors that contributed to drug/alcohol use/abuse/dependence
- List ten reasons to work on a recovery plan
- List ten lies you used to cover up drug/alcohol use
- Give five ways a higher power can help in recovery efforts
- Practice turning things over to higher power, write each event down and share during _____ group
- Practice healthy communication skills/core skills/CRT's/Principle of Recovery/Orientation to reduce stress and increase positive social interaction
- List reasons for drug/alcohol use and counter with positive alternatives
- Give options to drug/alcohol use in dealing with stress and find pleasure or excitement in life in _____ group

- Write a leisure-skills program to decrease stress and improve health
- List triggers that precipitate relapse
- Write a plan to cope with high-risk or trigger situations

Relapse Prone

Problem:
- Inmate has a history of multiple treatment attempts and relapse
- Negative emotions place the inmate at high risk for drug/alcohol use/abuse/dependence
- Friends and/or family members are drug/alcohol drug users/abusers/dependent
- Conflicts with family/friends/significant other(s) place the inmate at high risk for relapse
- Peer pressure encourages drug/alcohol use
- Inmate has never stayed focused on a recovery program long enough to maintain abstinence
- Mental illness places the inmate at high risk for relapse

Goals:
- Reduce the risk for relapse and maintain a recovery program
- Develop a plan for resolving conflicts with family/friends/significant other(s) and utilizing healthy communication skills
- Develop new supportive peer group
- Learn how to say no to drugs/alcohol
- Develop coping skills when experiencing high-risk situations and/or cravings/urges
- Learn and practice a recovery program
- Have inmate read and present to group each of the 12 Steps to increase knowledge/understanding

Objectives:
- Write a detailed drug/alcohol history describing treatment attempts and what lead to relapse
- Share your understanding of why you continue to relapse
- Share the powerlessness and unmanageability that resulted from drug/alcohol use/abuse/dependence and relapse
- During ____group/meeting accept your powerlessness over drugs/alcohol
- Share how your continued drug/alcohol use meets the 12-Step concept of insanity
- List and share five reasons why it is imperative to work on a daily recovery program
- List five reasons for your failure to work on daily recovery plan
- Turn problems over to higher power each day, praying only for His will and the power to carry it out. Write down each of the events and discuss during _____ group
- List five ways a higher power can assist in recovery from drug/alcohol use/abuse/dependence
- Share reasons you did not attend support groups long enough to maintain abstinence
- Develop a new supportive peer group
- Develop a recovery plan to deal with high-risk situations
- Practice healthy communication skills
- Write a plan to resolve interpersonal conflicts
- Practice saying no to drugs/alcohol
- Make a card of emergency phone numbers to call for help when in a high risk situation
- Develop a personal recovery plan

Spiritual Confusion

Problem:
- Confusion about spiritual matters leads to negative attitude about recovery
- Holding religious convictions that identify drug addiction/alcoholism as a sin rather than a disease leads to negative attitude about a 12-step recovery program
- Fearing that God is angry prevents inmate from connecting with a higher power
- Anger at God prevents inmate from consciously seeking contact with God/Higher Power

- Active involvement in a religious system that does not support a 12-Step recovery program
- Need for a higher power is not understood
- Existence of a higher power is not supported by spiritual beliefs

Goal:
- Make a conscious contact with God using prayer and meditation
- Understand the relationship between spiritual confusion and substance abuse/dependence
- Accept that a higher power can assist in relieving the inmate's drug/alcohol use/abuse/dependence
- Develop a concept of a higher power that is loving and supportive to recovery
- Learn the difference between religion and spirituality
- Learn and demonstrate the 12-step concept of "God as we understand Him"
- Develop and use a healthy concept of a higher power

Objectives:
- Admit to the powerlessness and unmanageability that results from spiritual confusion and drug/alcohol use
- Identify how spiritual confusion leads to drug/alcohol use
- Share how spiritual confusion can lead to a condemning attitude toward drug/alcohol use/abuse/dependence and resistance toward working a 12-step recovery program
- Share your understanding of spiritual confusion and its relation to drug/alcohol use/abuse/dependence and recovery
- List five instances when spiritual confusion led to drug use/abuse/dependence
- Share how drug/alcohol use/abuse/dependence and spiritual confusion left you spiritually bankrupt
- Share understanding of the 12-step fellowship concept of "God as we understood him"
- Share how many different religious and cultures can work a 12-step recovery program
- List ten ways a higher power can assist in recovery from spiritual confusion and drug/alcohol use/abuse/dependence
- Meet with a temporary sponsor (have them go to a meeting on the weekend) and discuss plans for resolving spiritual confusion and drug/alcohol use/abuse/dependence
- Share why you believe you need to begin a spiritual journey outlined in the 12 steps
- Write a plan to continue a spiritual journey outlined in the 12 steps
- Decide to turn your will and life over to the care of God as you understand Him
- Practice prayer and meditation at least _____ times per day/week
- Write a personal recovery plan that includes attendance at support groups, sponsor and any other treatment necessary to recovery from spiritual confusion and drug/alcohol use/abuse/dependence

Treatment Resistance

Problem:
- Severe denial of drug/alcohol use/abuse/dependence in spite of strong evidence of tolerance, withdrawal, negative consequences, etc
- Substitutes a secondary problem as the focus of concern rather than admit that drug/alcohol use/abuse/dependence is the real problem
- Angry at family members, court, etc. for mandating treatment
- Refuses to cooperate with the staff and is at risk of being removed from the program, etc.
- Verbally abusive to staff and other inmates, frequently irritable, restless, angry, etc.
- Dishonest with self and others, believes lies rather than facts regarding alcohol/drug use/abuse/dependence
- Constantly demands to be removed from the program
- Refuses to talk to or bond with counselor and/or groups members

Goals:
- Accept the truth about the problems caused by substance abuse and engage in the program
- Accept the powerlessness and unmanageability that drug/alcohol use/abuse/dependence has brought to your life and actively engage in the program
- Learn the facts about drug/alcohol use/abuse/dependence

- Accept responsibility for the problems drug/alcohol use/abuse/dependence caused and the need for the program
- Resolve interpersonal conflicts with staff and/or other inmates and agree to cooperate with the program
- Be honest with self and others regarding the extent of drug/alcohol use/abuse/dependence and commit to the program

Objectives
- Share during _____ group/meeting the reason for your resistance to the program
- Share the feelings you felt upon entering program
- Discuss any physical signs and symptoms you experienced due to drug/alcohol use/abuse/dependence
- List ten instances when drug/alcohol use/abuse/dependence lead to negative consequences
- Discuss the reasons for program resistance with program peers, during _____ group/meeting, and listen to their feedback
- Share plans, during _____ group/meeting, to refuse program with program peers and counselors
- Share your understanding of the program process/mission, etc
- Find a mentor from another phase and discuss reasons for wanting to leave the program, try to resolve reason for wanting to leave the program
- List five lies that you told to hide drug/alcohol use/abuse/dependence
- Write a personal recovery plan that includes the necessary steps to maintain sobriety

Adult Children of An Alcoholic/Addict Traits

Problem:
- A history of being raised in an alcoholic home that resulted in having experienced emotional abandonment, role confusion, abuse and/or chaotic, unpredictable environment
- Inability to trust others, share feelings, or talk openly about self
- Submissive to the wishes, wants, and needs of others; too eager to please others
- Fearful of abandonment and clings to destructive relationships
- Tells others what they want to hear rather than the truth
- Feelings of worthlessness and believes that being treated with disdain is normal and expected
- Feelings of panic and helplessness when faced with being alone when a close relationship ends
- Choose partners/friends who are addicts/alcoholics or have other serious problems
- Distrusts authority figures – trust only peers
- Takes on parental role in relationship
- Feels less worthy than those who had a more "normal" family life
- Feelings of alienation from others

Goals:
- Develop a recovery plan that reduces the impact of adult child of an alcoholic (ACOA) traits on sobriety
- Decrease dependence on relationships while beginning to meet his or her own needs, build confidence, and practice assertiveness
- Demonstrate healthy communication that is honest, open, and self-disclosing
- Recognize adult child of alcoholic traits and their detrimental effects on recovery
- Reduce the frequency of behaviors designed to please others
- Demonstrate the ability to recognize, accept, and meet the needs of self
- Replace negative, self-defeating thinking with self-enhancing messages to self
- Choose partners and friends who are responsible, respectful, and reliable
- Improve feelings of self-worth by helping others in recovery

Objectives
- Acknowledge the feelings of powerlessness that result from ACOA traits and drug/alcohol use/abuse/dependence
- Discuss the relationship between being raised in an addictive family and the repeating pattern of drug/alcohol use/abuse/dependence

- Share the rules of "don't talk, don't trust, don't feel" that were taught to him/her as a child and explain how these rules made relationships more difficult
- Share how an understanding of how ACOA traits contribute to substance use/abuse/dependence
- Identify how the tendency to take on the parental role in relationships is related to maintaining a feeling of security and control
- Discuss the fears of abandonment experienced in the alcoholic/addict home
- Share the feeling of worthlessness that was learned in the alcoholic/addict home and directly relates this feeling to your use/abuse/dependency of drugs/alcohol as a coping mechanism
- Identify the pattern in the alcoholic/addicted family of being ignored or punished when honest feelings were shared
- List the qualities and behaviors that should be evident in others before trust can be built
- Increase the frequency of telling the truth rather than saying only what the inmate thinks the other person wants to hear. Record each incident and feelings in a daily journal
- Acknowledge the resistance to sharing personal problems; then share at least one personal problem in _____group/meeting
- Share your understanding of how ACOA traits contribute to choosing partners and friends partners and friends that have problems and need help
- Initiate the encouragement of others in recovery to help reestablish a feeling of self-worth
- List ten reasons regular attendance at recovery is necessary to arrest ACOA traits and alcoholism/addiction
- Discuss how a recovery group can become the healthy family the inmate never had
- List five ways that belief in and interaction with a higher power can reduce fears and aid in recovery
- Share your feelings of serenity that result from turning problems that are out of your control over to the higher power
- Practice assertiveness skills and keep a daily journal of the times the skills were used in interpersonal conflicts
- Three times a day, begin a sentence with, "I feel..." and record it and then share it during _____ group

Anger

Problems:

- History of explosive, aggressive outbursts, particularly when under the influence of drugs/alcohol, that lead to acts of violence or destruction of property
- Tendency to blame others rather than accept responsibility for own behavior
- Angry overreaction to perceived disapproval, rejection, or criticism
- Passively withholds feelings, then explodes in a violent rage
- Abuses drugs/alcohol to cope with angry feelings and relinquishes responsibility for behavior
- Pattern of challenging or disrespecting authority figures
- Views aggression as a means to achieve needed power and control
- Use of verbally abusive language

Goals:

- Develop a recovery plan free of violent behavior and drug/alcohol use/abuse/dependence
- Decrease the frequency of angry thoughts, feelings, and behaviors
- Develop the ability to think positively in anger-producing situations
- Stop blaming others and begin to accept responsibility for own feelings, thoughts, and behaviors
- Learn and implement stress management skills to reduce the level of stress and the irritability that accompanies it
- Understand the relationship between angry feelings and the feelings of hurt and worthlessness experienced in the family of origin
- Learn the assertive skills necessary to reduce angry feelings and solve problems in a less aggressive and more constructive manner
- Learn and demonstrate strategies to meet the needs of self rather than depending on others
- Replace thoughts that trigger anger with positive self-talk that induces serenity

Objectives

- Keep a daily anger log, writing down each situation that produced angry feelings and the thoughts associated with the situation; then rate the level of anger on a scale from 1 to 10
- Identify and share the pain and hurt of past and current life that fuels anger
- Share your understanding of how anger has been reinforced as a coping mechanism for stress
- Discuss regret and remorse for harmful consequences of anger as well as steps necessary to forgive self and react more constructively
- Share your understanding of the relationship between the feelings of worthlessness and hurt experienced in the family of origin and the current feelings of anger
- Stop assuming to know the negative intentions, and feelings of others and start asking for more information
- Share your understanding of the need for and the process of forgiving others to reduce anger
- Share your understanding of how angry thoughts and feelings can lead to increased risk of drug/alcohol use/abuse/dependence. List instances in which anger has resulted in drug/alcohol use/abuse/dependence
- List five reasons angry thoughts, feelings and behaviors increase the risk of relapse
- Make a list of the thoughts that trigger angry feelings and replace each thought with a more positive and accurate thought that is supportive to self and recovery
- Practice relaxation skills _____ a day/week for _____minutes
- Report instances of using stress management skills such as prayer to higher power, relaxation, sharing feelings, regular exercise, healthy self-talk, etc. during _____ group/meeting
- List steps that are proactive to meet the needs of self without expecting other people to meet those needs and angrily blaming them when they fail
- Develop a recovery plan that details what he/she will do when feeling angry

Anti-Social Behavior

Problem:

- A history of breaking the rules or the law (often under the influence of alcohol/drugs) to get his/her own way
- A pattern of disregard for and violation of the rights of others
- Consistently blames other people for his/her own problems and behaviors
- Uses aggressive behavior to manipulate, intimidate, or control others
- Chronic pattern of dishonesty
- Hedonistic, self-centered lifestyle with little regard for the needs and welfare of others
- Lack of empathy for the feelings of others, even if they are friends or family
- A pattern of criminal activity and drug/alcohol use/abuse/dependence going back into the adolescent years
- Engages in dangerous, thrill-seeking behavior without regard for the safety of self or others
- Failure to keep commitments, promises, or obligations toward others, including his/her children, family, or significant others
- A history of many broken relationships with a lack of loyalty shown in intimate as well as superficial relationships

Goals:

- Develop a program of recovery that is free from drug/alcohol use/abuse/dependence and the negative influences of antisocial behavior
- Learn the importance of helping others in recovery
- Learn how antisocial behavior and drug/alcohol use/abuse/dependence is self-defeating
- Understand criminal thinking and develop self-talking that respects the welfare and rights of others
- Stop committing crimes and understand why illegal activity is harmful to self and others
- Understand the importance of a program of recovery that demands rigorous honesty
- Develop a structured program of recovery that includes regular attendance at recovery group meetings
- Obey the law as an essential part of a program of recovery
- Learn and practice behaviors that are prosocial
- Develop a program of recovery that demands rigorous honesty
- Respect the rights and feelings of others
- Take responsibility for his/her own behavior

- Demonstrate honesty, reliability, and commitment in relationships
- Abstain from drugs/alcohol as necessary part of controlling and changing antisocial impulses and behavior

Objectives:

- Share your acceptance of powerlessness and unmanageability over antisocial behavior and drug/alcohol use/abuse/dependence
- Discuss how drug/alcohol use/abuse/dependence encourages antisocial behavior and how antisocial behavior fosters drug/alcohol use/abuse/dependence
- State how antisocial behavior and drug/alcohol use/abuse/dependence are associated with irrational thinking
- Consistently follow all rules of institution and program
- Identify and list the consequences that failure to comply with the rules/limits has had on self and others
- List five occasions on which antisocial behaviors led to negative consequences, and list the many decisions that were made along the way
- List the ways in which dishonesty is self-defeating
- List the reasons criminal activity/thinking leads to a negative self-image
- Share how criminal thinking (e.g. a feeling of entitlement, needing power, lack of empathy, superoptimism, discounting others) is used to avoid responsibility and to blame others
- Share your understanding of why blaming others prevents learning from mistakes of the past
- Decrease frequency of statements blaming others or circumstances while increasing frequency of statements accepting responsibility for own behavior, thoughts, and feeling. Keep a log of these instances and share during _____ group/meeting
- Identify historic and current sources for the pattern of rebellious behaviors, thoughts, feelings
- Develop a list of prosocial behaviors and practice one of these behaviors each day
- Write a list of typical criminal addictive thinking thoughts; then replace each thought with a thought that is respectful to self and others
- List five ways 12-Step fellowship meetings and a higher power can aide you in overcoming antisocial behavior and drug/alcohol use/abuse/dependence
- Receive feedback/redirection from staff and other inmates without making negative gestures or remarks
- Discuss why it is imperative in recovery from antisocial traits and drug/alcohol use/abuse/dependence, to give assistance to others, and give examples of how you have been supportive
- Encourage at least one person in program each day
- State the reasons that having the trust of others is important
- Share your antisocial and drug/alcohol use/abuse/antisocial behaviors that have resulted in others' pain and disappointment, and therefore in a loss of their trust
- Discuss your desire to keep commitments to others and list ways that he/she could improve self to be responsible, reliable, loyal and faithful
- Share several ways a sponsor can be helpful in recovery; then make contact with a temporary sponsor
- List the recovery groups that have been beneficial to recovery from antisocial behavior and drug/alcohol abuse/dependence and develop a recovery plan to promote and support recovery

Childhood Trauma

Problems:

- History of childhood physical, sexual, or emotional abuse
- Irrational fears, suppressed anger/rage, low self-esteem, identity conflicts, depression, or anxious insecurity related to painful early life experiences
- Use of drugs/alcohol to escape emotional pain tied to childhood abuse
- Intrusive memories, guilt, or emotional numbing from early childhood trauma
- Unresolved emotions and maladaptive behavior that is the result of childhood trauma
- Inability to trust others, bond in relationships, communicate effectively, and maintain healthy interpersonal relationships because of childhood neglect or abuse

Goals:

- Drug/alcohol use/abuse/dependence that has been used as a means of coping with unresolved feelings associated with childhood traumas
- Develop an awareness of how childhood issues have contributed to drug/alcohol use/abuse/dependence
- Learn how childhood trauma resulted in interpersonal problems and drug/alcohol use/abuse/dependence
- Maintain a program of recovery free of drug/alcohol use/abuse/dependence and the negative effects of childhood trauma
- Agree to attend therapy/mental health appointments, etc., to resolve past childhood trauma and drug/alcohol use/abuse/dependence

Objectives

- Share your powerlessness and unmanageability experienced as a child and directly relate these feelings to substance abuse
- Identify the unhealthy rules and roles you learned in the family of origin
- Share your understanding of how childhood abandonment, neglect, or abuse led to current distrust, anger, low self-esteem, or depression
- Identify pattern of using drugs/alcohol as a means of escape from psychological pain associated with childhood traumas and verbalize more constructive ways of coping
- Share the unresolved grief tied to unmet needs, wishes, and wants of the childhood years
- Share your plan to fulfill unmet needs of childhood now that adulthood had bee reached
- List the dysfunctional thoughts, feelings and behaviors learned during the childhood trauma/neglect; then replace each self-defeating thought/behavior with a new thought/behavior that is positive and self-enhancing
- Share feelings and thoughts related to childhood traumas and explain how drug/alcohol use/abuse/dependence was used to avoid negative feelings during _____ group/meeting
- Discuss how the family handled conflict; then practice healthy rules of conflict resolution
- List current maladaptive relationships/communication skills and then develop and demonstrate new skills that are adaptive and healthy
- List five ways a higher power can assist in recovery from childhood trauma and drug/alcohol use/abuse/dependence
- Share your understanding of how a 12-Step Fellowship can provide a substitute for the healthy home you never experienced
- Develop and agree to participate in an aftercare program to continue to recover from childhood abuse and drug/alcohol use/abuse/dependence

Depression

Problems:

- Feels sad or down most days
- Experiencing symptoms of depression, including sleep disturbances, appetite change; anhedonia, fatigue, weight change
- Feelings of helplessness, hopelessness, worthlessness or guilt
- Loss of energy, excessive fatigue
- Poor concentration, indecisiveness
- Low self-esteem
- Mood-congruent hallucinations or delusions
- Engages in drug/alcohol use/abuse/dependence as a means of escaping feelings of sadness, worthlessness, and helplessness

Goals:

- Elevate mood by developing a recovery program free from substance use/abuse/dependence
- Decrease dysfunctional thinking and increase positive, self-enhancing self-talking
- Understand affective disorder and how these symptoms make him/her vulnerable to drug/alcohol use/abuse/dependence
- Develop a lifestyle full of pleasure work, social activity, and play

- Improve physical functioning and develop a recovery program that includes exercise, relaxation, and healthy eating and sleeping habits
- Improve social skills and develop a recovery program that includes regular attendance at recovery groups that includes regular attendance at self-help groups
- Increase feelings of self-worth and self-esteem through learning how to help others

Objectives:

- Share your powerlessness and unmanageability that result from using drugs/alcohol use/abuse/dependence to cope with depression
- Discuss your understanding of how depression leads to drug/alcohol use/abuse/dependence and this use/abuse/dependence leads to depression
- Identify a pattern of using drugs/alcohol as a means of escape from depression, and verbalize more constructive means of coping
- Identify the causes of depressed mood; develop positive statements and plans to cope with those causes
- Share your understanding of how depression and drug/alcohol use/abuse/dependence lead to a condition that 12 Steps call "insane"
- List five ways a higher power can be useful in recovery form drug/alcohol use/abuse/dependence and depression
- Keep a daily record of dysfunctional thinking that includes each situation associated with depressed feelings and the thoughts that triggered those feelings
- Replace negative, self-defeating thinking with positive, accurate, self-enhancing self-talk
- Read aloud ten positive, self-enhancing statements each morning
- Encourage someone in recovery each day. Write down each incident and discuss in _____group/meeting
- Discuss how you are important to others in the program
- Develop written plans and express hope for the future
- Write down five things each night for which he/she is grateful an share during _____ group/meeting
- Share thoughts and feelings related to depression and how drug/alcohol use/abuse/dependence has been used to avoid these negative feelings during _____ group/meeting
- Develop a recovery plan that includes attendance at support groups/mental health, etc.

Family Conflicts:

Problem:

- A pattern of family conflicts leading to dysfunctional relationships and drug/alcohol use/abuse/dependence
- Repeated family physical fights, verbal arguments or unresolved disputes
- Poor communication skills leading to an inability to solve family problems
- Physical or verbal abuse of family members
- Us of drugs/alcohol to cope with feelings of anger, alienation, or depression related to conflict within the family
- Unresolved conflicts leading to an inability to love family members
- Long period of noncommunication with family members due to unresolved conflicts
- A family that is not supportive to recovery
- Drug/alcohol using/abusing/dependent family members leading to poor recovery environment

Goals:

- Develop a recovery program free of drugs/alcohol use/abuse/dependency and family conflict
- Learn and demonstrate healthy communication and conflict resolution skills leading to harmony within the family and cessation of drug/alcohol use/abuse/dependency
- Develop a plan to resolve family conflicts and elicit the aid of family members in working on a stable recovery program
- Stop drug/alcohol use/abuse/dependency and implement more healthy coping behaviors to deal with the conflicts within the family
- Begin to emancipate from the parents in a healthy way by making reasonable arrangements for independent living
- Understand the relationship between family conflicts and drug/alcohol use/abuse/dependency

- Learn how the conflicts in the home of origin influence current family problems
- Forgive family members for the past

Objectives:

- Share your the powerlessness and unmanageability that resulted from using drugs/alcohol to cope with family conflicts
- Share your an understanding of how family conflicts led to drug/alcohol use/abuse/dependency and this use/abuse/dependency led to family conflict
- Write a detailed account of current family conflicts and how they relate to conflicts in the family of origin experienced as a child
- Discuss how attempts to seize power and control do not lead to healthy relationships
- Write a letter to each family member, taking the responsibility for the behavior of the past, stating feelings, and asking for what he/she would like from each member to support recovery, have inmate share during _____ group/meeting asking fellow members to edit and give feedback
- Have inmate write letter to family members asking them to write a letter sharing how they feel and stating what behavior they would like from the inmate during his/her recovery
- List which conflict resolution skills are going to be used when he/she is involved in a family argument
- List five ways a higher power can assist in recovery from family conflicts and drug/alcohol use/abuse/dependency
- Practice the assertive communication formula "I feel_____ When you _____I would prefer it if _____" during _____ group/meeting
- List instances when you shared feelings, wishes, and wants calmly and respectfully and have him/her share during _____ group
- Discuss the negative effects of passive or aggressive behaviors and list the positive effects of using assertive skills

Grief and Loss Unresolved

Problem:

- Unresolved bereavement resulting in substance abuse to cope with the grief
- Constant thoughts of the lost loved one to the point of inability to move forward in life to other plans or relationships
- Depression centered around a deceased loved one
- Excessive and unreasonable feelings of responsibility for the loss of a significant other, including believing that he/she did not do enough to prevent the person's death
- Feelings of guilt about being a survivor when loved one's have died
- Avoidance of talking about the death of a loved one on anything more than a superficial level

Goal:

- Understand feelings of anger, sadness, guilt, and/or abandonment surrounding the loss of the loved one and make plans for the future
- Develop a plan for life, renewing old relationships and making new ones
- Develop a program of recovery free from drugs/alcohol use/abuse/dependency and unresolved grief
- Let go of the deceased person and turn him/her over to a higher power

Objectives:

- Tell the story of the lost relationship
- Discuss the positive and the negative aspects of the lost relationship
- Share how the loss of the loved one led to drug/alcohol use/abuse/dependency to avoid painful feelings
- List several negative consequences that resulted from using drugs/alcohol to cope with grief and loss
- Discuss the feelings of anger, guilt, sadness, and/or abandonment caused by the loss
- Discuss why you should not feel guilty about the loss
- Share your understanding of how the dependence on the lost person and substance use/abuse/dependency are similar

- Write a plan for living a more independent life
- List five ways a higher power can assist in recovery from grief and drug/alcohol use/abuse/substance
- Share your understanding of how the death of someone can be a part of Higher Power's plan for the inmate
- Practice prayer and meditation each day, seeking Higher Power's help for living without the loved one and the power to carry that out
- Write a plan to increase social interaction with old friends and make new ones
- Write a letter of good-bye to the lost one, sharing feelings and thoughts

Impulsivity

Problem:
- A tendency to act impulsively, without careful deliberation, which results in numerous negative consequences
- Difficulty with patience, particularly while awaiting for someone or waiting in line
- A pattern of impulsive substance abuse
- Loss of control over aggressive impulses, resulting in assault, self-destructive behavior , or damage to property
- Seems to want everything immediately – decreased ability to delay pleasure or gratification
- A history of acting out in at least two areas that are potentially self-damaging (e.g., financial carelessness, promiscuous sexual activity, reckless driving, drug/alcohol use/abuse/dependency)
- Overreactivity to mildly aversive or pleasure-oriented stimulation
- A sense of pleasure, gratification, or release at the time of committing the ego-dystonic act

Goal:
- Maintain a program of recovery free from impulsive behavior and drug/alcohol use/abuse/dependency
- Reduce the frequency of impulsive behavior and increase the frequency of behavior that is carefully thought out
- Reduce thoughts that trigger impulsive behavior and increase self-talk that controls behavior
- Learn the techniques necessary to decrease impulsive thoughts feelings, and behaviors and develop a recovery program consistent with careful thoughts and behaviors
- Learn to stop, think, listen, and plan before acting (Inner Self)
- Learn to reinforce self rather than depend on others for reward

Objectives:
- Share your understanding of the powerlessness and unmanageability resulting from impulsivity and drug/alcohol use/abuse/dependency
- Discuss how impulsitivity and drug/alcohol use/abuse/dependency meet the 12 Step Fellowship definition of insanity
- Identify the negative consequences caused by impulsitivity and drug/alcohol use/abuse/dependency
- Identify several occasions when impulsive action led to drug/alcohol use/abuse/dependency and subsequent negative consequences
- Before acting on behavioral decisions, frequently review with group members or counselor for feedback regarding possible consequences
- Identify the thoughts that trigger impulsive behavior and drug/alcohol use/abuse/dependency; then replace each one with a thought that is accurate, positive, self-enhancing, and adaptive
- Develop a list of accurate, positive, self-enhancing statements to read each day, particularly when feeling upset, share during _____ group
- List the inappropriate behaviors displayed when feeling anxious or uncomfortable and replace each behavior with an action that is positive and adaptive
- List new ways to reinforce self without depending on others for reward
- Practice the assertive formula, "I feel _____ When you _____ I would prefer it if _____", during _____ group/meeting
- Identify situations where assertiveness has been implemented and describe the consequences during _____ group/meeting
- List instances where you have used Inner Self, citing the positive consequences

- Share your understanding of AA's Step 3 regarding the role of a higher power and explain how this step can be used in recovery from impulsivity and drug/alcohol use/abuse/dependency, share during _____ group/meeting

Legal Problems

Problem:
- Legal charges pending adjudication
- History of repeated violations of the law, many of which occurred while under the influence of drugs/alcohol
- Unresolved legal problems complicating recovery from substance use/abuse/dependency
- Fears of the legal system adjudicating current problems
- History of repeated violations of the law buying, selling, or using illegal drugs and DUI
- Court ordered treatment
- Pending divorce accompanied by anger, resentment, and fear of abandonment
- Chemical dependency that has resulted in several arrests
- Loss of freedom due to legal charges

Goals:
- Develop a recovery plan free from drug/alcohol use/abuse/dependency and legal conflicts
- Accept the responsibility for legal problems without blaming others
- Understand the role of abstinence in avoiding negative consequences that include legal problems

Objectives:
- Share your powerlessness and unmanageability that results from legal conflicts and drug/alcohol use/abuse/dependency
- Share your acceptance of the responsibility for substance abuse and legal problems without blaming others
- Admit responsibility for illegal activity and connect this behavior to incarceration and/or drug/alcohol use/abuse/dependency
- Outline the changes needed in behavior, attitude, and associates to protect self from harmful legal consequences
- Identify and verbalize the tendency to become involved in legal conflicts when under the influence of drugs/alcohol or in withdrawal
- Identify the negative emotional states associated with illegal activity and/or drug/alcohol use/abuse/dependency
- Identify ways to meet social, emotional, and financial needs in recovery without legal activity or drugs/alcohol
- Identify antisocial behaviors and attitudes that contributed to legal conflicts and learn prosocial behaviors
- Discuss the importance of obeying laws to maintain
- Identify and correct the criminal addictive thinking that led to legal conflicts and drug/alcohol use/abuse/dependency
- Discuss the importance of a higher power in recovery and list five ways that a higher power can assist in recovery and share during _____ group/meeting
- Discuss the importance of resolving legal issues honestly

Living-Environment Deficiency

Problems:
- Returning to an environment in which there is a high risk for relapse
- Returning to a relationship with an individual who is a regular user/abuser of alcohol or drugs
- Social life is characterized by significant social isolation or withdrawal
- Returning to an environment in which there is a high risk of physical, sexual, or emotional abuse
- Friends or relatives are alcoholics/addicts
- Family is angry or negative toward the inmate and not supportive of program
- Peer group members are regular users/abusers of alcohol/drugs
- Returning to neighborhood that has a high incidence of alcohol/drug use/abuse/dependency as well as crime

Goals:
- Develop a recovery plan free from drugs/alcohol use/abuse/dependency and the negative impact of the deficient environment
- Improve the social, occupational, financial, and living situation sufficiently to increase the probability of a successful recovery plan
- Understand the negative impact of the environment on recovery
- Develop a peer group supportive of recovery
- Motivate family members to be supportive of recovery
- Work on recovery program that necessitates attendance at outpatient and support groups

Objectives:
- Share your the sense of powerlessness and unmanageability that results from a deficient environment
- List several occasions when living environment deficit lead to negative consequences and drug/alcohol use/abuse/dependency
- Explain how peer/family group increases the chance for relapse
- List the specific living environment problems and write a plan to address each in recovery
- Identify social/occupational/financial needs and make a plan to meet each
- List ten reasons to become involved in a new peer group that is supportive of recovery
- List the ways in which a higher power can assist in recovery from a deficient living environment and drug/alcohol use/abuse/dependency
- Develop a written plan to establish how to react to family members who are alcoholics/addicts
- Practice drug/alcohol refusal exercises during _____ group/meeting

Narcissism

Problem:
- A grandiose sense of self-importance and self-worth
- Fantasies of unlimited power, success, intelligence, or beauty
- Believes that he or she is special and only other special people can appreciate him/her
- A powerful need to be recognized, admired, and adored
- Becomes angry and resentful when people do not immediately meet his/her wishes, wants, and needs
- Lacks empathy for others
- Unreasonable expectations of others in relationships with little concern for the other person
- Often envious of others or feels others are envious of them
- Brags about his/her achievements, exaggerated abilities, and body image
- Interpersonally manipulative and exploitive

Goals:
- Develop a recovery plan free of drugs/alcohol and the negative effects of narcissistic traits
- Develop a realistic sense of self without narcissistic grandiosity, exaggeration, or sense of entitlement
- Understand the relationship between narcissistic traits and drug/alcohol use/abuse/dependency
- Understand narcissistic traits and how the sense of omnipotence places the inmate at high risk for relapse
- Learn how to help others in recovery
- Develop empathy for other people, particularly victims of his/her narcissism
- Learn and demonstrate healthy impulse control skills
- Develop healthy interpersonal relationships and communication skills

Objectives
- Identify several narcissistic traits and state how they contributed to drug/alcohol use/abuse/dependency
- List specific instances in which narcissistic traits led to substance abuse and describe the negative consequences that resulted from it
- Make a commitment to honesty and humility as the basis for a recovery program
- Explain how manipulating others leads to interpersonal frustration and loneliness

- List ten lies told to exaggerate accomplishment and seek acceptance and recognition
- List several narcissistic strategies used to manipulate others in relationships
- In _____ group/meeting, identify regularly with the vulnerability revelations of others by sharing similar experiences, feelings, and thoughts
- Identify the feelings of others whom he/she has hurt by sharing similar situations from his/her family of origin experience of pain
- Identify a pattern of narcissism (anxious, fearful thoughts followed by exaggerated thoughts of power and importance) and replace that pattern with confident but realistic self-talk
- Share ways in which the family of origin dynamics led to a poor self-image and a sense of rejection and failure
- Admit that low self-esteem and fear of failure or rejection if felt internally in spite of the external façade of braggadocio
- List five ways a higher power can assist in recovery from narcissistic traits and drug/alcohol use/abuse/dependency
- Make a commitment to helping others as essential to recovery from narcissistic traits
- Practice Inner Self before acting impulsively and without regard for other's rights and feelings
- In _____ group practice honesty and realistic humility in communication

Occupational Problems

Problem:

- Rebellion against and/or conflicts with authority figures in the employment situation
- Underemployed or unemployed due to the negative effect of substance abuse on work performance and attendance
- Work environment is too stressful, leading to drug/alcohol use/abuse/dependency to self-medicate
- Employer did not understand addiction/alcoholism or what is required for recovery

Goal:

- Develop a recovery plan free of drugs/alcohol and occupational problems
- Make plans to change occupation in order to maximize chances of recovery
- Understand the relationship between the stress of the occupational problems and drug/alcohol use/abuse/dependency
- Communicate with coworkers and management to obtain support for treatment and recovery
- Engage in job-seeking behaviors consistently and with a reasonably positive attitude

Objectives:

- Identify occupational problems and explain how they related to drug/alcohol use/abuse/dependency
- Identify your role in the conflict with coworkers or supervisor
- Identify behavior changes you could make in interaction to help resolve conflict with coworkers or supervisor
- List five occasions in which drug/alcohol use/abuse/dependency led to occupational problems
- List five ways occupational problems led to drug/alcohol use/abuse/dependency
- Share how returning to previous occupation increases the risk of relapse
- Share your feelings of fear, anger, and helplessness associated with vocational stress
- Role-play assertiveness skills necessary to be honest with coworkers about _____ during _____ group/meeting
- List skills or changes that will be necessary to be successful in future occupation
- List five ways working a recovery program will improve occupational problems
- Write a plan for a job change that will be supportive to recovery
- List five ways a higher power can assist in occupational problems and share during _____ group
- Admit to the negative effect drug/alcohol use/abuse/dependency had on work performance

Partner Relational Conflicts

Problem:

- Relationship stress that provides an excuse for drug/alcohol use/abuse/dependency and this use/abuse/dependency exacerbates the relationship conflicts
- Lack of communication with spouse or significant other
- Marital separation due to drug/alcohol use/abuse/dependence
- Pending divorce
- A pattern of superficial or lack of communication, frequent arguing, and a feeling of emotional distance from partner
- A pattern of drug/alcohol use/abuse/dependency leading to social isolation and withdrawal
- A pattern of verbal or physical abuse present in the relationship
- Involvement in multiple superficial relationships without commitment or meaningful intimacy
- Inability to establish and maintain meaningful, intimate, interpersonal relationships

Goals:

- Develop a recovery plan free of drugs/alcohol and partner relational problems
- Understand the relationship between drug/alcohol use/abuse/dependency and partner relational problems
- Accept termination of the relationship and make plans to move forward in life
- Learn and demonstrate healthy communication skills
- Decrease partner relational conflict and increase mutually supportive interaction
- Encourage partner to seek treatment for drug/alcohol use/abuse/dependency
- Develop the ability to deal with partner relational conflict in a mature, controlled manner
- Develop the skills necessary to maintain open, effective communication, intimacy and enjoyable time together
- Decrease negative interaction and increase pleasurable activities together

Objectives

- Share the powerlessness and unmanageability that results from partner relational conflicts
- List five occasions when drug/alcohol use/abuse/dependency led to relational conflicts
- List five occasions when relational conflicts led to drug/alcohol use/abuse/dependency
- Accept your responsibility for your role in relationship problems and in choosing drugs/alcohol as a means of coping with them
- Identify positive and negative aspects of relationship
- Identify causes for conflicts within the relationship
- List the changes you believe your partner needs to make in order to restore relationship
- List changes you believe you need to make in order to restore relationship
- Develop a plan to change behaviors to improve relationship, for both individuals
- Learn and demonstrate healthy communication skills during _____ group
- Accept the need for continued therapy to improve relationship
- Make a list of pleasurable activities you can do with your spouse/significant other and make a plan to do these things upon release
- Write a letter to spouse/significant other sharing how you feel and ask for what you want in recovery

Peer Group Negativity

Problem:

- Many friends and relatives are alcoholics/addicts and encourage the inmate to join them in drug/alcohol use
- Peers are involved in the sale of illegal drugs and encourages the inmate to join them
- Peer group is not supportive of recovery
- Inmate is involved in a group that is supportive of criminal activity and drug/alcohol use/abuse/dependency
- Peers do not understand addiction/alcoholism or the need for recovery
- Peers laugh and joke about recovery and continue to use/abuse/depend on drugs/alcohol

Goals:
- Develop a recovery plan free of drugs/alcohol and the negative influence of peers
- Understand that continuing to associate with peer group upon release increases the risk of relapse
- Develop a new peer group that is drug/alcohol free and supportive of working a recovery program
- Educate family members and friends about addiction/alcoholism and the need for recovery
- Encourage family members and friends who are addicts/alcoholics to seek treatment
- Learn the skills necessary to make new friends who are not drug/alcohol users/abusers/dependents

Objectives:
- Share your powerlessness and unmanageability that results from peer group negativity
- Identify several occasions when peer group negativity led to using drugs/alcohol
- Discuss how peer group negativity and drug/alcohol use/abuse/dependence meets the 12 step fellowship criteria for insanity
- List five occasions in which peer group negativity led to criminal activity
- List ten reasons your peer group has to be changed to maintain abstinence from criminal behavior and drug/alcohol use
- Discuss the grief over the loss of peer group and make plans for meeting new people who are in recovery
- List five ways a higher power can assist in recovery from peer negativity
- Discuss why obeying the law is essential for working a recovery program
- Practice drug/alcohol refusal exercises, during _____ group/meeting, in high-risk situations

Post-Traumatic Stress

Problem:
- Past experience with a traumatic event that involved actual or threatened death or serous injury and caused a reaction of intense fear or helplessness
- Recurrent intrusive memories or dreams of the event
- Acting or feeling as if the trauma were recurring
- Intense distress when exposed to stimuli that prompt memories of the trauma
- Avoidance of stimuli that trigger traumatic memories
- Psychic numbing to avoid feelings or thoughts of the trauma
- Persistent symptoms of increased autonomic arousal (e.g., difficulty sleeping, irritability, angry outbursts, difficulty concentrating, hypervigilance, or exaggerated startle response)

Goals:
- Develop a recovery plan free of drug/alcohol use/abuse/dependence and post traumatic stress
- Understand the relationship between posttraumatic stress and substance abuse
- Learn the coping skills necessary to bring posttraumatic stress and substance abuse under control
- Agree to attend the continuing care program necessary to effectively treat posttraumatic stress and drug/alcohol use/abuse/dependence
- Understand posttraumatic stress symptoms and how they lead to drug/alcohol use/abuse/dependency in a self-defeating attempt to cope

Objectives:
- Share your powerlessness and unmanageability that result from posttraumatic stress and substance abuse
- Describe the traumatic events and the resultant feelings and thoughts in the past and present
- List the times that posttraumatic stress symptoms led to drug/alcohol use/abuse/dependence
- List ways working a 12 step program can assist in recovery from posttraumatic stress
- List five ways a higher power can assist in recovery from posttraumatic stress
- Identify negative self-talk and catastrophizing that is associated with past trauma and current stimulus triggers for anxiety
- Express anger without rage, aggressiveness, or intimidation

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[redacted]

Inmate Name: _____ EF #: _____

Problem # ___: _____

Goal: _____

Phase #	OBJ #	Objective (OBJ)	Date Due	Revised Date	Date Complete	I/M Init.

[redacted]

Problem # ___: _____

Goal: _____

Phase #	OBJ #	Objective (OBJ)	Date Due	Revised Date	Date Complete	I/M Init.

Counselor signature _____ Date _____ Inmate signature _____ Date _____

ITP Form Created on 11/04/99
Revised on 01/04/00

PROGRESS REVIEWS

Staff should conduct Progress Reviews for each RSAT/CRC member at least very 60 days. As defined below, each review would score ten performance categories, and a recent "favorable Review" (defined below) would be necessary for each occasion of member phase advancement. Progress Reviews also document judgements that should be given to the member as vital feedback on performance, and they generate data that is important for ongoing evaluation of the program itself.

Progress Reviews should be conducted in a formal unit team meeting. To facilitate team consideration the member's counselor should present the case with proposed scores. Unless otherwise determined by site authorities, final scoring should then be performed consensually by the team, with the so-called "Personal Recovery categories" being scored by treatment staff and the "Community Participation" categories by all team members.

Ratings should be based on concrete observations and *generally represent performance consistently maintained for the specific review period.* This includes all behaviors and communications as well as demonstrated reasoning ability, and displays of attitude and affect. Staff should not evaluate progress based on personal judgements of a member's internal state, such as motivation or sincerity. Nor should they recommend a rating score based on isolated events or very limited observations, unless the particulars observed are especially serve or meaningful.

PERSONAL RECOVERY CATEGORIES

In assessing these five categories for any given member, reasonable efforts must be made to gather relevant information and observations forma all treatment program staff.

Understanding and Awareness
Demonstrated practical grasp of concepts presented in the program, especially regarding Principles of Recovery (or Facts of Life)—focusing on recovery issues, addiction, and pro-social vs. pro-criminal styles—as they apply to self and peers. (Evidence: homework, assignments, class participation, exams, and individual sessions.)

Skills Mastery
Demonstrated ability to correctly use Core Skills, solve problems, apply other appropriate skill sets, etc. (Evidence: homework, assignments, class participation, exams, individual sessions.)

Social Support Building
Appropriate efforts to improve relationships with family or significant others and to establish healthy new relationships that support recovery in both institutional or freeworld settings. (Evidence: homework, assignments, individual sessions, class participation, exams, individual sessions.)

Resource Utilization
Appropriate efforts to engage groups and services that address personal needs and interests—self-help, employment, education, housing, spirituality, recreation, health, etc.—in support of recovery in both institutional or freeworld settings. (Evidence: homework, assignments, individual sessions, RePAC, contacts with other groups or persons.)

Regular Practice
Appropriate use of the various insights, skills, and practices of the program in day-to-day personal activities in any and all program settings. (Evidence: all observations.)

COMMUNITY PARTICIPATION CATEGORIES

In assessing these five categories for any given member, reasonable efforts must be made to gather relevant information and observations from all program staff with special importance placed on the observations of correctional and security personnel, including any written documentation from those personnel regarding the member.

Task Accomplishment
Correct and timely completion of regular unit responsibilities—personal space maintenance and cleaning, etc. – as well as other assigned work detail duties. (Relevant criminogenic factors: work ethic, authority relations.)

Personal Time Management
Productive and thoughtful use of discretionary and recreational time, as well as managing time sufficiently to meet all relevant institutional and program schedules. (Relevant criminogenic factors: work ethic, use of leisure time, criminal attachments/affiliation.)

Pro-Social Deportment
Maintenance of courteous, respectful, and honest relations and exchanges throughout the day with appropriate control of emotions so as to foster positive regard from others. (Relevant criminogenic factors: conning/manipulation, blaming, authority relations, emotional stability.)

Peer Support
Demonstrated practical concern for the needs and progress of others as a role model and helper, and as a responsible member of a shared community. (Relevant criminogenic factors: empathy, egocentrism, criminal attachments/affiliation, peer relations.)

Rule Compliance
Full compliance with all applicable rules of the program and facility. (Relevant criminogenic factors: impulsivity/frustration tolerance, consequential thinking, egocentrism, work ethic, authority relations.)

SCORING GUIDE FOR THE PROGRESS CATEGORIES

Guided both by category definitions and by phase-related expectations (see below), staff will score member performance in each category using a standardized 5-point scale as follows:

1 = **"very poor":** performance in this category is not acceptable; the member makes minimal effort and may show outright hostility to expectations of higher performance.

2 = **"poor":** effort is made in this category but performance remains uneven and generally low; it is clear the member is capable of maintaining a significantly higher standard.

3 = **"fair":** performance in this category is acceptable for the given phase, although would not likely be acceptable in the next phase (or in community settings for Phase III).

4 = **"good":** performance in this category fully meets expectations and the member makes a consistent and significant effort; by and large the performance would be acceptable in the next phase (or in community settings for Phase III).

5 = **"excellent":** performance in this category is exemplary; the member shows appropriate initiative and is believed to maintain the standard whether observed or not; the performance level would serve the member well in the next phase (or in community settings for Phase III).

A "Favorable" Progress Review produces:

- An aggregate score of at least 30;
- No more than two (2) ratings of "2";
- No rating of "1".

INTERPRETING PERFORMANCE BY PHASE

Each Phase would involve somewhat different specifics for each category. Thus, most issues of the Personal Recovery Categories would relate to the content of training groups and assignments that are specific to a given Phase; most issues of the Community Participation Categories would relate to program responsibilities that also vary by Phase.

Further, higher standards should apply for each of the categories as members advance to higher phases. Thus, for each category:

- **Phase I** members are expected to strive to overcome one's own resistance, apply oneself energetically and consistently to the issue, and generally adopt to pro-sober and pro-social norms of the program community.

- **Phase II** members are expected to maintain Phase I standards and also take appropriate initiatives to improve on one's performance with special attention to one's own special problems and stumbling blocks.

- **Phase III** members are expected to maintain Phase II standards and also focus especially on related issues of release preparation and on serving the program community as a positive role model.

- **Phase IV** members are expected to maintain Phase III standards and focus on the final preparations for release. They serve the program as the leaders who assist with scheduling of TSF groups, Morning Meeting, Seminars and Skills Practice sessions.

(For Homerville, please combine Phase II and Phase III information and use to evaluate and use Phase IV for your Phase III)

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PROGRESS NOTE

NAME:_____ NUMBER:_____

Phase #: _____ **Week #:** _____ **Program:** ☐ **PSAP** ☐ **RSAT** ☐ **CRA Homerville**

Level of Progress: ☐ Above Standard Level ☐ Standard Level ☐ Below Standard Level
(see instruction sheet)

Participation Quality: ☐ Appropriate ☐ Attentive ☐ Sharing ☐ Gave Feedback ☐ Received Feedback
☐ Supportive ☐ Monopolizing ☐ Resistant ☐ Argumentative ☐ Other

Summary of Progress (use specific behaviors when addressing progress, see instruction sheet):

Treatment Plan Review (use behavioral language to describe and measure problems, goals and interventions, see instruction sheet):

Plan of Action for the Next Week: (see instruction sheet)

Counselor's signature:

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PROGRESS REVIEW

Name _____ Number_____ Date Completed _____

Primary Counselor_____ Supervisor's Review_____

Participating Staff _____

Circle one numerical rating for each category: Very Poor=1, Poor=2, Fair=3, Good=4, Excellent=5.
See "Progress Reviews, Guidance for Staff" for fuller instructions.

PERSONAL RECOVERY CATEGORIES

Understanding & Awareness 1 2 3 4 5

Demonstrated practical grasp of concepts presented in the program, especially regarding Principles of Recovery (or Facts of Life)--focusing on recovery issues, addiction, and pro-social vs. pro-criminal styles--as they apply to self and peers. (Evidence: homework, assignments, class participation, exams, and individual sessions.)

Skills Mastery 1 2 3 4 5

Demonstrated ability to correctly use Core Skills, solve problems, apply other appropriate skill sets, etc. (Evidence: homework, assignments, class participation, exams, individual sessions.)

Social Support Building 1 2 3 4 5

Appropriate efforts to improve relationships with family or significant others and to establish healthy new relationships that support recovery in both institutional or freeworld settings. (Evidence: homework, assignments, individual sessions, RePAC, contacts with family or others.)

Resource Utilization 1 2 3 4 5

Appropriate efforts to engage groups and services that address personal needs and interests--self-help, employment, education, housing, spirituality, recreation, health, etc.--in support of recovery in both institutional or freeworld settings. (Evidence: homework, assignments, individual sessions, RePAC, contacts with other groups or persons.)

Regular Practice 1 2 3 4 5

Appropriate use of the various insights, skills, and practices of the program in day-to-day personal activities in any and all program settings. (Evidence: all observations.)

COMMUNITY PARTICIPATION CATEGORIES

Task Accomplishment 1 2 3 4 5

Correct and timely completion of regular unit responsibilities--personal space maintenance and cleaning, etc.--as well as other assigned work detail duties. (Relevant criminogenic factors: work ethic, authority relations.)

Personal Time Management 1 2 3 4 5

Productive and thoughtful use of discretionary and recreational time, as well as managing time sufficiently to meet all relevant institutional and program schedules. (Relevant criminogenic factors: work ethic, use of leisure time, criminal attachments/affiliation.)

Pro-Social Deportment 1 2 3 4 5

Maintenance of courteous, respectful, and honest relations and exchanges throughout the day with appropriate control of emotions so as to foster positive regard from others. (Relevant criminogenic factors: conning/manipulation, blaming, authority relations, emotional stability.)

Peer Support 1 2 3 4 5

Demonstrated practical concern for the needs and progress of others as a role model and helper, and as a responsible member of a shared community. (Relevant criminogenic factors: empathy, egocentrism, criminal attachments/affiliation, peer relations.)

Rule Compliance 1 2 3 4 5

Full compliance with all applicable rules of the program and facility. (Relevant criminogenic factors: impulsivity/frustration tolerance, consequential thinking, egocentrism, work ethic, authority relations.)

Ability & Strengths () Improving () Maintaining () Declining

TOTAL SCORE: _____ FAVORABLE UNFAVORABLE (CIRCLE ONE)

Progress Review Form
Revised on 01/04/00

Spectrum Health Systems, Inc.

PROGRESS NOTE INSTRUCTION SHEET

Please post or keep this sheet with you when completing Progress Note.

Participation Level:

- **Above Standard Level** = volunteered during discussion, role play and completed assignments
- **Standard Level** = participated in discussion, role play and completed assignments only when called on and/or coached into it
- **Below Standard Level** = No participation, exhibited pro-criminal behavior

Summary of Progress:

- Did inmate have any changes in attitude/behavior from last note, how did inmate get from point A to point B?
- Did inmate complete group assignments and did it reflect knowledge of material and was there effort/thought, how?
- Did inmate follow staff direction, how?
- Did inmate demonstrate knowledge of skills taught, how?
- Did inmate show pro-social or pro-criminal behavior, how?
- Did inmate generate options to problems, how?
- Did inmate control impulsive behavior, listen, speak out of turn, how?
- Did inmate interact positively with staff and peers, how?
- Did inmate demonstrate ability to use time-outs and other calming/core skills, how?
- Did inmate utilize counters effectively, how?
- Did inmate take responsibility for his/her behavior/thinking as demonstrated in his/her feedback and countering of tapes, how?
- Any push-ups/pull-ups; learning experiences, etc?
- Any interventions used by counselor or group members to address behavior or attitude problems? How did the inmate respond?

Treatment Plan Review:

- How does level of progress, in-group, relate to ITP problems, goals and/or objectives?
- Was the ITP revised during week(s) to reflect new information received from inmate or other persons?
- Were any new needs/strengths/weaknesses identified this week/period, if so what?
- Did inmate turn any assignments this week(s), if so, did they reflect thought/effort/ knowledge of material being taught?
- Did inmate make any behavior changes that reflect accomplishment of goals on ITP?

Plan of Action for the Next Week: This section is designed to put into behavioral terms the plan for the inmate in the next week. **Note**: Progress notes that are favorable also must have this section completed.

- Does the inmate have to redo an assignment from group or from ITP?
- Does the inmate have a learning experience to complete this week?
- Is the inmate going to continue working on the current goals/objectives/problem?
- Did you add a problem/goal/objectives?

Spectrum Health Systems, Inc.

Progress Notes Guidance for Staff
November, 1999

PROGRESS NOTES PROTOCOL

In keeping with the high standards we have for documenting information, progress or lack of progress on each inmate, all progress notes must be consistent in format, and describe progress using behavioral, measurable terms. By using a formatted progress note, each note will consist of a brief narrative that addresses the following five steps:

1. Note will begin with the **Phase and Week** of treatment – simply write in the phase and week number. (Homerville is on rolling admissions and will not put week number).

2. Operationalize progress (described in behavioral terms) Each note will include the following:
   Level of Progress:
   - **Above Standard Level** – if the inmate volunteered during discussion, role-play and completed assignments, they went above and beyond what was expected.
   - **Standard Level** – if the inmate participated in discussion, role-play and completed assignments only when called on and/or into it; only did what was expected and nothing more.
   - **Below Standard Level** – if the inmate did not participate, exhibited pro-criminal behavior.

   Participation Quality – this section and **Level of Progress** should be consistent with one another. For example: If the inmate had Below Standard Level, then he/she should have Monopolizing, Resistant, Argumentative or other checked.

   Summary of Progress:
   - Before writing your note, consider the questions listed on the **Progress Note Instruction Sheet** Summary of Progress section.
   - You do not have to write a comment on each question, only the ones that apply to that particular inmate during the week you are documenting.
   - Please do not limit yourself to these questions, other situations may occur that you need to document, do so in this section.
   - Make sure you are using understandable language to measure and describe the progress.
   - Avoid the use of generalizations such as "good", "fair" or "poor", use the listed categories on the **Performance Level Guide Sheet** as guides when addressing how inmate is performing, remember to use your own words, not the ones listed, use this only as a guide.
   - Remember to individualize the note to address the inmate's progress.

3. Treatment Plan Review:
   - Each inmate's Treatment Plan must be reviewed weekly using the questions listed on the **Progress Note Instruction Sheet.**
   - You must address each of these questions even if only to say that no changes have been made to the ITP and the inmate is continuing to work on current plan; no new information received regarding inmate, etc.

4. Plan of Action for the Next Week:
   - This section is designed to put into behavioral terms what is the plan for the inmate in the next week.
   - Progress notes that are favorable also must have this section completed.
   - Address questions on the **Progress Note Instruction Sheet,** however, do not just limit yourself to these areas, there may be other situations or issues they will be addressing during the week.

5. Counselor Signature, followed by credentials and title/position. Ex. John Doe, BS, CAC, CRA Counselor.

PERFORMANCE LEVEL GUIDE SHEET

Below is a list of behavioral terms, "operationalized" to be incorporated in your progress note. These terms are listed under three commonly used generalizations to describe inmate performance levels. **Remember to individualize statements to fit the inmate's performance level in your own words. Explain briefly in behavioral terms how inmate accomplished these things.**

GOOD	FAIR	POOR
All **assignments** completed on time **Homework** reflected knowledge of course material **Homework** reflected thought and effort	Minimal effort displayed in completion of **assignments**, often late, just enough to get by **Homework** reflected limited knowledge of course material **Homework** reflected minimal though and effort	Did not complete **assignments** as directed, always late **Homework** not reflective of course material No thought or effort was reflected in **homework**
Inmate follows **staff direction**	Follows **staff direction** Occasionally, however is distracted easily	Unable to follow **staff direction**
Role play and/or group exercise demonstrated knowledge of **skills taught**	Demonstrates some knowledge of **skills taught** as evidenced in	Unable to demonstrate any knowledge of **skills taught** as evidenced in lack of participation
Exhibited pro-social **attitudes and behaviors** Generated options to **problems** Demonstrates ability **to control impulsive behaviors, listens, sits, does not speak out of turn,** etc. **Interacts** positively with peers and staff	Inconsistent demonstration of pro-social **attitudes and behavior**, i.e. "the system sucks", etc. Demonstrates some ability to generate options to **problems** Displays some improvement with control of **impulsive behaviors,** occasionally reacts to feedback Sometimes **argumentative,** however, not a behavior problem, explain what they are argumentative about	Demonstrates pro-criminal **attitudes and behaviors,** i.e. aggressive verbal language, etc. Unable to generate options to **problems** Unable to control **impulsive behavior,** speaks out of turn, reacts to feedback, etc. **Interacts** poorly with peers & staff, always argumentative
Demonstrates ability to utilize time outs and other **calming skills,** etc.	Verbalizes knowledge of **calming,** however, has not demonstrated use	Continues to display impulsive behavior, does not utilize **time-outs**
Asks for and utilizes **help** from staff and peers	Accepts **help** when given, however does not ask for help	Does not ask for or accept **help** from peers or staff
Often demonstrates ability to **listen**	Sometimes demonstrates ability to **listen**	Unable to **listen** as evidenced in reaction to feedback, body language, etc.
Participates at above level of standard in group Volunteers in **group practice and reviews,** community meeting leader, 12 Step Fellowship leader, etc.	**Participates** at an average level in group Sometimes volunteers in **group practice and review**	**Participation** level is below standards Has not volunteered in **any group practice or review,** community meeting, 12 Step Fellowship meeting, etc.
Demonstrates ability to utilize **counters** effectively	Utilizes **counters,** however, needs improvement	Demonstrates poor use of **counters**

GEORGIA CORRECTIONAL PROGRAMS (RSAT)

RULES VIOLATION SANCTIONS/INTERVENTIONS

A primary goal of the RSAT programs, is to teach the inmates how to become better learners, to learn how to slow down and observe, to see different possibilities for solving problems, to learn how to ask for and accept support, and learn how to build self confidence. In this sense, every part of the RSAT is designed to provide the inmate with learning experiences and learning opportunities.

POSITIVE REINFORCEMENT

Staff should always keep in mind that rewarding and encouraging appropriate behavior is a more effective reinforcement than punishment. At the same time, corrective action for general offenses and disciplinary interventions for major, more serious offenses are necessary and must not be avoided.

Punishments are often indispensable for preventing unwanted behaviors but it is a well-known principle of learning and behavior change that rewards work better to help instill new behaviors. As an educational and skills-training program, the RSAT must therefore make effective use of positive reinforcement. Some researchers propose that effective prison rehabilitation, in fact, requires a four to one ratio of positive to negative reinforcements. No matter what the ratio, working with inmates in a prison environment clearly puts a premium on the need for positive reinforcement.

The chief reinforcer at the disposal of staff, and perhaps the most powerful one any prison program could hope to mobilize, lies in their attitudes and relations with inmates -- namely sincere encouragement and approval for effort. Indeed, to make the PSPA conducive to learning, the environment must be as positive, pleasant, and pro-social as possible. Supportive staff attitudes should permeate the program. Inmates must know that staff has complete faith in their potential to achieve a satisfying pro-social lifestyle.

Unless an inmate is actively violating Cardinal or Major rules, or projecting hostility or anti-social attitudes, he/she should always be treated in a respectful manner. A friendly "hello" is always appropriate. Humor is especially helpful as long as it is not insensitive or mocking. Self-deprecating humor from staff can go a long way towards helping staff overcome inmate resentment at their authority at the same time that it can actually help them win inmate respect.

In keeping with our "learn to learn" theme, great emphasis should be put on effort. Actual achievement – such as completion of assignments – should be duly honored. But it is at least as important that inmates be praised and encouraged for genuine work on a problem, no matter the outcome or rate of progress. Effort should be acknowledged, whether it's an attempt to answer a question in a CRT, complete an

assignment, or merely remember a staff person's name. Looking someone in the eye and saying, "Good try", or "Keep at it" is a vital tool. Let the inmate know always that as long as they keep trying they are on the right track. Above all, staff should never humiliate an inmate – especially the inmate who has tried but fallen short of some expectation.

For many helpers positive reinforcement implies a concern about self-esteem. Self-esteem is not a special concern of the RSAT – SELF-EFFICACY is. In other words, we are not aiming at helping the inmates "feel good about themselves", but we are concerned that hey have the necessary confidence that they can meet the practical needs of effort and accomplishment. Rather than try and raise self-esteem directly (a task often complicated by deviant but grandiose self-images already held by many inmates) we accept self-worth as a given and we emphasize self-improvement and especially efforts made to meet the RSAT's responsibilities.

Positive reinforcement should be particularly apparent in the CRT's, which are our richest learning groups. Everyone who shows any involvement at all should get some positive feedback. This first means recognition – it is vital that hands raised appropriately not be ignored. Staff should look for legitimate ways to offer praise and encouragement for input. Obvious forms are "Good point" or "That's it, let's have some more examples". Off the mark comments can be respected too: "That may not fit today's topic, but you're on to something important that we'll be talking about in another group". Even troublemakers sometimes earn a good word: "Man, you really made me work today, Jones. I know in your own way you take the issue seriously and I appreciate that". Occasionally mere physical presence is worth a nod: "You seemed to do a good job of trying to pay attention today, Mary. Thanks". Certainly just a friendly smile as inmates enter or leave the class can make a big difference. To regularly acknowledge inmates in a personable manner is fundamental. If inmates are ignored as people – no eye contact, no hellos, all questions waived off regardless of content or intent – they will be unlikely to make much effort in a class or otherwise.

It is not possible for most of us to maintain a cheery demeanor all day, and only the rarest personalities can do this in prisons. In any case, smiles are not always what are needed. Respect and sensitivity for the dignity and learning needs of the inmates matters most. These qualities can be demonstrated even if one's mood is sour or the workload feels painful or some event in the day has stung. And when a brief breather on the unit could help recharge the psychic batteries, staff should find the time and place to take it.

Finally, it is worth explaining what is meant by "dignity" as it could be said that the target for all positive reinforcement in the RSAT is inmate dignity. For our purposes, dignity refers to the importance and seriousness one gives to his or her life. Not only for oneself, but also on behalf of everyone else whose life is affected by that person. We think dignity means recognizing that one's experiences are precious, that one has the potential to learn and grow and become something more, that no matter what we have

done or who we have been our humanity and spirit is something greater, and that the humanity and spirit that every person possesses must never be debased.

Of course, it is precisely their own dignity that many inmates do debase. And it is further degraded or at least discounted, by so many other elements of prison life. It is the responsibility of the staff to respect that dignity – no matter what. Without dignity, or at least a sense of dignity, meaningful learning is all but impossible.

Respecting dignity does not imply overlooking or excusing what brought inmates to prison or how they act while in prison. Staff is not asked to project unconditional approval. By no means are they expected to "get down" with inmates and merge social identities with them. But staff should be able to convey that they take inmates' lives seriously and expect that inmates do, or will, as well. Staff should never doubt that any given inmate can do better than he/she shows at any given moment. Staff must always be prepared to relate to inmates at the most mature and respectful level that the inmate him/herself is also ready to assume. Respecting dignity means always treating inmates as persons in desperate need of growth and capable of it – whether they know it or not.

INTERVENTIONS

In effective Therapeutic Communities (TC's) as in all effective rehabilitation programs, corrective and disciplinary interventions are applied in both a timely and deliberate manner. That is, they are best applied as soon as practical after a given rules violation is discovered, but not impulsively. These sanctions or interventions are also best applied progressively. This means that less severe sanctions should normally be applied before more severe ones depending on the severity of the rules violation. The ultimate sanction (discharge from the program) would normally be recommended only when the Unit Team determines that all other interventions have failed to achieve the minimum of compliance on the part of the inmate or when the person has violated a Cardinal Rule.

Direct Interventions

The following interventions are best used for general rule violations, minor infractions or other inappropriate behaviors or isolated events that do not necessarily indicate major, ongoing problems. They are usually brief and to the point, can be used frequently, and may be done by any staff member. These interventions should be the principal tools to keep wavering inmates on track.

Pullups

Pullups are the most basic interventions. A Pullup is simply the act of identifying the misbehavior and reminding or asking the inmate to stop it. Pullups are succinct, direct, respectful and done on the spot: "Inmate Jones, please sit up straight and don't slump". They are best applied for any behavior that, if it were repeatedly performed in the free-

world, would cause the person to be regarded as irresponsible of disrespectful. Pullups may be given by any staff to any inmate or by any inmate to another inmate. It is appropriate for the inmate receiving the Pullup to respond with an equally respectful "thank you". There is no need for clinical documentation of the Pullup intervention.

Talking To

Only staff persons are allowed to utilize this intervention. The Talking To may be used on occasion where an inmate needs to be directly confronted about more serious, or consistent problematic behavior. Usually the Talking To would occur in a counseling session or a private exchange on the floor. The goal is for the inmate to understand clearly what you, or others see as the problem. Often it is appropriate for him to repeat that concern to demonstrate it is understood. The Talking To should convey responsible concern, meaning the issue should be addressed seriously and its possible consequences made clear, but respect should also be shown for the fact that the inmate has obvious difficulty overcoming the problem. The Talking To should emphasize a need for and expectation of positive change and a willingness to help bring it about. Four points should be made in a Talking To:

1. The unacceptable behavior must stop.
2. The inmate should be able to identify the specific unacceptable behavior and acknowledge personal responsibility for the behavior no matter what precipitated the behavior.
3. The inmate should be able to identify why or how this unacceptable behavior is damaging to him/herself and/or others.
4. An appropriate alternative behavior should be identified.

The staff member conducting the Talking To should document this intervention in the inmate record.

Staffing

A Staffing usually happens when an inmate has not responded to Pullups and Talking To's or other Learning Experiences. It may also occur when an inmate is acting irrationally, wants to sign out of the program, has been involved in consistently negative behaviors, or has consistently displayed a negative attitude.

The Staffing is a formal intervention. This intervention should include:

1. The inmate being "staffed".
2. The inmate's RSAT and GDC Counselor.
4. RSAT Program Director.
5. Security staff (if directly involved in observed behavior or an integral part of regular interventions).
6. Other Institutional staff if and when appropriate.

The staffing should be coordinated by either the RSAT Counselor or Program Director. Documentation of the Staffing should be done by the Primary Counselor or other counseling staff as designated.

The Staffing should be done in an office, door closed and preferably outside the view of any other inmates. If possible, a particular room should be designated and utilized for all Staffings. It should be NO MORE THAN 10 – 15 MINUTES in length. The RSAT Program Director, RSAT and GDC counselor and any other staff involved in conducting the Staffing should meet prior to the Staffing to discuss the situation and to establish the goal of this particular staffing. The inmate being Staffed will be brought to the Staffing room by Security Staff and sit in a chair on the opposite side of the table from Staffing members.

The Staffing should be documented in both the GDC inmate file and the RSAT inmate record.

Learning Experiences

Learning experiences (LE's) are special obligations or conditions imposed on members of the in response to behaviors that violate important standards or norms of the community or that otherwise demonstrate significant resistance to or difficulties with the recovery gains required by the RSAT. All Learning Experiences should be:

1. DISCIPLINARY by requiring real effort and self-control.
2. INSTRUCTIVE by conveying a useful lesson or helping to build a useful skill.
3. RELEVANT by addressing a problem that seems to underlie the given offense.
4. PROPORTIONATE by corresponding in its demands to the severity of the offense.
5. REALISTIC by aiming to reduce, not necessarily cure, the problem being addressed.
6. HONORABLE by requiring productive effort, not slavish tasks.
7. RESPECTFUL by challenging the person's Inner Self, not abasing their Habit Self.
8. SPECIFIC by clearly identifying what must be done for satisfactory completion.

Learning Experiences are especially appropriate for behaviors that not only signify personal recovery problems but also have had social consequences in the Therapeutic Community. Therefore, a given LE might often have a social purpose for the TC as well as a personal recovery process. It might, for example, oblige the inmate to perform some kind of "service to the therapeutic community" in compensation for a wrong done to the TC as a whole. Or it might involve "making amends" in some way to one or more particular people in or working for, the TC for specific wrongs done to them personally. Or, an LE could be applied to more than one inmate if, for example, they are all involved in the same offense and seem to need a similar response. This

last example could also include relationship-building work between two or more inmates who have developed mutual hostility and seem equally in need of help to overcome it.

Remember that the use of the Learning Experience usually occurs when the inmate has not successfully responded to lesser Interventions i.e. Pullups, Talking To's. Also remember that the Learning Experience is not meant to replace or minimize the use of the Disciplinary Report process.

If progression to the next Intervention level is deemed appropriate the Learning Experience would be utilized. Note that the "Learning Experience" form (see attached) would be used with this intervention. A discussion between the multi-disciplinary team, or primary counselor and RSAT Director is helpful in formulating a Learning Experience for an inmate, however, a Learning Experience can be given by any staff member. A few suggestions for Learning Experiences are:

1. Repeating a Core Skill class or classes that directly relates to the problem behavior.
2. Written or oral assignments or essays that address the problem behavior or situation.
3. Announcements in Morning Meeting (see write up on Announcements).

Remember; use the Learning Experience form for this type of intervention.

Workarounds/Essays

Workarounds are supplementary assignments. They can be a reformulation of an assignment that has proved unexpectedly difficult or they may focus more effort on a new problem related to behavior exhibited in the program. Typical Workarounds might be written essays on a specified topic, additional work related to a specific homework or ITP assignment or some form of specific communication with a staff member to acknowledge unacceptable behavior.

While Workarounds are most commonly used by Counseling staff as a reformulation of a homework assignment that has proven unexpectedly difficult for the inmate, they can also be used as a Learning Experience or part of an LE when the inmate's problem involves rules violations. As such, Workarounds can take the form of essays, research on various topics, seminars, and so on. Workarounds can be especially helpful components of an LE because they can be customized with careful staff input. As with all Assignments, Workarounds are issued by the inmate's Counselor.

Announcements

Announcements are public acknowledgements of problem areas or habits that are a problem for the inmate. They need to be worded keeping in mind the dignity of the inmate – they are not to be shaming in nature although we cannot prevent an inmate from maybe feeling embarrassed about the Announcement. Announcements are made in Morning Meeting. The wording of the Announcement is determined by staff with the

inmate and is directed towards the problem behavior. The Announcement should be written down and read exactly as written. During Morning Meeting the inmate announces "My name is _____ and I continue to _____. I need help with using my Core Skill _____ so I will stop _____.

Example: My name is Jones and I continue to be late for groups. I need help with using my Core Skills Prioritizing and Forecasting so I will remember that my recovery is my most important priority, that these groups are how I will learn to live a life of recovery and that if I continue to be late for group I may be terminated from the program.

Growth Reports

The inmate is required to report formally to the Community on progress or fulfillment of the conditions of the LE in order to share with and demonstrate to everyone the lessons that have been learned, the gains made, and so forth. Growth reports can be given at Morning Meetings, Evening Meetings or Community Meeting.

Setbacks

An inmate who has repeatedly failed to follow the rules of the Community or has failed to make adequate progress in the program but has not committed offenses sufficient to warrant termination may be Setback. This LE means being returned to Phase I, Day One to restart the entire program. Setback is not intended to take back what has been earned, or to punish, but to correct a situation where an inmate seems to have progressed in the program but their behaviors indicate that real growth and change has not taken place.

Spectrum Health Systems, Inc.

LEARNING EXPERIENCE FORM

Inmate Name: _____ **#:** _____ **Phase:** _____

Behavior Observed By: _____
Date & Time: _____

Description of unacceptable behavior: _____
_____

Behavioral Intervention

This section is to be completed by primary counselor in consultation with unit team. **ALL LEARNING EXPERIENCES MUST BE APPROVED BY THE PROGRAM DIRECTOR PRIOR TO IMPLEMENTATION.**

Behavioral Intervention Options: (check/describe all that applies)

( ) **Workaround/Essay:** _____
_____

( ) **Extra Work Detail:** _____
_____

( ) **Announcement:** _____
_____

( ) **Growth Report:** _____
_____

( ) **Setback:** _____
_____

The Unit Team and your primary counselor will review the above behavioral intervention. **While on a learning experience, you are not eligible for a phase change.** Failure to comply with the above behavioral intervention may result in program discharge.

==========

_____ _____
Inmate Signature Date

_____ _____
Primary Counselor's Signature Date

_____ _____
Program Director's Signature Date

(place in progress note section of record in chronological order)

Spectrum Health Systems, Inc.

[redacted]

Date:_____

Name:_____ Number:_____

As of _____ , you are being given a formal warning due to the following behavior(s):

_____

_____

_____

_____

_____

_____

_____

_____

Corrective Action:

_____

_____

_____

_____

_____

_____

_____

Continued failure to adhere to Program guidelines as stated in the program rules , housing unit rules, handbook and/or Corrective Action stated above, may result in your discharge from the program.

_____ _____

Counselor Inmate Signature

Spectrum Health Systems, Inc.

Termination Notice

Date:_____

Name:_____ Number:_____

As of _____, you are being discharged from the Correctional Recovery Community due to the following behavior(s):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Following a period of no less than _____ month(s), you may apply for re-admission. Your acceptance into the CRC will be contingent on approval by the Department of Corrections and Program Director. Upon re-admission, you will be required to begin the program in Phase I and be subject to all program criteria for successful completion.

_____ _____

_Program Director Inmate Signature

Term Notice
Revised on 01/04/00

Name: _____

EF #: _____

RESIDENTIAL SUBSTANCE ABUSE TREATMENT (RSAT)

RELEASE PREPARATION ACTIVITY CHECKLIST (RePAC)

AND

PRE-RELEASE SUMMARY

Name: _____

EF #: _____

Release Preparation Activity Checklist (RePAC)

Completion of this release preparation guide and pre-release summary is an essential part of the RSAT program. You will be expected to give it serious and detailed attention. Your RePAC must be completed and approved by your Counselor before you can move to Phase IV.

Solid information and detailed planning is the essential part of putting together a good plan for your release. Just being able to talk about your aftercare plans is not enough – you must write them down and commit to following your plan. The RePAC is meant to bring together many of the ideas and skills you have learned in other areas of the RSAT and put them to work for you in your home community.

Like other parts of the RSAT program, the RePAC is intended to promote genuine recovery from impulsive and self-destructive behaviors. Therefore, as you work on it, keep in mind that your plans should direct you to a productive life that is free of both crime and drugs.

Good RePAC work will give you a very big head start on a new and better life.

Name: _____

EF #: _____

GOALS

Define your most important specific goals for:

The first 10 days after your release:

_____
_____
_____
_____
_____

The first 3 to 6 months after your release:

_____
_____
_____
_____
_____

The first 6 months to one year after your release:

_____
_____
_____
_____
_____

LIVING ARRANGEMENTS

1ST Choice

Name & Relation of Person: _____
Address: _____
_____
County: _____
Phone Number: _____
Will Electronic Monitoring be allowed? Yes _____ No _____
Is there drinking or drug use there? Yes _____ No _____
Will you stay there for at least 1 year? Yes _____ No _____
If no, please explain: _____
_____

Name: _____

EF #: _____

Living arrangements (continued)

If electronic monitoring is not allowed at the above location or if this address is not approved by parole, what is your next living arrangement choice?

2nd choice

Name & Relation of Person: _____
Address: _____
_____
County: _____
Phone Number: _____
Will Electronic Monitoring be allowed? Yes _____ No _____
Is there drinking or drug use there? Yes _____ No _____
Will you stay there for at least 1 year? Yes _____ No _____
If no, please explain: _____
_____

EMPLOYMENT

Do you already have a job lined up? _____
If yes, company name: _____
Address: _____
Type of work you will do: _____
Phone #: _____
Supervisor's Name: _____
Weekly take home pay: _____
Are health benefits included? _____
What will your work hours be for each day of the week: (Fill in below, for instance 7:00 a.m. – 3:30 p.m.)

Monday _____ Tuesday _____ Wednesday _____
Thursday _____ Friday _____ Saturday _____
Sunday _____

If you do not have a job lined up, how will you find work?

_____
_____
_____
_____
_____

Name: _____

EF #: _____

What jobs could be risky for your continued recovery? _____
_____

Education (attach copies of certificates)

_____ Less than 8th grade
_____ 8th to 12th grade (No Diploma)
_____ High School Diploma
_____ GED
_____ Some College
_____ College Graduate
_____ Master Degree

Check any of the following vocational/academic programs completed while in prison:

_____ Automotive Cluster
_____ Elec. Wiring
_____ Building Maint.
_____ Auto. Mech.
_____ Cosmetology
_____ Graphic Arts
_____ CDL
_____ Masonry
_____ Diesel Mechanics
_____ Mechanics
_____ Computer/Office Technology
_____ Carpentry
_____ Heating & Air
_____ Wood Working/Carpentry
_____ Office Technology
_____ Drafting
_____ Small Appliance Repair
_____ Barbering
_____ Small Engine Repair
_____ Plumbing
_____ Tile Setting/Masonry
_____ Culinary Arts/Food Prep
_____ Service Industry
_____ HVAC
_____ Welding

O.J.T.:

_____ Paint & Body Repair
_____ Sm. Eng./Welding
_____ Building Maintenance
_____ Firefighting
_____ Masonry
_____ School Aide
_____ Food Preparation
_____ Tile Repair
_____ Heating and AC
_____ Clerical Skills
_____ Radio/TV Repair
_____ Building Cleaning
_____ Farm Operations
_____ Livestock
_____ Heavy Equip. Operations
_____ Diesel Mechanics
_____ Recycling
_____ Recreation Aide
_____ Other (Specify) _____
_____
_____ Barbering
_____ Auto Mechanics
_____ Custodial Maintenance
_____ Laundry/Dry Cleaning
_____ Paint Shop
_____ Warehousing
_____ Buffer
_____ Meat Processing
_____ Horticulture
_____ Grounds Keeping
_____ Welding
_____ Cannery Operations
_____ Farm Equip. Operations
_____ Inmate Construction
_____ Industrial Mechanics
_____ Commercial Painting
_____ Vehicle Fuel Dispensing
_____ Cust/Buffer Repair
_____ Upholstery
_____ Electrical Wiring
_____ Library Aide
_____ Plumbing
_____ Water Treatment
_____ Teacher Aide
_____ Graphic Arts
_____ Horticulture Warehousing
_____ Painting
_____ Audio/Visual Boiler Room
_____ Dairy Operations
_____ Farm Equip. Mechanics
_____ Wastewater Treatment
_____ Appliance Repair
_____ Vehicle Maintenance

Name: _____

EF #: _____

RECOVERY PARTNERS

List 3 people in the free world who will help you in your recovery:

1. Name _____
   Relationship to you _____

2. Name _____
   Relationship to you _____

3. Name _____
   Relationship to you _____

12 STEP FELLOWSHIPS

It is important that you become involved in a 12 Step Fellowship (AA, NA, CA, etc.). Many recovering people attend more than one of the different types of 12 step groups. It is a fact that recovering people, newly back in the free world, have a much better chance of staying clean and sober if they attend DAILY meetings. Please refer to the state-wide directory for AA/NA meetings to locate meetings in your area. Write the ones you plan to attend in the spaces below. Circle whether it is AA or NA.

Mondays	AA or NA	Group Name: _____ Location: _____ Time: _____
Tuesdays	AA or NA	Group Name: _____ Location: _____ Time: _____
Wednesdays	AA or NA	Group Name: _____ Location: _____ Time: _____
Thursdays	AA or NA	Group Name: _____ Location: _____ Time: _____
Fridays	AA or NA	Group Name: _____ Location: _____ Time: _____
Saturdays	AA or NA	Group Name: _____ Location: _____ Time: _____
Sundays	AA or NA	Group Name: _____ Location: _____ Time: _____

Name: _____

EF #: _____

RECREATION/LEISURE TIME

List 3 activities you will do in your free time:

1. _____

2. _____

3. _____

CRISIS PLAN

How do you plan on dealing with thoughts and/or feelings about drinking, drugging or doing crimes?

1. _____

2. _____

3. _____

FINANCIAL PLAN

How much money will you need to cover these monthly expenses?

Rent:	_____	Clothing:	_____
Heat/Lights:	_____	Recreation:	_____
Food:	_____	Child Support:	_____
Transportation:	_____	Phone:	_____
Parole Fee:	_____	Counseling:	_____

Total of the above expenses: _____

Will you take home enough pay to meet these needs? Yes ____ No _____
If not, what will you do? _____
_____

Will you be able to open a bank account? Yes ____ No ____
If not, what will you do? _____
_____

Name: _____

EF #: _____

Counseling

Check the groups you have completed during your incarceration:

Core: _____ Family Violence
_____ Victim Impact
_____ Substance Abuse 101
_____ Pre-release/Vital Issues

Risk Reduction:
_____ Violence & Substance Abuse
_____ Corrective Thinking
_____ Sex Offenders
_____ Anger Management
_____ Life Skills
_____ Alcoholics Anonymous
_____ Toastmasters
_____ Other: _____
_____
_____
_____

Name: _____

EF #: _____

Please provide the following information as an overview of your substance use/abuse history.

Substance Use History	Check all that apply	Age of first usage	Current Drug of Choice	Pre-incarceration: Amount of usage (#days/week or # days/month	Method(s) of usage (snorting, smoking, IV)
Marijuana					
Cocaine					
Crack					
Amphetamines					
Heroin					
Alcohol					
Other:					

Have you ever had any thoughts of suicide related to drugs or alcohol use?

_____

If so, when? _____ Why? _____

Have you ever had any thoughts of homicide related to drugs or alcohol use?

_____

If so, when? _____ Why? _____

Have you ever received treatment for substance abuse or mental health problems?

_____

If so, when? _____ Why?

_____

During incarceration what substance abuse programs did you complete?

____ SA 101(Psycho-ed Group)
____ SIP 1 (Psycho-ed Group)
____ SIP 2 (Psycho-ed Group)
_____PSAP (6 weeks residential)
_____ NA/AA (1-5 days/week)

Residential Substance Abuse Treatment Programs

Discharge Summary

The Discharge Summary should provide a concise overall synopsis of the inmate's course of treatment. Often, this summary is the only report a person may have regarding the inmate's treatment and should be written assuming the reader knows nothing about the inmate. The summary should give an indication of whether or not the initial treatment goals and objectives were met, how the goals and objectives may have changed, during the course of treatment, what recommendations were made at the time the inmate was discharged from the treatment program.

Instructions:

Diagnostic Impression: You will determine the Diagnostic Impression from the inmate's Initial Assessment. Some examples of how this will be stated are as follows:

- Inmate's assessment indicates the inmate meets the criteria for Alcohol Dependence or Alcohol Abuse or Substance Abuse or Dependence. Specify which substance.
- Inmate's assessment does not indicate the inmate meets the criteria for a Alcohol or Substance Abuse or Dependence, however, the inmate's GDC files indicates that the inmate has experienced legal, educational, employment, and/or personal, etc. (specify which) problems due to substance use or possession.

Initial Expectations or Goals of Treatment: This is a brief statement of the inmate's initial expectations, desired outcomes and/or goals of treatment (found in the Initial Intake, the Needs Assessment and the Individual Treatment Plan), as well as the counselor's expectations per the narrative summary.

Achieved Expectations or Goal of Treatment: You will make a brief statement on whether the Initial Expectations or Goals of Treatment were met, if so, how and if not, why not.

COURSE OF TREATMENT: In this section you will make a brief statement of how the inmate responded to treatment, address any interventions that were necessary to get and keep the inmate on track, any significant events in the inmate's life, any changes in the inmate's attitude towards treatment and behaviors in the program and list the inmate's strengths and weaknesses.

Aftercare Goals and Plan established in the RePAC: In this section you will give a brief synopsis of the goals and plans established by the inmate.

Other recommendations/comments: In this section you will make your recommendations for the inmate upon release.

Spectrum Health Systems, Inc.

RSAT Discharge Summary

Name: _____ Number: _____
Date of Admission: _____ Date of Discharge: _____

Reason for Discharge: (please check one)

____Completion
____Volunteer W/D

Termination:
____Disciplinary
____Alcohol/Drug Use
____Non-participation
____Classification
___Paroled
___Mental Health
___Medical

Diagnostic Impression (as indicated by Initial Assessment, please specify alcohol or drug of choice): _____

Initial Expectations or Goals of Treatment: _____

Achieved Expectations or Goals of Treatment (Briefly explain if and how expectations were met): _____

Name: _____

EF #: _____

This page to be completed by RSAT Counselor

CHRONIC MEDICAL CONDITION

Will this inmate need medical care for a chronic condition? Yes _____ No _____

If yes, provide a brief description of the chronic condition:

_____

_____

_____

COUNSELOR RECOMMENDATIONS

Is outpatient counseling recommended? Yes _____ No _____

Individual _____ Group _____ Couples/Family _____

(Check all that apply)

12 Step Fellowship: AA _____ NA _____

Frequency: _____

Educational/Vocational Needs

Literacy program	Yes _____	No _____
GED program	Yes _____	No _____
Vocational/Technical Training	Yes _____	No _____

Treatment Summary of RSAT program:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

If you have any questions regarding this inmate's treatment or aftercare plan, contact:

_____	_____	_____
Counselor	Prison	Phone Number

_____ _____

Counselor Signature Date

_____ _____

RSAT Program Director Date

RSAT REPAC
01/04/00

RESUME FORMAT

NAME
ADDRESS
TELEPHONE NUMBER

CAREER OBJECTIVE:

EMPLOYMENT HISTORY: (include prison assignments – Last job first)

AWARDS AND CERTIFICATES: (provide copies)

EDUCATION: (OPTIONAL)

GEORGIA DEPARTMENT OF CORRECTIONS

AUTHORIZATION FOR RELEASE OF OR REQUEST FOR MEDICAL INFORMATION

NAME _____

ID NO. _____

DATE OF BIRTH _____

SOCIAL SECURITY NO. _____

TO: _____

_____

_____

1. I, _____, give my permission for _____
(Name of Institution)

to:

RELEASE TO/REQUEST FROM: _____
the information named herein:

_____

_____

2. I consent only to the release of information specifically named in item 1 and only to the specific person or agency named therein.

3. The purpose or need for this information is as follows: _____

_____

_____ _____
Signature of Patient Witness

_____ _____
Signature of Legal Representative Date

CONFIDENTIAL AND PRIVILEGED

Any information authorized to be obtained from this agency will be held strictly confidential and cannot be redeemed by the recipient without written consent of the above. If the materials disclosed contain data related to alcohol and/or drug abuse, the information has been disclosed from records whose confidentiality is protected by federal law. Federal regulation (42CFR Part 2) prohibits making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

Check if applicable ____ Yes ____ No

The patient has been informed that release of this information directly to him/her has been determined by the physician to be detrimental to the physical or mental health of the patient and will not be released directly to him/her. The patient has requested in writing that the health record information be furnished to you. Please consider this information in any decision to disseminate this information directly to the patient.

COURSE OF TREATMENT (Brief summary of response to treatment, interventions necessary, significant events, changes in attitudes and behaviors, strengths and weaknesses): _____

Aftercare Goals and Plans established in the RePAC (give a brief statement): _____

Other recommendations/comments (give a brief recommendation addressing the following: Recovery Counseling; Support Groups; Education – Vocational and Technical; Employment; Legal/Parole/Probation; Family/Living Arrangement; Support System & Social Services; Positive Outlets): _____

Counselor signature _____ Date _____ Supervisor signature _____ Date _____