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State and Local Programs: Treatment, Rehabilitation, and Education

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About the Bureau of Justice Assistance

The Bureau of Justice Assistance administers the Edward Byrne Memorial State and Local Law Enforcement Assistance Program to support drug control and system improvement efforts focused on state and local criminal justice systems. The Bureau's mission, directed by the Anti-Drug Abuse Act of 1988, is to provide funding and technical assistance to state and local units of government to combat crime and drug abuse. Through funding and technical support, the Bureau assists the states in managing the growing numbers of anti-drug programs and the rapidly increasing volume of drug cases entering the criminal justice system. It also identifies, develops, and shares programs, techniques, and information with the states to increase the efficiency of the criminal justice system, as well as provides training and technical assistance to enhance the expertise of criminal justice personnel. The Bureau accomplishes these mandates by funding innovative demonstration programs, some of which are national or multi jurisdictional in scope; by evaluating programs to determine what works in drug control and system improvement; and by encouraging the replication of successful models through linkages with the Formula Grant Program and other resources.

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State and Local Programs: Treatment, Rehabilitation, and Education

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Results From State and Local Programs Workshops

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Introduction

This publication reports on the results of the Bureau of Justice Assistance State Reporting and Evaluation Program *State and Local Programs Working Meeting: Treatment, Rehabilitation, and Education* held April 7-9, 1994 in San Francisco, California. This meeting brought together over 40 State planners and local practitioners as well as researchers and analysts who have previously been or currently are involved in implementing and/or evaluating treatment, rehabilitation, and education programs from 16 States.

This publication identifies and documents treatment, rehabilitation, and education programs at the State and local level. The first section of the publication presents perspectives from four national experts. The second section of the publication presents a State's perspective, and the final section documents the State and local programs that were presented at the workshop.

Perspectives on Treatment, Rehabilitation, and Education

Moral Reconation Therapy: A Cognitive-Behavioral Treatment Strategy

Dr. Ken Robinson, President of Correctional Counseling, Inc. (Memphis, Tennessee), presented an overview of a cognitive-behavioral treatment approach called Moral Reconation Therapy (MRT).

Since the early 1980s, cognitive approaches have been used with offenders in an effort to alter their thinking and decision making process. Most offenders (about two-thirds) may be diagnosed as antisocial, making non-traditional treatment approaches most appropriate and possibly the only means of altering the behavior. Moral Reconation Therapy (MRT) was the first systematic cognitive-behavioral approach fully implemented in large prison-based drug treatment programs. The approach was developed in the early 1980s and employed in a 40 bed prison therapeutic community in 1985 at the Shelby County Correction Center in Memphis, Tennessee. Because of its effectiveness, MRT programming has steadily increased in a variety of sites including criminal justice programs in Connecticut, Oklahoma, Florida, Montana, Indiana, Ohio, and California, as well as in Puerto Rico, Bermuda, and Canada. It is estimated that nearly 20,000 individuals have been treated with MRT.

MRT is a systematic, cognitive-behavioral approach to treating offenders. Cognitive-behavioral treatment (CBT) strategies have seven characteristics:

- CBT approaches are based on scientific learning principles.
- CBT approaches focus on changing how a client thinks and acts. The focus is on beliefs and behavior rather than feelings.
- CBT interventions obviously and directly relate to the client's difficulties and problems. CBT practitioners deal with the clients' actual behavior and problems rather than looking for other symptoms.
- CBT approaches are systematic. MRT and other CBT methods are done in a prescribed sequence of interventions, in a prescribed manner, at a prescribed time, and in a prescribed order.
- CBT approaches are relatively short-term. Some problems are addressed in six CBT sessions. MRT typically takes 16 to 36 group sessions to complete.
- CBT approaches represent a blend of active client exercises, homework, tasks, and active skills development. MRT and other CBT approaches stress the active components of treatment rather than the passive (sitting and talking). All CBT activities directly relate to the client's difficulties.

- CBT practitioners conduct outcome research. CBT and MRT stress the scientific aspects of treatment and see outcome research as the most important, pivotal issue in treatment. Most rehabilitation approaches blame the client for failures and resist scientific outcome research on their clients.

MRT is a systematic, cognitive-behavioral approach to treating offenders. Counselors typically hold groups twice weekly with 8 to 15 clients per group. Offenders complete the MRT steps, each with its own objective tasks and exercises, during group and outside of groups. Limited individual counseling supplements the group time conventional counseling.

MRT focuses on changing how clients think and make decisions. The treatment elements of MRT are:

- *confrontation and assessment of self*: assesses clients' beliefs, attitudes, behavior, and defense mechanisms;
- *assessment of current relationships*: includes planning to heal damaged relationships;
- *reinforcement of positive behavior and habits*: raises awareness of moral responsibility;
- *enhancement of self-concept*: changes what clients think of themselves;
- *decrease of hedonism*: teaches clients to develop delay of gratification and control of pleasure-seeking behavior; and
- *development of higher stages of moral reasoning*: increases concern for others and social systems.

Programs implementing MRT integrate the approach into the current programming methods. MRT is typically used with Alcoholics Anonymous (AA), educational and vocational programs, behavioral programming, boot camp philosophies, or more traditional parole and probation supervision groups. MRT has separate formats for multiple DWI offenders and drug offenders and is usually used as the primary treatment approach with the program structure (rules, sanctions, and procedures) altered to incorporate MRT.

Unlike other educational and treatment approaches, MRT is data based. Steps and tasks were delineated and designed based on outcome data. In addition, substantial outcome research has been conducted on MRT. This includes rearrest, reincarceration, dropout, and attrition data, and effects on personality including moral reasoning, sense of purpose, and sensation seeking.

During its first two years of operation at the Shelby County Correction Center in Memphis, Tennessee, MRT's pre- and post- treatment effects on various personality variables were thoroughly researched. During its first two years, the addition of MRT to the traditional therapeutic community approach significantly increased participation by minority offenders, decreased program dropout, and led to changes in participants' personality test scores.

In 1987, MRT was pilot tested in group formats with offenders who attended two group sessions each week within the Shelby County prison compound. Pre- and post-tests on the group participants affirmed the earlier beneficial findings of the method on therapeutic community participants. In addition, all participants were followed at one year intervals for rearrest and reincarceration data. Earlier results on MRT have shown that MRT-treated offenders have lower reincarceration and rearrest rates than an appropriate non-treated control group.

In April 1993, rearrest and recidivism data were collected on the initial 70 clients treated with MRT during 1987 and 1988. All of the treated offenders were male and were released during 1987-88. The treated offenders averaged 31 group and individual MRT sessions and completed and an average of 6 MRT steps per client. Data were compared to a control group of 82 offenders who were incarcerated and released during the same time period. Controls applied for MRT treatment but did not receive treatment due to funding limits at that time. However, controls participated in other programming at the institution including 12-Step groups, educational and vocational programming, and various religious programs. No attempt was made to quantify controls' participation in other programs.

At the 5-year data collection point, 37 percent of treated offenders had been reincarcerated compared to 55 percent of controls. Treated subjects were arrested an average of 2.6 times after release in 1987-88 as compared to 2.84 mean arrests for control subjects. Post-release reincarceration data collected in December 1993 on 1,052 MRT treated felony offenders and 329 controls shows that reincarceration rates for MRT treated offenders are less than the control group.

As has been found in prior research, MRT treatment significantly reduces recidivism and reincarceration. Over time, the differences between treated and control group reincarceration rates widen leading to statistical significance at the four and five year periods. Treating offenders with MRT results in a recidivism rate that is nearly one-third lower than the recidivism shown by untreated controls after 5 years of release.

Delancey Street Foundation: A Process of Mutual Restitution

Dr. Mimi Silbert, President of Delancey Street Foundation (San Francisco, California), presented Delancey Street's approach to successfully rehabilitate criminal offenders and substance abusers.

Delancey Street Foundation is a residential treatment center for ex-addicts, alcoholics, convicts, and prostitutes. Delancey Street is a self-help center in the truest sense of the word. The Foundation receives no government funds, so that its financial support depends upon its residents. Delancey Street has no staff of experts, either professional psychologists or professional ex-drug addicts, so that its "therapy" also depends upon its residents. The Foundation supports itself primarily through a number of training schools which provide vocational skills to all the residents, and which also generate the Foundation's income through pooling the monies earned. Training schools include a moving and trucking school, catering, retail and wholesale sales, advertising specialties sales, among others.

There are 500 residents at the San Francisco complex that opened in 1990. About 500 others are going through this same program in Brewster, NY; Greensboro, NC; and San Juan Pueblo, NM. Delancey Street's population ranges in age from 12 to 68; approximately one-quarter are women; one-third Black, one-third Hispanic, and one-third Anglo. The average resident has a history of using drugs for eight years, and has been institutionalized four times. Many have been gang members; most have been trapped in poverty for several generations. Over half of the people who come to Delancey Street are referred by the courts through pretrial diversion, as an alternative to prison, or as a condition of parole. The others come in off the street. There is only one criterion for entry into Delancey Street: the person must ask for help himself. No payment is accepted. No requests from concerned parents or lawyers can substitute for the individual taking the first step of accepting the responsibility for his own life.

Despite long histories of violence common to its population, there has never been one incident of violence in the two decades of Delancey Street's existence. This is accomplished without any external controls, without the weapons needed in prisons, without the drugs utilized for control purposes in many hospitals, and without the humiliation and shame-oriented punishments in which some programs engage. It is accomplished primarily through peer pressure. Punishments for wrong-doing at Delancey Street involve extra work or losing rewards. The most serious punishment is being asked to leave Delancey Street. Residents employ negative sanctions, as well as positive rewards and role modeling, with one another. This process of people working with one another rather than for or on one another, is critical to the family feeling of unity, as well as to the integrity of the model, and ultimate success of the Foundation.

Although the average resident is functionally illiterate and unskilled when entering Delancey Street, all residents receive a high school equivalency certificate and are trained in three different marketable skills before graduating. The minimum stay at Delancey Street is two years; the average stay is four years. During that time, residents learn not only academic and vocational skills, but also the interpersonal, social survival skills, along with the attitudes, values, and self-esteem necessary to live in the mainstream of society drug free, successfully, and legitimately. Thousands of men and women have graduated into society as taxpaying citizens leading successful lives as lawyers, realtors, sales people, the various medical professions, truck drivers, mechanics, contractors, a deputy coroner, and a deputy sheriff.

Delancey Street's philosophy is that the individual must take the responsibility for his own actions so that he can exert some control over himself and create some viable options. Only from a position where the individual has some personal power over his or her life, can he move to demand his due from society to work to change the inequities of its system.

This philosophy of change at Delancey Street is based on what Dr. Silbert calls "mutual restitution." The residents gain the vocational, personal, interpersonal and social skills necessary to make restitution to the society from which they have taken illegally, consistently and often brutally, for most of their lives. In return Delancey Street demands from society access to the legitimate opportunities from which the majority of residents have been blocked for most of their lives. By living together and pooling resources, Delancey Street residents acquire enough strength and credibility that the demands to gain access to society's opportunities must be taken seriously.

In order to accomplish this process of mutual restitution, there is a constant training and education process which begins the day the new resident arrives. The first area of re-education is "school learning." Everyone who comes to Delancey Street is tutored in basic skills: reading, writing, and math, until they receive a high school equivalency certificate. After that, residents can go on to various forms of education.

The second area is vocational training. Delancey Street maintains training schools which also serve as the businesses by which the Foundation earns its living. These training schools include a restaurant, a catering business, a moving and trucking school, terrarium and sand painting production and sales, furniture and woodwork production and sales, specialty advertising sales, antique car restoration, the operation of outdoor Christmas tree lots, and a print shop. Residents who have traditionally been unemployable welfare cases, have started, worked, and managed these training school businesses so successfully that they are the Foundation's primary source of working capital.

Vocational training is accomplished in three phases. The first is in-house training, where the residents are trained to perform skills simply within the Foundation. The focus here is not only on learning basic skills, but on developing work habits and self-discipline. When residents have mastered the basic skill, they move on to testing these skills in work

performed through a Delancey Street company for people in the community. After they've achieved a level of competence there, they are ready to move on to the third phase, which is to get a job in the community, where they must work successfully for six months prior to graduating from Delancey Street.

Another area of education that Delancey Street focuses on is one of the most critical: social or community training. Following the philosophy of restitution, Delancey Street residents, in addition to working and studying, are encouraged to help others in the community. Residents work with senior citizens, escorting them to and from the bank, visiting homes, showing movies, presenting plays. Residents work with juveniles from poor areas, taking them on cookouts, on tours of the city, on tours of Alcatraz, and giving them crime and drug prevention seminars. By using their own experiences, by showing that involvement with crime and drugs is by no means tough and glamorous, residents provide a realistic assessment and hence a viable diversion from crime. Residents also do volunteer work with the handicapped and are engaged in police training. They help with fund raisers for the ballet and opera. They are all encouraged to vote; and while, like any group, they don't accomplish full voting, several of the residents do go out and work for candidates or issues in which they believe. In essence, they work and donate time and energy to improve the quality of American life.

Residents are also trained in social survival skills. Every morning and every noon at a daily seminar, they study a vocabulary word of the day and a concept of the day; they learn the basics of money management and of our economic system; of civics; of archaeology and cultural anthropology; of etiquette; of clothing, fashion and style; of sources of energy; of consumer awareness; of ecology; of all the concepts and ideas that provide us with the tools to build a well-rounded life. These sessions are conducted in seminar fashion, where each resident speaks for a few minutes on the subject being discussed. In this way residents learn not only the content of the subject matter but also the process of group speaking, of presenting an idea and connecting a theory to a personal experience.

One of the central areas of education in Delancey Street is interpersonal relations. The majority of residents have a very difficult time interacting with others. This learning process is accomplished informally twenty-four hours a day through communal living. For example, residents who were once members of racially-oriented gangs such as the Mexican Mafia, the Black Guerrilla Family, and the Aryan Brotherhood live together in Delancey Street in the same dorms; they must learn to fight the institutionalized racism which they have been a part of for so many years. Because residents work together, they must learn to accept authority and dispense authority to others. While residents may become comfortable in relating with one another, it is most important that they develop skills in relating with those who are outside the Foundation. The formal method for learning interpersonal skills is the group process in which residents must participate three times weekly for three to four hours each session. The focus of these groups is not on the individual's problems but on his or her style or relating to others.

While great numbers of people have succeeded in their task of no longer committing crime, the residents of Delancey Street have succeeded in more important ways. They have demanded of themselves that they make restitution to society, that they care not only about their own financial success in life, but that they care about honesty, integrity, and the values by which we remain more than a country of people living together: values which make us a society. They have pooled their resources to demand from society the restitution which grants them access to the same opportunities the middle class and upper class enjoy. Ultimately, then, the success of the residents of Delancey Street is that they are continuing to clean up the swamp which threatens to reinfect them, and perhaps infect us all.

Pioneer Human Services: Chance for Change

Gary Mulhair, President of Pioneer Human Services (Seattle, Washington), presented his organization's approach to providing services to its clients.

For more than thirty years Pioneer Human Services (PHS) has been true to its name by pioneering in the delivery of basic human needs. Working with the socially handicapped, PHS has offered a "chance for change" to thousands. It now serves more than 3,000 clients each year, employs approximately 500 people in its programs, and provides approximately $20 million worth of goods and services to its community and clients.

PHS is a nonprofit agency located in Seattle, Washington whose mission is to aid in the rehabilitation, training, care and employment of socially handicapped individuals, including but not limited to, alcohol and drug-related cases, convicts, parolees and persons on probation and under jurisdiction of the courts. PHS is revolutionizing the way that services are provided to people at risk. PHS creates solutions to problems for people living at the margins of society, and manages and develops self-supporting enterprises and programs that provide safe environments for human growth and generate needed resources. The enterprises and programs of PHS model the integration of jobs, housing, training, and support services essential for human development and productive community-building.

Unlike the majority of nonprofit human service providers, PHS is entirely self-supporting. PHS produces its revenues, or operating funds, by applying those principles and techniques characteristic of the business world to the operation of a nonprofit service agency. That is, PHS generates funds by charging clients fees for room and board; by providing a variety of vendor services to commercial clients at market rates; and by furnishing various treatment, custodial, and related services under contract to State and Federal agencies. This income is used to pay PHS's expenses as well as to expand programs and activities. The approach fosters creativity, innovation, and cost efficient management.

PHS is a community of people who make a positive contribution to both the individual and the community. As an organization, there are shared values and beliefs that give members meaning and guidance in the pursuit of the PHS vision: change, responsibility, action, ethical behavior, respect, understanding and compassion, teamwork, excellence and quality, creativity and humor, and sound financial performance and enterprise. These values and beliefs help the organization and its clients know themselves, define opportunities, and plan strategies.

PHS has incorporated into its mission statement practical, business-oriented philosophies to guide its program and management decisions. While these principles have been reexamined from time to time, they have remained constant. These three "guiding principles" influence all of the agency's decisions: serving the client, serving the community, and serving the cause.

PHS believes that each individual is responsible for his own behavior; that each person is an autonomous, self-fulfilling being and that all persons are deserving of equality and opportunity. Each human being, regardless of inherited characteristics and present condition, has potential for change toward a more satisfying and personally fulfilling lifestyle. Since those clients whom PHS serves are entitled to all their rights as human beings, they deserve every "chance for change" with which society can provide them. PHS's commitment is to help all clients achieve the maximum benefit of their human potential.

A second guiding principle is that PHS is community oriented. PHS envisions itself as a positive force for improving the community and making it a more humane and hospitable place in which to live. The issue of public safety versus personal freedom must be resolved with as little damage as possible to the two polarities. PHS strives to educate the community as to the methods of social rehabilitation which are required if it is to remain responsive to the needs of those who are socially disadvantaged and handicapped. The community, if it is to survive and thrive, must be an open society and afford itself the "chance for change" that is necessary to accommodate the needs and aspirations of all its people. PHS is a small community trying to influence the larger community which sometimes forgets those who live on the edge of society.

The final major principle, "Serving the Cause," involves helping people restore themselves to wholeness through a broad array of programs. Every worthy life, be it that of an individual or an institution, is concerned with causes--those great idealistic impulses which motivate mankind toward its more notable enterprises. Causes and concepts which are directed at improving the human condition and helping both the individual and society to maximize the potential in human life are the concerns of PHS. Alcoholism, drug addiction, and crime are three of the most potent threats to the social structure. While seeking to avoid the abuses of extremism, PHS attempts to work for their alleviation and allies itself in common cause with all other agents and agencies working for similar objectives.

PHS has developed 12 interrelated programs that address a variety of client needs. Six of these are considered traditional social services programs. The remaining six are regarded as "enterprise" programs, meaning that they are structured to parallel the operation of the private sector. These enterprise programs generate the bulk of the agency's revenue while simultaneously providing important social services that complement the base program.

Special Needs Housing provides low-cost, structured residential living for individual without families or who cannot return to families after completing in-patient substance abuse treatment. *Pioneer's Corrections Division* is composed of Adult Work Release, Electronic Home Monitoring, and Litter Control. *Adult Work Release* is a highly structured residential program designed to give offenders a chance to make the transition back into the community and that offers some assurance of employment. *Electronic Home Monitoring* provides services to the Federal, State, and county Department of Adult Corrections and its Department of Youth Services. It monitors offenders through the use of an electronic device. *Litter Control* is a contract service of litter pickup, pruning, mowing, and brush-

cutting along freeways and highways and in public transportation lots. *Involuntary Alcohol Treatment* is a secure, involuntary commitment program located in a semi-rural setting on State-owned grounds. *Youth and Family Services* provides a 12-bed juvenile residence under contract to the county government and outpatient counseling services to youth and their families. *Work and Career Development* is a comprehensive 18-month plan that combines on-the-job apprenticeship training and classroom courses with personal tutoring and counseling.

Pioneer Industries is a sheltered workshop that engages in sheet metal machining, fabrication, and finishing. *Pioneer Properties* is a separate holding company that develops and manages Pioneer's real estate. *Food Buying Service* is a wholesale grocery company whose goal is to provide low-cost groceries to nonprofit food banks. *Pioneer Food Services* provides low-cost, highly nutritional meals for Work Release residents and sells and delivers meals to outside customers under contract. *St. Regis Hotel* is a 132-room hotel located in downtown Seattle and licensed to operate 45 rooms as a conventional hotel and the remainder as single room occupancy units as part of PHS's Special Needs Housing program.

This kind of diversity has been a critical factor in both Pioneer's corporate and human services success. One value of the widely diverse mix of services is the comprehensive system of support that they provide PHS clients. The comprehensive services eliminate the stress that often results from the more conventional service delivery system that requires clients to seek different types of assistance, such as housing, food, and job training, from different sources. The personal energy saved through this virtual "one stop shopping" enables clients to focus on their personal progress and goals for growth.

The remarkable success that PHS has enjoyed--generating millions of dollars in income annually while serving thousands of clients as well as the community--is the result of its innovative approach that grows out of the marriage of two conventional ones: the application of tried, sound, profit-driven business practices and the wise utilization of its nonprofit status. What has developed, through much effort and deliberation, is both a success story and a model program.

The leaders of the agency have no rigid protocols to pass along, no "off the shelf" service-delivery modules to package, no particular programming insights that might revolutionize the way services are delivered to the at-risk population. Rather, they promote a mindset, a different approach to viewing and managing the basic social service delivery process. This approach utilizes entrepreneurial methods, concentrates on outcomes, gives primary attention to core competencies, and focuses on serving--the cause, the client, and the community. In doing so, it provides a "chance for change" for the people it serves.

Intermediate Sanctions: What Can They Do?

Dr. Doris MacKenzie, Associate Professor, Department of Criminal Justice, University of Maryland, is a national expert on intermediate sanctions. Her presentation focuses on the following questions: what we want from them, what we know about them, what their drawbacks are, and where they should go in the future.

Dr. MacKenzie provided an overview of the development of intermediate sanctions, which were at one time referred to as community-based corrections. In the 1950s and 1960s the emphasis in corrections was on reintegrating individuals into the community in order to avoid labeling offenders and eliminate the negative influences of incarceration. After the 60s, during the period of "nothing works" and "let's get tough on crime," community-based corrections changed to "intermediate punishments." During this time period, sanctions did not emphasize rehabilitation.

Intermediate sanctions then began to resemble the justice model, which required punishment intermediate between probation and prison. System fairness, justice, and an emphasis on punishment were characteristic goals at the time; a rational system should have ranks from severe prison sentences to less severe probation, as part of a large system able to punish people fairly. Achieving cost effectiveness, deterrence, and community protection was the rationale behind the approach. Some programs included rehabilitation. Intermediate sanctions responded to what the public wanted, attempting to look innovative and "exciting", as public policy makers needed them to be. The development of intermediate sanctions responded to two goals: reduce prison crowding and change offender behavior to reduce recidivism.

Dr. MacKenzie described several types of intermediate sanctions:

Intensive Supervision. As of 1990, all states had intensive supervision programs, but the delivery of services differed from state to state. In most cases, the programs require face-to-face contacts, more surveillance, and more curfews. A RAND study of over 2,000 offenders found no effect on recidivism, one of the program's major goals. The focus of Intensive Supervision is on surveillance and control. Analysis of intensive supervision programs including a treatment component found some difference in results, but surveillance and control, rather than treatment, were the focus.

Electronic Monitoring/Home Confinement. In 1986, 95 offenders were electronically monitored. By 1990, the number increased to 12,000. The problem with electronic monitoring was that expectations for technology--which can't make decisions or indicate what should be done--were too high. Again, surveillance became the primary focus of the sanction.

Day Fines. In West Germany, 81% of adult crimes are punished solely with fines. In England, 38% of all crimes are punished by day fines, on a sliding scale depending on income and increasing as net income increases. Research results are limited, but day fines appear to indicate success. Rates of recidivism are similar to those of other sanctions examined. Six states implemented day fines in 1990, and others are considering them.

Residential Community Correction Centers. These vary greatly in services, scheduling, drug testing, and client contact. Their focus is on surveillance and contacts. Results on recidivism are mixed, and it should be noted that more low-level offenders enter this program.

Drug Courts. The goal of drug courts is not to expedite cases, but for judges to become involved in requiring treatment, which is the program's focus. There presently exist fifteen drug courts. Preliminary data from the Miami court look positive.

Boot Camp Prisons. The goal of boot camp prisons is to reduce prison crowding and address recidivism. Few cases indicated a reduction in recidivism rates. However in those cases where there was a reduction in recidivism, a treatment component was present. Evaluation results on the effectiveness of boot camp prisons varied across states.

Intermediate sanction program results are mixed, usually not strongly supportive of an impact on recidivism. Results with respect to the reduction of prison crowding are uncertain. Dr. MacKenzie's "correctional pie" places a third of offenders in prison and two- thirds on probation. It is difficult to calculate the percentage of offenders in intermediate sanctions programs because an offender's punishment may involve several components of punishment. However, it is estimated that two percent of offenders in the "correctional pie" are in intermediate sanctions programs. This percentage is not enough to reduce the number in prison. There is no strong argument that the deterrent aspect of intermediate sanctions has reduced prison crowding, although this does not mean the programs do not have the potential to do so. Protecting the community is another goal. Even without a difference in recidivism, with intensive supervision more repeat offenders will be caught and brought in.

Research shows that rehabilitation seems to have a positive effect. The influence of coercion into treatment has not been investigated. Results of the 1968 Task Force on Narcotics and Drug Abuse show that it can have a positive effect to coerce an individual to stay in treatment longer, which is not a focus of intermediate sanctions.

Intermediate sanctions have not fulfilled the necessary goals. They appear to work, but there is not much support that this is a result of the surveillance components of intermediate sanctions. Evidence shows that treatment and rehabilitation work, and this is the direction intermediate sanctions should pursue.

A State Perspective on Treatment Strategies

Florida

Drug Treatment and Rehabilitation Programs for Offenders

Statement of the Problem

Florida's unique geography and demographic profile make the state, unfortunately, a national leader in substance abuse and its negative consequences. From the individual tragedy of drug addiction to the societal horror of violent crimes committed because of drugs, Florida has too much experience. Cocaine powder, crack cocaine and marijuana are available in all of the state's 67 counties. The number of drug offenses increased 7.2 percent in the past year while all other offenses rose 1.1 percent. This, in spite of increased overall prevention and enforcement efforts, reinforces the need for rehabilitation and treatment programs for drug crime offenders to break the vicious cycle of addiction and crimes committed to satisfy the addiction.

Goals and Objectives

The goal of Florida's rehabilitation and treatment programs is to break the cycle of drug use and related crime by reducing the demand for drugs. The objectives are to retrain the offender's physical and psychological needs through treatment services, and to substitute viable academic and vocational skills that offset the financial incentives for drug involvement through rehabilitation services. Indeed, Florida's emphasis on prevention and treatment approaches to fighting substance abuse has led the state to spend approximately 47 percent of Drug Control System Improvement (DCSI) funds since federal fiscal year 1990 on rehabilitation and treatment.

Program Components

The DCSI grant is administered in Florida by the Department of Community Affairs (DCA). DCA staff:

- conduct fiscal and programmatic monitoring of all grant-funded projects at least annually, using an automated grants processing, monitoring and management information system (GPMMIS), which tracks program expenditures and performance;

- require subgrantees to submit quarterly, annual and final program performance reports. Data from these reports are entered into GPMMIS to assess the efficiency

and effectiveness of services;

- direct subgrantees to submit and receive approval on numerous fiscal documents such as budgets, claims for reimbursement, budget amendments, etc. These reports are entered into GPMMIS for tracking; and

- contract with Florida State University to evaluate selected purpose areas.

Subgrantees are awarded funds on a formula basis that takes into account the county size and problems with substance abuse. At least 51 percent of the units of government within the county representing at least 51 percent of the county's population must sign off on a project to receive funds. This approach, unique to Florida, has resulted in programs that are based more on community and social services and medical treatment than on law enforcement.

Treatment and rehabilitation services are provided either by the state or by local providers to drug offenders who are either incarcerated, on probation or in pre-trial status. The settings in which the services are delivered vary, but are primarily in prison, jail or in the community. In spite of the differences in operators (state or local) and venue (state prison or local/county jail or community), treatment programs are very standardized in Florida. They are licensed by the Department of Health and Rehabilitative Services and must comply with minimum state standards.

Treatment in three of the four provider/venue combinations is provided in several modalities: detoxification; Treatment Alternatives to Street Crimes (TASC) and community-based intervention; non-residential services; and several levels of residential services that range from 30 days to a year in length. Not all projects provide treatment in all modes, and not all services are provided in projects of like modes. Services provided by the state within prison, the fourth provider/venue, are classified as Tiers: Tier 1 is a 40-hour drug education program; Tier 2 is an eight-week on-site residential program; Tier 4 is an eight-week outpatient program; and Drug Intervention Centers (DIC) are longer term, off-site residential programs.

The services available and their definitions (from Chapter 10E-16, Florida Administrative Code) include:

- **admission/readmission** - obtains basic background information including a brief history and identifies problems; includes determination of person's eligibility for the program and their motivation towards treatment;
- **ancillary** - supplements primary treatment and rehabilitation services; includes prenatal care, diagnostic testing (see separate definition), public assistance and transportation;
- **medical assessment** - identifies person's physical health needs; includes medical history, physical examination, laboratory testing;

- **psychosocial assessment** - addresses psychological and sociological factors contributing to a person's need for services; includes case history and clinical impressions;
- **case management** - ensures that persons participating in the program receive services appropriate to their needs either in the program or upon referral; includes assessment, planning, linking, monitoring and advocacy;
- **court liaison** - establishes and maintains lines of communication between the program and the courts in responding to the treatment needs of drug offenders eligible to participate in the program;
- **diagnostic** - determines the need for special services; includes psychological tests, special educational tests, psychological assessments and psychiatric evaluations;
- **drug screening** - identifies offenders who may be abusing drugs at the time; includes on-going monitoring to ensure offenders remain drug-free;
- **meals** - includes up to three meals per day;
- **nursing care** - includes emergency medical services, patient observation and re-evaluation;
- **tracking** - follows the progress an offender makes in the program and reports according to a consent agreement and/or treatment plan; progress reports must be provided to the criminal justice system or referral source as required by state regulation;
- **rehabilitation** - provides non-clinical services such as educational and vocational training, job placement and basic living skills;
- **short-term counseling** - provides professional guidance and advice;
- **treatment** - provides individual, group or family therapy according to an individualized treatment plan that includes goals, objectives and type and frequency of services the offender needs; need for continuing care after discharge is also documented.

Results and Impact

The minimal outcome for any rehabilitation or treatment service is successful completion, defined as completion of steps or classes described in an individual's treatment plan. The optimal outcome is the elimination of the offender's criminal behavior, measured as recidivism (re-arrest rates). Additional performance measures ranging from demographic characteristics of offenders served to reasons for unsuccessful outcomes are gathered from providers.

All but recidivism data are from GPMMIS; some successful completion and all re-arrest data are from field research done by Florida State University (FSU) as part of contract evaluations for DCA. The GPMMIS data are reported by service providers in quarterly, annual and, when a project closes, final reports. These data represent 48 months of reporting on 79 projects that served a total of 187,047 offenders. The FSU data are a sample, are client-based and come from examining case files in the field. They cover 12 to

18 months of project operations and include data on 2,876 individuals from 38 of the 79 projects.

Performance Measures

Caveats. The FSU evaluators found the interpretation of treatment completion rates as outcome indicators complicated by a number of intervening variables. The program definitions of "successful" completion varied greatly in spite of a uniform standard applied by DCA (the completion of steps outlined in the individual's treatment plan). Furthermore, staff applied different tolerances of project eligibility with some project staff allowing multiple positive urine screens while others ejected participants after a single positive screen.

There are similar difficulties in interpreting the re-arrest data. The low incidence of drug offense re-arrests may simply mean that the drug related behavior has not changed, but the criminal behavior has, or vice versa. Finally, re-arrest data probably underrepresent the actual numbers of crimes committed, since most criminal justice experts believe that offenders commit several crimes before they are apprehended.

Note that FSU and DCA data are organized differently. FSU researchers categorized offenders into the type of program service in some instances, the type of offender status in some instances, and divided the population into adults and juveniles. The DCA database aggregates offenders of all ages and separates results by provider/venue.

Data. DCA staff established uniform objectives to measure program activities for each purpose area. Within the treatment and rehabilitation purpose area these vary by treatment modality (e.g., detoxification, intervention, etc.), but generally they measure the number of offenders receiving a specific set of services such as intake and screening, diagnostic services, case management, or short-term counseling. Project staff establish the level of performance they expect to achieve and communicate this expectation to DCA when applying for grant funds.

There are differences between providers and settings, but overall, the services provided most frequently, with one exception, are procedural -- intake and screening, case management, tracking and court liaison. The exception is short-term counseling, which ranks between case management and tracking. This service array matches the program definition for successful completion of treatment/rehabilitation: completion of the steps outlined in an individualized treatment plan (as opposed to long-term follow-up data).

The FSU data showed that the successful completion rates for adult offenders in treatment averaged 48.2 percent overall, and ranged from 31.7 percent in residential treatment, to 57.5 percent in pre-trial release programs. Successful completion percentages were calculated as the ratio between offenders who successfully completed the program and offenders who left the program, successfully or unsuccessfully. Caucasian males had the highest rate of

successful completion, and females tended to complete treatment less frequently than males.

The more highly structured offender tracking programs, such as TASC and pre-trial intervention, tended to have higher completion rates. Educational attainment and prior treatment history did not appear to influence successful completion rates. However, further analysis of treatment history and analysis of the type of drug(s) used, the frequency of arrests/re-arrests, certain demographic traits such as race and age and a one-year follow-up to the Addiction Severity Index administered to a sample of offenders may reveal different information.

Among juvenile offenders the average successful completion rate was 46.1 percent, with juvenile TASC programs completed least often (35.9 percent), and juvenile outpatient programs completed by 48.4 percent of the participants. African-American males and females were significantly less likely to complete treatment than were their Caucasian counterparts. Prior treatment experience was not a factor in determining successful program completion.

GPMMIS data showed that state-provided services for incarcerated offenders had the highest overall successful completion rate (76.9 percent), followed by community-based services provided by the state (75.8 percent); followed by locally-provided services to incarcerated offenders (55.7 percent); followed by locally-provided services to offenders in the community (43.6 percent). Successful completion percentages were calculated as the ratio between offenders who successfully completed the program and offenders who left the program, successfully or unsuccessfully.

Successful completion within these provider/venues varied significantly by treatment modality, from a high of 92.1 percent for locally-provided/in-jail detoxification to a low of 39.6 percent for locally-provided/community-based TASC/community intervention. Residential treatment, often perceived to have a good chance of successful completion because of 24-hour supervision and long-term care, had the highest rate of successful completion in only one provider/venue -- state-provided/community-based services. Non-residential treatment services had similar successful completion rates across the three comparable provider/venues (11B, 13A, 13B), ranging from 51.0 percent to 54.2 percent.

FSU's post-treatment tracking of offenders served by the programs evaluated yielded some discouraging arrest statistics. Whatever treatment effect may have come into play during the first 6 months is quickly lost within the first year post-treatment. By the end of 18 months, well over 90 percent of the treatment participants had experienced at least one new arrest. African-American adult males were significantly more likely than any other group to be arrested within six months post-treatment, but arrest rate differences related to race disappeared after 12 months. Arrest rates for female offenders remained significantly lower than those of male offenders over time.

African-American juvenile offenders were significantly more likely to be arrested within 6

months post-treatment, Caucasian males closed this gap at the 12 month point. When compared with males, juvenile females had experienced significantly fewer arrests at the 12 month point, but this difference was significantly reduced after 18 months.

Offenders who had successfully completed their prescribed treatment experienced a slightly lower arrest rate than their unsuccessful counterparts, especially at the 6 months post-treatment point, but over time the differences became less significant. This convergence phenomenon was significantly more pronounced among the juvenile offenders.

When only those post-treatment arrests that were drug offenses are examined, the picture is considerably more positive. Data indicate a loss of treatment effect over time. The apparent loss of treatment effect by the end of one year is again obvious for both adults and juveniles, but the overall percentage of drug offenses is relatively small. When compared with other race/sex groupings, Caucasian males maintained a significantly lower drug offense arrest rate throughout the 18-month period.

When examined by race/sex groupings, drug offense arrests among juvenile offenders revealed extremely high arrest rates for African-American males. At the 12 months post-treatment point 26.5 percent of the African-American males in the FSU sample had at least one drug offense arrest, while only 3.3 percent of the Caucasian males had a drug offense arrest. During this same period, none of the African-American females experienced a drug offense arrest, while 7.6 percent of the Caucasian females had at least one drug arrest.

Offenders who successfully completed treatment were significantly less likely to experience a drug offense post-treatment arrest than were their unsuccessful counterparts. This effect was somewhat more pronounced in the adult offender group, but can also be observed in the juvenile offender data.

The type of treatment received appears to be a significant factor in post-treatment drug arrests. Adult offenders who successfully complete residential treatment are the least likely to experience a post-treatment drug arrest within one year (1.9 percent), while adult offenders who are unsuccessful in residential treatment are the most likely to be arrested on a drug charge (17.0 percent). Successful completion of adult outpatient treatment is also associated with a low post-treatment drug arrest rate (0.8 percent), while 10 percent of their unsuccessful counterparts experienced at least one drug offense arrest within one year after leaving treatment. Successful completion of pre-trial release programs also appears to be associated with lower drug arrest rates (3.0 percent per compared with 11.1 percent). Successful completion of in-jail and adult TASC programs did not lessen post-treatment drug arrest rates relative to non-completers.

The reasons for unsuccessful treatment also varied by provider/venue. For state-provided services/incarcerated offenders, it was offender request (35.3 percent of the total of unsuccessful reasons); for locally-provided/incarcerated offenders, it was unexcused

absences (42.2 percent); for state-provided/community-based services, it was failed drug tests (45.4 percent); and for locally-provided/community-based services, it was "left program against advice" (59.1 percent). Re-admission rates were highest in the shortest-term, least intensive service levels in all provider/venue categories.

Primary referral sources reflected the nature of the provider/venue. For example, state-provided/incarcerated offenders were usually referred from the state corrections/parole agency, while offenders in locally-provided, community-based programs were referred by inmate request. The average wait for services, expressed as a range of days per modality, was longest for state-provided services for incarcerated offenders, shortest for state-provided, community-based services.

Caucasians made up 52.1 percent of those served, African-Americans, 43.3 percent. With two exceptions, the single largest cohort of offenders served was Caucasian males aged 18-29. For the exceptions, it was African-American males aged 18-29 among offenders served by the state in state prisons, and African-American males served by local providers in community-based Level II residential services. Males averaged 83.7 percent of all offenders served. Females were served in locally-provided, incarcerated programs more frequently than in any other provider/venue combination.

The percentage of repeat felony offenders served varied by provider/venue, being highest for locally provided/incarcerated services (60.6 percent). The next highest category was state-provided/incarcerated services (51.0 percent), followed by state-provided/community-based services (45.8 percent), followed by locally-based/community-provided services (37.7 percent).

The less restrictive the treatment setting, the more likely the offenders were to use drugs during treatment. That is, only 2 percent of all offenders served in state-provided/incarcerated services tested positive for one drug or more, while 26.2 percent of offenders served in locally provided/community-based services tested positive for one or more drugs. The first drug of choice, overall, was alcohol. By provider/venue, cocaine was most often chosen by offenders served by state-run programs, alcohol by those in locally-run programs.

Completion rates for the rehabilitation components of DCSI programs ranged from 5.4 percent for locally provided/community-based academic programs to 48.8 percent for locally-provided/community-based vocational programs. However, these completion rates represent a small percentage of all offenders served -- fewer than ten percent enrolled in academic or vocational programs.

Overall, it appears that programs with the most control over the offenders have the most impact on drug use, at least by the short-term, immediate measures reported by providers. Offenders likely to have the most severe problems with drugs and alcohol, i.e., those with histories of intravenous use and repeat felony offenders, are not necessarily served in the

most intense programs. This may affect successful completion rates, but existing data do not permit a complete analysis of this possibility.

It appears, from data analysis conducted to date, that treatment for drug abuse does not reduce non-drug offense criminal behavior. Treatment may reduce criminal behavior that is related to drug use, but this is not clear. If the goal of treatment and rehabilitation programs is to "break the cycle of drug use and related crime by reducing the demand for drugs," then it is not clear that current treatment programs in Florida are successful over the long term. However, if the goal is to generally reduce criminal behavior, particularly in the short term, and more specifically, drug offense criminal behavior, then Florida's treatment programs have enjoyed some measure of success.

Implementation Problems

The primary implementation problems have been a gap between the need for services and flow of offenders into available program spaces; low successful completion rates for some treatment modalities; and high recidivism rates. Changes in sentencing practices and improved local level coordination are necessary to assure that eligible offenders are served if possible, and that ineligible offenders are referred to appropriate programs. Specifically, too often, new projects do not put enough thought into accurately assessing the level of need for new treatment programs or the willingness of referral sources to use a new program. As a result, start-up times are excessive before services are delivered efficiently. Successful completion rates improve with stricter offender oversight by the criminal justice community. This level of oversight is not a feature of every provider/venue.

Successes and Accomplishments

The successes include those offenders who have been successfully treated or rehabilitated, whose cases advance knowledge of how to treat and rehabilitate drug offenders. Specific accomplishments include higher-than-expected successful completion rates and the institution of outcome measures as management tools in the day-to-day operations of programs. The FSU analysis of drug abuse treatment outcome data continues. Although the findings to date appear to support the conclusion that treatment programs have been effective only in reducing drug offense arrests, upon further examination, this may not be as clear or be the whole picture. Additional analysis is expected to reveal information about the efficacy of drug treatment in reducing both the frequency and types of criminal behavior.

Prospects for Replication

There are two aspects for Florida's treatment and rehabilitation programs to consider replicating - procedural and programmatic. Procedurally, Florida's GPMMIS system allows immediate administrative response to implementation problems, such as claims requests, budget amendments, etc., as well as permitting much more detailed desk audits, reducing travel time and costs. In addition, GPMMIS offers local level project managers the ability to make programmatic adjustments to meet their performance objectives, because their

current performance on these objectives is instantly available to them. As the evaluations from Florida State University have shown, not all project directors have taken advantage of this use of the GPMMIS, but continuing education efforts by DCA are converting more and more project managers into performance-based objective believers.

Programmatically, programs succeed when the approach for the individual concerned is as comprehensive as possible, i.e., when prevention education is made relevant and carries on outside of the classroom; when treatment includes family members and addresses underlying problems; when incarceration includes treatment and aftercare and deals with the issues that led to substance abuse and criminal activity in the first place. Projects work best when they are well-funded, assured of support, and when jurisdictional limits and false barriers can be waived for effectiveness and efficiency.

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State and Local Programs: Treatment, Rehabilitation, and Education

California

Continuity of Care Project

Statement of the Problem

The California Department of Corrections is the largest correctional agency in the nation, housing over 121,000 inmates and supervising over 85,000 parolees in the community. In the past 10 years, the prison population has increased by 82,000. A major factor in this alarming increase is substance abuse and drug-related criminality. The number of offenders committed to the Department of Corrections for drug offenses increased from 7.1 percent in 1983 to 24.1 percent by the end of 1993. A recent survey of new admissions found that 78 percent of all new admissions had histories of drug abuse.

A California Blue Ribbon Commission on Prison Population Management confirmed that substance abuse is a driving factor in prison overcrowding and subsequent parole revocation. Until recently, no intervention within a correctional setting prepared the substance abusing offender to return to society.

In 1989, the Department of Corrections formed the Office of Substance Abuse Programs (OSAP) and initiated California's first intensive substance abuse program at the R. J. Donovan Correctional Facility near San Diego, California. This project was created through a partnership with a community-based treatment organization, Amity, Inc., and the correctional system.

A treatment program structure was developed in which selected drug abusing, medium-security inmates would serve their last year of incarceration within a therapeutic community setting. Two hundred inmates are assigned to this project, which uses proven substance abuse treatment techniques including group meetings, seminars, group and individual counseling, video feedback, relapse prevention, and urine testing. The program is designed to assist substance abusing offenders in developing the skills and abilities which will enable them to maintain an acceptable level of in-prison conduct and remain drug-free after their return to the community.

The correctional therapeutic community at R. J. Donovan is a housing unit isolated from the general population of the prison with its own hierarchical structure, but participants do integrate with the general community for other activities. Program participants gain status and responsibility as they internalize socially acceptable values and behaviors. This model was piloted in the New York "Stay 'N Out" Program in 1977 and within Amity's Pima County Jail project in Tucson, Arizona.

The community treatment provider selected for this project, Amity Inc., is a nationally recognized substance abuse treatment organization which has been called upon to develop jail and prison-based programs across the country. The U.S. Department of Justice, Bureau of Justice Assistance has used Amity's technical experience to implement and expand Project Reform and Project Recovery, a series of drug treatment programs within State correctional facilities. Amity uses experienced recovering individuals in the provision of services to the offender population. This approach has been effective in quickly engaging offenders in treatment, breaking down barriers of denial and isolation.

During the in-prison treatment program, a detailed transition plan is developed to assist the inmate in planning for his return to the community. Offenders returning to the San Diego County area have an opportunity to participate in continued residential treatment which is funded by the current Bureau of Justice Assistance grant allocation. Correctional treatment research emphasizes the fact that continued treatment in the community is critical to continued pro-social adjustment after release from institutional treatment programs. Community treatment programs often do not have the space to accommodate paroled offenders, thus diminishing the opportunity for continued treatment, reduced drug use and its associated criminality, and other positive social impact.

Goals and Objectives

The Continuity of Care Project was established with the assistance of the California Office of Criminal Justice Planning in 1991. It enables institutional treatment graduates to continue intensive treatment in a community setting while under parole supervision. To carry out this project, the Department of Corrections, the Office of Criminal Justice Planning, and Amity Inc. established the Vista, California, continuance facility.

The first goal of the Continuity of Care Project is to provide substance abuse treatment services for offenders graduating from the in-prison component. At least 190 inmates will graduate from the in-prison component. Seventy parolees will enter the transition facility after completing the in-prison project, with an average length of stay at the transition facility of 120 days. A minimum of 400 non-transition facility parolees, family members, and friends will attend ancillary groups, workshops, or seminars at the facility. It is anticipated that 60 parolees will complete the Continuity of Care Project annually.

The second goal is to provide pre-parole planning for the in-prison program participants to enhance the likelihood of success on parole. This goal will be accomplished by conducting planning sessions, completing transition plans, providing contacts, and conducting pre-parole interviews.

The third goal of the project is to assure continued community safety through parole supervision by the project's parole agent staff. To accomplish this goal, urine tests will be administered at the transition facility, initial interviews will be conducted by the parole agent, and case contacts will be made by the parole agent at the facility.

In addition, the following items are monitored regarding parole supervision: (1) the number of incidents requiring an activity report (technical violations of the conditions of parole); (2) the number of positive urine samples and types of drugs detected; (3) the number of participants returned to custody; (4) the number of successful parole discharges; (5) the number of hours of community service donated by participants; and (6) the number of participants employed.

Program Components

The Continuity of Care Project includes three distinct program areas: pre-parole transition planning, substance abuse treatment services, and parole supervision.

Pre-Parole Transition Planning. The pre-parole transition planning at the R. J. Donovan Correctional Facility requires contracted treatment personnel to make an adequate assessment and to develop an appropriate program plan. The transition plan identifies specific deficits in an individual's profile and establishes goals which must be achieved in order for this individual to complete parole successfully. This transition planning may include residential treatment, outpatient treatment, outreach groups and seminars, Alcoholics and Narcotics Anonymous Programs, the monitoring of relationships with past associates, and guidance of the offender through problematic intimate relationships. This last point has been found to be a direct cause of relapse and return to custody.

Critical to this pre-parole planning is the involvement of the project's parole agent in planning work at the institutional site. This is often the only positive contact an offender has with parole staff. It establishes a clear understanding of the offender's responsibility regarding parole supervision and offers the offender the maximum opportunity for successful reintegration. Coordination and integration of parole supervision and treatment create a considerable force to motivate the offender and reinforce pro-social behavior.

Substance Abuse Treatment Services. The second major area of the project is the provision of substance abuse treatment services at the continuation facility. The actual treatment components are consistent with those provided within the institution and include individual counseling, on-going assessment of progress towards the achievement of established goals and objectives, group counseling, psychodrama, problem-solving skills development, self-examination, and educational seminars. These activities are supplemented with regular workshops which include active parolee participation in the areas of substance abuse education, relationships, recreation, nutrition, support networks, family dynamics, personal chronologies, and communication skills. All of these discussions are focused on

providing participants with the necessary tools and skills to continue a successful adjustment during parole.

These treatment services are offered in a physical environment which is supportive, drug-free, and "home-like." Amity Inc. creates this environment within a residential setting in San Diego County without diminishing the importance of the reason offenders are placed at the facility, which is to receive substance abuse treatment and cognitive restructuring.

Parole Supervision. The third major project component is parole supervision, which requires the parole agent assigned to the project to provide extensive liaison with treatment and custody staff at the institution, ongoing contact with other community programs, and increased communication with the County Alcohol and Drug Administration staff to facilitate long-term parole planning.

The parole agent is integral in the case management process and maintains a close liaison with the continuance facility staff and the offenders residing at the location. Once again, a team approach in managing the offender's program is emphasized.

Urine testing is conducted on the substance abusing offenders placed in the facility to ensure that they remain drug-free and move towards successful program completion. The parole agent invests a great deal of time at the facility maintaining contact with the offenders and obtaining collateral information to validate the offender's progress through the program. Detailed initial interviews with each parolee placed in a facility are conducted, and progress towards meeting the objectives in the established transition plan is closely monitored. Of significant importance to the project is the parole agent's role in monitoring offender behavior in the community to ensure that public safety is protected throughout the offender's reintegration.

Results and Impact

Implementation Problems

When the project was initially implemented in 1991, it quickly reached capacity (six beds). Capacity was later expanded to ten parolees. However, during the second year of funding through the Office of Criminal Justice Planning, without an increase in funding, the Department of Corrections and Amity, Inc. located a residential facility in Vista, California which now provides sufficient residential capacity for 40 beds. This larger program now provides services for a minimum of 70 residential placements during the program year. The larger facility allows greater flexibility in program operation, adequate space to conduct daily group counseling sessions, weekly focused seminars, monthly family retreats, and daily individual counseling efforts.

Currently, the program is at capacity and unable to serve all those who need aftercare services. A waiting list exceeding 20 individuals has been established for future program participation. Recent "Three Strikes and You're Out" legislation has spurred offenders' interest in addressing their substance abuse needs, and greater interest in the program has been expressed both in the institution and in the community.

Successes and Accomplishments

The success of correctional treatment programs is often measured by the recidivism rates of project participants. While preliminary data indicate that program participants are returned to custody at significantly reduced rates (13 percent compared to 37 percent), and while these results are encouraging, it is premature to proclaim the program an unqualified success. Consequently, the Department of Corrections has entered into a relationship with the National Institute on Drug Abuse (NIDA) to conduct a major evaluation effort which will track offender progress over a five year period. A particular focus in this evaluation will be the Continuity of Care portion of the program.

The outcome of substance abuse programs must also be evaluated by examining such information as the average number of months a participant is drug-free while in the program, the proportion of offenders completing the program without new arrest, and the proportion of offenders leaving the program without relapse. This strategy for measuring program accountability is suggested by the U.S. Department of Justice, National Institute of Corrections in the Report entitled "National Task force on Correctional Substance Abuse Strategies."

To date, the program has increased the average length of stay of offenders in treatment to nearly double that found in community treatment programs. This significant length of stay indicates that there are compelling program elements which have been tailored to the offender population allowing them to become engaged in this specific treatment program.

The hours and numbers of specific treatment services offered at the continuance facility continue to increase. In the past 6 months alone, over 400 groups, workshops, and seminars have been administered, double the anticipated service delivery rate. Urine testing has been administered continuously throughout the project, and no positive samples have been returned. No visible signs of drug use have been detected.

The Department of Corrections is pleased with this program and its progress to date. The project, with the cooperation of the Office of Criminal Justice Planning and Amity Inc., has delivered a comprehensive, long term treatment program to a very difficult, high-risk population.

Prospects for Replication

In light of the successful implementation of this project, the Department of Corrections is in a position to draw upon this experience and expand the availability of services. This project was specifically cited in recent legislation which authorized the construction of a 1,000 bed substance abuse treatment prison. The legislation specifically cited this program's achievements and called for project development consistent with this model.

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Idaho

Anti-Chemical Dependency Program

Statement of the Problem

The Duck Valley Indian Reservation is located on the border between Idaho and Nevada, with approximately one half of the Reservation in each State. The Reservation is remote; the closest major services are 100 miles south in Elko, Nevada or 100 miles north in Mountain Home, Idaho. The town of Owyhee, just inside Idaho's border, is the focal point of the Reservation.

Programs administered on the Reservation, whether Tribal, State, or Federal, provide services to the Indian and non-Indian populations. There are approximately 2,000 Paiute and Shoshone Indians and 100 non-Indians residing on the Reservation.

It has been estimated that there are 785 people with alcohol and/or drug problems living on the Reservation. The Shoshone and Paiute Tribes' Social Services Department planning staff conducted a survey of households to determine the types of social services needed and if these needs were substance abuse related. The survey indicated that substance abuse affected 95 percent of the households in the service area.

In 1991, the Tribe social worker was the only social services staff, other than the police, available to respond to crisis situations regarding alcohol/drug-related incidents after hours and on weekends. The Owyhee Police Department indicated that there were 369 reports of alcohol/drug-related incidents, 418 arrests, and 785 cases that year. During 1992, the Owyhee Police Department received 588 calls for assistance which were investigated by police officers. Three hundred ninety-six (396) resulted in criminal charges filed against persons involved directly with alcohol-related offenses.

A report from Indian Health Services (IHS) states that during FY 1992 there were 11 suicidal acts in which alcohol was involved. Two of these were gestures, seven were attempts, and two were completed suicides. In January 1993, there were 6 suicidal acts reported to the hospital--all alcohol-related.

The final report from May and Associates Rural Health System Analysis, Design, and Management recommended that the Tribes develop a Chemical Dependency Center and hire two full-time professionals to operate it. It was also recommended that the Duck Valley Health System make substance abuse a priority by focusing initiatives on both preventive and curative services.

It is difficult to determine or control the amount of drugs on the Reservation because there are no drug laws to enforce, with the exception of legislation against driving while intoxicated. As a result, police have not been able to prosecute for drugs other than alcohol found in the possession of intoxicated persons. Statistics from the Owyhee Police Department are the only indicator of the amount of drugs present.

Goals and Objectives

The goals of the Anti-Chemical Dependency Program are to alleviate the problems of substance abuse and chemical dependency, to build a strong and healthy community which promotes self respect, and to help those individuals with substance abuse problems become contributing members of the community.

Program objectives include combatting the entry of drugs into the community, increasing alcohol and drug education, making drug and alcohol-related information available to students, youth, and the entire community, and providing preventive and curative services.

An additional objective in 1993 was to provide service, through at least one individual or group guidance activity, to each of the 785 people having direct problems with alcohol or drugs on the Reservation.

Program Components

The Anti-Chemical Dependency Program was implemented with a Project Director and a Staff Assistant, hired by the Tribal Council, who were responsible for developing a Comprehensive Anti-Drug Program by coordinating all available resources. A formal structure was developed defining the process a client is required to follow when seeking assistance from an agency if alcohol or drugs are involved . Interagency agreements ensued from this joint effort.

A prevention component of the program was developed, including the Police DARE project in the schools, increasing alcohol and drug education, and making information available to students and youth. In addition, the Program Director trained the Health Programs Staff to provide alcohol and drug education and prevention services.

The therapeutic component of the Anti-Chemical Dependency Program was developed for individuals who have not received treatment and are in need of services. This aspect of the program provides individual counseling, group therapy, and other activities which help develop self esteem, clarify values, and enhance decision making in order to avoid relapse. In the Intensive Alcohol and Drug Program, a Certified Substance Abuse Counselor was hired to develop aftercare activities and to address domestic violence, parenting, co-

dependency, suicide, child abuse, and other alcohol-related problems.

Through the program, the Police Department received assistance in identifying the problem areas of the community and developed a plan to combat the entry of drugs into the community. Cooperation continued with systemwide efforts, communication, and feedback from the law enforcement authorities.

The Tribal Court began working with a new judge and probation officer. The Inter-Agency Judicial Committee was created to improve the coordination process within the agencies in the community. The outreach referral process was adopted. Funds from other possible sources are being sought in order to develop an Anti-Chemical Dependency Center.

Program personnel have developed the following activities and services: needs assessment (case work), counseling, education/guidance, re-orientation support, family involvement, court and other reports, evaluation/testing/diagnosis, placement and placement-related activities, referrals, home visits, transportation, and presentations to the community by the program staff.

Results and Impact

Performance Measures

Expected results of the program include: (1) a decrease in the number of crimes related to alcohol abuse (D.U.I.'s, reckless driving, domestic violence, spouse abuse, suicide, child abuse and neglect, etc.); (2) a decrease in alcohol consumption on the Reservation; (3) an increase in people's participation and involvement in community activities; and (4) a general improvement in health conditions on the Reservation.

There are several measures being used to assess program performance. The Department of Social Services, Indian Health Services (IHS), and the Police Department gather statistics. Monthly reports to the Tribal Administration and to the Business Council are required on all activities performed, which must address how these activities relate to the stated goals. Once a year the program is reviewed by the Tribal Council in a General Meeting, and its budget is justified. Finally, quarterly reports on the activities performed are submitted to the funding source. There are plans to conduct a formal evaluation, which will be facilitated by the new Reservation court system and the data it will provide.

Implementation Problems and Successes

There have been several problems in implementing the Anti-Chemical Dependency Program. For one, the collapse of the Tribal judicial system reduced support for the program. Another problem has been the large number of dysfunctional families--95 percent are affected by alcoholism--requiring services. Negative response from various agencies at the beginning of the program made the coordination process difficult. The nature of the American Indian Tribes, who tend to be skeptical and not open to new ideas and ways of thinking, also created difficulties.

After meeting with the agencies and establishing the procedures, the program has been effective in improving the coordination process with every agency in the community. The Indian House Service, Mental Health and Social Services, the Police Department, and schools have all been involved in the program. Awareness and acceptance of both the alcohol problem and the availability of services have been enhanced through community presentations and videos.

Successes and Accomplishments

During the first year of its existence (FY 1992), the Anti-Chemical Dependency Program provided service to 550 people in about 475 individual and/or group activities. The Program Director/Counselor earned certification as a State Certified Substance Abuse Counselor and attended about 200 hours of training sessions.

During the program's second year (FY 1993), the program impacted 1,040 people in 90 group activities (client count may be repeated). Also, 1,127 individual (one-on-one) activities were carried out for 103 single-count clients. Two additional Certified Counselors under the Program Director's supervision have helped to carry out these activities. Three additional Alcoholics Anonymous (AA) and support meetings are being held weekly, and attendance at these meetings has increased 100 percent. The number of students earning a high school diploma or G.E.D. (General Equivalency Diploma) has increased 100 percent. The training and involvement of the Health Program's staff in the development of preventive and educational activities as part of the Anti-Chemical Dependency Program has been very effective.

Prospects for Replication

The Anti-Chemical Dependency Program can be easily replicated on other Indian Reservations because it addresses the social and economic problems unique to populations living on Indian Reservations. The success of this type of program, however, depends on effective coordination and multi-agency cooperation.

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Indiana

Madison Correctional Unit Substance Abuse/Transition Program

Statement of the Problem

The Madison Correctional Unit is a minimum security level facility located on the grounds of the Madison State Hospital in Madison, Indiana. Programs offered in the unit include assessment, pre-treatment group, intensive treatment group, aftercare, and transition programs. This Department of Correction facility also provides many support services to the Mental Health Department through its offender work force.

Madison Correctional Unit first opened in January 1989. The primary purpose of the facility was to provide an intensive substance abuse treatment program for minimum security offenders. This program was created in response to recommendations from the Governor's Task Force To Reduce Drunk Driving. In Indiana's attempt to reduce the likelihood of an offender committing another alcohol-related offense, an intensive substance abuse program was established in the Department of Correction. The first group of offenders was treated in March 1989. The average length of stay for the substance abuse offenders was 12 to 18 months.

As time passed, an increasing number of offenders were identified as having been incarcerated due to drug-related offenses. The treatment program adapted to meet those needs and is now designed to treat any type of substance abuse. To meet the challenge of increasing offenders' ability to reintegrate into society and decreasing their high rate of recidivism, a continuum of care was developed. This continuum provides a range of treatment services to the substance abuse offender. After a pre-screening to determine individual needs, recommendations are developed for the parole office substance abuse counselor for follow-up care. Post-incarceration counseling is used to assist the parolee in completing a successful period of supervision, as well as to become a productive member of the community.

Goals and Objectives

The primary goals of the Madison Correctional Unit Substance Abuse Program are to provide effective treatment services that will reduce offender substance abuse, increase offender potential for successful reintegration into society, and reduce recidivism. The objectives used to achieve these goals are: (1) to identify and apply resources effectively and make appropriate types of substance abuse services available to offenders demonstrating a need for such services; (2) to provide substance abuse assessments, education, treatment, and referrals appropriate to each offender's individualized needs,

within the constraints of available resources; (3) to provide services that focus on a holistic approach to substance abuse treatment; (4) to develop and utilize standards and measures to evaluate program performance; and (5) to develop a continuum of care which includes a strong relationship with the community.

Program Components

Assessment. Shortly after arriving at Madison Correctional Unit, an offender is evaluated by the substance abuse counselor supervisor to determine if substance abuse treatment is appropriate, and if so, what type of treatment would be beneficial to the offender. If treatment is indicated, the individual is then placed on a waiting list for that program.

Pre-Treatment Group. These offenders have been identified as needing substance abuse treatment and complete this group before entering the intensive phase of treatment. This group is designed to assist the offender in beginning the process of treatment.

The pre-treatment group focuses on offender resistance to the treatment process, confronts denial, assists offenders in making the connection between substance use and its consequences, familiarizes them with the 12-Step Model of Recovery, and educates offenders on group dynamics. The pre-treatment group is a three to six-week program, but it can be longer depending on the offender's response to the group. The core components of this program are: Understanding Group Therapy, The 12 Steps, Rationals and Irrationals, (Rational Emotive Therapy, by Albert Ellis), and an introduction to self help programs.

Intensive Treatment Group. The intensive program consists of open-ended groups which meet for 9 to 12 weeks. There are no more than 10 offenders in each group. Offenders meet 16 hours per week for six hours of therapy groups, eight hours of education, and two hours of other activities.

Offenders in the intensive phase are expected to complete all methods developed in a treatment plan outside of the group setting. They are expected to be active in group sessions, listening and participating verbally. Participants in the intensive phase are required to attend two Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) meetings per week while in the program. Urine drug screening is also part of the program. Participants in the program may be discharged for continued non-compliance or continued disruptive behavior.

Aftercare. Offenders who have been identified in the intensive phase of the program as needing an aftercare program at the time of discharge from the intensive phase, and offenders who meet the admission criteria for the aftercare program at the time of assessment are admitted to this program. Groups meet one to two hours once per week for 12 to 16 weeks. Groups are closed and consist of a maximum of ten members. Offenders

in the aftercare phase are expected to attend all group sessions, complete treatment plan methods, and meet the AA/NA attendance requirement prior to being discharged from the group. Grounds for discharging the offender from the program include continued non-compliance with the program or continued behavior problems.

Transition. The transition program is presented during the last 90 days of an offender's sentence at the Department of Correction. This program is designed to assist the offender with reintegration into society. This program provides specific information relevant to a successful transition from an incarcerated setting to one in the community. The core of this 80-hour program addresses economic issues, stress, family and domestic issues, parenting skills, health care issues, leisure activities, community resources, substance abuse education, and social identity through the use of classroom-style curriculum and lesson plans. Other optional areas addressed include assistance for individual needs such as counseling, AIDS testing, developing a job resume, applying for colleges, financial assistance, or even applying for a social security card.

Parole. When an offender completes the confinement portion of his sentence, he is supervised on parole for a period of twenty-four months or until the expiration of the maximum sentence. The parole district substance abuse counselors assist the parole agents and district supervisors by conducting offender assessments, reviewing release plans prepared by transition staff and facility substance abuse treatment counselors, and coordinating the delivery of services with community-based treatment programs.

Results and Impact

Performance Measures

An annual evaluation process will review progress toward program goals. This process will include the involvement of all substance abuse counselors and their supervisors. Measurement tools include pre-treatment expectations, pre-treatment tests, post-treatment evaluations, and post-treatment tests. Also, staff performance evaluations are completed annually by supervisory staff.

Implementation Problems

Due to time factors (release, transfers, etc.), it is sometimes impossible for an offender to complete the continuum of care provided. Offenders who fail to complete the program have a lower potential for successful integration into society. Improved communication with probation/parole officers could aid in continuing recommended services in the community after the offender's release. At the present time, substance abuse counselors are unable to communicate freely with probation officers without issuance of a court order since probation officers are not employees of the Department of Correction.

The ability to provide a balance between treatment, work detail, and custody issues has

improved. Within the bounds of the correctional facility, it is difficult to provide a therapeutic environment conducive to treatment efforts. Treatment group schedules are now posted for the convenience of custody staff and the offenders. Communication is emphasized between all facility disciplines via a weekly team meeting with representation of substance abuse counselors, correctional counselors, custody staff, the superintendent, the lieutenant of the correctional staff, and the nursing staff.

Successes and Accomplishments

Since 1989, the Madison Correctional Unit Substance Abuse Program has grown from a single component program to one which is complex and multi-faceted. Expansion has enabled the program to include a program supervisor and four substance abuse counselors who provide group and individual therapy and education sessions five days per week. An orientation has been added to inform the substance abuse offender about the dynamics of group therapy and 12-step work. Aftercare follows the intensive phase of the program, providing continuity of care. Prior to release into the community, transitional education is provided. Since July 1993, 84 offenders have completed the intensive substance abuse program. Forty-two of these same offenders have gone on to complete the transition program with success. The focus of the program emphasizes a continuum of care to reduce the increasing rate of recidivism for substance-related offenses and/or for those crimes where the use of substances was a major factor in the crime being committed. Recommendations for further services are communicated to parole and probation (if court ordered) by professional staff at the correctional facility.

Prospects for Replication

To replicate this program, a suitable facility should be available with an adequate professional staff which would include to substance abuse counselors and a flexible custody staff open to therapeutic approaches to treatment. The program has strong potential for success due to the continuity of care and follow-up services provided from incarceration to re-entry into the community. Staff involved in planning and implementation of the program are willing to share written materials and experiences encountered while developing the program.

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New Hampshire

Adult Felony Diversion Program, County of Merrimack

Statement of the Problem

Merrimack County, New Hampshire has two penal facilities. The State's prison houses inmates with sentences in excess of one year and has an extensive substance abuse treatment facility for prison inmates. However, once an inmate is released on parole, there are very few programs available for continuation of the treatment provided during incarceration. The county maintains a combination holding facility for pretrial defendants and correctional facility/farm for defendants with sentences of less than one year. The House of Correction has no substance abuse programs other than Alcoholics Anonymous and Narcotics Anonymous. Most of the inmates are released to a term of probation to find few opportunities for productive interaction with responsible members of the community.

In 1992, the State had few well-developed rehabilitative programs available to criminal offenders serving sentences outside of penal institutions, such as those on probation or parole, those with suspended or deferred sentences, or those conditionally discharged. Probation supervision caseloads were as high as 100 offenders per probation officer. In addition, there was not a well-developed community service/restitution program. There was no consistent drug and alcohol dependence/abuse assessment within the justice system to identify, prior to sentencing or charging criminal defendants, which were in need of services. An offender was likely to find productive rehabilitative opportunities only if incarcerated in the State prison. First time offenders were returned to the community without any real incentive for behavioral change. Without some change in the manner in which the system dealt with first offenders, rapid growth in criminal dockets and penal populations would have continued.

Goals and Objectives

Like most rural and small city jurisdictions, the New Hampshire criminal justice system has traditionally relied upon incarceration, fines, and probationary supervision to effect the appropriate rehabilitative impact on criminal offenders. The rehabilitative potential of these methods is limited, and scarce criminal justice resources can be used more efficiently by focusing on rehabilitation at the outset of prosecution in cases where successful rehabilitation is likely. Toward this end, Merrimack County developed the Merrimack County Adult Felony Diversion Program in partnership with the New Hampshire Department of Corrections to provide an effective alternative to traditional sanctions for nonviolent first time felony offenders.

The goals of the program are to decrease court costs, increase the productive and continued employment of offenders, and decrease the incidence of recidivism. To accomplish these goals, the following objectives were established: (1) provide an alternative to prosecution at the outset of the process for a target group of offenders who demonstrate a substantial potential for rehabilitation; (2) insure the appropriate selection of offenders for the program through professional assessment of the individual offender's needs; (3) provide required substance abuse treatment and supervision for the target group of offenders in order to remove them from the underground social environment and eliminate the debilitating effects of addictive substances on their self control and personal values; (4) involve the community in the rehabilitation of the target group of offenders and the reintegration of those offenders into that community; (5) hold offenders personally accountable for their conduct and rehabilitation and ensure restitution to victims and the community; and (6) obligate offenders to correct specific deficits in educational and employment skills to enhance their potential for socially acceptable and gainful employment in the economy.

Program Components

Upon the arrest of a felon who falls within the qualifying profile, the police, prosecutor, or public defender requests that the offender be considered for diversion. Upon screening, the prosecutor determines whether the individual qualifies for diversion and negotiates the appropriate waivers to allow for a formal assessment (60 - 90 days).

The Diversion Program director, responsible for tracking the case throughout the assessment phase, forwards the appropriate information for assessment of the offender's rehabilitative potential. The three major components of the assessment are (1) educational and vocational skills and deficits, (2) restitution obligation and community service ability, and (3) substance abuse and chemical dependence.

A placement counselor assesses the needs, abilities, and disabilities of the defendant through testing and interviews. The assessment includes a proposal for remedial programs, referrals, and a plan for completion by the offender during diversion. The goal is to employ the offender productively.

A specific plan is completed for the defendant to be placed in community service. The goal is to integrate the offender into the community and provide restitution to the community and the victim for the offense committed.

The offender's needs are assessed and a program is designed to eliminate or control problems of chemical dependency and substance abuse.

Upon completion of the assessment and acceptance by the Diversion Program, a contract is offered to the offender and his/her attorney. The contract sets out the specific requirements of diversion and the period of time (up to five years) in which the offender must complete

those requirements. The State agrees to refrain from prosecution during the term of the contract, as long as the terms are fulfilled. The goal is to make the offender responsible for his/her own rehabilitation.

The Merrimack County Adult Advisory Board provides the insight and support of the Merrimack County community. The Board has two major functions: to review program policy and procedure with staff, and to review the performance of individual Diversion Contracts. When the Advisory Board is convinced that the offender has met the conditions of the contract, the members recommend the offender's release from the liability of the criminal charge and conviction. The goal is to involve the community in the rehabilitation of the offender.

At any time the offender may be removed from the diversion process for misconduct or failure to progress in good faith. Upon the recommendation of the Advisory Board, the offender is referred to the prosecutor for prosecution without credit for any time spent in diversion. If the offender successfully completes the requirements of the contract, the prosecution is dismissed.

Results and Impact

The program's success will be tracked over a period of five years, which is the contract term of the first participants. Recidivism rates and community acceptance will be assessed. Positive outcomes are expected in several areas.

It is expected that the program will produce a substantial savings in incarceration costs in both the long and short term. The program is expected to include 75 individuals annually. These individuals would have served an average of thirty days incarceration in a county facility at the rate of $50.00 per day, representing a net savings of $75,000 annually. This amount does not take into account the savings from the decreased need for construction due to overcrowded facilities. In addition, these individuals would have been under probation supervision for as long as two years.

Implementing the program will avoid trials, pretrial hearings, and post trial sentencing court time and costs. The estimates for a per defendant cost are broad and conflicting, but it is undisputed that court dockets are greatly overburdened. The jury cost alone for one panel drawn for a single trial is in excess of $2,000. The removal of 75 cases from the docket of approximately 800 felonies annually will relieve the burden on the courts dramatically.

The direct cost of law enforcement court time devoted to pretrial hearings and trials will also be reduced. According to the U.S. Department of Justice, Bureau of Justice Statistics Bulletin *Prosecutors in State Courts, 1992*, the average cost per closed case is $400 ($400 x 75 = $30,000 in savings).

The cost to society of repeated criminal conduct escalating in severity will be reduced if this target group does not re-offend. Additionally, restitution will be collected for the victim much more quickly, and community service will be provided at no cost to towns and cities. Eight hundred (800) hours per offender x $5 per hour = $4,000 x 75 offenders = $300,000 over the term of their contracts.

The loss of a potentially productive individual who chooses a life of criminal conduct is difficult to calculate, but real nonetheless. This loss can be avoided by channeling resources to those who have a potential for rehabilitation.

Implementation Problems and Successes

The initial reaction to the concept of removing criminals from the justice system and providing them with treatment was mixed. Some in the law enforcement community were skeptical of helping criminals and reducing criminal dockets. Most police administrators and line officers recognized that if a diversion program was to be successful in reducing recidivism, it had to have a sophisticated screening process and a mechanism to insure accountability. The use of contractual obligations based upon extensive professional assessments coupled with the long term nature of the obligations overcame most objections.

Civil liberties advocates and the defense bar were concerned about the subjective nature of supervision and the potential for revocation. The citizen advisory board, functioning as the review and referral mechanism in revocations, combined with specific contractual obligations agreed to by all parties, eliminated many of these concerns.

Another challenge was to establish policies and procedures which further the goals of a program funded with limited resources. The staff had to be very flexible and creative in using the resources available within the community.

The major political issue was the placement of the program within the county government structure. It was integrated into the county corrections department, which made it possible to use the diversion components, especially substance abuse assessment and treatment and community service projects, for appropriate short term incarcerated offenders.

A major adjustment will come at the end of the second year of the program when the State probation/parole department function, including the substance abuse component, will be separated from the county Diversion Program. This revision is needed to allocate resources more effectively among competing demands.

Successes and Accomplishments

Because the program has not been formally evaluated, its success is based on preliminary data and anecdotal information. Within its first eighteen months, the program reviewed over 75 offenders with more than 50 contracts in place. Screening has been successful in placing only offenders with the potential to complete the terms of the contract. The recidivism rate is under 15 percent. An evaluation for further assessment is being planned.

Substantial community service projects have been completed, and community acceptance has been universal. Law enforcement personnel who were once skeptical of the program now encourage it. This program also has helped law enforcement to develop a positive view of treatment programs. Testimony from the participants has reinforced the success of the program, many of whom feel that without the support of the program they would have relapsed and have had to spend time in jail.

Prospects for Replication

The program was designed for a county government structure and is intended to provide a model for implementation in all ten jurisdictions state-wide. The administration procedures and policies may be modified according to the size of each of the other rural counties in the State. Policy is reviewed within the Community Advisory Board, which is unique in each county.

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New York

Drug Treatment Alternative to Prison (DTAP) Program

Statement of the Problem

The surge of drug-related arrests and commitments to prison over the past decade has been well documented. In many cities and states, drug offenders now represent the largest single group of persons arrested and incarcerated. In New York, the number of drug offenders entering State prison has increased nearly six-fold since 1985. Drug offenders represent nearly one-half of recent commitments to prison, and they account for one-third of the State's current prison population. Growth in commitment levels of drug offenders has been paralleled by increases in the overall prison population and, not surprisingly, by escalating corrections budgets. New York's "predicate felony" offender law, which requires a mandatory State prison term for persons convicted of a second felony offense, has intensified these demands on the prison system and the taxpayer.

As the growth of drug problems and mandatory sentencing laws have increased pressure on public budgets, New York State has developed and expanded alternative, cost-effective criminal justice initiatives which maintain community safety while addressing the underlying causes of drug-related crime. Designed and initially implemented by the Kings County (Brooklyn) District Attorney in 1990, the Drug Treatment Alternative to Prison Program (DTAP) is one such effort. Now also operating in the New York City boroughs of Manhattan and Queens, DTAP offers repeat, non-violent defendants bound for prison the option of attending a long-term, community-based residential drug treatment program. If they complete treatment, charges against them are dismissed. Those who fail face the prospect of at least an 18 month minimum prison term — a prospect whose probability is enhanced by the special DTAP enforcement teams that apprehend and return those who abscond from the program.

Goals and Objectives

The short-term goals of the program are to lower costs by diverting prison-bound defendants to less expensive treatment beds and retaining relatively large numbers of them in treatment. In the long run, DTAP aims to reduce drug use and criminal recidivism and improve the vocational and social capabilities of program participants.

The program objectives identified to achieve these goals include the following: (1) identify at least 300 second-felony defendants who are judged eligible for admission to DTAP treatment by prosecutor and treatment program staff; (2) identify an equivalent number of residential treatment slots in privately-run therapeutic communities (TCs) that are available to DTAP participants on a priority basis; (3) develop collaborative relationships between DTAP prosecutors and treatment providers to ensure the appropriate and efficient selection

of participants and reliable reporting on their progress in treatment; (4) implement enforcement mechanisms, including special warrant squads, to ensure the rapid apprehension of program absconders; (5) maintain a program completion rate of at least 60 percent (i.e., at least 60 percent of all those admitted to DTAP complete treatment and have charges dismissed); (6) maintain a criminal recidivism rate of no more than 25 percent for those completing the program (i.e., no more than 25 percent of those completing DTAP are re-arrested within one year of completing the program); and (7) evaluate the impact of the program in light of these goals and objectives.

Program Components

Noting the promising early results of the Brooklyn Prosecutor's program, New York State began, in the spring of 1992, to support the expansion of DTAP to other boroughs in New York City. That summer, Edward Byrne Memorial formula grant funds were allocated to the Brooklyn program as well as to the development and implementation of DTAP programs by the District Attorneys of New York (Manhattan) and Queens County, as well as to the City's Special Narcotics Prosecutor. Technical assistance was also provided to these programs from two State executive agencies, the State Division of Criminal Justice Services (DCJS) and the Office of Alcoholism and Substance Abuse Services (OASAS). A private agency, the Legal Action Center, was enlisted to provide assistance on confidentiality and contractual issues, and the Vera Institute was contracted to help develop and implement an evaluation of the program.

Most of the core elements of the Kings County model were adopted by the three new sites. All DTAP participants are defendants charged with felonies who, if convicted on the charge, would be mandated to prison terms as second felony offenders. All participants are assessed to be in need of drug treatment and have demonstrated motivation to participate in treatment. All agree to attend, in lieu of prison, a residential drug treatment program that lasts 14 to 24 months. All programs serving DTAP are run by private, community-based agencies employing the therapeutic community treatment model.

If participants complete the treatment program, charges against them are dismissed. An early departure from treatment is met with a prison sentence that is at least as lengthy as that which the defendant would have served in the absence of DTAP.

Each program employs a specialized enforcement team of investigators whose responsibility it is to verify participants' community contacts prior to treatment and to search for and return persons absconding from the program.

The programs differ in some important respects. To identify DTAP candidates, the Brooklyn District Attorney reviews all cases appearing in the borough's drug courts, soliciting program applications from defendants with prior non-violent felonies charged with B felony narcotics sales in a strong "buy and bust" case. The other three programs have adopted a more conventional approach, informing the defense bar about the program and its admission criteria and taking applications initiated by the defense in Criminal Court.

On occasion, judges in the Supreme Court may refer cases to the program.

The legal mechanism underlying the Manhattan, Queens, and Special Narcotics programs is deferred sentencing. All DTAP defendants in these programs must plead to C felony charges before entering the program. In contrast, Brooklyn defers prosecution on the DTAP defendant's case. Individuals who abscond from these programs face minimum prison terms ranging from 18 months to three and a half years. Persons who drop out or otherwise fail in treatment, but who "turn themselves in" to the prosecutor, face less lengthy terms — typically the same sentence they would have been given in the absence of the offer to attend DTAP. As noted above, in all four programs charges are dismissed and pleas are withdrawn for those completing treatment.

One other difference among the programs concerns flexibility in the enforcement of the plea policy. In the new programs, DTAP staff review the circumstances of each treatment failure and, on occasion, may choose to refer the participant to a second treatment program. The programs of the City's Special Narcotics Prosecutor, and to a lesser extent Queens, show the most flexibility. Second referrals are not made in the Brooklyn program, whose administrators believe that "second chances" reduce the sense of legal pressure or coercion that keeps participants in treatment. Queens' DTAP is also distinctive in its use of the local TASC program, which serves as their liaison with treatment programs and conducts case screening, referrals, and monitoring.

Results and Impact

Performance Measures

The DTAP programs at each prosecutor site collect data on program performance, which are then compiled and aggregated by the State. For each District Attorney site, these include: the number of defendants screened for admission, accepted in the program, and placed in treatment; the number who abscond, are discharged, or otherwise leave treatment early; and of those leaving treatment, the number remaining at large. At any given time, each program must also be able to report the number of DTAP participants currently occupying beds at each private treatment provider used by the program. Data on program completions will be compiled once participants begin graduating from treatment. Additionally, the State's substance abuse office (OASAS), together with the DA sites, maintain a count of the number of treatment slots designated for each DTAP, their location (i.e., the provider agency), and the number currently available.

Separate from these efforts, the Vera Institute is conducting State-supported research on the three newer programs, and the Brooklyn DTAP performs additional monitoring of its own participants and their outcomes. In addition to compiling program data similar to those described above, Vera conducts interviews with all participants of the Manhattan, Queens, and SNP programs and monitors program retention and the outcomes of persons leaving treatment. Vera's focus, apart from gathering extensive descriptive data on DTAP participants, is on DTAP retention and the role of legal pressure and other factors in retention performance. Vera and the State's interest in this issue derives from the widely-

accepted notion that retention in treatment is the best predictor of program success.

Implementation Problems

The State's DTAP effort has yielded a number of promising early results. However, some difficulties have surfaced during the course of the programs' implementation. Most notable is the limited access to long-term residential treatment slots. Without funds to pay for *new* bed capacity for DTAP, treatment providers make DTAP-designated beds available on a priority basis, meaning that they are not set aside, but become available to DTAP if and when they are vacated. Thus, each DTAP site typically has a waiting list of up to 20 or more participants who are accepted in the program but are awaiting an opening. Finding available treatment slots for persons with special needs — those who are pregnant, speak only Spanish, are mentally ill chemical abusers, or are in advanced stages of AIDS or have other severe or chronic medical problems — has been especially difficult.

Other problems identified during the first year and a half of implementation include: (1) unexpectedly long (and expensive) stays in detention for candidates being screened for the program due to delays in getting medical history data to treatment providers; (2) concerns raised by treatment providers that DTAP makes inordinate demands on their staff for screening, transferring, and reporting on DTAP clients; (3) concerns raised by some providers that DTAP participants are especially difficult because they enter treatment with more problems (suffer more from physical and mental ailments, are less connected to jobs and families, are more criminally-involved) than most clients; and (4) the apparent lack of cooperation by Legal Aid lawyers at one DA site.

Successes and Accomplishments

Brooklyn DTAP, which began in October 1990, has been admitting participants under State/Federal sponsorship since November 1992. The Special Narcotics Prosecutor's program began admitting participants in November 1992, the Queens DTAP admitted its first defendants in January 1993, and the Manhattan DTAP began in March of last year.

During the first year of the expansion, arrangements were made with fifteen private, community-based treatment agencies to provide 300 DTAP-designated beds for participants. The Brooklyn DTAP has been allocated 107 of these beds and has had access to additional beds through arrangements made prior to the State's involvement, Special Narcotics has been allocated 62 beds, Queens has 72, and Manhattan has 59.

Since November 1992, over 1,000 defendants have been screened for DTAP participation under the State's initiative. By mid-March 1994, close to 400 individuals were admitted to the program, and 370 had been placed in treatment beds. Just over two-thirds of all DTAP admissions have remained in treatment — a retention rate which compares favorably to the 20-30 percent rates usually cited in the literature for therapeutic community treatment modalities.[1] Of those leaving treatment, less than one in four remain at large, the rest being returned to custody.

[1]This retention figure (250 of 370, or 68 percent) applies to an average "at risk" period of about eight months post-admission. De Leon (1992) presents retention curves plotted from days after admission for several hundred clients in several TC programs showing, for example, that 60-70 percent of program admissions remain in these programs one month after entry, while 30-40 percent remain after four months and 20-30 percent remain at eight months.

The most frequently used DTAP treatment providers have been Daytop Village and Veritas, which have each admitted more than 70 participants from one or more of the four DA sites. Odyssey House has also admitted a relatively large number of DTAP clients (about 40). Other therapeutic communities admitting more than ten DTAP participants include Samaritan Village, Damon House, Phoenix House, Promesa House, and Inward House. Other treatment sites include HELP-Project Samaritan, Project Return, Resurrection, Educational Alliance, Queens Adult Drug Rehabilitation, and River Edge. Of those TCs admitting ten or more DTAP clients, retention rates ranged from 86 percent to 50 percent. Most treatment programs posted a retention rate of about 70 percent for DTAP clients over the period of time reflected in these data.

Vera Institute researchers have examined DTAP retention results in greater detail, assessing the relationship between participant characteristics (demographics, vocational history, etc.), motivational measures, and program attrition. *Tentative* results from early data assessing attrition of DTAP participants at 45 days after admission have shown higher attrition to be found among men, Hispanics, persons over 35 and those under 25 years of age, persons without a G.E.D. or diploma, persons who did *not* report substance abuse problems among other family members, and persons reporting chronic medical illnesses or current psychological problems. In addition, Vera's analyses of an experimental perception of legal pressure scale suggested that attrition at 45 days was associated with the participant's lower level of information and knowledge about the rules of participation in DTAP and about the consequences of treatment failure; the belief that it would take some time before DTAP would learn if they left the program; and the view that prison is not extremely aversive or undesirable.

Prospects for Replication

New York is committed to expanding DTAP to other jurisdictions around the State, and the program has drawn attention in Washington and elsewhere as a model for replication nationally.

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Ohio

Early Dropout & Violence Prevention Program

Statement of the Problem

This program targets African-American males who demonstrate high-risk behavior in target elementary schools in Cuyahoga County. The Cleveland Public School District and several surrounding suburban school districts report dropout rates for African-American males to be between 25 and 50 percent. This is not only an educational concern; school failure in turn augments the rate of crime and violence committed by juvenile offenders.

According to the Department of Rehabilitation and Corrections, approximately 70 percent of their current inmates are high school dropouts. Since 1986, Cuyahoga county Juvenile Court recorded 126 drug cases involving juveniles; in 1991 there were 1,108 drug cases. During this same time period, the number of juveniles charged for assaults increased by 38 percent.

The problem of youth violence and school failure is not confined to Cleveland or Cuyahoga Counties. Ohio ranks eighth among the 50 states in violent death rates for ages 15 to 19. Twenty-eight black males were homicide victims in 1992 in the 0 - 20 age group. African-American males accounted for 70 percent of the County's homicides in this age group. The prevention of school failure is a vital and cost-effective strategy for the reduction of crime and violence.

Under optimum circumstances, educational achievement provides a solid basis for the attainment of economic stability, which fosters healthy home and community environments. These environments in turn provide role models, motivation, and rewards for appropriate behavior and for success in formal and informal learning processes.

Conversely, problematic home and community environments provide no role models, motivation, or rewards for educational achievement. They create consistent difficulties in the formal learning process, hinder progress in appropriate behavioral and informal learning, and preclude support systems that nurture students' receptivity to learning.

In this scenario, consequent feelings of low self-esteem are soon manifested in the classroom in frequent truancy, poor academic performance, inappropriate behavior, inability to resolve conflict peacefully, early gang affiliation, drug use, and "voluntary early departure" from high school. The cycle of achievement is replaced by a cycle of poverty and disillusionment, with student drop-outs confronting unemployment, resorting to criminal behavior to survive economically and to support drug use, or searching for a sense of belonging, even if to a marginal group in society.

The Cleveland Public Schools' high school drop-out rate approaches 50 percent, confirming the existence of a complex and urgent situation in the city, particularly among African-American males. The problem is no less serious at the elementary level; the number of students having to repeat one or more grades is a serious cause for concern.

Goals and Objectives

The Early Dropout & Violence Prevention Project (EDVP), a small-scale pilot project now in its fifth successful year, addresses these issues. Its mission is to provide students and their families with the qualitative and practical support needed to enable students to learn, encourage them to stay in school, and reduce their aggressive and delinquent behavior in order to restore the cycle of educational achievement.

The following objectives further the Project's mission:

- Schools identify high risk students, address the development of pre-dropout behavior, address behavioral problems, and improve the classroom learning environment.
- Families work to improve the parent/child relationship, the parent/teacher relationship, and parent involvement in the educational process.
- Students work to improve attendance, academic performance, behavior, self esteem, and skills in resisting peer pressure.

Program Components

The first program activity is identification. Research conducted by the Universities of Kentucky and Wisconsin indicates that pre-dropout behavior begins as early as the fourth grade. For this reason, the EDVP addresses behavioral problems at the elementary school level. Through coordination with teachers, administrators, attendance officers, and parents, highest-risk students--those demonstrating truancy, poor academic performance, behavioral problems, or lack of parental support or control--are identified. The program uncovers weaknesses or failures in home environments that stunt students' receptivity to learning.

Participants in the program receive trophies and certificates to recognize their achievements. These educational incentives provide positive reinforcement to at-risk students who do not usually receive praise.

Many EDVP participants are in need of extra tutorial assistance. Additional personnel who provide tutoring enable students to receive this help.

Home visits, school conferences, and telephone follow-ups are conducted by the Project Coordinator to assess periodically each EDVP student's home environment, act as a liaison between home and school, and encourage parental involvement. Visits sometimes are made in conjunction with attendance officers. Home visits are a critical component of the program because evaluation of the home situation frequently explains the origin of students' problems.

The Project Coordinator initiates individual counseling and intervention with children in situations that require close monitoring for specific and acute problems and possible referral to a community service agency.

In peer support groups led by the Project Coordinator, students are encouraged to disclose problems and rely upon positive adult counseling and peer support to improve attendance, behavior, and academic performance. Students review issues such as proper study habits, appropriate dress for school, courtesy and respect, interpersonal relationships, problem solving, and conflict resolution. By providing structure and an alternative sense of belonging, these groups deter gang association and drug use. The Project Coordinator has noted that non-member students battle for admission, which is limited in order to maximize the program's effectiveness.

Guest speakers of various educational and career backgrounds speak monthly to peer support groups. Students are given the opportunity to gain information and interact with positive role models, which are lacking in the inner-city.

Field trips provide opportunities to increase students' motivation to pursue future goals and careers by exposing them to a variety of positive environments and lifestyles, including parks, museums, and sports activities.

The EDVP Project sponsors Community Awareness Parenting Services (CAPS) workshops for parent training. Emphasis is placed on the importance of responsibility and mutual respect in the parent-child relationship, involvement in the child's education, and the search for assistance when necessary. Information is offered on community service agencies that provide assistance with tutoring and other educational needs, basic needs, family violence, recreation, substance abuse, community problems and teenage pregnancy--all of which ultimately influence the outcome of the formal educational process. The Project Coordinator also collaborates with the Parent-Teacher Associations (PTAs) and School-Community Councils (SCCs).

Results and Impact

Implementation Problems and Successes

To date the project has been successful in achieving its goals. Other schools within the Cleveland School District seek integration of the program into their schools, and outside

districts view the EDVP as a model for establishing their own programs. The program has been well received by parents and teachers who praise it for preparing students to learn and improving classroom behavior. Another indicator of the program's success is that students frequently request to participate in the program. Student demand for services offered by the program is such that the program has not been able to accommodate all students' needs. Early assessment of the initial EDVP quickly determined that the program size would have to be reduced because student needs were greater than anticipated.

Another implementation success has been the maintenance of computerized data for each participant's grade point average, attendance, and tardiness, facilitating tracking of year-to-year progress.

Successes and Accomplishments

During the 1992-1993 school year there were 74 students served. Eighty-five certificates, four plaques, and 22 trophies were presented this school year.

Prospects for Replication

Two distinct strategies are under consideration to determine which will better serve the program's objective of broader quality implementation. The difficulty lies in maintaining current levels of success with increased numbers of students. Program quality rather than speed of implementation is a primary concern of the committee formed to study the issue.

The first possibility is to institutionalize the process by replicating the model throughout the Cleveland School District. A task force would oversee development of a plan, ensure its adoption by the Cleveland School District, and implement replica programs system-wide. Program ownership would shift to the District. A program bureaucracy would be responsible for funding, staffing, planning, and programming.

An Executive Committee was formed to serve as an advisory board to help insure the continuation of the project through fund raising, monthly meetings, and the institutionalization of the Early Dropout Prevention Program. Plans are underway to arrange a meeting between committee members and the new Superintendent of the Cleveland Public Schools system, a first step toward the infusion of the Early Dropout Prevention Program into the schools' curriculum.

In the second case, the task force would not serve as a catalyst but instead would provide technical assistance to "entrepreneur schools" wishing to adopt and administer the program in response to their specific needs. The EDVP Project Coordinator would function as a trainer for others.

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Oklahoma

Systems Approach to Treatment Through Moral Reconation Therapy

Statement of the Problem

The Oklahoma Department of Corrections has the responsibility of managing 13,053 incarcerated offenders as well as 32,632 offenders who are under community supervision. Approximately 80 percent of these offenders have a history of substance abuse. Prior to September 1993, the Department of Corrections (DOC) supported various treatment programs in correctional facilities that operated independently of each other. Treatment programs were not systematically available at all levels of security or linked to the community to form a systematic approach to treatment.

In September 1993, the Oklahoma Department of Corrections, through a professional services contract, implemented a systematic approach for treating offenders with histories of substance abuse called Moral Reconation Therapy (MRT). MRT is a systematic cognitive-behavioral approach for delivering substance abuse treatment.

Goals and Objectives

The goal of the DOC is to implement a cognitive behavior treatment strategy in correctional centers, work centers, probation agencies, and parole agencies. The target population are offenders with documented histories of substance abuse. Information regarding substance abuse history is obtained through self-reports, District Attorney narratives, pre-sentence reports, and any other documented offender information.

The objectives of this project are to: (1) research current cognitive programs operating in correctional environments; (2) develop a strategy for a marketing campaign for systematic implementation; (3) select the program most likely to "fit" into the DOC's system and arrange training dates for staff and volunteers; and (4) implement a quality assurance plan. It was determined that the program most likely to respond to the DOC's need for a cognitive-based treatment modality was MRT.

Program Components

The program components of MRT in the DOC consist of five major activities:

Staff Training. The Department of Corrections is divided into four operational regions.

Within each region there are correctional facilities, work centers, and probation and parole districts. Staff from each area are brought together for training to implement the "systems" approach to treatment. Each region is trained as a unit so that the staff within the regions can develop a treatment network.

Implementation. Once the staff in each region are trained, they return to their workplaces and establish an offender group within thirty days of their training graduation date. An operational handbook is given to the graduates to assist them in implementing MRT.

Data Collecting. Upon receiving the training, each staff member is briefed on the importance of reporting the requested data. Data elements include the number of offenders completing each step of the program and the number of MRT clients. Each counselor is responsible for sending information on his or her group participants to the Research and Evaluation Unit of the DOC on a monthly basis.

Quality Assurance. One of the most important components of implementing the MRT program is conducting quality assurance visits to the program sites. The visits are conducted by MRT program experts and help to assess the commitment of staff to MRT techniques. The visits also assist the counselors in delivering a "pure version" of the MRT treatment philosophy. These visits, conducted by MRT program experts, validate the importance of the program.

Information Reporting. Subsequent to each quality assurance visit, a written report is generated by the experts who conducted the visit. This information is shared with each Regional Director and upper level management staff to inform them about the current status and commitment to the project. A final evaluation report will be generated at the conclusion of the project in June 1994.

Results and Impact

Implementation Problems and Successes

One problem encountered in implementing MRT is that some staff have been reluctant to believe in the effectiveness of MRT techniques, resulting in a lack of enthusiasm among the staff for MRT. This lack of enthusiasm makes it difficult to determine whether the program has been effectively implemented.

Successes and Accomplishments

Over 250 staff have been trained in MRT. Forty percent of those trained have implemented MRT with another 15 percent to 25 percent expected to do so. Offenders are using the services of the program. Six-hundred offenders are currently participating in 90 groups held at all levels of security and in the community.

Never before has the same treatment modality been available at all levels of security and in the community. Even though the quality assurance visits have indicated that probation and parole staff have been reluctant to initiate the treatment program, through encouragement, approximately 50 percent of those who have received the training are now leading MRT groups. Due to the popularity of the program, waiting lists have been established at the correctional facilities. The paroling authority and the Pardon and Parole Board have officially sanctioned MRT as the program that fulfills the parole stipulation for substance abuse treatment.

The Oklahoma DOC is encouraged by the reception of MRT techniques. The systematic approach of this treatment modality places responsibility and accountability on the offender. It also provides staff the opportunity to confront and assist in changing criminal and substance abusing behaviors.

Prospects for Replication

Several states have inquired about the use of MRT in correctional settings. Washington has implemented a similar program that ties community corrections to the community when offenders are released. MRT can be replicated easily in State correctional and community-based treatment modalities.

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Utah

Juvenile Intensive Supervision Program

Statement of the Problem

The State of Utah has experienced a significant increase in juvenile crime over the past decade. Criminal referrals to the Juvenile Court have increased 126 percent since 1982. In the past five years juvenile violent crime has increased 86 percent. This increase has accompanied a tremendous proliferation of gangs in Utah during the past five years. Traditionally, Salt Lake City has been the location for the main concentration of gangs. While this continues to be the case, gangs are now moving into smaller cities and towns and even into the rural parts of the State.

The number of youth referred to the Juvenile Court has increased significantly over the ten year period, but the number of staff to work with these youth has not kept the same pace. During the same period, the workload increased 126 percent while the number of new workers increased only 26 percent. The Third District Juvenile Court Probation Department made two changes to deal with this disparity: it increased the number of youth placed on probation, from 300 to nearly 600 annually, and it put more serious offenders on probation. Eight years ago the average youth placed on probation had a prior record of 6.5 offenses. During the past three years, the average youth has had a prior record of 10.5 offenses.

To meet the demand of the work load and the increasing problems of managing the serious delinquent offender, the Second and Third Juvenile Court Districts jointly developed an Intensive Supervision Probation (ISP) program. It has been financed with matching funds from the Utah State Courts and the Bureau of Justice Assistance, through the Utah State Commission on Criminal and Juvenile Justice.

Goals and Objectives

The goals of the juvenile ISP program are to: (1) enhance social control and increase public safety; (2) increase probationer accountability; (3) promote treatment services as determined by individual assessments; and (4) reduce the length of juvenile court supervision.

Program Components

Research has indicated that 75 percent of probation recidivists are referred back to the court within the first 90 days of being placed on probation. For this reason, the ISP program focuses on this critical time period.

The key elements of ISP are as follows:

Restrictions. Each youth is placed under house arrest by court order. This house arrest lasts a minimum of two weeks. With compliance to house arrest, the youth can move to a 5:00 p.m. curfew. Compliance for another two weeks can earn a 6:00 p.m. curfew and so on until a 10:00 pm curfew is achieved. This is the latest curfew allowed during the first 90 days.

Contacts. During the first 30 days of probation, each youth is seen daily by a Probation Officer or a Deputy Probation Officer. These contacts are made at the youth's home or school, or at the probation office. Contacts are made seven days a week and at various times of the day and night. If there is satisfactory compliance with the restrictions and no criminal referrals during the second 30 days, the contacts are dropped to four contacts per week. In the third 30 days, the contacts can be reduced to two contacts per week.

Deputy Probation Officers (DPO). Deputy Probation Officers (DPO) were hired to work part time (20 hours per week) in the evenings and on weekends. The initial focus was to hire students and give them work experience before they graduated. The DPOs make the majority of the contacts with the probationers at their homes to make certain curfews are being observed. It is important that they vary the times they check on the youth.

Services. The probation officer working with each youth provides an assessment of the probationer's needs and makes referrals to appropriate agencies.

Length of Probation. Previous to the implementation of the ISP project, offenders were kept on probation an average of 18 months. The expectation was that the youth would be referral-free and doing well in all areas of life. However, it was determined that it was not realistic to "cure" these youth. In this project the focus is primarily on compliance with the restrictions and remaining referral-free. If these two areas are satisfactory, a youth can be recommended for termination from probation after 90 days. Offenders placed on probation for a felony against a person are excluded from the early termination group.

Drug and Alcohol Testing. All youth are tested for drug and alcohol use through urine analysis.

Electronic Monitoring. There are five electronic monitoring anklets used as an alternative to secure detention for probationers.

Results and Impact

Implementation problems

One initial problem was the reluctance of staff to change the delivery of probation services. It was necessary to start with staff who accepted and were excited about the changes. The biggest problem was the ability to maintain caseloads small enough so that contact expectations could be met. When caseloads exceeded 20, staff were unable to maintain the contact expectations. There was some initial resistance on the part of both staff and judges to move for 90-day terminations. However, this limitation was necessary to prevent an increase in caseloads.

Successes and Accomplishments

This project was met with overwhelming support by law enforcement and the community. All felt that the court was doing something positive to address the growing problems of crime and gangs.

Preliminary results for the first few years of ISP were drawn from two groups: an experimental group and a control group. The youths in the ISP were the experimental group. The control group consisted of youths who did not receive the intensive service because they were put on probation five months prior to the upstart of ISP.

In general, the ISP group showed a modest reduction in recidivism, from 85 percent to 75 percent. The biggest change in recidivism is that the ISP participants did not relapse as quickly as the control group. In the control group 65 percent were referred back to the court in the first 90 days. In the ISP group, only 46 percent were referred back in the first 90 days. A major accomplishment of this project has been to reduce the average length of time a youth is on probation. This accomplishment allows more offenders to be placed on probation. In comparison, the control group's average length of probation was almost 18 months (532 days). The ISP group averaged nine and a half months (287 days).

Prospects for Replication

There are four important components needed for the replication of the ISP program. There must be a commitment from the entire organization to do things differently. Commitment is necessary from line staff to judges. There must be funds to hire Deputy Probation Officers or "trackers" to work evening and weekend shifts. Focusing on services to the probationers must be equally as important as making the contacts and enforcing restrictions. Finally, involving the parents is critical to improving the success of the program.

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Virginia

Intensive Supervision Program

Statement of the Problem

There is growing concern in Virginia about prison crowding and the increasing costs of prison construction. The dilemma is that some methods for decreasing the prison population are also costly or place public safety at risk. In response to these concerns, Virginia has developed a variety of alternative sanctions to divert offenders from jail or prison, including the Intensive Supervision Program (ISP).

Goals and Objectives

The primary goal of Virginia's ISP, as outlined in the *1993 DOC Intensive Supervision Program Guide*, is "to offer an alternative to incarceration which provides public safety and addresses offender needs in a cost-effective and less restrictive manner [than prison]." The ISP should provide a high level of surveillance and treatment services to selected high risk and/or high need offenders who would otherwise be incarcerated. The purpose of the ISP is to reduce incarcerated populations and improve services by functioning as an alternative to incarceration for probationers and as a mechanism for early release for parolees. In addition, the ISP should reduce levels of offender recidivism and correctional costs.

Program Components

Virginia's ISP was established in 1985 with three pilot sites. In 1987, the program was expanded to include a total of 17 districts. Further expansion occurred in 1988 when two additional districts received separate federal grants to establish ISP programs for drug offenders. In July 1990, the Virginia Department of Criminal Justice Services (DCJS) began funding ISP using federal Anti-Drug Abuse Act (ADAA) monies. At that point, the focus of ISP in the districts receiving ADAA funds shifted to drug-involved offenders. The budget for Fiscal Year 1994 includes provisions for further expansion of ISP.

A Special Programs Manager and a Treatment Services Manager, located in the central office of DOC, oversee statewide ISP activities. The Special Programs Manager is responsible for making all financial decisions regarding the allocation of resources and personnel to the local districts. The Treatment Services Manager oversees activities related to drug testing and substance abuse treatment issues associated with ISP and regular supervision. This individual is also responsible for developing, enhancing, and monitoring activities associated

with mental health, sex offender, and other special needs programs.

Regional administrators maintain contact with the ISP program through District Chiefs and regional ISP meetings. On the district level, Chiefs of Probation and Parole are responsible for the operation of ISP. The Chief, or a designated Deputy Chief, is involved in hiring ISP officers, determining how ISP will operate within the district, monitoring the compliance of ISP with departmental standards, and establishing contracts with local treatment agencies for services provided to ISP offenders.

Intensive Supervision Programs operate within existing district Probation and Parole (P&P) offices. The number of ISP officers assigned varies across districts, depending on their size and resources. Once ISP officers are assigned to a district, the Chief is responsible for designing and implementing a program that fits the district's resources and needs and operates under the standards of the ISP Program Guide.

Each ISP program is staffed with one or more of the following types of Probation and Parole Officers: Senior Intensive Supervision Officer (SrISPO), Intensive Supervision Officer (ISPO), and/or Surveillance Officer (SO).

ISP officers supervise offenders much like regular P&P officers, but they supervise a smaller caseload of more difficult offenders and provide more intensive services than would a regular supervision officer. The SrISPO is the leader of the ISP team and handles administrative tasks such as the assignment, review, and supervision of cases. The function of the SO is to assist the ISP officers with field contacts, thus allowing the ISP officers to concentrate on casework. The maximum caseload for a single ISPO is 24 active cases. In team supervision settings, the maximum for a SrISPO is 20 active cases. The total caseload for the program may be increased by eight cases for each SO added. In comparison, the average caseload per regular P&P officer as of 1992 was 68.

Virginia operates three distinct types of ISP programs including ISP Teams, Single ISPOs, and Single SOs. An ISP team consists of two or more ISP officers working together to provide ISP services. In 1993, 13 districts were operating ISP teams across the state. A team can include a variety of staff combinations ranging from a small team of two in Winchester (one ISPO, one SO) to a large team of six in Richmond (one SrISPO, four ISPOs, one SO). Additionally, 19 districts operated with a single ISPO, who was responsible for the district's entire ISP caseload. Single SO programs, which were operating in only four of the state's P&P districts, include one SO charged with assisting regular P&P officers in the surveillance of ISP offenders.

The Intensive Supervision Program provides for offender assignment from the Circuit Court, Parole Board, or DOC's Probation and Parole Districts. Parole Hearing Examiners or Hearing Officers may refer technical violators to ISP as well. Additionally, boot camp graduates are referred to ISP along with offenders assigned directly to Home Electronic Monitoring (HEM).

Once an offender is referred to ISP, the case must be assessed by the district's screening committee to determine if ISP is an appropriate placement. The screening committee includes the Chief P&P Officer and/or Deputy Chief P&P Officer and representatives of the ISP program. The committee is responsible for determining ISP client acceptability, continuance, and release. The committee considers the offender's risk/needs score, relevant background information, motivation for and receptivity to the program, and potential to benefit from the services offered.

Upon successful completion of the ISP program, offenders are either released from supervision or maintained on regular supervision. Offenders who are unsuccessful in the ISP program are subject to revocation proceedings and possible incarceration.

Virginia's ISP includes two phases of supervision. Each phase lasts a minimum of three months but may be extended. Phases are defined in terms of the number and types of contacts with the offender that are required. ISP provides a higher frequency of face-to-face contacts than regular supervision, the use of curfews, weekly record checks, and required participation in employment, vocational training, or educational classes. These characteristics increase public safety and reduce the likelihood of offender recidivism.

Results and Impact

Performance Measures

The ISP program, as implemented, included very few performance measures. For purposes of program evaluation, both quantitative and qualitative information was gathered from offender treatment files, existing databases and interviews with individuals involved in the program. Specific data items collected include: offender's prior criminal history, offense of conviction, rate of re-arrest, etc. This information, along with that of a matched comparison group of non-ISP offenders, was used in completing recidivism, diversion, implementation, and cost analyses.

Implementation Problems and Successes

Issues left unaddressed during the early stages of program development have hampered ISP effectiveness. Inadequate training in various areas is one problem. Another is that access to providers has not been sufficiently improved. Procedures for assessing, selecting, and referring clients are inadequate. Follow-up and documentation of the program are also in need of attention. Despite implementation difficulties, Virginia's ISP was able to achieve several successes:

- Offenders in the ISP study group receive higher levels of substance abuse treatment than do offenders in the non-ISP study group.

- Nearly 71 percent of all ISP probationers are true diversions from either jail or prison, and thus represent both cost and bed-space savings to the criminal justice system.

- As presently operated, ISP supervision is only slightly more expensive than regular offender supervision.

Prospects for Replication

Prospects for replicating Virginia's ISP at this time are poor. District personnel received minimal guidance towards appropriate operationalization of ISP goals, management of caseloads, and development of client service networks. Consequently, programs exhibit wide variation in philosophy, procedure, and effectiveness across the state. In districts where ISP has been successful, is due to the result of effective leadership and management at the local level rather than of a statewide policy guiding program development, implementation, or operation. However, the Department of Corrections is currently working towards standardization of programming and training.

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About the State Reporting and Evaluation Program

The Bureau of Justice Assistance (BJA) established the State Reporting and Evaluation Program (SREP), a State-based program with an orientation toward establishing Federal, State and Local partnerships, to assist in implementing the reporting and evaluation requirements of the Anti-Drug Abuse Act of 1988. Through SREP, BJA provides technical assistance and training to the State and local offices and agencies responsible for implementing, monitoring, and evaluating violent crime and drug control programs funded under the Drug Control and System Improvement Formula Grant Program. SREP is coordinated for BJA by the Justice Research and Statistics Association (JRSA).

The SREP project is designed to:

- meet States' needs for technical assistance for the development of drug control strategies and the development of State monitoring plans;
- provide technical assistance and training on drug control project performance monitoring and evaluation;
- publish reports for State and local audiences on special topic areas related to drug control program performance monitoring and results of evaluations; and
- disseminate reports and information to the States and territories as a result of BJA and SREP activities.

A National Planning Group, comprised of State and local representatives from the criminal justice community provides input to the project. The National Planning Group plays a critical role in the development and implementation of the SREP projects, and also plays an integral role in the development of national indicators for performance monitoring. Since 1987, JRSA has worked with BJA and the States to establish data collection and analysis projects. JRSA and the States have produced numerous reports and technical assistance products covering many criminal justice programs and themes, including: multijurisdictional law enforcement task forces, innovative rural programs; crime laboratory enhancement programs; county-level trends in drug arrests, convictions, and sentencing; State citizen surveys on drug use and control; drug offender processing; and forecasting for criminal justice policy analysis.

The State Reporting and Evaluation Program is a unique program that focuses primarily on enhancing States' monitoring, reporting, and evaluation capacities. States participate in all aspects of the SREP project from planning and development to the implementation and delivery of technical assistance and training services. The project is designed to provide a forum for States to share information and to receive the assistance they need to develop and implement effective monitoring, reporting, and evaluation systems.

For more information about the
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